Dealing with the Psychiatric Patient

A "psych emergency" call comes in for a patient who is talking to himself on a main street in town. You respond cautiously, and, although the police are on the scene, you scan it carefully for hazards. The patient is sitting on the steps of a family grocery talking with the police. The police officer sees you coming and smiles. He turns to you and says, "I'd like you to meet Jesus."

Before you can even formulate a response, the patient tells you, "It's OK. He doesn't believe me. But quite frankly, I have been taking persecution for years, and it continues to this very day."

Anyone who has been in EMS for any amount of time has seen patients with delusional thoughts. Psychiatric emergencies are common calls for EMS providers. Some estimate that more than 20 million people in the United States are being treated for depression. To put this in perspective, a similar number of people experience asthma. Zoloft and Lexapro (antidepressants) and alprazolam (Xanax, for anxiety) were included in the top 20 most prescribed medications in recent years.

Altered Mental Status

EMS providers should consider all behavioral emergencies as altered mental status until proven otherwise. The stories of diabetic patients acting like they're drunk or experiencing behavioral emergencies are many-and costly, if this basic concept is overlooked.

Even patients who have a history of psychiatric conditions can experience medical problems like diabetes. Medications taken for psychiatric conditions are powerful. Misuse, either intentional or accidental-can cause alterations in the patient’s mental status and serious acute medical conditions. The mnemonic AEIOU-TIPS is commonly used to identify conditions in the differential diagnosis for altered mental status (See Table 1). Note that there are many versions of this mnemonic. All of these diseases/conditions need to be considered when dealing with a patient with an altered mental status.
Pathophysiology of Psychiatric Disorders

While brain chemistry is the focus of pharmacologic treatment, some of the causes of psychiatric conditions remain less than clear.

It is widely held that changes in levels of neurotransmitters in the central nervous system are responsible for conditions like depression. What makes listing an exact pathophysiology challenging is the fact that many people are not clinically depressed until a particular event or series of events occur in their life. This means that their neurotransmitters were either in a normal or subclinical range until some sort of emotional trauma caused changes in these important substances. Furthermore, in some cases, patients may be successfully treated without medications (behavioral and cognitive therapies) to improve conditions such as depression, anxiety and obsessive-compulsive disorders without altering neurotransmitter levels pharmacologically.

Neurotransmitters send impulses through the synaptic cleft, commonly called synapse, or space, between two nerve cells. The neurotransmitter is released from the presynaptic neuron and crosses the synaptic cleft to the postsynaptic neuron. When the neurotransmitter binds to the receptor on the postsynaptic neuron, the cell depolarizes and propagates the impulse through the nervous system.

The neurotransmitter is then broken down by an enzyme and undergoes a process of reabsorption or reuptake. This process occurs in milliseconds and is repeated continuously in the central nervous system. As mentioned previously, it is believed that a reduced level of neurotransmitters is responsible for conditions like depression.

Medications

While medications are commonly discussed in the treatment category, in fact, there are few field medications for the patient with a behavioral emergency. Since many medications are designed to alter the level of neurotransmitters in the brain, this section
logically follows here. Antidepressants will be used as an example, due to their prevalence in relation to other medications.

Early antidepressant medications were the tricyclics. Named for their chemical structure, tricyclic antidepressants targeted the neurotransmitters norepinephrine and serotonin. In about the same time period, another class of drugs, the monoamine oxidase (MAO) inhibitors, were introduced. In addition to targeting reuptake of norepinephrine and serotonin, MAO inhibitors also targeted dopamine.

While effective for treating depression, the side effects of tricyclics and MAO inhibitors and strict dietary requirements of the MAO inhibitors were often prohibitive.

A newer class of drugs, serotonin-selective reuptake inhibitors (SSRIs), was introduced with fewer side effects and without dietary restrictions. This class of antidepressant is in widespread use today. A class of drugs called serotonin-norepinephrine reuptake inhibitors (SNRI) has been introduced that affect levels of serotonin and norepinephrine (as the older tricyclics did), but without the side effects of tricyclics and without some of the potential sexual side effects of SSRIs.

Other medications, sometimes called atypical antidepressants, are also in use. One of these is Wellbutrin (buproprion), which acts on serotonin, norepinephrine and dopamine, with concentration on dopamine. Medications like lithium may also be used when conventional medications do not provide therapeutic effects. Lithium is a mood elevator often used in bipolar disorder and to elevate the mood of depressed patients.

Medications in the antidepressant class are frequently used for other conditions, such as anxiety disorder and obsessive/compulsive disorder. Common medications, listed by class, are shown in Table II.
Behavioral Emergencies

In the EMS world, we like definites, although we aren't always allowed to have them. We know that bradycardia is a heart rate below 60 and tachycardia is a rate greater than 100. If only behavioral emergencies were that easy. In fact, we sometimes try to base our clinical decisions in the field on a "normal baseline." Even this can be challenging, since "normal" is a very subjective word. Rather than being a baseline, "normal" is a wide, gray area that borders mental illness. Further confounding definitions of mental illness are the varied beliefs and norms of the culturally diverse society we live in.

What is the difference between depression and clinical (or serious) depression? When does behavior tip the scale to be considered actual depression? When a loved one dies, isn't depression "normal?" When is behavior outrageous enough to be considered psychosis?

The simple, field impression is based on whether the patient is a harm to him/herself or others. This is often the barometer for when we transport a patient for further care.

Clinically, mental illness is diagnosed using a set of criteria outlined in the Diagnostic and Statistical Manual of Mental Disorders (DSM). The DSM is published by the American Psychiatric Association and lists specific diagnostic criteria for conditions that otherwise may seem less than objective.

In addition to whether the patient is a harm to him/herself or others (a difficult determination in many cases), the DSM relies on other factors including:

- The patient's clinical presentation (as determined in a mental status examination)
- How long the condition has persisted
- How the condition has affected the patient's life including:
  - Relationships
  - Employment
  - Living conditions
  - Appetite and nutrition (weight gain or loss).

Examples of diagnostic guidelines for major depressive disorder and schizophrenia are listed below. Note the specific criteria for each diagnosis.

Criteria for Major Depressive Disorder (MDD)

- Depressed mood or a loss of interest or pleasure in daily activities for more than two weeks.
- Mood represents a change from the person's baseline.
• Impaired function: social, occupational, educational.
• Specific symptoms, at least 5 of these 9, present nearly every day:
  ▪ Depressed mood or irritable most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful).
  ▪ Decreased interest or pleasure in most activities, most of each day
  ▪ Significant weight change (5%) or change in appetite
  ▪ Change in sleep: Insomnia or hypersomnia
  ▪ Change in activity: Psychomotor agitation or retardation
  ▪ Fatigue or loss of energy
  ▪ Guilt/worthlessness: Feelings of worthlessness or excessive or inappropriate guilt
  ▪ Concentration: diminished ability to think or concentrate, or more indecisiveness
  ▪ Suicidality: Thoughts of death or suicide, or has suicide plan.

Criteria for Schizophrenia
• Characteristic symptoms: Two or more of the following, each present for much of the time during a one-month period (or less, if symptoms remitted with treatment).
  • Delusions
  • Hallucinations
  • Disorganized speech, which is a manifestation of formal thought disorder
  • Grossly disorganized behavior (e.g. dressing inappropriately, crying frequently) or catatonic behavior
  • Negative symptoms: Blunted affect (lack or decline in emotional response), alogia (lack or decline in speech), or avolition (lack or decline in motivation)

If the delusions are judged to be bizarre, or hallucinations consist of hearing one voice participating in a running commentary of the patient's actions or of hearing two or more voices conversing with each other, only that symptom is required above. The speech disorganization criterion is only met if it is severe enough to substantially impair communication.

Mental Status Examination
The patient who is experiencing a behavioral emergency should receive the same history and physical exam as any other patient, with an eye toward the differential diagnoses of the altered mental status patient (AEIOU-TIPS).

Once the sample history and physical exam are completed, and you believe that you are in fact dealing with a patient experiencing a behavioral emergency, move to the mental status examination. This examination, performed routinely in both out- and in-patient facilities, will allow you to obtain pertinent psychiatric findings not present in the SAMPLE
history, as well as accurately and intelligently document the patient's psychiatric signs and symptoms.

Components of the mental status examination include:

- **Appearance and General Impression**
  How does the patient appear to you? How is he acting in general? Note the patient’s attire and level of hygiene.

- **Affect**
  What is the patient’s affect (often defined as the outward projection of the patient’s mood or behavior)? It may range from excited to flat (absent).

- **Thought processes**
  This step looks at thought content and processes. Does the patient’s thinking make sense? Is it in keeping with his environment? Is there a consistent association between his thoughts? Is there evidence of hallucination (auditory, visual, tactile, olfactory)? Does the patient feel he has any special ability or powers, or believe he is someone he isn’t? Does the patient feel as if he is being watched or controlled by an outside force? These are called delusions. Delusions are categorized into four different groups:

  - **Bizarre delusion:** A delusion that is very strange and completely implausible; an example of a bizarre delusion would be that aliens have removed the reporting person's brain.
  - **Non-bizarre delusion:** A delusion that, though false, is at least possible, e.g., the affected person mistakenly believes that he is under constant police surveillance.
  - **Mood-congruent delusion:** Any delusion with content consistent with either a depressive or manic state, e.g., a depressed person believes that news anchors on television highly disapprove of him, or a person in a manic state might believe she is a powerful deity.
  - **Mood-neutral delusion:** A delusion that does not relate to the sufferer's emotional state; for example, a belief that an extra limb is growing out of the back of one's head is neutral to either depression or mania.

- **Speech**
  Observe the patient's speech as an indicator of thoughts (above), as well as a sign in itself. Does the patient speak? Does the speech appear pressured (as though words are forced out when the mouth is opened)? Is speech slow or monotone?
• **Judgment and Insight**
  How does the patient feel he is doing right now? Does he feel he needs help? Has the patient done or suggested anything (taking off clothes in public or cold temperatures, running in traffic) that indicates judgment that is questionable or harmful? Has the patient mentioned or attempted suicide?

  Use these components of the mental status examination as a guide to observation and history-taking. The categories and descriptions contained within also pose a suitable framework for documentation of your exam. It is often difficult to describe someone who is acting in an usual manner. Use of the word "abnormal" should be avoided. Instead, detail the patient’s affect, thoughts, speech and judgment descriptively and with examples.

**Care for the Behavioral Emergency Patient**

Just as the assessment of a patient experiencing a behavioral emergency may seem subjective, the lack of steadfast rules in caring for the behavioral emergency continues the challenge for EMS providers. Following are a few concrete guidelines for patient care:

- Ensure safety during the scene size-up and throughout the call. While not all behavioral emergency patients will be out to hurt themselves or you, caution is always warranted. Seek law enforcement assistance early in the call.
- Observe for and maintain an open airway.
- Consider all patients experiencing unusual behavior as having altered mental status until proven otherwise. This tenet of care has saved many providers from a lawsuit when assuming a diabetic, stroke or disabled patient was really a "psych." Remember that medications taken for psychiatric conditions are extremely dangerous if taken in excess.
- Treat all medical and traumatic conditions.
- If restraint is required, **never** restrain the patient face down.

  Much of the care we give is interpersonal, not clinical. After ensuring safety and ruling out treatable medical conditions, our interpersonal dealings with the patient form the bulk of our care. What to say or when to say something must come from you, using the following guidelines:

  - Be calm and direct. Don’t hesitate to talk to the patient about his/her condition. In fact, it is often better to be direct and respectful rather than
tentative and uncomfortable. If you can’t talk about a patient’s condition with him or her, they won’t talk to you.

- Use appropriate body language. Show interest and openness while maintaining a safe position and distance. Avoid looking disinterested or using closed body language.

- Have a plan. Patients are surprisingly receptive to a plan expressed confidently. Conversely, patients will detect hesitance in your voice. Explain slowly and clearly what you are going to do. Patients who feel they are losing control may respond positively to this. "I am going to take you to the hospital. The police are going to help us get to the ambulance, and then I’ll put you on the stretcher for the trip. We’re going to take good care of you." Asking whether the patient wants to go to the hospital when there really is no choice is counterproductive.

- Never play into delusions. Don’t agree with or further a patient’s delusions. It is unprofessional and counterproductive to the patient’s care. Many times, a part of the patient is clinging to reality and he will sense patronizing behavior.

**Restraint**

In some cases, restraint will be required to ensure the safety of the patient and crew during transport to the hospital. Restraint must be done in accordance with local laws and protocol. In Wisconsin, police have the ability to authorize transportation of a patient against his will.

Restraint may be accomplished by a number of methods, which will vary depending on the number of persons attempting restraint and the equipment available. While, in theory, law enforcement should do the restraining, it is common practice for EMS to perform restraint alongside law enforcement personnel. Concepts of effective restraint include:

- Have enough people to perform restraint effectively—generally four or five people, when possible. This allows one person for each extremity and another for the head, or to assist another provider. When working around the patient’s head, use caution to avoid suffering a bite wound or spitting from the patient. Spit hoods are commonly used by law enforcement and some EMS providers but extreme caution must be exercised to maintain airway patency.

- Use soft, humane restraints. Avoid handcuffs or flex-ties.
• Restrain the patient in a face-up position. Although spitting and derogatory remarks about your mother may tempt you to restrain in the prone position, don't.

• When restraining, position the patient so he can't use major muscle groups (e.g., biceps) to pull against your restraints.

• **Monitor the patient continuously.** Be especially aware of patients who have been struggling and agitated but suddenly become quiet and calm. In some patients, this may be an indication of unresponsiveness and apnea. In addition, if extremities have been restrained, check distal pulses to make certain circulation has not been compromised by the restraint or positioning.

**Conclusion**

Behavioral emergencies lack some of the objective clinical signs and symptoms we have become accustomed to in other medical emergencies. By being familiar with some of the criteria used to diagnose these conditions, as well as some of the terminology, assessment and treatment considerations, the care of your next behavioral emergency patient will be more effective.

Please review the following Aurora Health Care protocols for care of these patients.
1. Assess **SCENE AND PERSONAL SAFETY**. Call law enforcement personnel to scene, if needed. Above all, **DO NOTHING TO JEOPARDIZE YOUR OWN SAFETY**.

2. **Initial Medical Care**; special considerations:
   * Determine and document if patient is a threat to self or others; or if patient is unable to care or provide for self
   * Protect patient from harm to self or others
   * Do not touch a patient with a mental illness without telling them your intent in advance

3. Verbally attempt to calm and reorient the patient to reality as able. Do not participate in a patient's delusions or hallucinations.

4. If patient is combative: Refer to Patient Restraint Protocol, use physical restraints as necessary per Patient Restraint Protocol. Document reasons for use.

5. Consider medical etiologies of behavioral disorder and treat according to appropriate SOP:
   * Hypoxia
   * Substance Abuse/Overdose
   * Neurologic disease (CVA, intracerebral bleed, etc.)
   * Metabolic derangements (hypoglycemia, thyroid disease etc.)

6. Initial Medical Care as situation warrants.

7. Consult Medical Control from the scene in ALL instances where a refusal of transport is being considered.

8. If patient is an imminent threat to self or others, or is unable to care for themselves, and is refusing transportation: Have Police Department evaluate situation for Chapter 51.
# Patient Restraint

## Verbal De-escalation Guidelines:
1. Make every attempt not to aggravate or worsen pre-existing injuries or medical conditions.
2. Attempt to control the patient with verbal counseling.

## Verbal De-escalation Procedure:
1. Remain calm and friendly, be aware of your feelings.
   - Be mindful of your body language.
   - Breathe slowly and deeply.
   - Maintain a safe distance and refrain from touching the patient.
2. Position yourself so that the patient cannot block your access to an exit.
3. Keep your hands in front of your body in a non-threatening manner.
4. Only one provider should communicate with the patient.
5. Maintain a soothing tone of voice.
6. Listen to patient’s concerns.
7. Empathize; use positive feedback.
8. Be reassuring and point out choices.
9. Be willing to slow down and disengage, if appropriate.
10. Calmly set boundaries of acceptable behavior.

## Patient Capacity Issues:
1. “Medical decision making capacity is defined as the ability to give informed consent to go through a particular medical test or intervention or the ability to refuse such intervention.”
2. When tasked to determine the mental capacity of a patient to refuse treatment, ask yourself these questions about your patient:
   - Is the patient in danger of hurting himself or others?
   - Is there or could there be an underlying medical emergency that may lead to death or worsen considerably if not treated soon?
   - Is there an emergency medical intervention that must be made to avoid a worsening in your patient's condition?
   - Does your patient understand the risks of refusing these treatments or interventions? Have you made those clear?
3. These questions apply only to the patient’s immediate situation, not to long-term medical care.

## Physical Restraint Procedures:
1. Ensure sufficient personnel are present to control the patient while restraining him/her. **Use Law Enforcement Assistance when available.**
2. Place the patient face up (supine) on cot.
3. Secure ALL extremities to the cot.
   - Try to restrain lower extremities first using soft restraints around both ankles.
   - Next, restrain the patient's arms at the side using soft restraints around each wrist.
4. Place padding under patient's head and wherever else needed to prevent the patient from further harming him/herself or restricting circulation.
5. If the patient is spitting, place a soft mask or commercially available spit hood over their mouth and provide supplemental oxygen.
6. Document circulatory status of restrained extremities every 15 minutes.
### LEVEL 1 Patient Restraint

#### Chemical Restraint Guidelines:
1. Sedative agents may be used to provide a safe, humane method of restraining the violently combative patient who presents a danger to themselves or others and to prevent the violently combative patient from further injury while secured by physical restraints.
2. These patients may include but are not limited to the following:
   - Alcohol and/or drug intoxicated patients.
   - Restless, combative head-injury patients.
   - Mental illness patients.

#### Chemical Restraint Procedure:
1. Assess the possibility of using physical restraint first; evaluate the personnel needed to safely attempt to restrain the patient.
2. **Versed 2-5 mg IV/IO/IM/Nasal, repeat every 5 minutes**
3. **Ketamine 1.5 -2 mg/kg IV/IO or 4 – 5 mg/kg IM**
4. Assess the need for sedation carefully.
   - For excited delirium give 1000 ml 0.9 Normal Saline and 1 amp or Sodium Bicarbonate.
   - Patients who are physically restrained and aggressively fighting their restraints and head injury patients who are combative and compromising their airway and C-spine may be candidates for sedation.

#### Chemical Restraint Precautions:
- Side effects may include hypotension and respiratory depression.
- Monitor Airway

#### Documentation (Minimum):
1. In what manner was your patient violent? Record patient’s comments *verbatim*.
2. Did you feel threatened? Why?
3. Were you concerned about your patient's outcome without emergency medical interventions? Why?
4. Could you treat your patient appropriately without the use of restraints?
5. What Law Enforcement Officer was present?
6. Document the frequency of respiratory and mental status change assessments. **Note:** Constant evaluation of your patient’s airway status and documentation of such is extremely important.
7. If your patient was physically restrained, was he supine?
8. What kind of restraints did you use?
9. Where on your patient were these restraints placed?

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