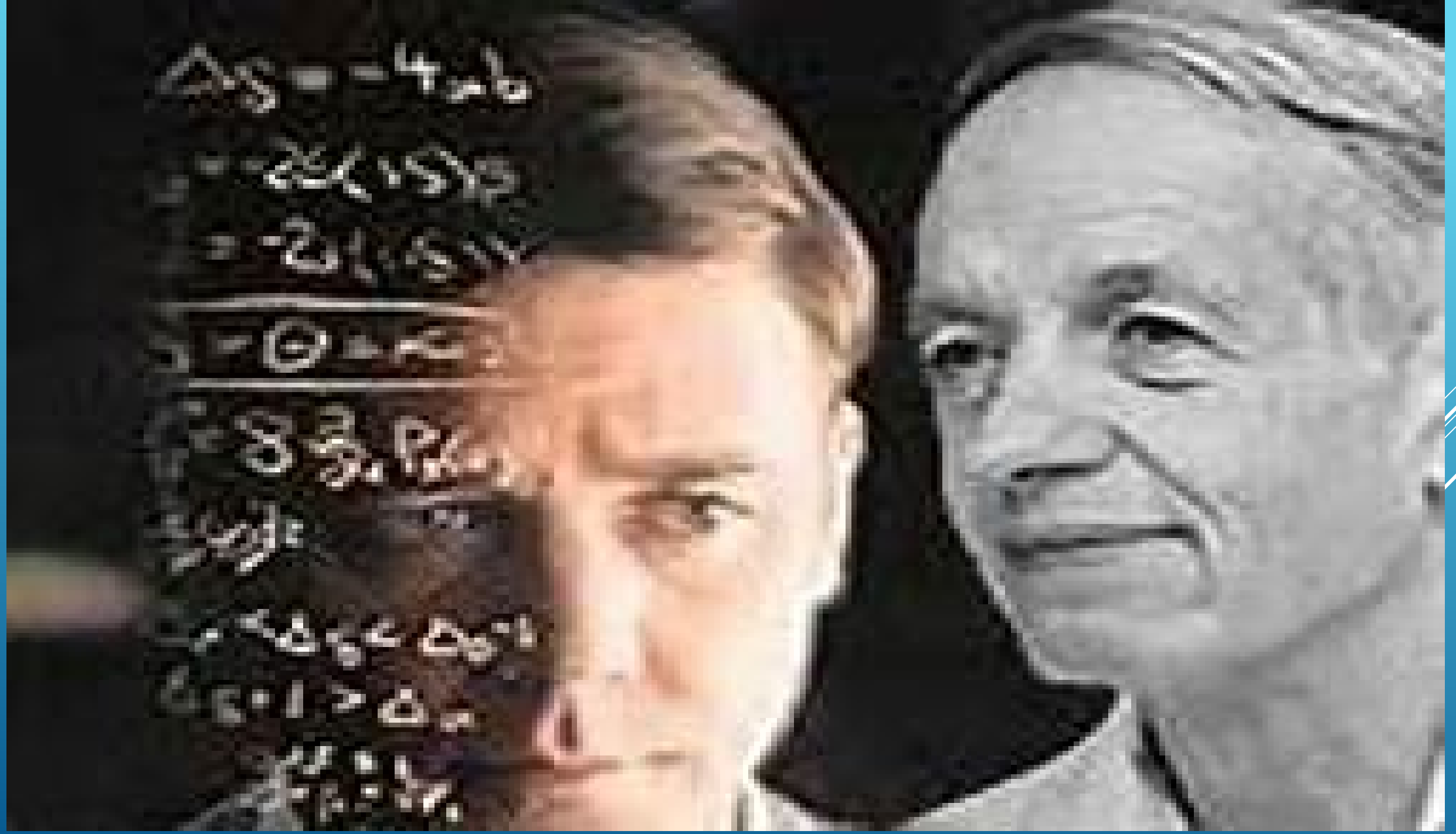
BEHAVIORAL EMERGENCIES

Douglas Bekenyi

WHAT COMES TO OUR MIND WHEN WE THINK OF BEHAVIORAL EMERGENCY?



OBJECTIVE

- Knowing when EMS intervention is needed
- Treatment and **CARE** for every behavior emergency
- Overview of common behavioral emergencies you may encounter

WHEN DOES ABNORMAL BEHAVIOR BECOME A BEHAVIORAL EMERGENCY?

- When the patient is a danger to themselves or others.
- When their condition inhibits them from caring for their own basic needs.
- Not all mental health issues are emergencies. Many need no intervention on our part.

SELF CHECK—REMEMBER YOUR ROLE

- Many mental health situations are exacerbated by the attitude that EMS brings to the scene.
- Don’t let your prejudgments negatively steer the call.
- Most behavioral emergencies can be deescalated with no force.

WHAT'S YOUR OWN MENTAL HEALTH LOOK LIKE TODAY?

- Tired
- Irritated
- Hungry
- Angry
- Afraid


YOU WONT LIKE ME
WHEN IM HUNGRY
memegenerator.net

SCENE SAFETY

SCENE SAFETY: ARRIVAL

- Don’t rush in, consider staging
- Introduce yourself and your crew
- Position yourself in a non-threatening way
- Do you have a goal? A plan?
- Backup plan?
- Remember this 911 call is a crisis for them

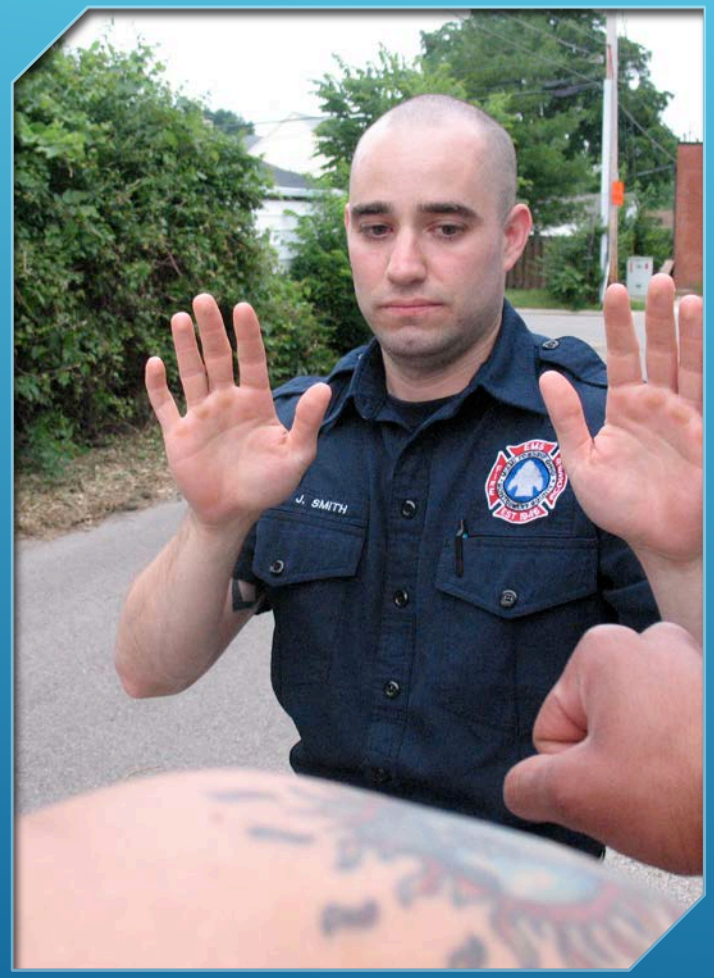
SCENE SAFETY: INITIAL SIZE UP

WHO??

- How many in your crew
- Law enforcement
- Bystanders—potential resource or hazard
- Animals—feel their owners mood

WHAT

- Drug paraphernalia
- Weapons
- Living conditions
- Medications



BODY LANGUAGE: YOURS & THEIRS

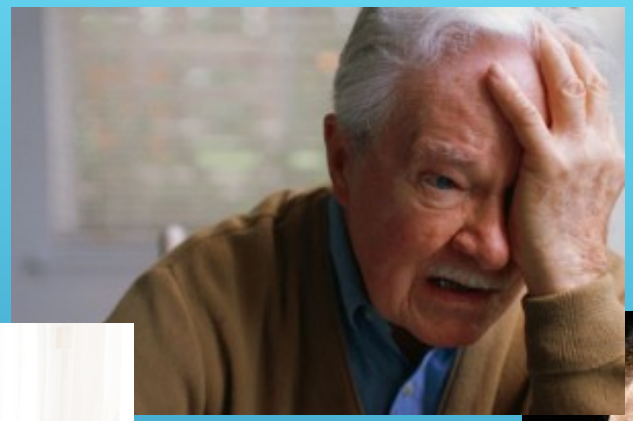
Agitated

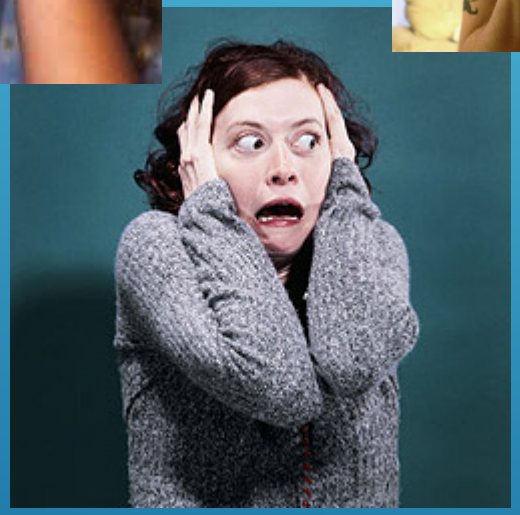
Afraid

Defensive

Paranoid

Hopeless





AGGRESSION STEMS FROM FEAR, ITS YOUR JOB TO REDUCE YOUR PATIENTS FEAR


Every good conversation starts with good listening.
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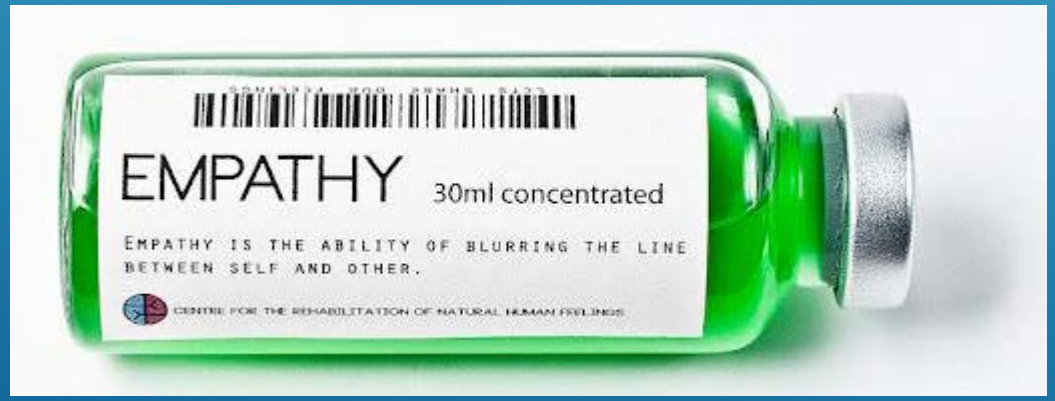
EMPATHY (OR THE PERCEPTION OF) IS YOUR STRONGEST TREATMENT TOOL

You don't know the road that led your patient to their current situation—don't assume you do and don't pass judgment.

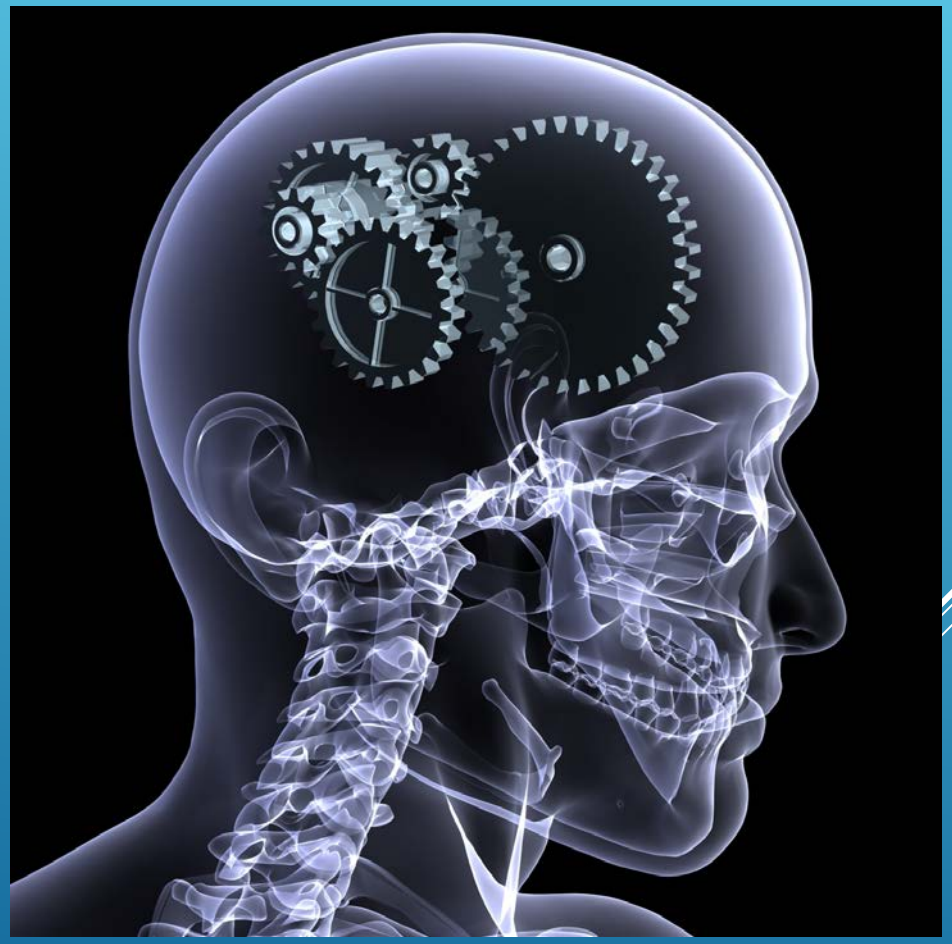


MEDICAL CAUSES OF BEHAVIORAL SYMPTOMS

- Prescribed medications: digitalis, steroids, amphetamines
- Illicit drug use: PCP, LSD, alcohol, Spice, bath salts
- Infections
- Neurologic: Seizures, CVA, brain tumor, TBA, Dementia
- Cardiovascular: heart failure, hypoxia, hypotension
- Endocrine: thyrotoxicosis, Cushing's syndrome
- Metabolic: DKA, hypoglycemia, electrolyte imbalance

COMMONLY ENCOUNTERED BEHAVIOR EMERGENCIES

- Neurotic Disorders
- Mood Disorders
- Psychotic Disorders
- Excited Delirium



NEUROTIC DISORDERS

GENERAL ANXIETY

Dominate mood is fear and apprehension. Chronic anxiety can accumulate over time, easily triggered panic attack.

PANIC ATTACK

Acute episodes that may or my not be prompted by a stressful situation

Can come out of the blue

Person functions normally between episodes

- SOB, smothered feeling
- Palpitations
- Sweating
- GI symptoms
- Dizziness
- Chest discomfort
- Choking feeling
- Carpal spasms
- Trembling
- Detached feeling

ALTERATIONS IN BEHAVIOR

Negative Behaviors

Missing behaviors that the patient would normally have

- Mutism
- Flat affect
- Lack of hygiene
- Poor house keeping

Positive Behaviors

Added behaviors that don't normally exist with the individual:

- Talking to themselves
- Compulsions
- Hallucinations
- Echolalia

MOOD DISORDERS

DEPRESSION

- Leading cause of disability for15-44 y/o
- Acute or chronic
- Pervasive recurring thoughts of suicide

MANIA

- Alert but distracted
- On top of the world
- Insomnia
- May resist treatment because they think nothing is wrong

BIPOLAR DISORDER

Alternate between manic and depressive states

PSYCHOTIC DISORDER SYMPTOMS

Disorganized Speech

- Repeating
- Stories that don't make sense
- Neologisms (invented words)
- Garbled words
- Mutism
- Echolalia (echoes words heard)

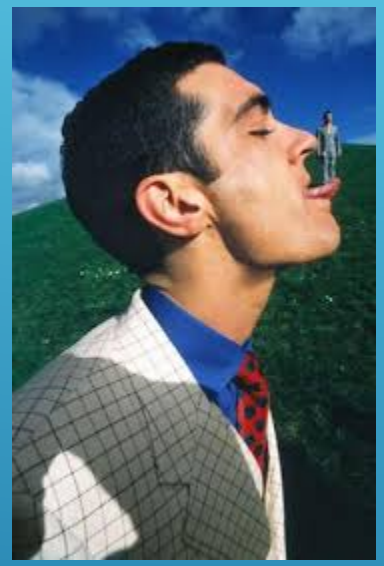
Disorganized Behavior

- Pacing
- Screaming
- Agitation
- Compulsions
- Restlessness
- Stereotyped movements

PSYCHOTIC DISORDER SYMPTOMS

Delusions

- A fixed belief that is not shared by others in the person's cultural background and that cannot be changed by reasonable argument; a false belief
- "The president is trying to steel my thoughts"



Hallucinations

- A sense perception not founded on objective reality; a false perception
- "I see dead people"

MENTAL HEALTH AND SUBSTANCE ABUSE

More often than not

Some people use drugs to self-treat

Some exacerbate their mental illness

Consider withdraw

Mental Illness

Substance Abuse

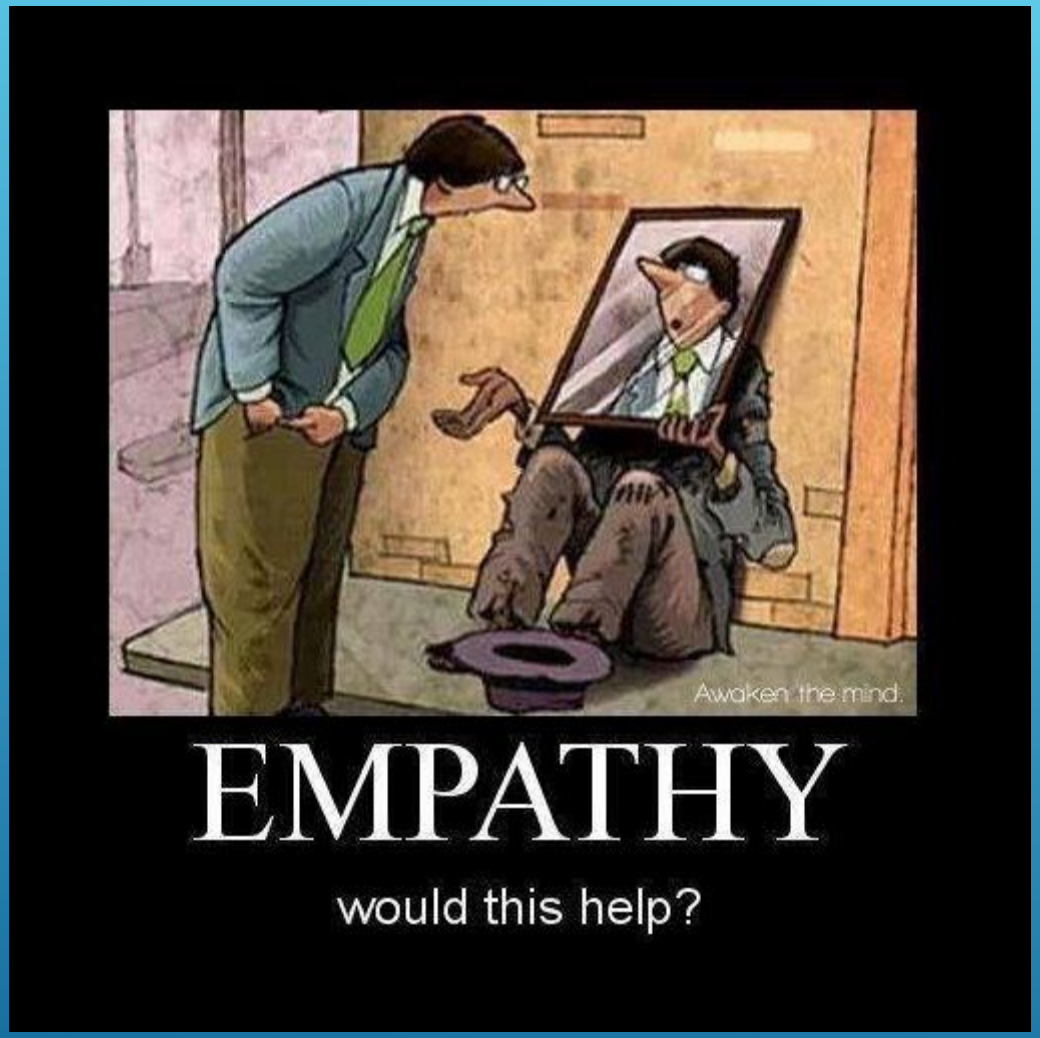
911

Homelessness

Excited Delirium SPD

IN CUSTODY DEATH SYNDROME

- Extreme mental and physiological excitement
- Hyperthermia, removing clothing
- Agitation, animal sounds
- Hostility, unexpected physical strength
- Psychosis (paranoia)
- Increased pain threshold
- Sudden tranquility


Awaken the mind.
EMPATHY
would this help?

TREATMENT OF BEHAVIORAL EMERGENCIES

- Listen
- Calm and de-escalate
- Determine the cause if possible
- Give the patient options and a bottom line
- When restraint is necessary
- When sedation is necessary
- Documentation

LISTEN FIRST

Determine if the patient is:

1. A danger to themselves
2. A danger to others
3. Capable of making decisions

CALM AND DE-ESCALATE

Respond selectively

Be honest

Be respectful

Do not get loud

DETERMINE THE CAUSE IF POSSIBLE

Mental health??

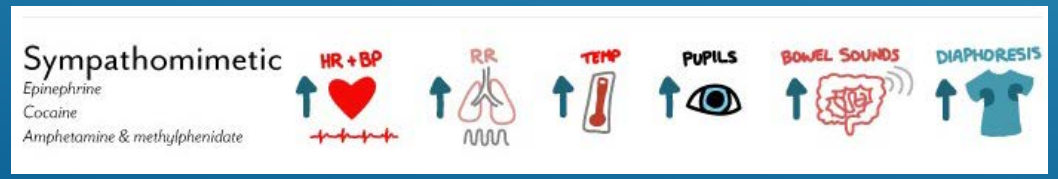
Medical??

Substance abuse??

NON-PSYCHIATRIC CAUSES

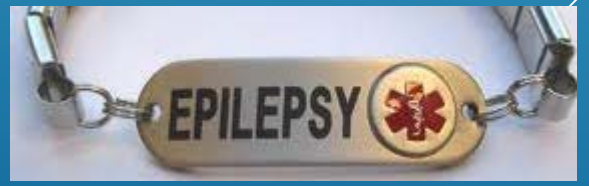
Substance Abuse

- Consider Toxidromes
- Look for clues in the house
- Police call history



Medical

- Good history taking
- Medications
- Physical findings



DRUG INDUCED PSYCHOTIC SYMPTOMS

- Opiates: Sedation, depression, anxiety
- Stimulants: Anxiety, depression, psychosis, agitation, excited delirium, Hl, Formications, may appear manic.
- PCP: Depression, confusion, psychosis, excited delirium
- MJ: Sedation, psychosis, anxiety
- Alcohol: Depression, anxiety, confusion

INVOLUNTARY TRANSPORT

- Always involve law enforcement with transporting against patients wishes
- Error on the side of bringing them in
- Call base station if there is a question
- Firmly and directly tell them that they are going to the ED and they have choices in how that will happen

PSYCHOTIC DISORDERS: SCHIZOPHRENIA

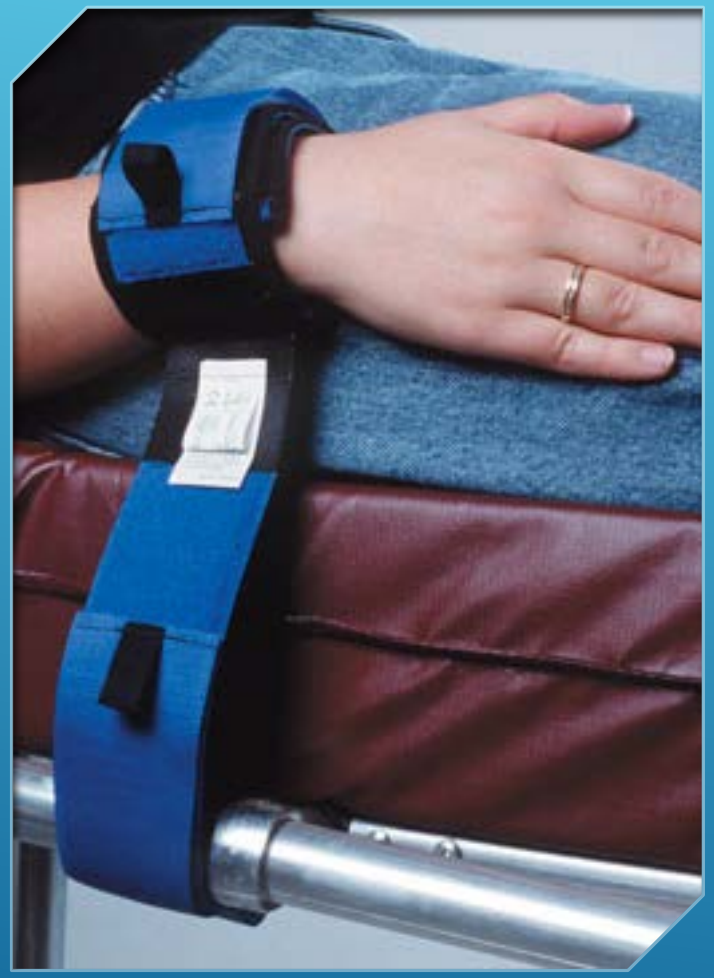
Disorganized Behavior

Disorganized Speech

Delusions

Hallucinations

50% will attempt suicide



WHEN RESTRAINT IS NECESSARY

- Verbally or physically threatening
- Hurting themselves
- Refusing transport (involuntary admissions)

- Radio on shoulder
- Scissors in pocket
- No PD
- Drop off behind EMS personnel
- Concrete floor

TAKE DOWNS: PROBLEMS?

- Spit prevention
- One arm up one are down
- Patient supine NOT PRONE
- Monitor circulation and vital signs
- Continuously calm
- Do not constrict breathing

RESTRAINT CONSIDERATIONS

- NEVER make a backboard sandwich, EVER
- Avoid touching the patients neck
- Keep them supine
- Ensure adequate ventilation

USE ONLY NECESSARY FORCE

WHEN TO SEDATE

- De-escalation and calming fail
- Patient continues to fight through restraints
- Excited delirium
- Hyperventilation or extreme anxiety
- Extreme fear and apprehension on the part of the patient

IDEAL TAKE DOWN SET UP

- One person in charge
- Other 4 are each assigned to a limb

- 5 personnel: at least one PD and 4 EMS
- No loose hanging items on your uniform
- Long hair tied back
- Avoid hard surface take down when possible
- Restraints are pre-attached to the cot or backboard

SEDATION METHODS

Versed (Midazolam)

- 1 to 5 mg (may need lower dose)
- Very potent
- Fast IM onset
- Ideal for combative patients

Ativan (Lorazepam)

- 0.5 to 2 mg
- Less potent
- Ideal for anxiety
- Viscus longer onset IM

Valium (Diazepam)

- 2 to 10 mg
- Less potent
- Ideal for anxiety

LET'S TALK ABOUT SUICIDE FOR A MINUTE…

On average in the United States 55,000 people commit suicide each year

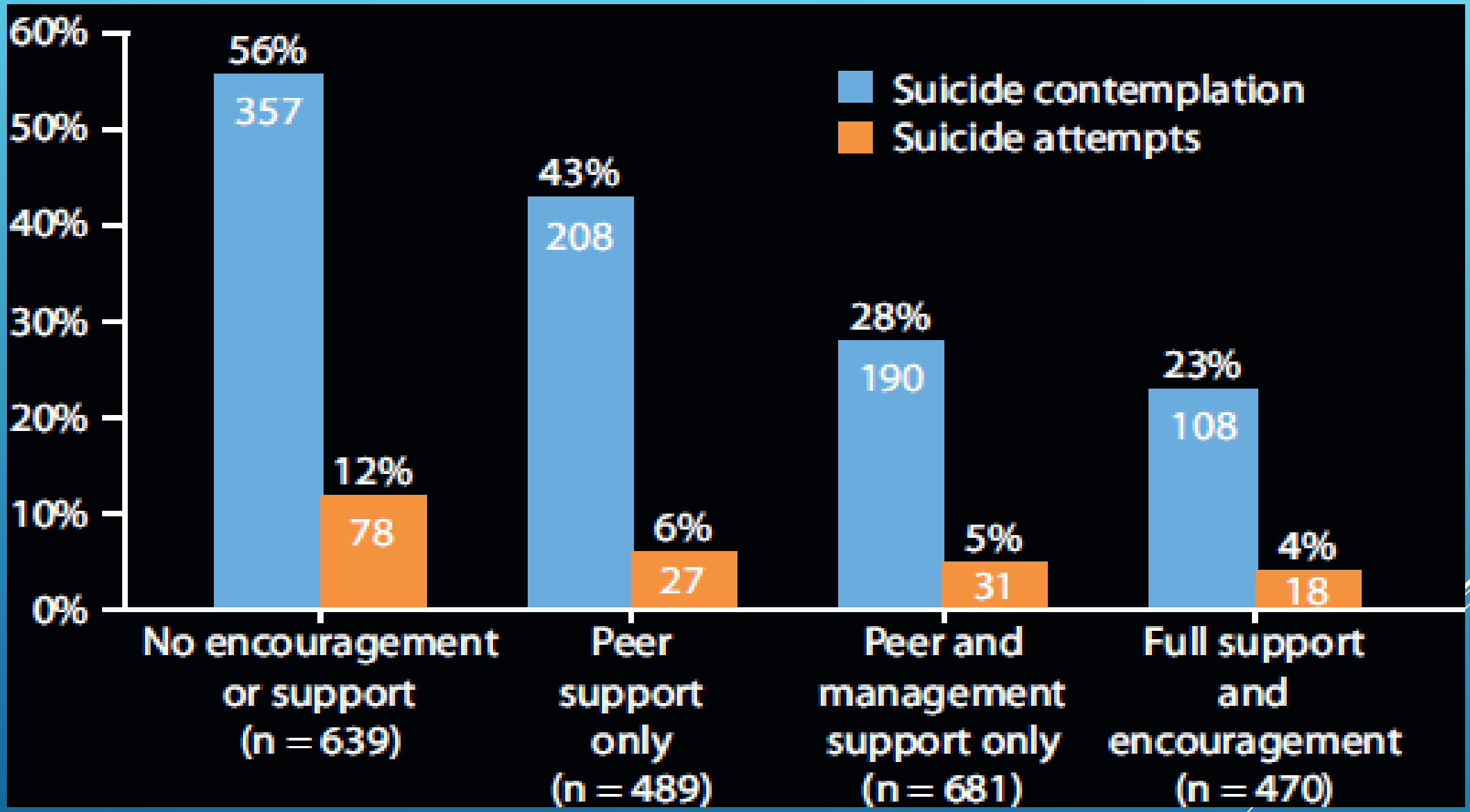
That's roughly 1 every 12 minutes.

Washington State it's 1 every 8 minutes

What does someone who's thinking about suicide look like?

MAYBE THEY LOOK LIKE THIS…

OR MAYBE HE LOOKS LIKE THIS…


60%
50%
40%
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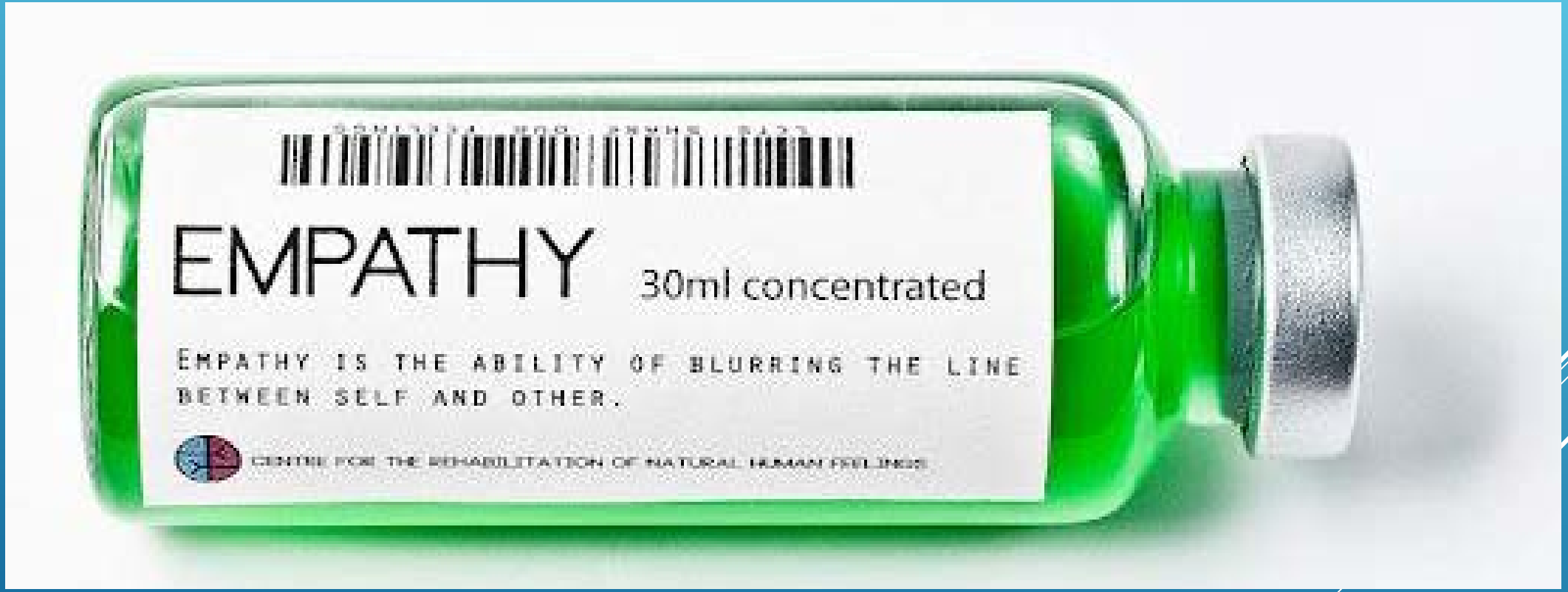
10%
0%
56%
357
12%
78
43%
208
6%
27
28%
190
5%
31
23%
108
4%
18
Suicide contemplation
Suicide attempts
No encouragement or support (n = 639)
Peer support only (n = 489)
Peer and management support only (n = 681)
Full support and encouragement (n = 470)

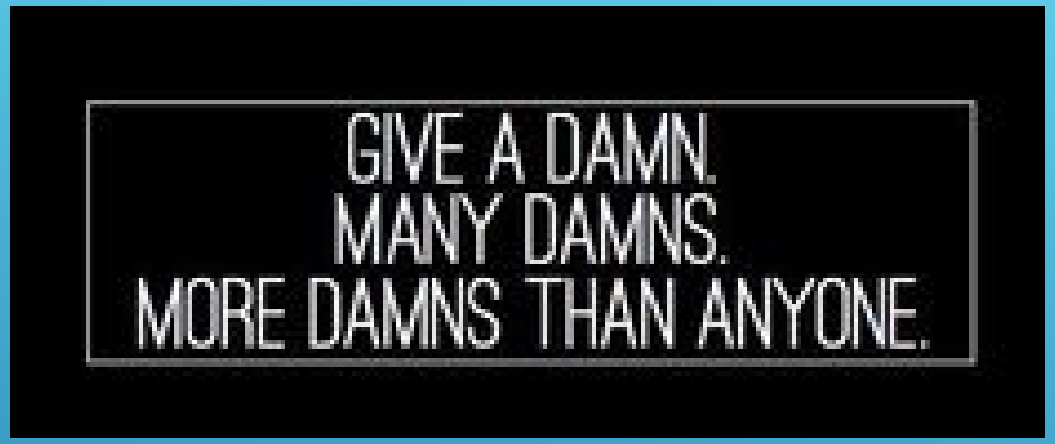
Treatment Conclusion



DOCUMENTATION

- Recent calls for the same
- Collateral people information
- Medications allergies
- SI, HI, Drugs
- Presentation
- PD involvement
- Condition of the home
- Force used and restraints
- Sedition

CONCLUSION



PROFESSIONALISM AND RESPECT: BE NICE TO PEOPLE

Even when they are not nice to you.

- Doug Bekenyi
- 360-362-6113
- dbekenyi@hotmail.com

Call or text anytime you need to talk!!