

Lesson Plans and Objectives

At the end of this lesson the student should be able to:

1. Determine whether a psychiatric emergency is caused by a pre-existing psychiatric condition or another cause.
2. Be better able to manage the suicidal or violent patient.
3. Know the correct medicine, dosage, and route of administration for chemical restraint of a violent patient.

Psychiatric Emergencies

Behavioral emergencies are very common in the pre-hospital setting and Lubbock EMS certainly gets their fair share. Often we see the same patients on a fairly regular basis. It is important, however, that we treat each patient, and each call, on an incident by incident basis. We must remember that any occurrence of a behavioral emergency could be the result of one or numerous causes.

In a nutshell, a psychiatric emergency exists when a patient behaves in a way that is unacceptable or intolerable to the patient, family or community. When possible, it is vital to obtain a reliable history. If no family or friends are present, a quick check of the patients medicines could be the key to a quick and successful treatment. For instance, a patient with a history of bi-polar disorder could also be a diabetic. Not all patients who are violent or suicidal present disoriented, in fact, many will answer person, place, and time questions correctly.

It is very important for paramedics to remember that unusual behavior could be caused by factors other than pre-existing psychiatric conditions. Consumption of drugs or alcohol, or both, can definitely precipitate intolerable behavior. In some cases, even non-

psychoactive drugs could cause an untoward reaction that might result in unusual behavior. Another cause could be hypoglycemia, caused by either diabetes or other conditions such as pancreatitis or prolonged vomiting. In trauma cases, injury to the brain can and often does result in violent uncooperative behavior. Again, there may be numerous factors to consider in the treatment of a psychiatric patient; therefore, obtaining an accurate history is of the utmost importance.

Suicidal patients are very common in the pre-hospital setting. Often, these patients are already being treated for depression. They may be taking medicines such as prozac, paxil, or zoloft. Others may have had a sudden onset of depression, such as the loss of a loved one or losing their job. Regardless of the cause, it is important to remember that these patients feel hopeless and no longer in control of their life. As with other psychiatric patients, the paramedic should rule out treatable causes such as drug abuse, hypoglycemia, or hypoxia. Once those factors have been ruled out, then it is important to attempt to restore a feeling of control and hope. To simply fill out your paperwork, call in your radio report, and then ignore your patient is doing a great disservice to them. Show genuine interest in your patient by speaking to them. Determine if they had a specific plan for suicide. From there, attempt to convey to them that

there are people to whom they are important. At no time should you talk down to them, nor should you try to “suck up” to them, as this gives the impression that your concern is artificial. One final note, although your suicidal patient may seem docile, depressed, and or hopeless, you should keep in mind that if they are willing to kill themselves, should they become violent, they probably would be willing to kill you as well.

Violent patients may be homicidal, suicidal, both, or neither. Your primary concern, prior to treatment and transport, should be the safety of you, your partner, bystanders, and the patient in that order. With all violent patients, it is imperative that police officers be present to assist in restraining and also searching the patient. If possible, clear the immediate area of bystanders, unless you genuinely feel they could have a calming effect. Some violent psychiatric patients may become more violent if people are watching them, due to paranoia, while others simply enjoy “playing to an audience”. Physical restraint may be used to secure a violent patient, if verbal attempts to calm the patient fail. The level to which a patient should be restrained must be determined on a case by case basis. For instance, it is doubtful one could justify restraining a 90 pound 13 year old female who is extremely violent in the same way one might restrain a 250 pound 30 year old male. Often, the

police will handcuff the patient with the patient's hands behind their back. This could be detrimental to treatment of the patient who is hypoglycemic or intoxicated by narcotics. Therefore, once the patient is in the ambulance, it might be preferable to utilize a four point restraint, securing both hands and feet to the cot using manufactured hand/leg restraints or kerlix. Remember to assess the distal circulatory status of each extremity restrained. These types of restraints, however, do little to restrain the knees, pelvis, trunk and head. In extreme cases, a back board can be placed over the patient's trunk and legs and secured to the cot. If this method is used, be sure to place the backboard in such a way that it will not interfere with the throat or expansion of the chest during respiration. Fortunately, Lubbock EMS has a protocol located on P-34 which allows the paramedic to restrain the patient chemically. The administration of 1-5mg versed IV is allowed per protocol. If an IV cannot be obtained, the same dosage can be administered I.M. If this method is used be sure to ascertain whether the patient has an allergy to benzodiazepines prior to administering the drug. It is also mandatory to monitor EKG, pulse ox readings, and blood pressure throughout transport. If you have never implemented this protocol, I highly recommend it. It allows for a much more thorough assessment and possible treatment of the underlying

cause for the violent behavior. A final, but very important note, remember to thoroughly document the reason and method for restraint as if you were explaining it to a jury, because you may find yourself doing just that, down the road.

In summation, it is not as important to understand individual classes of mental illness, as it is to find another cause for abnormal behavior. Whether the patient is schizophrenic, bi-polar, or depressed, it is important to remember that there may be other causes for their psychiatric emergency. Schizophrenia and bi-polar disorder should be of little importance in the pre-hospital setting, unless you are an aspiring psychiatrist. Treat what you can treat appropriately otherwise be understanding, yet firm. Some psychiatric patients seem to feed on others fear, never allow yourself to be intimidated by the erratic behavior of a psychiatric patient. Always insure that the patient is not carrying items which could be used to harm you, themselves, or others.