Psychiatric emergencies

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20 August 2024

https://rushem.org/2021/05/25/pearls-for-psychiatric-emergencies/
https://pressbooks.uwf.edu/uwfmentalhealthnursing/chapter/module-5-trauma-and-stressor-related-disorders-2/

Layout of presentation

Introduction and Overview (30 minutes)

- Definitions and typical scenarios of acute behavioural emergencies.

- Legal and ethical considerations in EMS response.

- Importance of early recognition and intervention.

Practical Strategies and Safety (60 minutes)

- Initial assessment techniques for behavioural emergencies.

- De-escalation principles and strategies.

- Use of restraints, sedatives, and legal considerations.

- Team communication strategies and personal safety measures.

Case Studies and Q&A (30 minutes)

- Review of case studies and practical scenarios.

- Q&A session addressing participant questions and concerns.

- Evaluation and feedback collection.

Conclusion

- Summary of key takeaways and resources for further learning.

Psychiatric Emergencies Principles

Recognition of
- Behaviors that pose a risk to the health provider, patient, or others

Assessment and management of
- Basic principles of the mental health system
- Suicidal/risk

The mind and body are inseparable.
- Illness affects a person's behavior.
- Changes in mental state affect physical health.

Conditions that may pose a risk

- Acute psychosis
- Agitated delirium
- Cognitive disorders
- Thought disorders
- Mood disorders
- Anxiety disorders
- Substance-related disorders
- Patterns of violence/abuse/neglect

Definitions

Behavior is the way people act or perform.

- Overt behavior is generally understood by those around the person.
- Covert behavior has hidden meanings or intentions.

Psychiatric emergency

- Behavior that threatens a person's health or safety and the health and safety of another person.
- A disturbance in thought, mood and/or action which causes sudden distress to the individual/others and sudden disability or death, thus requiring immediate management.

Causes of Abnormal Behavior

Biologic or organic
- Organic brain syndrome
- Conditions that alter the functioning of the brain

Environmental
- Psychosocial and sociocultural influences
  - Consistent exposure to stressful events
  - Sociological factors affect biology, behavior, and responses.

Injury and illness
- Illness results in stress and impair coping mechanisms.
- Acute trauma and post-traumatic stress disorder (PTSD)

Substance-related
- Alcohol
- Illicit drugs
- Other substances

Legal and ethical considerations in EMS response

Criteria for Involuntary Treatment in Consultation with Patient's Family

Psychiatric patients pose a unique challenge as many do not accept treatment or admission in hospital due to lack of insight. Nevertheless, following conditions warrants treatment:

- Presence of a mental disorder (as defined by internationally accepted standards) and in need of treatment.
- Loss of insight and unable to provide for own basic needs.
- Serious likelihood of immediate or imminent danger to oneself (suicide) or to others (homicide).

72 hour observation units

Mental Health Care Act, 17 (Act No 17 of 2002) and its Regulations

Legal and ethical considerations in EMS response

LEGISLATIVE FRAMEWORK

Constitution of Republic of South Africa, 106 (Act No 106 of 1996).

National Health Act, 61 (Act No 61 of 2003).

Mental Health Care Act, 17 (Act No 17 of 2002) and its Regulations.

Mechanical means of restraint may only be used in a health establishment run under the auspices of an organ of the State or in a private health establishment, which has been licensed in terms of the Mental Health Care Act No 17 of 2002.

Seclusion and mechanical restraint may only be used to contain severely disturbed behaviour, which is likely to cause harm to self, others or property and where the other treatment techniques have failed.

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Legal and ethical considerations in EMS response

Mechanical restraint and seclusion should be used only when there is a greater likelihood of injury to self or others and only as a last effort when all other less restrictive alternatives have been considered and found to be not feasible, and thus failed to ensure the safety of the mental health care user, others or property.

The use of less restrictive and less intrusive alternative treatment interventions should be encouraged at all times.

Promote safe use of physical means of restraint and seclusion that values and incorporates risk assessment and early intervention.

Mental health care users and their families should be educated about the use and purpose of seclusion and mechanical restraint.

Seclusion and restraint to be used only in emergency situations, where there is an occurrence of, or serious threat of extreme violence by the mental health care user and alternative less restrictive interventions have been determined to be ineffective.

Legal and ethical considerations in EMS response

Older mental health care users may be at particular risk of adverse events resulting from physical health problems or frailty. They should be monitored closely if seclusion or restraint cannot be avoided.

Mental health care users with a history of trauma (physical or psychological) may be at particular risk of compounded trauma through the use of seclusion and mechanical restraint.

The mental health care user's head and face must not be obstructed during seclusion and restraint.

All medication administered to the mental health care user must be prescribed by a qualified mental health care practitioner.

The period of seclusion and restraint must be limited to the minimum time required to remove the risk.

Seclusion and mechanical restraint must be terminated once indications of risk for harm have ceased to be present.

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Legal and ethical considerations in EMS response

There should be a complete biopsychosocial assessment of the user, which should include the developmental history, any history of trauma (physical or sexual and other traumatic events), particular cultural needs which may affect the delivery of care, physical condition (hydration status, and bowel and bladder needs, etc) and mental status.

There should be concurrent screening and assessment for co-morbid illnesses (including the possibility of substance intoxification or withdrawal) to ensure that emergent physiologic needs are addressed.

While the mental health care user is mechanically restrained or secluded, he or she must be subject to observation at least every 30 minutes and such observations should be recorded

- Behaviour while in seclusion or under restraint.
- Medication administered and response to the drugs given.
- Attention to hydration, nutrition, comfort, and toileting.
- The vital signs and mental health status.

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General principles

When behavior, speech, and thoughts are erratic, it can be difficult to communicate.

- Ensure scene safety, when in doubt do not act alone
- Relax the environment (remove stimuli)
- Search for a medical cause behind the behaviour
- Attempt verbal de-escalation-use a calm, firm voice
- Inform the patient aggressive behavior is not acceptable
- Offer PRN medications to help the patient return to a calm state. Obtain consent when possible.
- Be clear in your explanations.
- Situations with a strong behavioral component may have a sudden and unexpected turn of events.

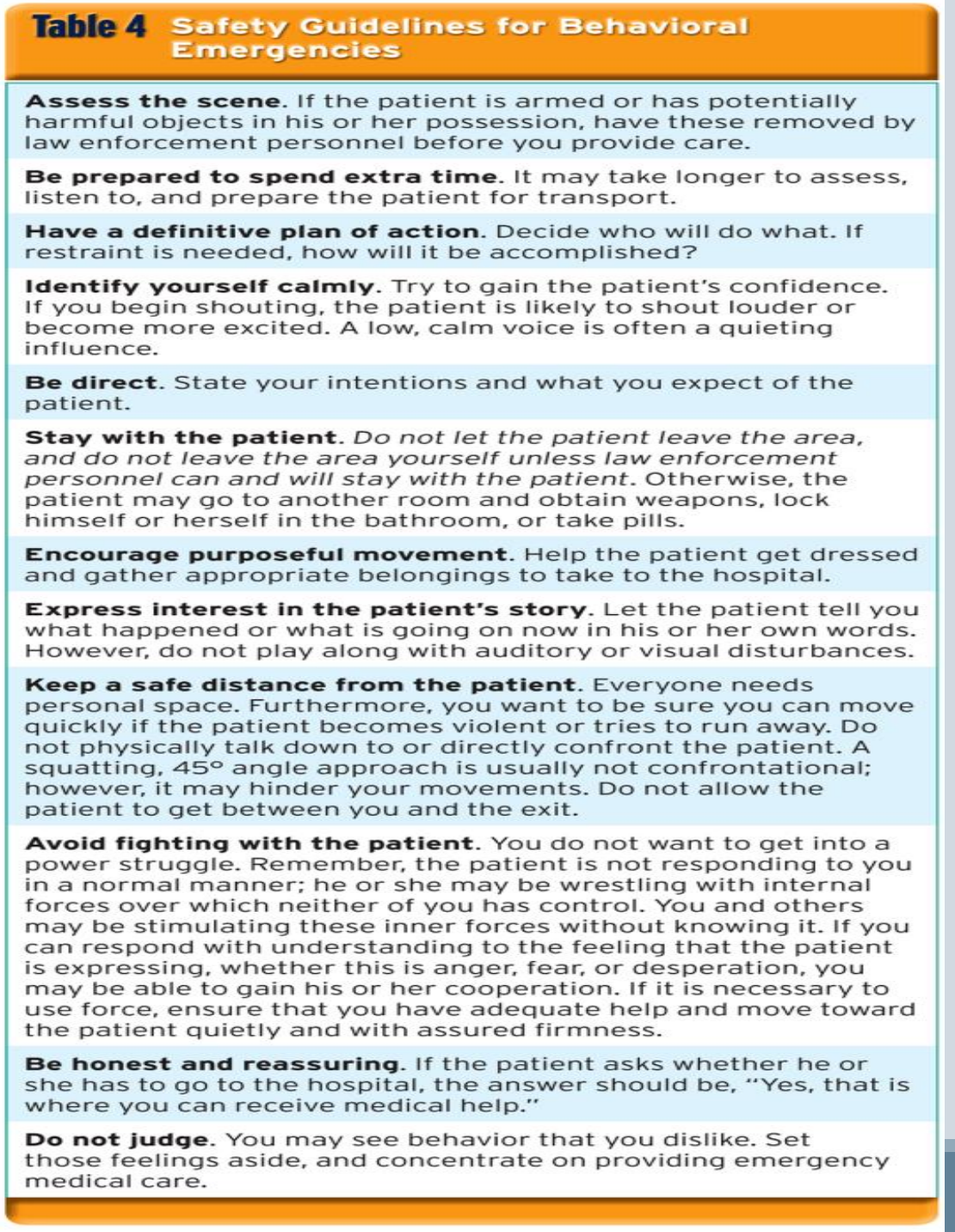


Table 4 Safety Guidelines for Behavioral Emergencies

Assess the scene. If the patient is armed or has potentially harmful objects in his or her possession, have these removed by law enforcement personnel before you provide care.

Be prepared to spend extra time. It may take longer to assess, listen to, and prepare the patient for transport.

Have a definitive plan of action. Decide who will do what. If restraint is needed, how will it be accomplished?

Identify yourself calmly. Try to gain the patient's confidence. If you begin shouting, the patient is likely to shout louder or become more excited. A low, calm voice is often a quieting influence.

Be direct. State your intentions and what you expect of the patient.

Stay with the patient. *Do not let the patient leave the area, and do not leave the area yourself unless law enforcement personnel can and will stay with the patient*. Otherwise, the patient may go to another room and obtain weapons, lock himself or herself in the bathroom, or take pills.

Encourage purposeful movement. Help the patient get dressed and gather appropriate belongings to take to the hospital.

Express interest in the patient's story. Let the patient tell you what happened or what is going on now in his or her own words. However, do not play along with auditory or visual disturbances.

Keep a safe distance from the patient. Everyone needs personal space. Furthermore, you want to be sure you can move quickly if the patient becomes violent or tries to run away. Do not physically talk down to or directly confront the patient. A squatting, 45° angle approach is usually not confrontational; however, it may hinder your movements. Do not allow the patient to get between you and the exit.

Avoid fighting with the patient. You do not want to get into a power struggle. Remember, the patient is not responding to you in a normal manner; he or she may be wrestling with internal forces over which neither of you has control. You and others may be stimulating these inner forces without knowing it. If you can respond with understanding to the feeling that the patient is expressing, whether this is anger, fear, or desperation, you may be able to gain his or her cooperation. If it is necessary to use force, ensure that you have adequate help and move toward the patient quietly and with assured firmness.

Be honest and reassuring. If the patient asks whether he or she has to go to the hospital, the answer should be, "Yes, that is where you can receive medical help."

Do not judge. You may see behavior that you dislike. Set those feelings aside, and concentrate on providing emergency medical care.

Table 3 Classification of Psychiatric Signs and Symptoms

Disorder	Psychiatric Signs and Symptoms
Disorders of consciousness	Distractibility and inattention Confusion Delirium Stupor and coma
Disorders of motor activity	Restlessness Stereotyped movements (repetition of movements that do not seem to serve any useful purpose) Compulsions (repetitive actions that are carried out to relieve the anxiety of obsessive thoughts) Slow movements
Disorders of speech	Slow speech Acceleration or pressure of speech (the pouring out of words like water escaping under pressure) Neologisms (words the patient invents) Echolalia (the patient echoes words he or she hears) Mutism (the patient does not speak at all)
Disorders of thinking	Disordered thought progression: ▪ Flight of ideas (accelerated thinking in which the mind skips very rapidly from one thought to the next) ▪ Slowness of thought ▪ Perseveration (repetition of the same idea over and over again) ▪ Circumstantial thinking Disordered thought content: ▪ Delusions ▪ Obsessions ▪ Phobias (obsessive, irrational fears of specific things or situations, such as fear of heights, fear of open places, fear of confined spaces, or fear of certain animals)
Disorders of mood and affect	Anxiety Euphoria Depression Inappropriate affect (emotion that is out of synch with the situation; for example, wearing a waxy smile while discussing a parent's death) Flat affect (the absence of emotion; appearing to feel no emotion at all)
Disorders of memory	Amnesia Confabulation (inventing experiences to fill gaps in memory)
Disorders of orientation	Disoriented to person, place, and time
Disorders of perception	Illusions Hallucinations
Disorders of intelligence	Difficulty learning

Patient Assessment

Assessment of the patient with a behavioral emergency differs from other methods.

- Health care professional is the diagnostic instrument.
- The assessment is part of the treatment.

Mental status examination

- Use COASTMAP

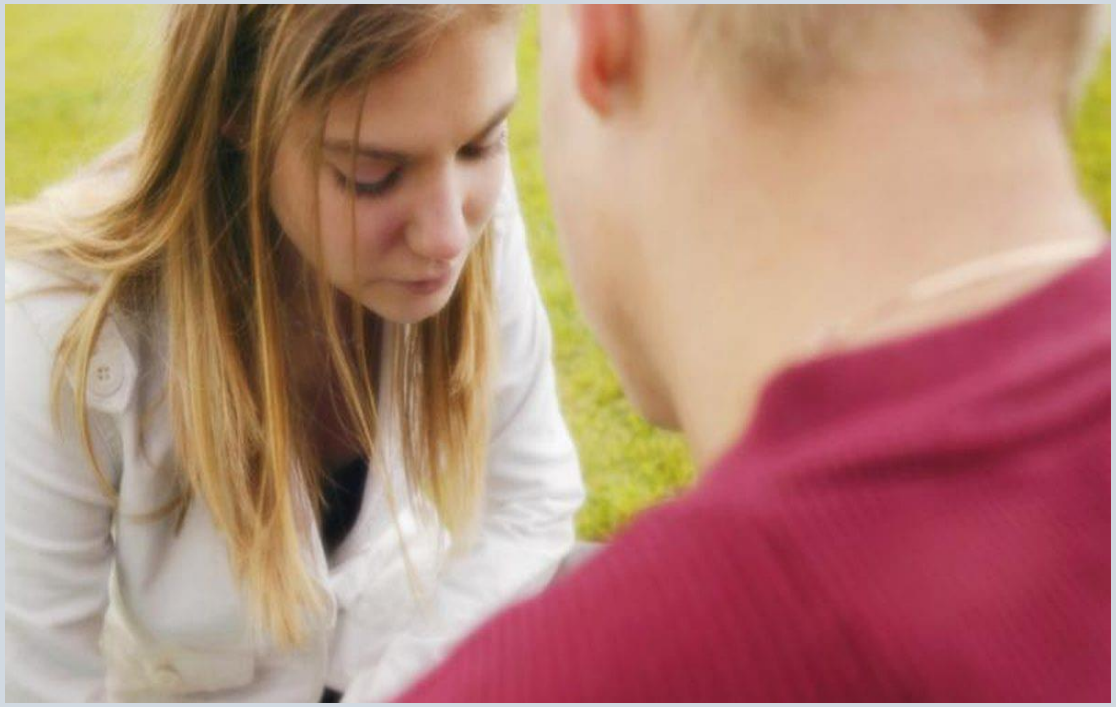
Examine skin temperature and moisture.

Inspect the head and pupils.

Note unusual odors on the breath.

In examining the extremities, check for:

- Needle tracks
- Tremors
- Unilateral weakness or loss of sensation



Patient Assessment

Clearly identify yourself.

Form a general impression.

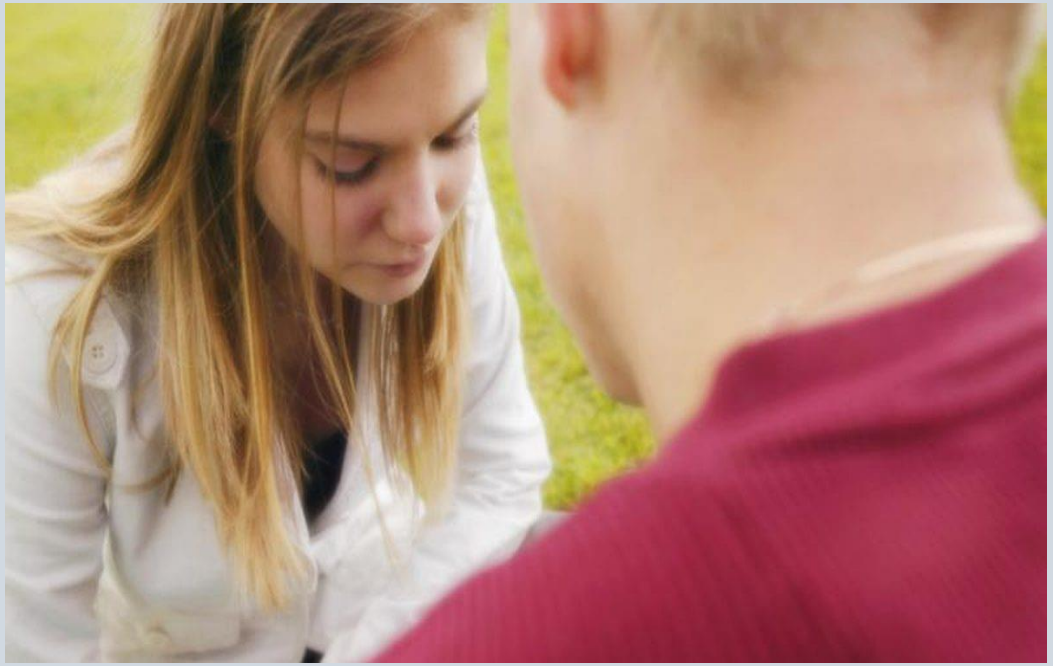
- Assess appearance, posture, and pupils.
- Limit the number of people around the patient.
- Stay alert to potential danger.

Airway and breathing

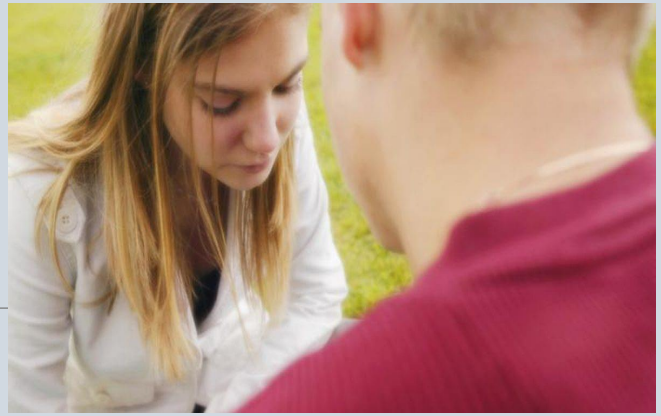
- Assess the airway and evaluate breathing.
- Provide interventions based on your findings

Circulation

- Assess the pulse rate, quality, and rhythm.
- Blood pressure
- Evaluate for shock and bleeding.
- Assess the patient's perfusion level.



COASTMAP



Consciousness
- Level
- Concentration

Orientation
- Year/month
- Location

Activity
- Behavior
- Movement

Speech
- Rate, volume, flow, articulation, and intonation

Thought
- Is the patient making sense?

Memory
- Recent
- Remote
- Immediate

Affect and mood
- Do the inner feelings seem appropriate?

Perception
- “Do you hear things others can not hear?”

Emergency Medical Care

If the erratic behavior could be caused by a medical disorder:

- Treat before presuming the behavior is due to an emotional or psychiatric cause.

Treatment decisions

- Disturbed patients should see a physician.
- If a patient withholds consent, they may be taken against their will with the help of SAPS
- Danger to self or others - Mental Health Care Act

Communication Techniques

Begin with an open-ended question.

Let the patient talk.

Listen, and show that you are listening.

Ask questions.

- Avoid “yes-no” or leading questions.
- Use “how” and “what” questions.

Adjust approach as needed.

Do not be afraid of silences.

Acknowledge and label feelings.

Do not argue.

https://medium.com/@larrylilian/the-importance-of-building-effective-communication-skills-d6cedf961097

Crisis Intervention Skills

Be calm and direct

Exclude disruptive people.

Sit down.

- Preferably at a 45-degree angle (SOLER)

Stay with the patient at all times.

Bring all medication to the hospital.

Never assume that it is impossible to talk with any patient until you have tried.

Maintain a nonjudgmental attitude.

Provide honest reassurance.

Develop a plan of action.

- Once the plan is set, allow the patient to exercise some control.

Physical Restraint

Discuss the plan of action before you begin.

- Include SAPS.
- Use the minimum force necessary.
- Don’t immediately move toward the patient.

If the show of force does not calm the patient, move quickly.

- Grasp at the elbows, knees, and head.
- Apply restraints to all four extremities.
- The best position is supine.

Once in place:

- Don’t remove restraints.
- Don’t negotiate or make deals.
- Place a mask over the face of a spitting patient.

Physical Restraint

Continuously monitor the patient.

Never place patient face down.

Check peripheral circulation every few minutes.

Be careful if a combative patient suddenly becomes calm.

Document everything

Never:

- Tie ankles and wrists together
- Place a patient facedown in a stretcher

Chemical Restraint

Use of medication to subdue a patient

- Only use with approval from medical practitioner
- Follow protocols and guidelines.

Haloperidol

- Administered either IM or IV
- Should not be administered to:
  - Patients younger than 14 years
  - Those with a suspected head injury
  - Those who may be pregnant

Chemical Restraint

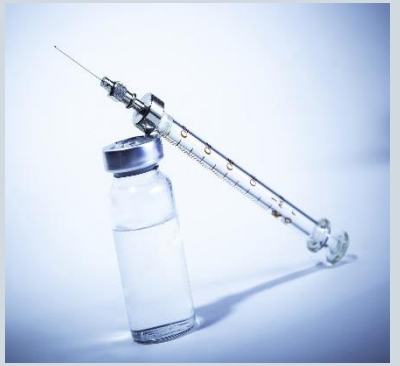
Benzodiazepines
- Diazepam (Valium), and lorazepam (Ativan).
- Side effects are usually mild and easily treated.

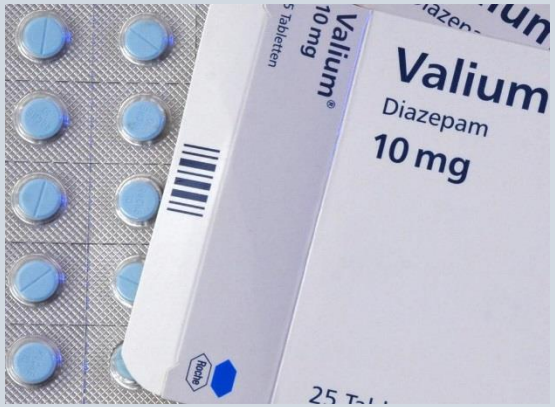
Closely monitor
- Pulse rate
- Blood pressure
- Respiratory rate

Be prepared to support ventilation.

Emergency use of medications are often required with violence.

Before administering chemical restraint, assess:
- Allergies
- Medical and medication history





Acute Psychosis

Pathophysiology

- Person is out of touch with reality
- Occur for many reasons
- Episodes can be brief or long-term (schizophrenia).

Assessment

- Characteristic: profound thought disorder
- A MSE is rarely possible.
- Use COASTMAP.

Consciousness

- Awake and alert
- Easily distracted

Orientation

- Disturbances more common in organic disorders

Activity

- Most commonly accelerated

Speech

- Neologisms

Acute Psychosis

Thought
- Disturbed in progression and content

Memory
- Relatively or entirely intact

Affect and mood
- Mood is likely to be disturbed.
- Affect may reflect mood or be flat.

Perception
- Auditory hallucinations

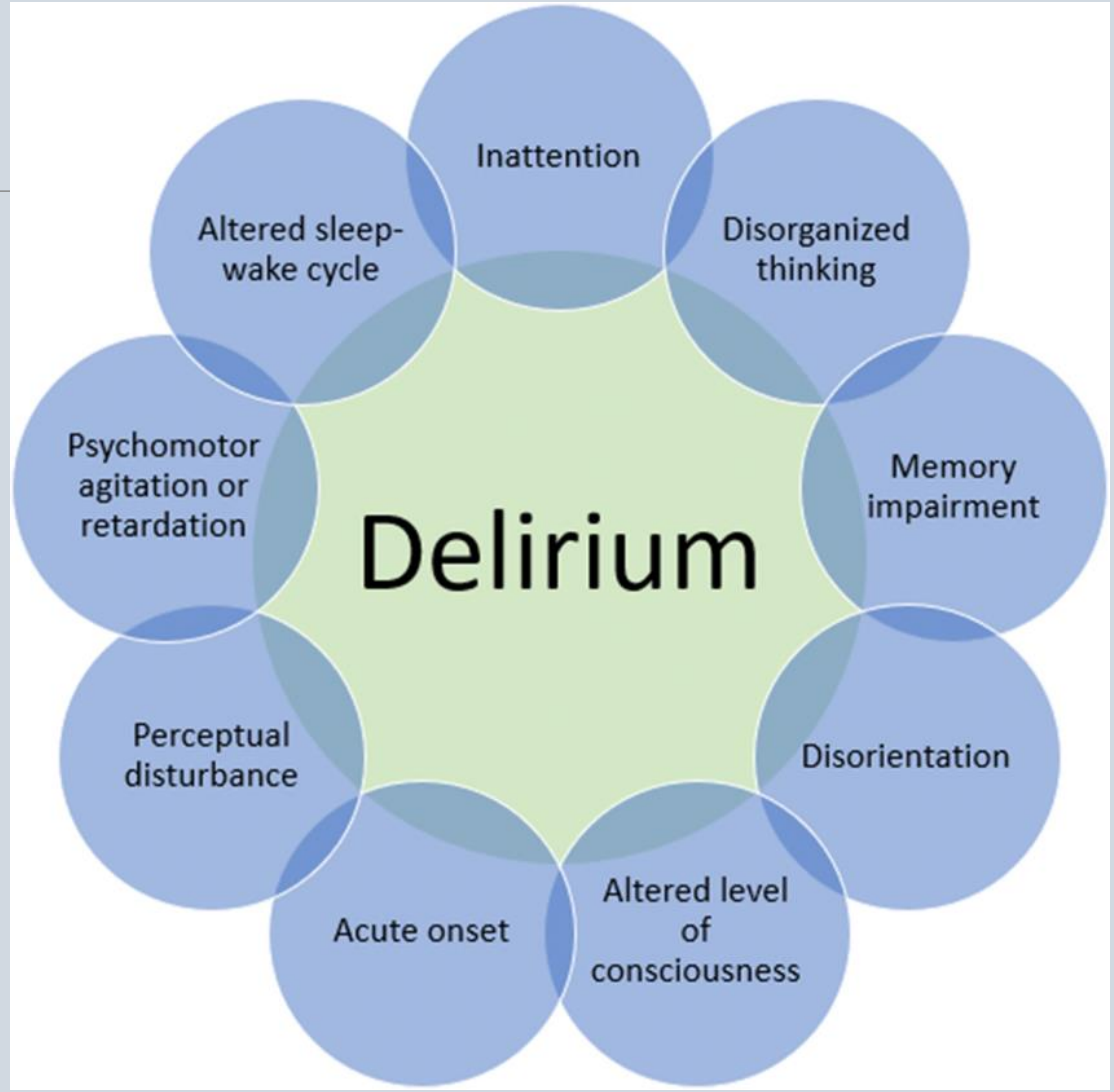
Management
- Reasoning does not always work.
- Explain what is being done.
- Directions should be simple and consistent.
- Keep orienting the patient.
- Before pharmacologic treatments, try:
  - Maintaining an emotional distance
  - Explaining each step of the assessment
  - Involving people the patient trusts
- When methods fail, it may be appropriate to:
  - Safely restrain the patient.
  - Administer medication.

Agitated Delirium

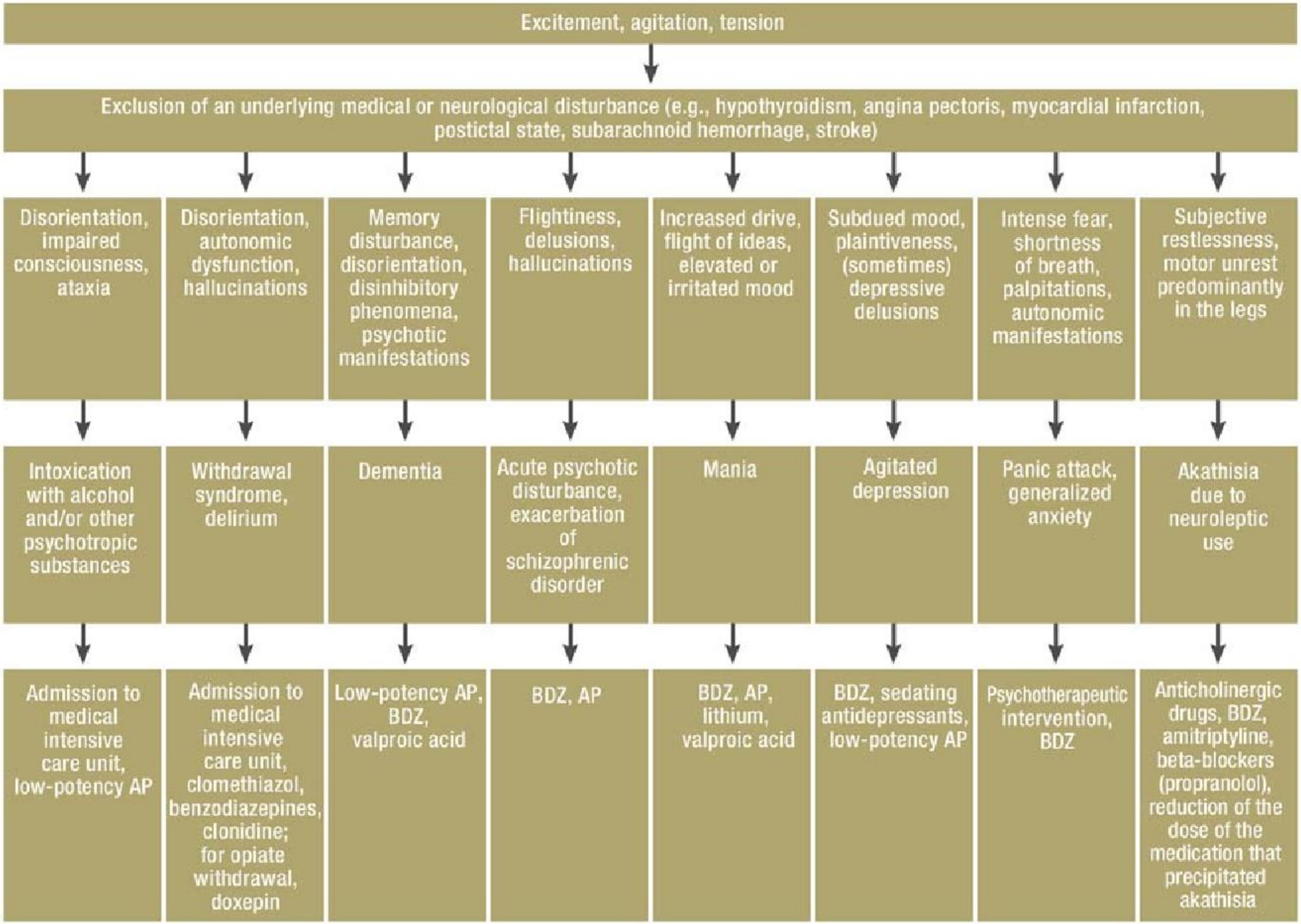
Pathophysiology
- Delirium: a state of global cognitive impairment
- Dementia: more chronic process
- Patients may become agitated and violent.

Assessment
- Try to reorient patients.
- Perform a thorough assessment.

Management
- Identify the stressor or metabolic problem



https://www.researchgate.net/publication/350326549_Delirium_Among_Adults_Undergoing_Solid_Organ_Transplantation



The differential diagnosis and acute treatment of psychomotor excitement and agitation

Patterns of Violence, Abuse, and Neglect

Abuse and neglect

- Assess the following:
  - The patient
  - The environment
  - Other persons involved
- Document findings, and report concerns according to protocols.

Violence

- Most angry patients can be calmed by a trained person who conveys confidence.
- Should prepare to deal with hostile or violent behavior. Preventive action is best to ensure no harm.

Identify situations with the potential for violence.

- Preventive action starts with being prepared for a possible violent encounter.

Warning Signs of Abuse and Neglect

Child	Elder
Serious injuries with no trauma history	Frequent injuries and seeking medical assistance at several locations
Delay in seeking treatment	Reluctance to seek treatment or denial of injury
Provided injury history is inconsistent with severity of injury	Disorientation or grogginess (possible misuse of medications)
Inconsistency or change to child history during evaluation	Fear or nervousness around family member or caregiver
Unusual injuries based on age and developmental level	Isolation from friends/family; sudden lack of contact from outside friends/family
High occurrence of UTIs or injuries to genitalia/rectum	Withdrawal, depression, helplessness, anger, or agitation
Unreported old injuries	Unpaid bills, sudden sale or disposal of property/belongings
Poor personal hygiene	Poor personal hygiene; presence of rashes, sores, or lice

Patterns of Violence, Abuse, and Neglect

Risk factors

- Alcohol or drug consumption
- Crowd incidents
- Violence has already occurred
- People who are:
  - Intoxicated
  - Experiencing withdrawal
  - Psychotic
  - Delirious

Warning signs

- Posture: sitting tensely
- Speech: loud, critical, threatening
- Motor activity: unable to sit still, easily startled
- Clenched fists, avoidance of eye contact
- Your own feelings

Management of the violent patient

- Assess the situation.
- Observe surroundings.
- Maintain a safe distance.
- Try verbal interventions first.

Management violent behavior

Remain calm, listen to what they are saying, ask open-ended questions.

Reassure them and acknowledge their grievances.

Provide them with an opportunity to explain what has angered them. Understanding the source of their frustration may help you find a solution.

Maintain eye contact, but not prolonged.

Aim to position yourself between the patient and the exit, keep away from corners and know how to raise the alarm in an emergency.

If the patient has a weapon, ask them to put it down. Don’t ask them to hand it over.

Use the panic button or call for help.

Leave the room and call security or the police.

If possible, move the patient to an area away from public view.

https://www.medicalindependent.ie/comment/medico-legal/a-guide-to-preventing-and-responding-to-violent-incidents/

Mood Disorders

Depression

Leading cause of disability in people 15- to 44-year olds

- Can occur in episodes with sudden onset and limited duration
- Onset can also be insidious and chronic.

Manic behavior

- Patients typically have abnormally exaggerated happiness with hyperactivity and insomnia.
  - Pressured and rapid speech
  - “Tangential thinking”
  - Grandiose and unrealistic ideas
- Be calm, firm, and patient.
- Minimize external stimulation.
- If the patient refuses hospitalisation, apply Mental Health Care Act.

Diagnostic features (GAS PIPES)

- Guilt
- Appetite
- Sleep disturbance
- Paying attention
- Interest
- Psychomotor abnormalities
- Energy
- Suicidal thoughts

Suicidal Ideation

Pathophysiology

- Suicide: any willful act designed to end one's life

Assessment

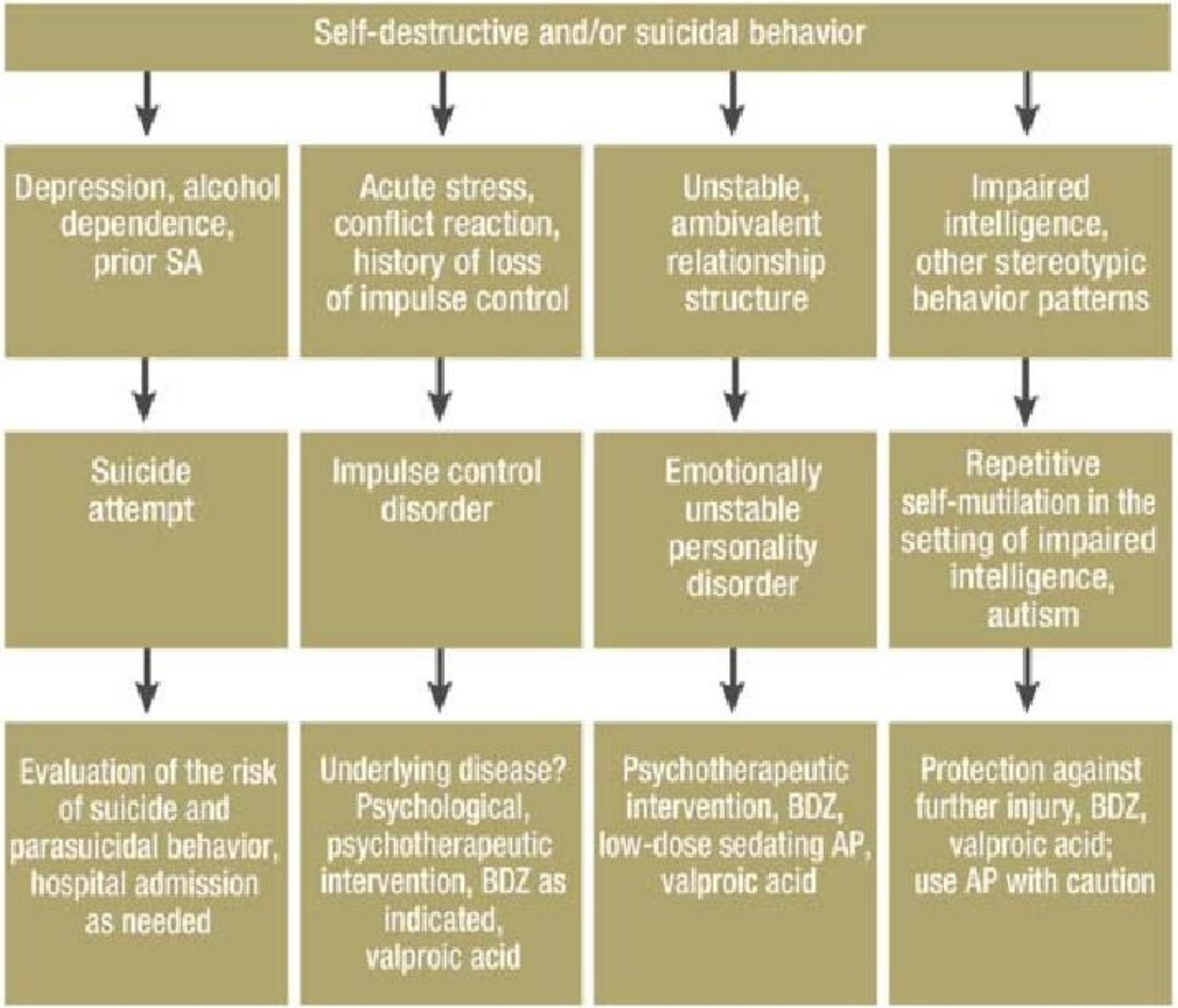
- Every depressed patient must be evaluated for suicide risk.
- Most patients are relieved when the topic is brought up.
- Broach the subject in a stepwise fashion.
- Higher-risk patients include patients who have:
  - Made previous attempts
  - Detailed, concrete plans
  - A history of suicide among close relatives

Management

- Don't leave the patient alone.
- Collect implements of self-destruction.
- Acknowledge the patient's feelings.

Table 6 Risk Factors for Suicide

■ Depression, or sudden improvement in depression	■ Expresses suicidal thoughts and concrete plans for carrying them out
■ Male gender, age < 55	■ Caucasian
■ Single, widowed, or divorced	■ Social isolation
■ Alcohol or other drug abuse	■ Previous suicide attempt(s)
■ Recent loss of spouse or significant relationship	■ Financial setback or job loss
■ Chronic, debilitating illness	■ Family history of suicide
■ Schizophrenia	


Self-destructive and/or suicidal behavior
Depression, alcohol dependence, prior SA
Acute stress, conflict reaction, history of loss of impulse control
Unstable, ambivalent relationship structure
Impaired intelligence, other stereotypic behavior patterns
Suicide attempt
Impulse control disorder
Emotionally unstable personality disorder
Repetitive self-mutilation in the setting of impaired intelligence, autism
Evaluation of the risk of suicide and parasuicidal behavior, hospital admission as needed
Underlying disease? Psychological, psychotherapeutic intervention, BDZ as indicated, valproic acid
Psychotherapeutic intervention, BDZ, low-dose sedating AP, valproic acid
Protection against further injury, BDZ, valproic acid; use AP with caution

Panic disorders

Panic Disorder is characterized by a white-knuckled, heart pounding terror that strikes with the force of a lightning bolt, without warning.

Some people feel like they are going mad, devoured by fear, dying of heart attack.

Because they cannot predict these attacks, many experiences persistent worry that another attack could overcome them at any time.

Most panic attacks last only a few minutes but could last up to ten minutes in rare cases.

Management includes a brief but relevant history and examination, investigation to rule out serious physical conditions.

If panic attack is suspected or confirmed, calm the patient and relatives.

Explain the symptoms and reassure patient that this is not a heart attack or life-threatening condition.

Teach breathing and relaxation exercises

- Separate from panicky bystanders.
- Provide a calm environment.
- Reassure the patient.
- Help the patient regain control.

Substance-Related Disorders

Regarded on four levels:

- Substance use
- Substance intoxication
- Substance abuse
- Substance dependence

Determining the most effective treatment requires an integrative approach.

Alcohol withdrawal seizures are often mistaken for epileptic seizures and treated wrongly.

Start oral diazepam detoxification regimen immediately

Diazepam 10 mg IV slowly stat and as required if patient develops withdrawal seizures or becomes very agitated and violent.

Give thiamine 100 mg IV stat before starting any IV fluid.

Determine types of drug abused and give symptomatic treatment such as non-opioid pain killers for pain, antispasmodic drugs for intestinal cramping pain or non-addictive major tranquilizers such as chlorpromazine and tricyclic antidepressant amitriptyline for insomnia.

Eating Disorders

May experience severe electrolyte imbalances.

Co-morbidity: anxiety, depression, and substance abuse disorders.

Bulimia nervosa
- Consumption of large amounts of food
- Compensated by purging techniques

Anorexia nervosa
- Weight loss jeopardizes health and lives
- Typical patient:
  - Decreased body weight based on age and height
  - Intense fear of obesity
  - Experience amenorrhea

Medications for Psychiatric Disorders and Behavioral Emergencies

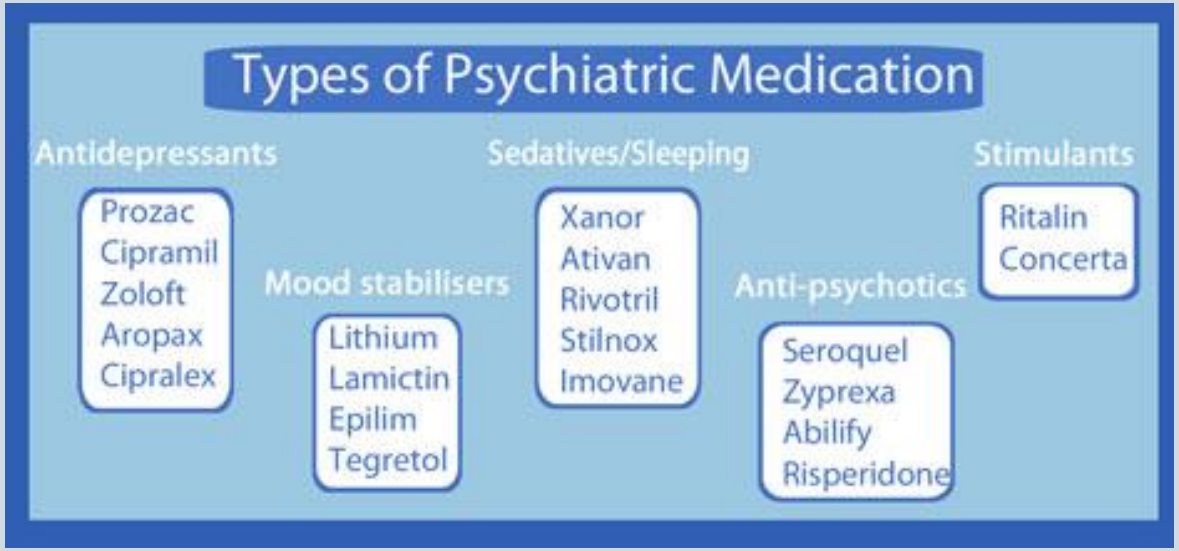
Patients may be taking any of several types of psychotropic drugs.

During assessment, determine:

- Which medications have been prescribed
- Whether they are being taken

Problems associated with medication noncompliance

- Increases the likelihood that a person with mental illness will commit a violent act



Psychiatric Medication Types

Antidepressants

- Combat the symptoms of depressive illness
- Alter levels of neurotransmitters in the autonomic nervous system

Antipsychotics

- Newer medications have less risk of adverse effects and are more effective.
- Known as atypical antipsychotic (AAP) drugs
- Relieve delusions and hallucinations.
- Improve symptoms of anxiety and depression.
- May cause metabolic side effects
- Cardiovascular effects depend on medication.
- May cause an acute dystonic reaction
- May cause atropine-like effects

https://www.healthcarefinancenews.com/news/mental-health-emergency-department-visits-outpace-non-psychiatric-episodes-study-says

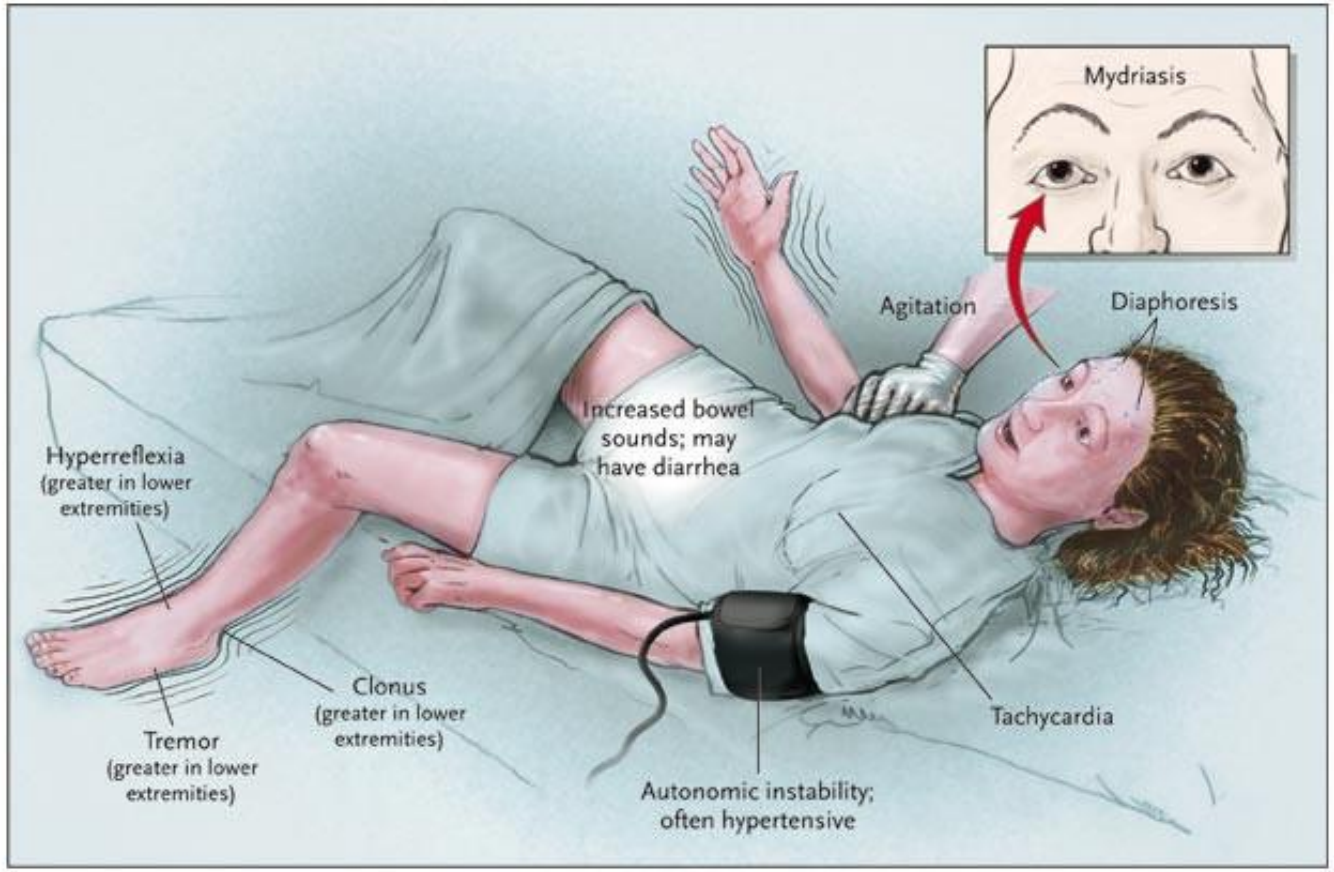
Psychiatric Medication Types

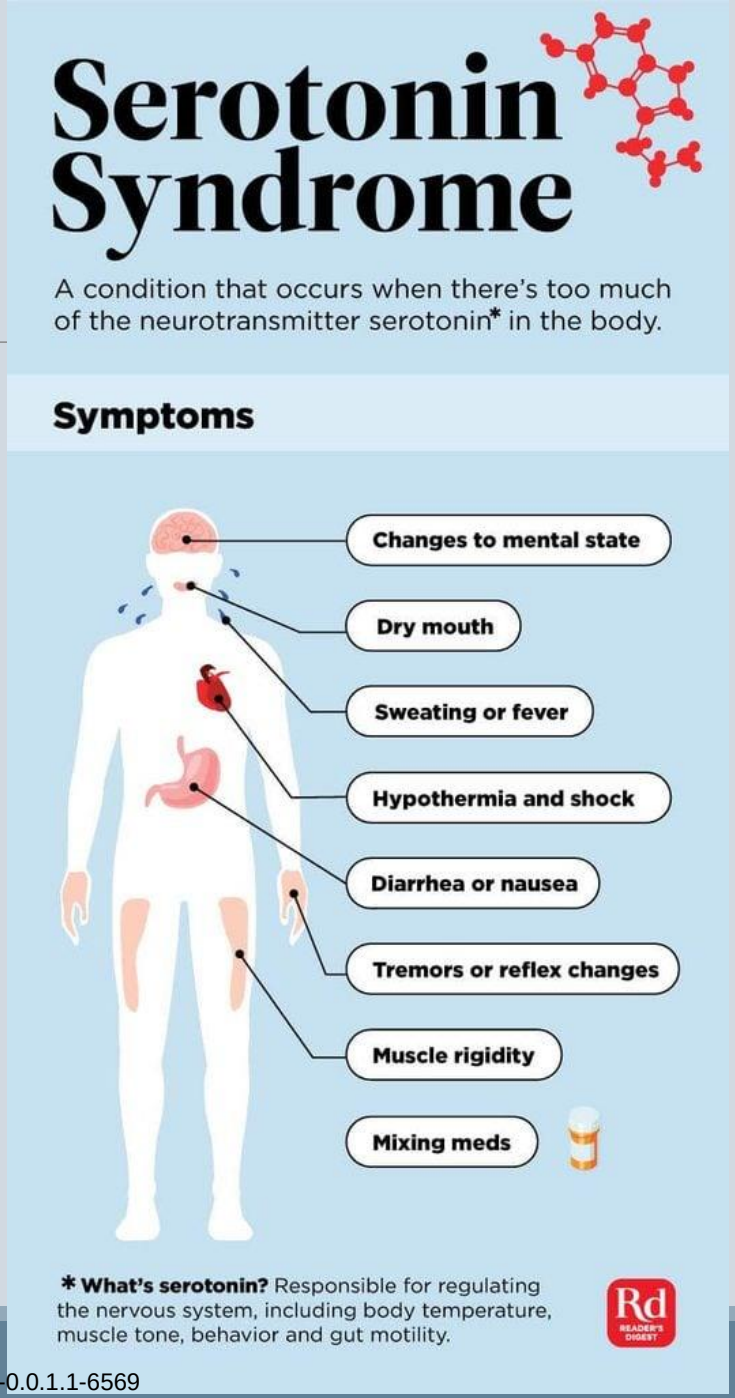
Benzodiazepines

- May be prescribed for severe emotional distress
- Contraindicated in patients with:
  - Known hypersensitivity to benzodiazepines
  - Acute, narrow-angle glaucoma
  - First-trimester pregnancy

https://www.healthcarefinancenews.com/news/mental-health-emergency-department-visits-outpace-non-psychiatric-episodes-study-says

Neuroleptic Malignant Syndrome





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Case study

Mrs G calls the ambulance three days after Mr G stopped drinking alcohol. Mr. G, age 49, got rid of all his alcohol and stopped drinking after his daughter threatened him with involuntary admission because of his longstanding harmful drinking habits. Mr. G's wife felt he was doing fine the first day, but his condition increasingly worsened the second and third days. Mr. G is tremulous, vomiting, and sweating. He seems preoccupied with pulling at his shirt, appearing to pick at things that are not there.

Case study

EMS arrive at the home of Mr. H, age 50, after his wife calls 911. She reports he has depression and she saw him in bed with a firearm as if he wanted to hurt himself. Upon arrival, the EMS enter the house and find Mr. H in bed without a firearm. Mr. H says little about the alleged events, but acknowledges he has depression and is willing to go the hospital for further evaluation. Neither his wife nor the officers locate a firearm in the home.

Case study

A 36-year-old man is running naked down the street. He claims the devil is talking to him and he is uncooperative. He refuses attempts to get him into the ambulance, and threatens aggression if forced. He is willing to take the EMS staff to his home where he stays with his wife.

Case study

EMS called by neighbors as John awakened and scared them by setting ladders against the house at 3:00 AM. Patient shouts from the ladder and tells EMS staff that he is “God” and would be rewriting the ten commandments. He is willing to answer questions but seems irritable and agitated. His wife is on the scene, crying and shouting at John to get off the ladder immediately.

History: 34 year old John is a house painter and began painting houses without owners’ permission since last week. He stated that they could pay him if they liked his work. He chose bizarre colors not routinely used in house painting. John is on medication prescribed by a psychiatrist three months ago for depression after his daughter moved to the UK.

Case study

32 year-old female paramedic recently promoted to supervisor. Despite things going well at work, and fairly well at home, she begins suffering depressive symptoms. Patient loses interest in job and in her children's activities. Patient refuses to work for fear that she might injure a patient or wreck an ambulance. Patient loses 18 pounds in a month and sleeps 18 hours a day. Patient cries often and feels that her life is hopeless. EMS called as patient threatened to cut her wrists but refuses to leave the house to see a doctor.

Case study

Michael is a 70 year old patient with sudden confusion. Stays on his own and found by his daughter in a confused state. He is irritable, restless and hyperactive. He walks up and down with a kitchen knife in his hand and threatens to stab the EMS staff stating they are police officers who want to arrest him and he did nothing wrong.

Michael is on medication for hypertension. He started using herbal medicine a week ago for his arthritis on advice of a friend.

Case study

Dave is a 22-year-old male presenting with difficulty breathing at the shopping mall. He points to his chest and utters the following, in between gulping for air: “Its my wife’s fault… she forced me to do the shopping today…I am going to die today…help me….”

History when you called Dave’s wife: Over the last 6 months, Dave has had several instances where he felt an intense fear that would reach a peak within a few minutes. During these instances, he would also experience sweating, heart palpitations, chest pain and discomfort, and shortness of breath. At times, Dave worried that might die. As a result, Dave has persistent worry and has begun to avoid unfamiliar places and people. His doctor did several tests and told Dave and his wife that he must just try to relax as there is absolutely nothing wrong with him.

Case study

41 year old Jane was found by her husband, Tom who suspected she took an overdose.

Tom returned from the rugby match, smells of alcohol, talks loudly and is overly eager to provide information.

Jane is lying in bed and is responsive but mumbles incoherently when asked a question.

History: Jane verbalised suicidal thoughts over the past two months. She has a history of Bipolar 1 and takes medication for epilepsy. She recently lost her sister, Anne to suicide. Anne was her family support system. Tom is Jane's 2nd husband and becomes aggressive when drunk.

Summary

Behavioral emergencies can present unique challenges in patient management. Focus on reducing the patient's stress without exposing yourself to unnecessary risks.

A behavioral or psychiatric emergency is any reaction to events that interferes with activities of daily living.

Behavioral emergencies can be a temporary response to a traumatic event.

Calls for behavioral emergencies have special medical and legal considerations.

Always involve SAPS when called to assist a patient with a severe behavior or psychiatric crisis.

Situations involving violence, abuse, and neglect can have the potential for escalation and the possibility of evoking emotional responses in you.

Patients with psychiatric emergencies may be taking any of several types of psychotropic drugs. During assessment, determine which medications have been prescribed and whether the patient is actually taking them.

Summary

If a patient poses an immediate threat, leave the area until SAPS secure the scene.

Underlying causes of behavioral emergencies: biologic (organic) causes, causes resulting from the person's environment, causes resulting from acute injury or illness, and causes that are substance related.

Psychiatric signs and symptoms occur when mental health is challenged and psychological mechanisms or behaviors mobilize to return the person's mental state to homeostasis.

Assessment of a disturbed patient differs from other assessment methods: you are the diagnostic instrument. Assessment is also part of the treatment.

When providing care, be direct, honest, and calm; have a definitive plan of action; stay with the patient at all times; and express interest in the patient's story.

When sizing up the scene, pay special attention to potential dangers and objects that may be used as potential weapons, hazardous chemicals, etc. Remove potentially harmful objects.

Summary

Primary assessment includes identifying yourself, forming a general impression of the patient's condition and the nature of the problem, assessing the ABCs, making a decision about transport, and taking a history via the mental status examination.

Secondary assessment involves looking for signs of an organic cause of the behavioral emergency.

Use of chemical or physical restraints is reserved for times when verbal intervention fails to reduce severe agitation.

Management is focused on ensuring scene safety and maintaining awareness of life-threatening conditions, while treating the patient for any medical disorders.

Effective communication techniques include beginning with an open-ended question, showing that you are listening, allowing silence when appropriate, avoiding argument, facilitating communication, and asking questions.

Summary

Crisis intervention skills include staying calm and being direct, excluding disruptive people from the scene, maintaining a nonjudgmental attitude, developing a plan of action, and assuming that the patient can hear and understand everything you say.

Pathophysiologic factors that contribute to behavioral disturbances include cognitive impairment, thought disorders, mood disorders, anxiety disorders, substance-related disorders.

You may encounter patients with psychosis, a thought disorder characterized by hallucinations or delusions in which the person is out of touch with reality.

You may encounter patients with agitated delirium. This is impairment of cognitive function that can present with disorientation, hallucinations, or delusions, and is characterized by restless and irregular physical activity.

The threat of suicide requires immediate intervention. Depression is the most significant risk factor for suicide.

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