EMS Subspecialty Certification Review Course

1.3.10 Behavioral Emergencies
1.3.10.1 Managing Combative Patients
1.3.10.1.1 Use of Restraints (Chemical vs Mechanical)

Version: 2017

Question

Which of the following is recommended when physically restraining a patient?

a) Transport prone
b) Avoid law enforcement assistance
c) Use soft restraints
d) Monitor the patient until control is achieved

Learning Objectives

Upon the completion of this program participants will be able to:

• Provide an overview of how to assess and treat the patient with a behavioral or psychiatric emergency in the pre-hospital setting.

• List 5 criteria patient’s with behavioral emergencies must fulfill to exercise no transport option

• Discuss the modified approach for the evaluation and management for the behavioral patient versus the routine patient.

• Describe the methods of patient restraint, pros and cons of both, and important issues to be addressed in EMS protocols for restraint.
Introduction

- The EMS Medical Director must appreciate a relative paucity of published literature on the approach to the patient with behavioral emergencies (BE).
- Being confronted by a patient with BE can be stressful and time consuming and often requires special attention to patient and provider safety.
- The evaluation and management of the emotionally disturbed patient requires a modified approach from that of the routine patient.

Conditions to Consider

**Organic Disorders with Behavioral Manifestations**
- Neurologic
  - E.g. Mass lesions, CNS Infections
- Drug Intoxication & Poisoning
  - E.g. anti-cholinergic syndromes
- Withdrawal Symptoms
  - E.g. alcohol
- Metabolic
  - E.g. hypoglycemia
- Endocrinologic
  - E.g. Addison's Disease

**Common Psychiatric Conditions**
- Anxiety Disorders
  - Panic attacks
- Major Depressive Disorder
  - Suicidal ideation
- Schizophrenia
  - Hallucinations, paranoid, bizarre delusions, disorganized speech / thinking
- Bipolar Disorder
  - Manic, depressive, rapid cycle

Many different causes for both the examples in each column.

Neurological: CNS infections, head trauma, hypertensive encephalopathy, stroke, seizure disorder, dementia
Drug Intoxication: alcohol, amphetamines, cocaine, LSD, marijuana, bath salts, PCP
Withdrawal: barbiturates, opiates
Metabolic: hypoxia, renal failure, acidosis, electrolytes, hepatic failure
Endocrine: hyper/hypothyroid, cushings

Anxiety Disorder – may have physiologic changes inc/HR, incr RR, sweating, weakness
Panic Attack – acute extremely heightened level of anxiety, disorganization of personality and function
Major depression – check for suicidal thoughts, ideation
Schizophrenia – disturbance of thought, mood, behavior, relationship to external world
Bipolar disorder – Mania, depression, may or may not be separated by periods of normal mood
Common Approach to BE Patients

• **Priority - Ensure scene safety** for patient and providers.
  • Attempt to perform a **brief medical assessment** to ensure medical stability.
    – Special attention to environment, history, and physical examination for abnormal neurological findings.
    – **Suspicion for organic / medical cause of psychiatric symptoms?**
  • Once medical stability determined, perform more thorough history and physical
    – Blood glucose
    – Oxygen sats
    – Recent drug ingestion
    – Vital signs
• Any abnormal vital signs OR new onset psychiatric symptoms should be considered organic etiology until proven otherwise!

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Common Approach to BE Patients

• If medically stable, determine whether the patient’s mental state represents a **danger to self or others**.
• If uncooperative patient, attempt to gain rapport / patient confidence. Use EMS physician if needed.
• Careful and extensive **documentation**.
• Utilize a **coordinated response** with police as required.
• Medical Clearance of psychiatric patients in the field is difficult and no-transports should be done only under direct physician supervision. Use extreme caution!

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Scene safety – await law enforcement if any question of scene safety

Controversies and Common Mistakes include

1. failure to perform a complete medical evaluation
2. tendency for EMS personnel to minimize the need for EMS intervention
3. not spending sufficient time talking to the patient ad establishing rapport
4. lack of interagency coordination

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Critical Elements of Non-transport of the BE Patient

1. The patient has the capacity to refuse.
2. Organic etiology has been ruled out by appropriate medical evaluation.
3. No evidence of suicidal or aggressive behavior is present.
4. There is a known past history of psychiatric disorder with similar behavior.
5. Appropriate social, family or mental health support is available.

Capacity vs. Competence is a legal judgment

The EMS provider must choose between:
- Assault of the patient (battery) by forcing medical care on the patient who is refusing.
- Inadequately treating an incapacitated patient with subsequent accusation of negligence and/or abandonment.

Most systems would find it easier to defend transport against a patient’s desires vs. finding a person dead in their home holding a signed EMS refusal form.

Consultation with the direct medical oversight physician is essential.

When the patient is unable to adequately make decisions and is uncooperative with care, law enforcement involvement may be required.

If the patient is a danger to him or herself and/or to others then the use of physical and or chemical restraints should be carefully considered.

Depending on the jurisdiction this may mandate law enforcement involvement.

Exceptionally careful documentation of these situations is essential.

Refusals are medico legal

The Suicidal Patient

- More people die from suicide than homicide in the US
- Always take suicidal threats seriously. UP to 2/3 of patients who complete suicide were seen by a physician within the previous month.
- EMS providers should show empathy. Avoid challenging comments and negative attitude.
- Transport patient secured to stretcher, away from exits. Consider pharmacologic intervention.
- If patient is refusing, EMS physician must be involved. Involve law enforcement.
- Involuntary transport laws vary from state to state.
Passive suicidal ideation – thoughts without a plan
Active suicidal ideation – accompanied by a plan
Suicidal gesture – self-inflicted harm without realistic intent / expectation of death
Suicide attempt – self-inflicted harm with clear expectation of death

Some people inflict self-harm to relieve anxiety (cutting, pica, etc.)

Scene
- Law Enforcement if needed
- All weapons should be removed from scene
- If a person on scene is part of crisis, remove that person

Look for signs of suicidality

Consider pharmacologic intervention – benzos for anxiety and agitation,
Alternatives may be neuroleptic or diphenhydramine
Ketamine emerging as sedative.

High-risk factors for suicide completion

- History of attempts
- Detailed / violent plan
- Psychiatric diagnosis (depression, Schizophrenia, bipolar disorder, etc.)
- Medical problems – terminal disease, chronic pain
- Drug and/or alcohol abuse
- Widowed/divorced, recent loss of a loved one
- Unemployment
- Poor social support
- Family history of suicide / psychiatric disorders
- Age over 45
- Women attempt more often, Men complete more often

The Violent Patient

- EMS providers not well trained in management of violent patients
- Safety evaluation first – law enforcement involvement
- Look for signs of medical instability, organic etiology
- Look for clues of impending violence – loud voice, moving around, gesticulating, etc.
- Investigate for history of violence, psychiatric illness, substance abuse
Scene safety:
- Never leave patient alone
- Maintain a safe distance from patient
- Maintain providers' escape route(s)
- Remove weapons
- Avoid prolonged eye contact
- Attempt to verbally de-escalate situation
- Be supportive, never argumentative

Patient Restraint

- Major indication is when the patient is considered to have lost the capacity for medical decision making and their behavior precludes a thorough evaluation and/or emergent treatment.
- Three general methods of patient restraint:
  -- Verbal De-escalation
  -- Physical Restraint
  -- Chemical Restraint
- EMS Physician must be involved in the decision, and must know his/her state statutes regarding transport of a patient against his/her will.

Key Principles with Restraint

- Every EMS agency should have a protocol for dealing with violent or combative patients.
- Personnel Safety, followed by patient safety
- Patient Dignity
- Methods of Restraint
- Indications for Restraint
- Documentation Requirements
- Medical Oversight and Quality Improvement
Physical Restraint

• **Coordinated response** with law enforcement in initiation of restraint and transport.
• EMS personnel have limited training and experience in appropriate restraint techniques & may become injured in the application.
• Minimal physical restraint needed to maintain responder and patient safety should be used. Use soft four-point restraints. Avoid use of hard restraints.
• Providers should **maintain constant monitoring** of vital signs, resp status, and neurovascular status limbs.
• **NEVER** “hog-tie”, “sandwich”, or transport in the prone position!

Chemical Restraint

• More effective and humane than physical restraint
• May help prevent complications of physical restraint (asphyxia, aspiration, acidosis, rhabdo, cardiac arrest)
• Combo chemical-physical restraint is best approach
• Must involve EMS physician oversight
• Med used should:
  — Be available in IM or IN form, in case IV not available
  — Have rapid onset and short half-life
  — Limited CNS depression, resp depression, and side effects
• Butyrophenones (i.e. haloperidol) or benzodiazepine or combo.
• Ketamine emerging

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Take-Home Points

• Psychiatric and behavioral emergencies represent a unique challenge for out-of-hospital care professionals.
• An organic etiology must always be assumed until proven otherwise.
• Evidence-based protocols and frequent training sessions with other safety agencies yield optimal results.
• EMS agencies should have robust protocols for physical and chemical restraint of patients.