Behavioral Issues and the Legal Ramifications

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Psych…ARG

- How do you handle psychiatric problems?
- How do you document it?
- What is important?
- AM I GOING TO GET IN TROUBLE OVER THIS?

Behavioral Issues and the Legal Ramifications

- ECO [Emergency Custody Order]
- TDO [Temporary Detention Order]
- Commons Psychiatric Problems/Emergencies
- Common Medical Problems Mimicking Psychiatric Emergencies
- Psychiatric Medications “Pearls”
- Current Hot Topics In EMS: Excited Delirium

- “The length of this document defends it well against the risk of being read.”
  - Winston Churchill

ECO: Emergency Custody Order

- Order allowing a law enforcement officer to take a person into custody and transport them for treatment
- Issued by a Magistrate
- From information given by sworn petition of:
  - Responsible person (EMS, family, friends, CSB, suicide hotline staff)
  - Treating physician
  - Magistrate's own motion

ECO: Probable Cause

- Probable cause that a person has a mental illness and that they are likely to:
  - Cause serious physical harm to themselves or others as evidence by recent behavior causing, attempting, or threatening harm and other relevant information
  - Suffer serious harm due to their lack of capacity to protect themselves from harm or to provide for their basic human needs
  - Need hospitalization or treatment
- Is unwilling to volunteer or incapable of volunteering for hospitalization and treatment

ECO: Capacity

- Determining whether or not a patient is psychologically or legally capable of adequate decision-making.
- Illness, medications or substance abuse may:
  - Impair the ability of a patient to make decisions about their health
  - Render them unable to make decisions at all
  - Lead them to make choices that are not in their best interests and may result in serious harm

ECO: Capacity

- Awake, alert and oriented to person, place, time and situation?
- Any drugs, alcohol or other substance impairing judgment?
- Is there an injury or suspected injury?

ECO: Magistrate

- Takes into account:
  - Recommendations of any treating or examining physician or psychologist licensed in Virginia
  - Any past actions of the person
  - Any past mental health treatment of the person
  - Any relevant hearsay evidence
  - Any medical records available
  - Any affidavits submitted if the witness is unavailable
  - Any other available information that the magistrate considers relevant

ECO: Transport

- After being taken into custody and transported to a convenient location to be evaluated to determine whether the person meets the criteria for TDO
- May need EMS transport due to:
  - Trauma: lacerations
  - Ingestions: Overdose
  - Emergency medication for patient's safety: Hadol and Ativan
  - Need to stabilize other medical problems
  - Off medications

ECO: Issue

- Magistrate specifies the primary law enforcement agency and jurisdiction to execute the ECO and provide transportation
- Medical facility to obtain medical evaluation or treatment

ECO: Evaluation

- What happens when the patient gets to the Emergency Department?
- Medical clearance
- Do they need to be hospitalized or treatment plan?
- This can only be done by CSB

ECO: Police

- Any law enforcement officer based on their observation or the reliable reports of others, has probable cause to believe that the person meets the criteria for emergency custody, may take that person into custody and transport that person to an appropriate location to asses the need for hospitalization or treatment without prior authorization
- 4 hours, can extend 2 hours if:
  - CSB needs more time to find a facility for TDO
  - Medical evaluation needs more time
- After 6 hours time is up – order expires…

- “I don’t suffer from insanity; I enjoy every minute of it.”
  - unknown

Assessing Mental Status

- Behavior: What is the patient doing or what have they done?
- Affect: What feelings are the patient displaying?
- Orientation: Does the patient know what is happening, where, when, and who?
- Language: Is the patient understand and being understood?
- Memory: Can the patient recall historical details, recent and remote?
- Thought content: Is the patient reporting beliefs that make sense?
- Perceptual abnormalities: Is the patient experiencing unusual sensory phenomena?
- Judgment: Is the patient able to make rational decisions?

For example…

Examples of EMS: Case 1

“Presented W/ a mid 50's male responsive to voice. Pt A&Ox3 sitting against a fence, dirty, emesis present on shirt. Police on scene stated they were called due to patient being "too drunk" to walk. Strong odor of ETOH present pt admits to drinking a" few "drinks. Pt denied any injury. Pt stated "Just leave me alone and I can make it home, I don't need to go to the hospital." Asked patient to stand so his ability to walk could be assessed. Pt able to get on all fours, unable to stand on own without stumbling and falling. Pt was prevented from falling by EMS crew. Pt assisted to stretcher. Pt compliant with requests to sit on stretcher to be assessed. Pt again denied any injuries. Head to toe RTA: unremarkable. Vitals as charted WNL. Pt not aware of when he had vomited. Pt again stated he did not want transport to the hospital. Informed pt it was too dangerous to leave him on the street. Pt became more cooperative as he was taken into back of medic. Vitals retaken and remained WNL as charted. Pt had episodes of crying and self-deprecation. Consoled pt and continued transport. TOT ER staff w/ report no changes in pt condition.”

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Examples of EMS: Case 2

- C: 32 yo female A&Ox2. Agitated, screaming and crying at family and police. Dispatched for overdose- suicide. Pt had cut self with knife to left forearm. Pt holding towel to forearm. Police secured knife and scene. Multiple bottles of medication open. Numerous pills on bathroom floor. Pt family stated pt started taking random pills before she cut herself. Not sure how many and what amounts. Pt stating she wasn't going to the hospital. H: Hx of manic/depressive, seizures, attempted suicide in past has been hospitalized long term for psyche disorders. Pt family stated pt may have stopped taking her meds. possibly 4 days to a week ago.
  A: RTA:Head/neck:-dcapbtls, chest:-dcapbtls abd:-dcapbtls, pelvis: stable; ext:-dcapb +2 inch laceration on left forearm into muscle, oozing of blood no spurting, or contusion present. good pms in left wrist, other ext: -dcapbtls. Vitals as charted.

Examples of EMS: Case 2

- R: While attempting to asses pt's injury she became combative to crew and police on scene. Pt restrained manually, and then with soft restraints and handcuffs in supine position on stretcher. Positive pulses in all ext. No secondary injuries found due to restraint of pt. Wound dressed with 4x4 gauze and kling. Pt despondent and not responding to questions about when she last took her prescribed medications, or how much of which medications she took in bathroom. All bottles from bathroom brought to ER.

- T: Pt continued to be non cooperative, in providing any information on medications taken. She was still agitated and cursed at medic crew and police who accompanied Medic to ER. Core report called no orders given. TOT ER staff pt still combative and tried to get off of bed prior to restraints being tied back down.

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Examples of EMS: Case 3

- C: Presented with 42yo male alert yet disoriented. Pacing in day room not making eye contact or regarding EMS presence. Called to group home for AMS of pt who has hx of schizophrenia. Staff stated he has had several out bursts which have made no sense. Staff suspect he has been hiding his medication and spitting it out. H: Schizophrenia, depression, OCD

Examples of EMS: Case 3

- A: Pt was mumbling, and talking in a tangential stream of phrases and statements. When he was approached he backed to the wall and became silent, appeared to brace himself. Medic crew backed out of room to door, keep view of patient. Asked staff if any possible weapons in day room told pt probably had dinner knife. Contacted dispatch to send engine company and police. Upon arrival of police and engine company pt had resumed pacing and mumbling to self. Police knew patient and stated he did get violent at times. Police instructed pt onto stretcher. Pt had backed to the wall again and braced himself. Haldol IM dose prepared. Crew and police given limb assignments.. Police took pt down, with engine company assist, 5mg Haldol given IM. Pt restrained to stretcher with soft restraints in supine position. Good pulses all ext. Vitals as charted. Pt remained sedated in route to hospital. Core report given no orders.

- T:Pt still sedated upon TOT ER staff. Vitals WNL

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De-Escalation

- Remain calm and friendly, use a soothing tone of voice
- Position yourself between the patient and YOUR exit
- Keep your hands in front of your body (Non-threatening manner)
- Only one provider should communicate with the patient
- Listen to the patient's concerns
- Empathize, use positive feedback
- Be reassuring. Outline the patient's choices
- Be willing to slow down and disengage if appropriate
- Calmly set boundaries of acceptable behavior

- “Always laugh when you can. It is cheap medicine.”
  - Lord Byron

TDO: Involuntary Temporary Detention Order

- Commits a person to psychiatric treatment when they are unwilling to volunteer or incapable of volunteering for hospitalization or treatment.
- A magistrate orders the TDO
- CSB person who has evaluated the patient can petition for a TDO

TDO: Involuntary Temporary Detention Order

- Criteria for issuing TDO:
  - Mental illness that could cause serious physical harm to the patient or others
  - Possibility of suffering serious harm due to the patient's lack of capacity to protect himself or to provide for his basic human needs
  - Evidenced by recent behavior causing, attempting, or threatening harm and other relevant information
  - The patient is in need of hospitalization or treatment

- “Isn’t it a bit unnerving that doctors call what they do ‘practice’?”
  - Goerge Carlin

Commons Psychiatric Problems/Emergencies

- Substance Abuse
- Severe Cognitive Impairment: Dementia, Delirium, Amnesic
- Schizophrenia
- Mood Disorders: Depression and Bipolar (mania)
- Affective Disorders
- Anxiety Disorders
- Antisocial Personality Disorder

Commons Psychiatric Problems/Emergencies

- Is this person or will this person be harmful to themselves or others?
- Do they need protection from themselves and others?

Substance Abuse: Intoxication

- Recent ingestion of a specific exogenous substance producing a maladaptive behavior and impairment of:
  - Judgment
  - Perception
  - Attention
  - Emotional control
  - Psychomotor activity without delirium or hallucinations

Substance Abuse: Withdrawal

- Particular to the drug/substance
  - Alcohol: sweating, tachycardia, hallucinations, global confusion, Delirium Tremens (DTs)
  - Narcotics: anxiety, insomnia, yawning, lacrimation, diaphoresis, rhinorrhea, diffuse myalgias, piloerection, mydriasus, nausea, vomiting, diarrhea, and abdominal pain
  - Benzodiazepines: anxiety, irritability, insomnia, nausea, vomiting, tremor, sweating, anorexia, confusion, psychosis, and seizures

Severe Cognitive Impairment

- Dementia: abnormal memory, limited abstract thinking, impaired judgment, changes in personality or other problems with higher cortical functions such as language
- Delirium: clouding of consciousness and reduction in the awareness of the external environment, varying degrees of alertness
- Amnesia
- These patients cannot recognize that they have a problem
- Underling Reversible Causes: Metabolic and endocrine disorders, polypharmacy and depression

Schizophrenia

- 1% of the world's population
- Presents with deterioration in function:
  - Psychotic Symptoms
  - Primary Delusion: fixed false beliefs that are not amenable to arguments of facts to the contrary and are not shared by others of similar cultural backgrounds (Persecutory, Grandiose, Bizarre)
  - Hallucinations: false perceptions, experienced in a sensory modality and occurring in a clear consciousness

Schizophrenia

- Symptoms ongoing for 1 month
  - Disorganized speech or behavior
  - Catatonic behavior
  - Blunt affect
  - Emotional withdrawal
  - Lack of spontaneity
  - Anhedonia
  - Attention impairment
  - Loose Associations and Incoherence

Schizophrenia

- Reasons for transport and emergency medical evaluation of a Schizophrenic patient
  - Stress or non-compliance with medication
  - Suicidal behavior
  - Violence
  - Extrapyramidal side effects of medication
  - Homeless, unable to care for their own medical problems

Other Psychotic Problems

- Schizophreniform: when a patient meets criteria for Schizophrenia but symptoms have been present for less than 6 months
- Brief Psychotic Disorder: acute psychotic symptoms lasting less than 4 weeks after an extremely traumatic life event

Mood Disorders

- Affects 10 to 15% of US population
- Episodic
- Types
  - Major Depression
  - Bipolar (mania)
  - Dysthymic Disorder

Mood Disorders: Major Depression

- Persistent sadness, depression or loss of interest in usual activities lasting for at least 2 weeks
- Guilt over past deeds, self-reproach, feelings of worthlessness or hopelessness, inability to experience pleasure
- Recurrent thoughts of suicide
- Problems sleeping, fatigue, appetite loss, inability to concentrate

Risk factors for suicide

- Male
- Separated, divorced or widowed
- Chaotic or stressed family and family history of suicide, unsupportive family, socially isolated
- Relationship turmoil or recent break up
- School problems
- Unemployed
- Health problems
- Previous attempts

Mood Disorders: Bipolar

- Mania cycling with periods of depression
- Mania mood is elation or irritability, patients are hyper-energetic
- Decreased sleep, rapid pressured speech, racing thoughts
- Grandiose ideas, unrealistic plans can become delusional
- Poor judgment: excess spending, promiscuous sexual behavior, lack of insight

- “They said patient is a Axis I problem, what does that mean?”

Multiaxial Psychiatric Assessment

- Axis I: Mental disorders
- Axis II: Personality disorders and mental retardation
- Axis III: General Medical Conditions
- Axis IV: Psychosocial and environmental problems
- Axis V: Global assessment of functioning

- “Be nice to your your medic or nurse, needles come in the size that they choose.”
  - Unknown, from somewhere on the internet

Common Medical Problems Mimicking Psych Emergencies

- Hypoglycemia: CHECK BLOOD SUGAR!
- Meningitis: fever, stiff neck, rash
- Thyroid problems
  - Thyroid storm
  - Severe hypothyroid
- Drugs and medication reactions: dystonic reactions
  - Drugs used for treatment of nausea and depression
- Stroke
- Head injuries

Common Medical Problems Mimicking Psych Emergencies

- Is the patient stable or unstable?
- Does the patient have a serious medical condition causing abnormal behavior or thought processes?
- Do I need to force the patient to come in for emergency evaluation? [Call a law officer for ECO]
  - Violent behavior

- “Nothing sucks more than the moment during an argument when you realize you’re wrong.”
  - unknown

Psychiatric Medications

- Medications used to treat problems can also cause problems
- Medications are symptom- NOT disease-specific
  - Antipsychotics (Neuroleptics)
  - Anxiolytics
  - Heterocyclic Antidepressants (Tricyclics)
  - Monoamine Oxidase Inhibitors
  - Selective Serotonin Reuptake Inhibitors
  - Mood Stabilizers: Lithium and Anticonvulsants

Psychiatric Medications

Emergencies most common drugs:

- **Haldol**: Haloperidol-high potency rapid onset neuroleptic
- Contraindications: previous allergies, pregnancy, overdose with anticholinergics, Parkinson's disease or other movement disorders, PCP toxicity
- 5 mg IM most common dose

Haldol and/or Lorazepam (Ativan)

- **Lorazepam**: Anxiolytic Benzodiazepine
- Safer if an overdose is expected
- Treats cocaine intoxication and alcohol withdrawal
- 1 to 2 mg IM or IV most common dose

Psychiatric Medications: Antipsychotics

- Antipsychotic (neuroleptics) medications block dopamine receptors in the CNS
- Used to control behavior that constitutes an imminent danger to the patients or others
  - Violence
  - Agitation
  - Hostility
  - Tension

Psychiatric Medications
Antipsychotic

- Side Effects:
  - Acute Dystonia: spasms of the neck, face, and back. Treated with Benadryl or Benztropine
  - Akathisia: sensation of motor restlessness with subjective desire to move, treated by stopping the drug that caused it, beta blocker
  - Parkinsonism: bradykinesia resting tremor, cogwheeling, shuffling gait, masked affect
  - Anticholinergic: sedation to delirium
  - Cardiovascular effects: Torsades De Pointes
  - Neuroleptic Malignant Syndrome (NMS)

Antipsychotic: Typical vs Atypical Agents

- Typical (also called “Conventional”): used to control hallucinations, delusions and disorders of thought- older medications:
  - Thorazine, Compazine, and Haldol
- Atypical: new drugs, fewer side effects
  - Zyprexa, Seroquel, Risperdal, and Geodon

Psychiatric Medications: Anxiolytics

- Used for severe emotional distress, panic attacks, muscle relaxation, seizures, alcohol withdrawal,
- Benzodiazepines
  - Long acting can cause dementia like side effects
- Only used in patient allergic to Benzodiazepines: Barbiturates and Propanediols

Psychiatric Medications: Heterocyclic Antidepressants

- Down regulation of norepinephrine and serotonin
- Tricyclic Antidepressants:Amitril, Elavil, Doxepin, Imipramine
- Other: Trazodone
- Side Effects Anticholinergic, T wave prolongation atrial and ventricular dysrhythmias,
- Elderly – causes orthostatic hypotension

Psychiatric Medications: Monoamine Oxidase Inhibitors

- Treatment of major depression
- Increases neurotransmitters in presynaptic nerve terminals
  - Phenelzine (Nardil), tranylcypromine (Parnate), and isocarboxazid (Marplan)
- 1 death per 100 overdoses: low level of severe toxicity; 2 to 3 mg/kg can be life-threatening
- Symptoms are delayed 6 to 12 hours after ingestion
  - Tachycardia, hypereflexia, fasciculation, nystagmus, hyperventilation, skin flushing, diaphoresis, chest pain, hypertension, diarrhea, hallucinations, confusion, hyperthermia, trismus, coma, cardiac arrest
- Serotonin syndrome

Psychiatric Medications: Selective Serotonin Reuptake inhibitors

- Also called atypical antidepressants
- Adults: Trazodone, Wellbutrin, Remeron, Effexor, Prozac
- Children: Zoloft, Luvox
- Serontonin Syndrome
- Wellburtin can cause seizures

Psychiatric Medications: Mood Stabilizers

- Lithium: interferes with the release and re-uptake of neurotransmitter norepinephrine at nerve terminal sites, enhances serotonin release
- 75 to 90% of all patients will develop toxicity at some time, usually when other medications have been added
- Signs of toxicity: tremors, memory loss, confusion, increased urination, rigidity, hypertonia, hypotension, seizures, coma and myoclonus

- “Knowledge is knowing a tomato is a fruit; wisdom is not putting it in a fruit salad.”
  - Brian Gerald O’Driscoll

Current Hot Topics In EMS: Excited Delirium

- A patient presenting with: psychomotor agitation, anxiety, hallucinations, speech disturbances, disorientation, violent and bizarre behavior, insensitivity to pain, elevated body temperature and superhuman strength
- Deregulation of dopamine transporters, elevated dopamine
- Median age 35

Current Hot Topics In EMS: Excited Delirium

- Usually tazered, maced or shot by police
- Reported associated with drugs like Cocaine, PCP, methamphetamines, and recently “Bath Salts”
- Hyperthermia comes before death
- Sudden Death

Current Hot Topics In EMS: Excited Delirium

- Treatment
  - 5mg of IM Versed
  - Cooling measures

The END

- “We, the unwilling, led by the unknowing, are doing the impossible for the ungrateful. We have done so much, for so long, with so little, we are now qualified to do anything with nothing.”
  - Mother Teresa