English Teachers On Call

Behavioral Emergencies

http://wellingtonretreat.com/2012/05/alcohol-and-other-drug-use-disorders-and-co-occuring-psychiatric-disorders-and-medical-conditions/disorders/

Patients who are experiencing severe changes in mood, thoughts, or behavior or severe, potentially life-threatening drug adverse effects need urgent assessment and treatment. Non-specialists are often the first care providers for **outpatients** and **inpatients** on medical units, but whenever possible, such cases should also be evaluated by a psychiatrist.

When a patient's mood, thoughts, or behavior is highly unusual or disorganized, assessment must first determine whether the patient is a

- Threat to self
- Threat to others

The threat to self can include inability to care for self (leading to self-neglect) or suicidal behavior. Self-neglect is a particular concern for patients with psychotic disorders, dementia, or substance abuse because their ability to obtain food, clothing, and appropriate protection from the elements is impaired.

Patients posing a threat to others include those who are actively violent, those who appear **belligerent** and **hostile** (ie, potentially violent), and those who do not appear threatening to the examiner and staff members but express intent to harm another person (eg, spouse, neighbor, public figure).

Causes: Aggressive, violent patients are often psychotic and have diagnoses such as **polysubstance** abuse, schizophrenia, delusional disorder, or acute mania. Other causes include physical disorders that cause acute delirium and intoxication with alcohol or other substances, particularly **methamphetamine**, **cocaine**, and sometimes **phencyclidine**

(PCP) and club drugs (eg, MDMA [3,4-methylenedioxymethamphetamine]).

General Principles

Management typically occurs simultaneously with evaluation, particularly evaluation for a possible physical disorder; it is a mistake to assume that the cause of abnormal behavior is a mental disorder or intoxication, even in patients who have a known psychiatric diagnosis or an odor of alcohol. Because patients are often unable or unwilling to provide a clear history, other collateral sources of information (eg, family members, friends, caseworkers, medical records) must be identified and consulted immediately.

Actively violent patients must first be restrained by

- Physical means
- Drugs (chemical restraint)
- Both

Such **interventions** are done to prevent harm to patients and others and to allow evaluation of the cause of the behavior (eg, by taking vital signs and doing blood tests). Close monitoring, sometimes involving constant observation by a trained sitter, is required. Although clinicians must be aware of legal issues regarding involuntary treatment, such issues must not delay potentially lifesaving interventions.

Potentially violent patients require measures to defuse the situation. Measures that may help reduce **agitation** and aggressiveness include

- Moving patients to a calm, quiet environment (eg, a **seclusion** room, when available)

- Removing objects that could be used to inflict harm to self or others
- Expressing sympathetic concern for patients and their complaints
- Responding in a confident yet supportive manner

Speaking directly—mentioning that patients seem angry or upset, asking them if they intend to hurt someone—acknowledges their feelings and may elicit information; it does not make them more likely to act out.

Counterproductive measures include

- Arguing about the validity of patients' fears and complaints
- Issuing threats (eg, to call police, to commit them)
- Speaking in a **condescending** manner
- Attempting to deceive patients (eg, hiding drugs in food, promising them they will not be restrained)

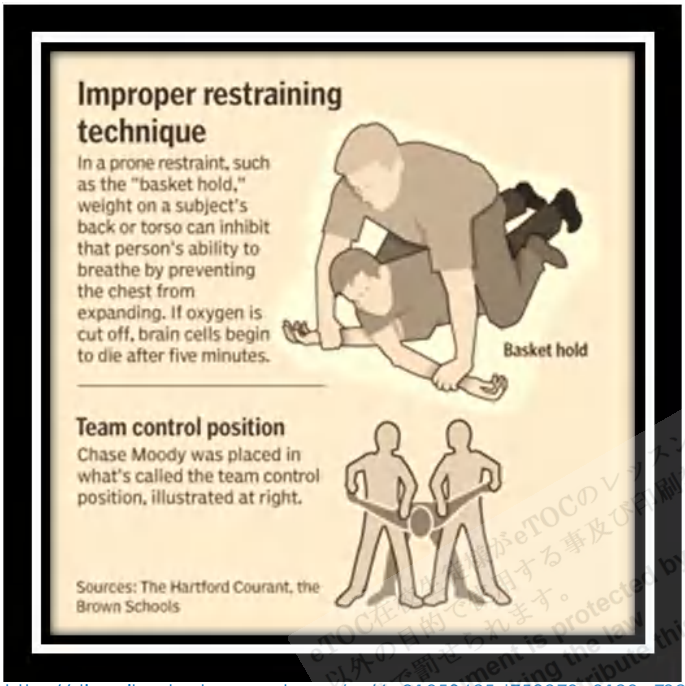
Staff and public safety: When hostile, aggressive patients are interviewed, staff safety must be considered. Most hospitals have a policy to search for weapons (manually, with metal detectors, or both) on patients presenting with disordered behavior.

Patients who are hostile but not yet violent typically do not **assault** staff members randomly; rather, they assault staff members who anger or appear threatening to them. Doors to rooms should be left open and staff members should avoid positioning themselves between patients and the door so that patients do not feel trapped or threatened; it is preferable that patients run out than assault staff members. Staff members may also avoid appearing threatening by sitting on the same level as patients. Staff members may avoid angering patients by not responding to their hostility in kind, with loud, angry remarks or arguing. If patients nonetheless become increasingly agitated and violence appears **impending**, staff members should simply leave the room and **summon** sufficient additional staff to provide a show of force, which sometimes **deters** patients. Typically, at least 4 or 5 people should be present (some preferably young and male). However, the team should not bring **restraints** into the room unless they are definitely to be applied; seeing restraints may further agitate patients.

Verbal threats must be taken seriously. In most states, when a patient expresses the intention to harm a particular person, the evaluating physician is required to warn the intended victim and to notify a specified law enforcement agency.

Specific requirements vary by state. Typically, state regulations also require reporting of suspected abuse of children, the elderly, and spouses.

Physical Restraints



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Use of physical restraints is controversial and should be considered only when other methods have failed and a patient continues to pose a significant risk of harm to self or others. Restraints may be needed to hold the patient long enough to administer drugs, do a complete assessment, or both. Because restraints are applied without the patient's consent, certain legal and ethical issues should be considered.

Restraints are used to

- Prevent clear, imminent harm to the patient or others
- Prevent the patient's medical treatment from being significantly **disrupted** (eg, by pulling out tubes or IVs) when consent to the treatment has been provided
- Prevent damage to physical surroundings, staff members, or other patients
- Prevent a patient who requires involuntary treatment from leaving (when a locked room is unavailable)

Restraints should not be used for

- Punishment

- Convenience of staff members (eg, to prevent **wandering**)

Caution is required in overtly suicidal patients, who could use the restraint as a suicide device.

Procedure: Restraints should be applied only by staff members **adequately** trained in correct techniques and in protecting patient rights and safety.

First, adequate staff are assembled in the room, and patients are informed that restraints must be applied. Patients are encouraged to cooperate to avoid a struggle. However, once the clinician has determined that restraints are necessary, there is no negotiation, and patients are told that restraints will be applied whether or not they agree. Some actually understand and appreciate having external limits on their behavior. In preparation for applying restraints, one person is assigned to each extremity and another to the patient's head. Then, each person simultaneously grasps their assigned extremity and places the patient **supine** on the bed; one physically fit person can typically control a single extremity of even large, violent patients (provided all extremities are grasped at the same time). However, an additional person is needed to apply the restraints. Rarely, upright patients who are extremely **combative** may first need to be sandwiched between 2 mattresses.

Leather restraints are preferred. One restraint is applied to each ankle and wrist and attached to the bed frame, not the rail. Restraints are not applied around the chest, neck, or head, and gags (eg, to prevent spitting and swearing) are forbidden. Patients who remain combative in restraints (eg, attempting to upset the stretcher, bite, or spit) require chemical restraint.

Complications: Agitated or violent people brought to the hospital by police are almost always in restraints (eg, handcuffs). Occasionally, young, healthy people have died in police restraints before or shortly after hospital arrival. The cause is often unclear but probably involves some combination of **overexertion** with subsequent metabolic derangement and hyperthermia, drug use, **aspiration** of stomach contents into the respiratory system, embolism in people left in restraints for a long time, and occasionally serious underlying medical disorders. Death is more likely if people are restrained in the hobble position, with one or both wrists **shackled** to the ankles behind their back; this type of restraint may cause **asphyxia** and should be avoided. Because of these complications, violent

patients presenting in police custody should be evaluated promptly and thoroughly and not dismissed as mere socio-behavioral problems.

Chemical Restraints

Drug therapy, if used, should target control of specific symptoms.

Drugs: Patients can usually be rapidly calmed or **tranquilized** using

- Benzodiazepines
- Antipsychotics (typically a conventional antipsychotic, but a 2nd-generation drug may be used)

http://dalje.com/en-world/kids-using-anti-psychotic-drugs-gained-weight/279709

These drugs are better **titrated** and act more rapidly and reliably when administered IV, but IM administration may be necessary when IV access cannot be achieved in struggling patients. Both classes of drug are effective sedatives for agitated, violent patients. Benzodiazepines are probably preferred for **stimulant drug** overdoses and for alcohol and benzodiazepine drug withdrawal syndromes, and antipsychotics are preferred for clear exacerbations of known mental disorders. Sometimes a combination of both drugs is more effective; when large doses of one drug are required, using another drug class may limit adverse effects.

Regulatory Issues in Use of Physical Restraints in Aggressive, Violent Patients

Use of physical restraints should be considered a last resort, when other steps have not sufficiently controlled aggressive, potentially violent behavior. When restraints are needed for such a situation, they are legal in all states as long as their use is properly ordered and documented in the patient's medical record. Restraints have the advantage of being immediately removable, whereas drugs may alter symptoms enough or in a way that delays assessment.

The Joint Commission on Accreditation of Healthcare Organizations guidelines for use of restraints in the psychiatric setting state that restraints must be applied under the direction of a licensed independent practitioner (LIP). The LIP must assess the patient within the first hour of restraint placement. The order for continued restraint may be written for up to 4 h at a time. The patient must be evaluated by an LIP or registered nurse during the 4-h interval and before further continuation of the restraint order. At 8 h, the LIP must reevaluate the patient in person before continuing the restraint order.

Hospital accreditation standards require that patients in restraints be continuously observed by a trained sitter. Immediately after restraints have been applied, the patient must be monitored for signs of injury; circulation, range of motion, nutrition and hydration, vital signs, hygiene, and elimination are also monitored. Physical and mental comfort and readiness for discontinuation of restraints as appropriate are also assessed. These assessments should be done every 15 min.

Table 4

Drug Therapy for Agitated or Violent Patients

Drug	Dosage	Comments
Lorazepam	0.5–2 mg q 1 h IM (deltoid) or IV prn	IV is preferred because absorption from IM injection may be **erratic**. Respiratory depression is possible.
Haloperidol	1–10 mg po, IM (deltoid), or IV q 1 h prn (1–2.5 mg for mild agitation and for frail or older patients; 2.5–5 mg for moderate agitation; 5–10 mg for severe agitation)	The drug is usually required only if psychosis is clear. The drug can make some substance intoxications (eg, with phencyclidine) worse and may cause **dystonia**. A liquid concentrate may be used for rapid absorption if the patient can take the drug po. Respiratory depression does not occur.
Ziprasidone	10–20 mg (may repeat 10-mg dose q 2 h or 20-mg dose q 4 h; maximum, 40 mg/day)	ECG monitoring may be needed. **Concomitant** use with carbamazepine and ketoconazole should be avoided.

Adverse effects of benzodiazepines: Parenteral benzodiazepines, particularly in the doses sometimes needed for extremely violent patients, may cause respiratory depression. Airway management with **intubation** and assisted ventilation may be required. The benzodiazepine antagonist, flumazenil, may be used, but caution is required because if sedation is significantly reversed, the original behavioral problem may reappear.

Benzodiazepines sometimes lead to further disinhibition of behavior.

Adverse effects of antipsychotic drugs: Antipsychotics, particularly dopamine-receptor antagonists, at therapeutic as well as toxic doses, can have acute **extrapyramidal** adverse effects, including acute dystonia and **akathisia** (an unpleasant sensation of motor restlessness). These adverse effects may be dose dependent and may resolve once the drug is stopped. Several antipsychotics, including thioridazine, haloperidol, olanzapine, risperidone, and ziprasidone, can cause long QT-interval syndrome and ultimately increase the risk of fatal arrhythmias. Neuroleptic malignant syndrome is also a possibility.

Table 5

Treatment of Acute Adverse Effects of Antipsychotics

Symptoms	Treatment	Comments
Acute dystonic reactions (eg, oculogyric crisis, torticollis)	Benztropine 2 mg IV or IM (may be repeated once in 20 min) Diphenhydramine 50 mg IV or IM q 20 min for 2 doses	Benztropine 2 mg po may prevent dystonia when given with an antipsychotic.
Laryngeal dystonia	Lorazepam 4 mg IV over 10 min, then 1–2 mg IV slowly	Intubation may be needed.
Akinesia, severe parkinsonian tremors, bradykinesia	Benztropine 1–2 mg po bid Diphenhydramine 25–50 mg po tid	In patients with akinesia, the antipsychotic may have to be stopped, and one with a lower potency used.
Akathisia (with other extrapyramidal symptoms)	Amantadine 100–150 mg po bid Benztropine	The **causative drug** should be stopped, or a lower dose used.

	1–2 mg po bid Biperiden 1–4 mg po bid Procyclidine 2.5–10 mg po bid Propranolol 10–30 mg po tid Trihexyphenidyl 2–7 mg po bid or 1–5 mg po tid (or for the sustained-release form, 2–7 mg bid)
Akathisia associated with extreme anxiety	Lorazepam 1 mg tid po Clonazepam 0.5 mg bid po

Legal Considerations

Patients with severe changes in mood, thoughts, or behavior are usually hospitalized when their condition is likely to deteriorate without psychiatric intervention and when appropriate alternatives are not available.

Consent and involuntary treatment: If patients refuse hospitalization, the physician must decide whether to hold them against their will. Doing so may be necessary to ensure the immediate safety of the patient or of others or to allow completion of an assessment and implementation of treatment. Criteria and procedures for **involuntary hospitalization** vary by **jurisdiction**. Usually, temporary restraint requires a physician or psychologist and one additional clinician, family member, or close contact to certify that the patient has a mental disorder, is a danger to self or to others, and refuses voluntary treatment.

Danger to self includes but is not limited to

- Suicidal ideation or attempts

- Failure to attend to basic needs, including nutrition, shelter, and needed drugs

In most jurisdictions, knowledge of intent to commit suicide requires a health care practitioner to act immediately to prevent the suicide, for example, by notifying the police or another responsible agency.

Danger to others includes

- **Homicidal** intent
- Placing others in **peril**
- Failing to provide for the needs or safety of dependents because of the mental disorder.

Reference: ***http://www.merckmanuals.com***