BMRC Fall 25

# Psychiatric and Behavioral Emergencies

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BMRC Fall 25

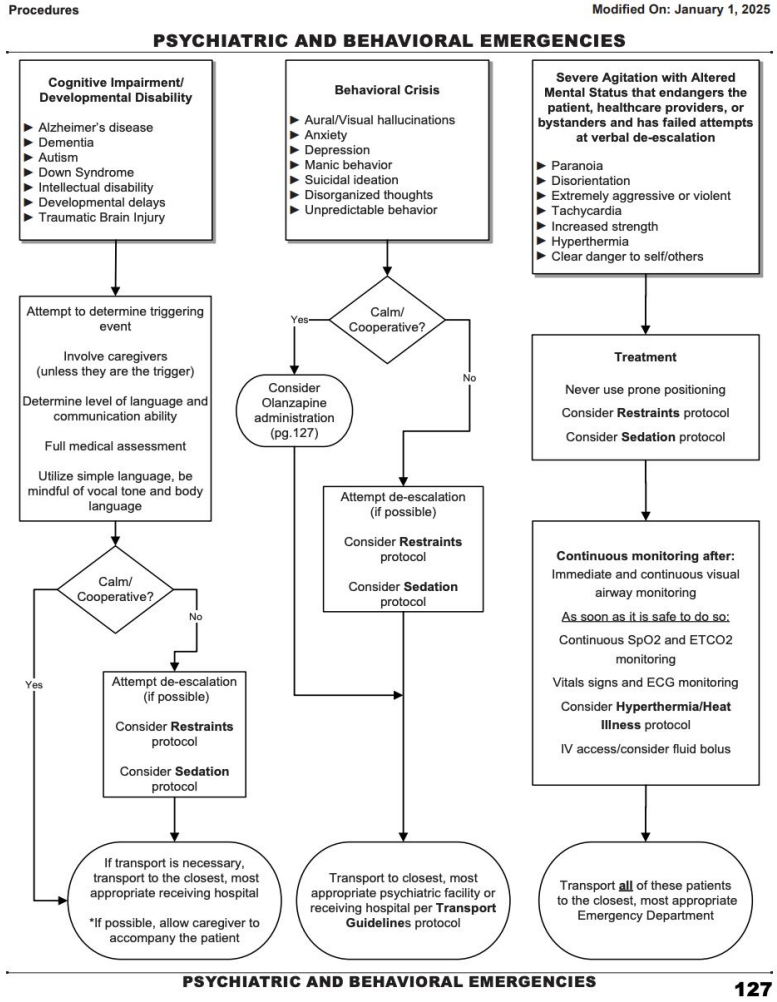
# 01

# How Do You Identify If A Patient Is Having A Psychiatric Emergency?

“How do we even begin to understand these types of emergencies ?”

# Psychiatric Problems and Emergencies

- **Psychiatric Disorder** = An abnormal mental condition
- **Psychiatric Emergency** = A behavior that poses an immediate danger of harm to the individual or others, requiring immediate intervention
  - Abnormal behaviors (disturbance in thought, mood)
  - A threat to themselves or others
  - Shows rapid change in cognition
- **Behavioral Changes** = This is a very broad term! Caused by Individual's actions or behaviors, which can overlap with psychiatric issues!
  - Has many causes (as we will soon see…)
  - ****ALWAYS** Consider that an apparent behavioral emergency may have a *physical cause***




# What Does ALCO Protocol Have to Say About This?

- "Cognitive Impairment/ Developmental Disability"
  - Alzheimer's, Dementia, Autism, Down Syndrome…
  - Can be classified under a "Psychiatric Disorder" or "Behavioral change"
- "Behavioral Crisis"
  - Hallucinations, Anxiety, Depression, Manic Behavior…
  - **Can also** be classified under "Psychiatric Disorder" or "Behavioral change"
- "AMS endangering patient and others"

So what can we do as EMT's? First step is to recognize what could be happening!

# Medical Conditions That Commonly Produce Psychiatric Symptoms: "MEND-A-MIND" or "AEIOU-TIPS"

## Mend a Mind

| | |
|---|---|
| **Metabolic** | Electrolytes, Cushing's disease … |
| **Electrical** | Epilepsy, temporal lobe seizures … |
| **Nutritional** | Thiamine/folate deficiency, anemia … |
| **Drugs/toxins** | Street and/or medical drugs, lead … |
| **Arterial** | Stroke, TIA |
| **Mechanical** | Brain injury, subdural/epidural hematoma |
| **Infection** | HIV, syphilis, meningitis, hepatitis C |
| **Neoplastic** | Primary or metastatic tumor |
| **Degenerative** | Alzheimer's disease, Parkinson's disease, Creutzfeldt-Jakob disease, multiple sclerosis … |

# Medical Conditions That Commonly Produce Psychiatric Symptoms: "MEND-A-MIND" or "AEIOU-TIPS"

| | |
|---|---|
| **A** | Alcohol, Abuse of substances, Ammonia |
| **E** | Endocrine Disorders, Epilepsy, Encephalopathy, Electrolyte Abnormalities |
| **I** | Infection, Intussusception, Inborn errors of metabolism |
| **O** | Overdose, Oxygen Deficiency |
| **U** | Uremia |
| **T** | Trauma, Tumor, Toxins |
| **I** | Insulin |
| **P** | Psychiatric conditions |
| **S** | Shock, Stroke, Space-Occupying Lesions |

# “Behavioral Changes”: Is it Psychiatric?

1. Do a *Mental Status Exam*
    a. Check their visual appearance and demeanor? What are you looking for?
        i. Are they groomed? What’s their build? What’s their behavior
    b. During the exam, **pay attention to these speech issues!!**
        i. What’s their speech pattern (fast, slow, loud, etc)? Are they slurring? How appropriate are their responses?
    c. Be aware of their skin signs.
        i. Color, Temperature, Condition?
        ii. What’s their posture or gait (walking pattern)? Look for unusual movements
    d. Check their Orientation, Memory and Awareness
        i. Person, Place, Time, Event (A/O x#)
    e. What’s their body language?
        i. Are they doing threatening gestures or have threatening expressions?
        ii. **Check for Tardive Dyskinesia** (VERY common for those who take medications that manage mental conditions)… this is your involuntary smacking of lips, excessive blinking, involuntary facial movements
        iii. **Check for Dystonia** (similar to Tardive Dyskinesia, but this is neurological! Not caused by medication) – basal ganglia is the culprit here.

# More on the Mental Status Exam – Determining If the "Behavioral Change" is Psychiatric

1. Mental Status Exam:
    a. What is the patients perception like? Their thought contents?
        i. How organized is their thinking pattern?
        ii. Any indications of hallucinations, delusions, or phobias?
        iii. Does the patient rapidly shift in topic?
        iv. Repeated words?
    b. Assess for "Mood and Affect"
        i. Do they have a normal **mood** (**emotional state**)? Are they angry? Euphoric? Irritable?
        ii. Do they have a restricted or "flat" **Affect** (how they **show** their emotional state)
        iii. Do they have rapid shifts in emotion?
    c. Test their judgement
        i. Are they **rational** in their decision making
        ii. Do they have insight to the things that are happening (either to themselves or others)

That's a wrap to the Mental Status Exam. Remember Mood and Affect! This will not go away.

# “Behavioral Changes”: Is it Physical?

1. Find some clues that may indicate a physical cause!
    a. So what are some indications?
        i. Sudden onset of symptoms (Suggests metabolic, infectious, or toxic cause (psychiatric disorders usually develop gradually)
        ii. Memory Loss or Impairment (Could indicate hypoxia, head trauma, intoxication, dementia, or delirium)
        iii. Pupillary Changes (Drug use (opioids, stimulants), neurological injury, stroke)
        iv. Excessive Salivation (Pesticide poisoning, organophosphate exposure, seizure activity)
        v. Incontinence (oopsies there's a stain on your gurney)
        vi. Unusual odors on the breath
            1. Diabetic ketoacidosis (fruity), liver failure (musty), alcohol, or toxins (acetone, ammonia)
    b. Perform a History and Physical Exam
        i. OPQRST, SAMPLE – this helps determine if whether the patient’s condition is psychiatric in nature
            1. A patient with schizophrenia will often have *history*, meds, or prior episodes. A patient with **acute delirium or hypoglycemia will not**—and that difference determines your next move.
        ii. A patient who experiences their first psychotic break might begin hallucinating, or having delusions resulting from psychiatric decompensation (like early onset schizophrenia… more on this later!)

**IMPORTANT!!** Don’t assume crazy means psych. Rule out hypoglycemia before you call it a psychiatric emergency… TLDR… always check blood-glucose levels (BGL).

# 02

# What Types of Psychiatric Problems Will You Encounter?

– “Now that I can tell if the patient is experiencing a psychiatric emergency, what do these emergencies look like ?”

# Anxiety Disorders

- Anxiety = A state of uneasiness about impending problems
- Characterize by agitation and restlessness
- Panic Attack = A discrete period of intense fear or discomfort
    - Different for everyone! Some show this very clearly, while some do not (closely related to “Fight, Flight, Fawn”)
- Phobia = An irrational fear triggered by a specific object or event

Classic physical signs: tachycardia, SOB, muscle rigidity

NOTE: *Do not rush these patients, these type of calls are considered a slow burners and must be taken lightly*

# Bipolar and Related Disorders

- -Bi(two) -polar (different phase) Disorder = Rapid shift in mood from “very high” to “very low,” each termed “manic phase” and “depressive phase” respectively
  - These “shifts” can happen suddenly or by triggers; bad news bears… people in uniform (ie. us) are typical triggers.
- Manic Phase = Abnormally elevated, expansive, or irritable mood.
  - Oddly enough, the patient may appear very euphoric, anxious, angry, or a mix of all three
  - Manic Phase can alternate with normal OR depressed moods. So “high-to-mid”, or “high-to-low”
- Depressive Phase = Abnormally reduced and helpless mood.
  - The patient will have all symptoms of a *depression*, appearing very sad with flat affect, crying, withdrawal, etc.

NOTE: *These calls are often scary since the patient is unpredictable, show compassion & patience with them, do your best to remain stable with yourself*

# Depressive Disorders Part I

- Depression = this is a very broad word for something quite serious… so we will refer to *Major Depressive Disorder* when dealing with patients who are "Depressed."
  - **IT'S NOT AN EMOTION! *depression* (Major Depressive Disorder) is a chemical imbalance in the brain that causes the patient to consistently feel a particular "dampening" of the "self"**
    - Patients typically describe this as "a weight" or feeling "heavy"
  - Typical symptoms due to depression include feelings of sadness, worthlessness, discouragement
- This is a huge factor in a majority of suicides, typically on these calls, LEO's will have arrived on scene before you, so be mindful that the patient may be anxious upon your arrival
- Typical Signs: Flat affect, withdrawal, crying
  - The patient may share more-detailed history depending on your rapport, describing changes in appetite or sleeping, feelings of guilt or indecision

NOTE: *These calls are also slow burners and require a lot of mental fortitude, these are hard to manage as you (a stranger) is just happening to appear in a very intimate time in the patient's life – be mindful.*

# Depressive Disorders Part II

- Disruptive Mood Dysregulation Disorder (DMDD) = This is a pediatric mood disorder, in which peds patients have periods of irritability, angry mood and temper outbursts that are inappropriate
    - These episodes are present most of the day and in multiple settings (home, school, public)
- DMDD is **NOT** your average angry kid where discipline is an issue, it's a neurological issue that is **not** caused by anyone. The typical scheme of DMDD patients is that they will lash out violently, destroy property, or harm themselves.
    - Because these episodes require a lot of physical energy, the child might appear tired, remorseful or confused upon your arrival.

NOTE: *These calls often involve you consoling the caregiver. Remember! DMDD is not a traumatic based disorder! Remind the caregiver that it isn't their fault (if you know the child has DMDD) and that it's also **not** the child's fault too, it's science's fault*

# Depressive Disorders Part III

- Neurocognitive Disorder = This is the current medical term for the previously very stigmatizing term, “dementia” (remove “dementia” from your mind! We’re not in the 80’s anymore). But this term is an umbrella term for other disorders like….
- Hyperactive Delirium = A type of neurocognitive disorder and physiological response
    - Delirium = A general word for changed in cognition, attention, or awareness that develops over a short time frame
    - Hyperactive Delirium typically presents as a violent patient. These patients are automatically a danger to you and others and should NOT be taken lightly.
        - Because the strain on the patient who is experiencing this neurocognitive disorder is very harsh, they patient can suffer a sudden cardiac arrest

NOTE: *LEO’s will most often than not already be on scene before us, so expect a rowdy handoff and be wary! Expect typical signs of anxiety and angry mood (as mentioned with anxiety: SOB, tachycardia, muscle rigidity).*

# Depressive Disorders Part IV: Schizophrenia Spectrum and Other Psychotic Disorders

- Schizophrenia = This is a chronic (long lasting) mental illness, characterized by distortions in speech and thought.
    - Typical Symptoms include:
    - Delusions, hallucinations, social withdrawal, catatonic behavior (like rigid posture, sitting in uncomfortable position without moving for long periods performing strange movements, repetition of words or behaviors), lack of emotional expressiveness
- Paranoia = This is a psychological disorder that causes the patient to experience an exaggerated or unwanted mistrust and suspicion (sometimes without explanation, or a very exaggerated “feeling”).
    - These patients may have delusions of persecution, or being watched
    - They may appear aloof, or hypersensitive, even argumentative.
    - If approached wrongly or if the patient experiences this paranoia towards you, their behavior will become unpredictable and can be aggressive

NOTE: *These calls may not have a LEO on scene, so make sure to take necessary precautions (restraints… more on this later) if they become aggressive toward you. Also, it is vital that you take these calls slow, and stay at an easy pace of movement with these patients – do not provoke them, even probing questions can trigger exaggerated mistrust toward you.*

# Depressive Disorders Part V: Schizophrenia Spectrum and Other Psychotic Disorders

- Psychosis = This is a disorder where the patient becomes out of touch with reality. Typically the patient lives within their own reality (*no* not narcissism)
  - Presentation of psychosis can include delusions, hallucinations, disorganized speech or behaviors, and loose associations with objects, people or situations
  - The delusions of someone experiencing psychosis is typically…
    - Referential (“The T.V. is sending me messages”)
    - Persecutory (“everyone is plotting against me”)
    - Grandiose (“I’m a secret government scientist”)
    - Erotomanic (“That celebrity is in love with me”)
    - Nihilistic (“The world ended last week, we’re all ghosts”)
    - Somatic (“There are bugs living under my skin”)

NOTE: *These calls are rather funny sometimes, but do NOT engage in their reality or provoke it – do not argue that their reality doesn’t exist! Say sometime like “I understand that’s what you see.” Minimize stimulation (turn off lights, place them in quiet spaces – not crowds).*

# Depressive Disorders Part VI: Substance Use and Addictive Disorders

- An individuals use of drugs and alcohol results in clinically significant impairment and distress
- Some common substances of abuse include:
    - Alcohol, Caffeine, Cannabis, Hallucinogens, Inhalants, Opioids, Sedatives, Hypnotics, Anxiolytics, Stimulants, and tobacco
- Substance abuse is probably going to be the most common call you go on! So here are some typical signs of substance abuse:
    - Slurred speech, pinpoint (opioid use.. Narcan time) or dilated pupils (stimulants or hallucinogens… **not** Narcan time), sweating, tremors, tachycardia
    - Paranoia, hallucinations, respiratory depression (especially after opioid or sedative use)

NOTE: *This is your typical grab the unconscious patient and go. Once you administer Narcan (which is standard in suspected opioid use), sometimes the patient may wake up confused, angry (sometimes swinging), or with a smile… these experiences are different with everyone! Expect anything. If the patient is awake, have an emesis bag handy ;).*

# Depressive Disorders Part VI: Trauma-Related and Stressor-Related Disorders

- Trauma = this is defined as being a deeply distressing or disturbing experience
    - This is very broad! Everyone has different tolerances to trauma, so it is hard to gauge if someone who just experiences a (what we might think to be) traumatic event, but that person may actually call it an average wednesday.
    - This also goes out to **everyone!** Including **EMT's**.
- When on scene with someone who has experienced a trauma, these calls are deep. Mostly sad and can cause **us** psychological harm as well. So it is important that when treating the patient, you do a BSI on your psyche.
- Avoid judgement of any kind when treating the patient, and know you will be treating both emotional and psychological shock.

NOTE: If Trauma is not dealt with appropriately, the experience can develop into PTSD

- Post-Traumatic Stress Disorder (PTSD) = Described as intrusive memories, avoidance, hypervigilance, and emotional numbness.
- Be mindful to your own exposure to repeated trauma! **DO NOT "tough it out"** these things end lives
- Remember: Everyone's carrying something! The trick to is recognize trauma early before it festers

# Common Psychiatric Medications

| | |
|---|---|
| **Antidepressants** | SSRIs—Prozac, Celexa, Lexapro, Zoloft, Paxil, Luvox. SNRIs—Pristiq, Fetzima, Cymbalta, Effexor. |
| **Antipsychotics** | First generation—Thorazine, Haldol; second generation—Clozaril, Zyprexa, Seroquel, Risperdal, Geodon |
| **Mood stabilizers** | Lithium, Lamictal, Symbax, Risperdal |
| **Anticonvulsants/bipolar medication** | Tegretol, Neurontin, Trileptal, Topamax, Depakote, Rexulti |
| **Antianxiety** | Benzodiazapines—Xanax, Klonopin, Valium, Ativan |
| **Stimulants** | Strattera, Adderall, Concerta |

- Remember from the *Mental Status Exam* that taking psychiatric medications can cause **Tardive Dyskinesia.**
- Extrapyramidal Symptoms = Symptoms caused by a dopamine depletion in the brain, this causes the motor system to create involuntary muscle movements
    - This is a direct result of taking certain psychiatric medications

# Psychiatric Problems and Emergencies: Violence

- There are two forms of violence that EMT's will face, **violence to the self**, and **violence to others…** let's discuss violence to the self.
- Suicide = Any willful act designed to end one's own life
- It is statistically evident that at least **half** of ALL people who commit suicide attempted it previously
- Many patients give verbal or behavioral warnings before the act – but these are often missed
    - Signs include: recent loss/ major life stressor, hopelessness, guilt, giving away belongings, withdrawal from friends and family, sudden calmness after severe depression (can indicate a resolution to act), access to lethal means
- In the case of being called to a scene of an attempted suicide, it is **imperitive** that you document statements by the suicide-attempt patients, suicide notes, and any other evidence of suicide attempts at the scene
- It is important to note that patients that threaten suicide **cannot** refuse transport.

NOTE: *These calls are heavy-hitters, and will involve pure practice of empathy and compassion. Patience is key here, and allowing a space for your patient to share information with you. LEO's will be on scene before you in these cases, direct the LEO's to remain outside after you ensure the patient does not have any items that can harm you or themselves – this allows a more intimate space.*

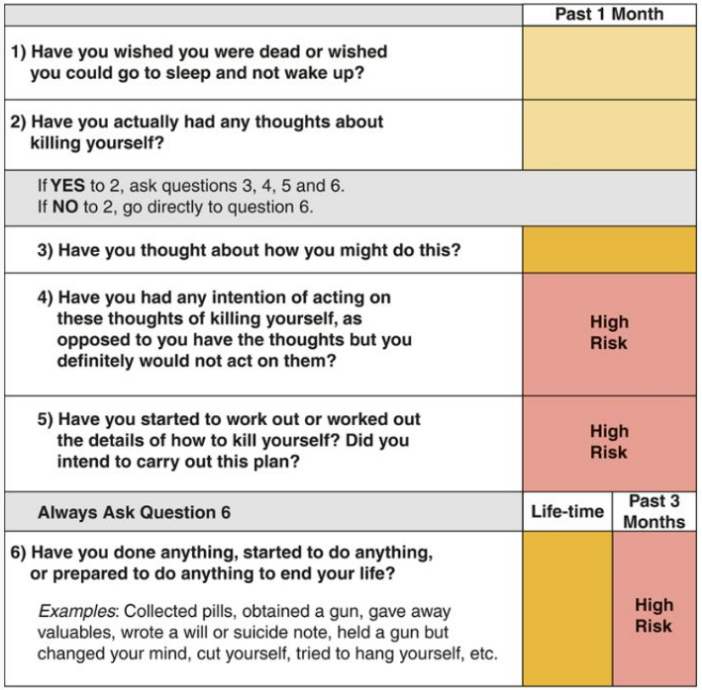
# Psychiatric Problems and Emergencies: Violence

- In the other case, where someone does an act of violence to others…
- There are some signs that a person has lost control and may become violent:
  - Nervous pacing, Shouting, Threatening, Cursing, Throwing objects, Clenched teeth and/or fists
- In either cases of violence, the end result is a patient who has been broken psychologically. You may not be able to fix their pain in 10 minutes, but you *can* make them feel heard – and that's often the first step in saving their life.

# Mini Assessment for Common Psychiatric Emergencies

- We already mentioned the *Mental Status Exam*, but recall that this will provide you with an **indication** that you may be dealing with a psychiatric emergency
- **OUR ROLE IS TO DIAGNOSE** (but don't put a diagnosis on the PCR… thats illegal).
  - Look for imminent risk
  - Assess for anything that could be life threatening
- In cases of *suicidal ideation*, be **straightforward** and **direct**.
  - Identify clearly if the patient has a plan to harm themselves, and if they have a means to the plan and/or intent
  - Question the patient… but how do you do that?

# Columbia Suicide and Severity Rating Scale (C-SSRS)



| | Past 1 Month | |
|---|---|---|
| 1) Have you wished you were dead or wished you could go to sleep and not wake up? | | |
| 2) Have you actually had any thoughts about killing yourself? | | |
| If **YES** to 2, ask questions 3, 4, 5 and 6. If **NO** to 2, go directly to question 6. | | |
| 3) Have you thought about how you might do this? | | |
| 4) Have you had any intention of acting on these thoughts of killing yourself, as opposed to you have the thoughts but you definitely would not act on them? | High Risk | |
| 5) Have you started to work out or worked out the details of how to kill yourself? Did you intend to carry out this plan? | High Risk | |
| **Always Ask Question 6** | **Life-time** | **Past 3 Months** |
| 6) Have you done anything, started to do anything, or prepared to do anything to end your life? *Examples*: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, held a gun but changed your mind, cut yourself, tried to hang yourself, etc. | | High Risk |

- A common tool to assess suicide is the *Columbia Suicide and Severity Rating Scale* (C-SSRS)
- Of course your not going to have the patient fill out a questionnaire, these are questions **you** ask the patient!

# 03

# How To Deal With Psychiatric Emergencies

“Now that I know how to tell if a patient is experiencing a psychiatric emergency, and what specific emergency they are having, how do I deal with it ?”

# Techniques For Treating Psychiatric Emergency Patients: Part I

- Approach the patient slowly, Engage in **active listening**, be supportive and empathetic, **limit interruptions** within your interview with the patient
- After establishing some rapport, **ask the patient** if it's okay to for you to get a little closer – some patients will some this very comforting.
    - At minimum **stay 3 feet away from the patient!**

# Techniques For Treating Psychiatric Emergency Patients: Part II

- Speak in a calm **reassuring** voice, maintain a comfortable distance, seek the patient's cooperation, maintain good eye contact, **do not** make any quick movements, **respond honestly** to the patients questions
- **NEVER THREATEN OR ARGUE** with the patient (this goes for violent patients too!)
- **DON'T "PLAY ALONG"** with the visual or auditory hallucinations the patient may have (even if they say "can you hear the music")
- If possible, involve trusted family members
- ****Be prepared to spend a lot of time at the scene****
- If the patient is not violent, do not immediately restrain them!
- **DO NOT** force the patient to make immediate decisions
- Get the patient to engage in motor activity

# Assessment-Based Approach: Part I

1. Scene Size-up
    a. Behavioral emergencies are unpredictable and volatile!
    b. DO NOT enter a **dangerous situation without law enforcement** support
    c. Be aware of the dangers associated with the patients choice of mechanism for suicide
    d. Locate the patient **before** entering the scene – look for anything that can be used as a weapon
    e. Don’t assume there is only one patient!

# Assessment-Based Approach: Part II

1. Scene Size-up
2. Primary Assessment
    a. Formulate a **general impression**
    b. Assess the patient's mental status (use the *Mental Status Exam* for apparent psychiatric emergencies)
    c. Assess the airway and breathing
    d. Control bleeding! (assess for shock) – this should be the first thing you do before anything if there is any bleeding.

# Assessment-Based Approach: Part III

1. Scene Size-up
2. Primary Assessment
3. Secondary Assessment
    a. Obtain a history (OPQRST and SAMPLE)
    b. Be polite And respectful, respect their privacy!
    c. Use active listening
    d. Ask **open-ended** questions

- In the case of suicidal patients:
    - Remember to consider what we already talked about! Be considerate and be direct
- In the case of violent patients:
    - Involve law enforcement early!
    - Take a history
    - Look at the patient's posture (to make sure you can predict their next actions)
    - Listen to the patient
    - Be **firm and clear**
    - Be prepared to use restraints if necessary

Remember these signs and symptoms, indicative of a psychiatric emergency!

- Fear, anxiety, confusion, *behavioral changes (remember how broad this was!), anger, mania, depression
- Withdrawal, loss of contact with reality, sleeplessness, change in appetite, loss of sex drive, crying

# Assessment-Based Approach: Part IV

1. Scene Size-up
2. Primary Assessment
3. Secondary Assessment
4. Emergency Medical Care
    a. Maintain your own safety!
    b. Assess for trauma and medical conditions
    c. Calm the patient and stay with them
    d. If needed to protect yourself, others, or the patient themselves from harm, **use restraints**
    e. Transport to the appropriate facility!
    f. Reassess

# Restraining A Combative Patient

**Operations** **Modified On: January 1, 2025**

**RESTRAINTS**

1. Patient restraints are to be utilized only when necessary and in those situations where the patient is exhibiting behavior deemed to present danger to him/herself or to the field personnel. When restraints are used:

   1.1 The minimum restraint necessary, to accomplish necessary patient care and safe transportation, should be utilized

   1.2 Circulation to the extremities (distal to the restraints) will be evaluated q 5 minutes

   1.3 Leather or soft restraints, designed specifically for patient restraint, are the only authorized method of restraining patients.

   1.4 The restraints must not be placed in such a way as to preclude evaluation of the patient's medical status (e.g. airway, breathing, circulation) necessary patient care activities, or in any way jeopardize the patient medically

2. If the patient is under arrest and handcuffs are applied by law enforcement officers:

   2.1 The patient will not be cuffed to the stretcher and a law enforcement officer shall accompany the patient in the ambulance, if the handcuffs are to remain applied

   2.2 A law enforcement officer may elect to follow the ambulance in a patrol car to the receiving facility if the patient has been restrained on the gurney using leather or soft restraints

- If you believe a patient is a danger to themselves or others **contact law enforcement!!**
- Use restraints **ONLY** for a patient who is in danger to themselves or others
- Seek **medical direction <u>before restraining</u>** and follow the ALCO protocol!
- **One** rescuer should talk to the patient throughout the restraining process
- This process typically takes 4 people at minimum – plan with your team on how you are all going to restrain (someone has one leg, the other an arm, etc.)
- Approach the combative patient as a team **at the same time**
- **DO NOT RESTRAIN A PATIENT IN THE PRONE POSITION!! YOU ARE BLOCKING THEIR AIRWAY**
- Secure the patient to the stretcher in a supine position with multiple straps
- If the patient is spitting, place a mask on their face (there are actual masks designated for this!)

# 04

# How to NOT Get Sued And Lose Your License

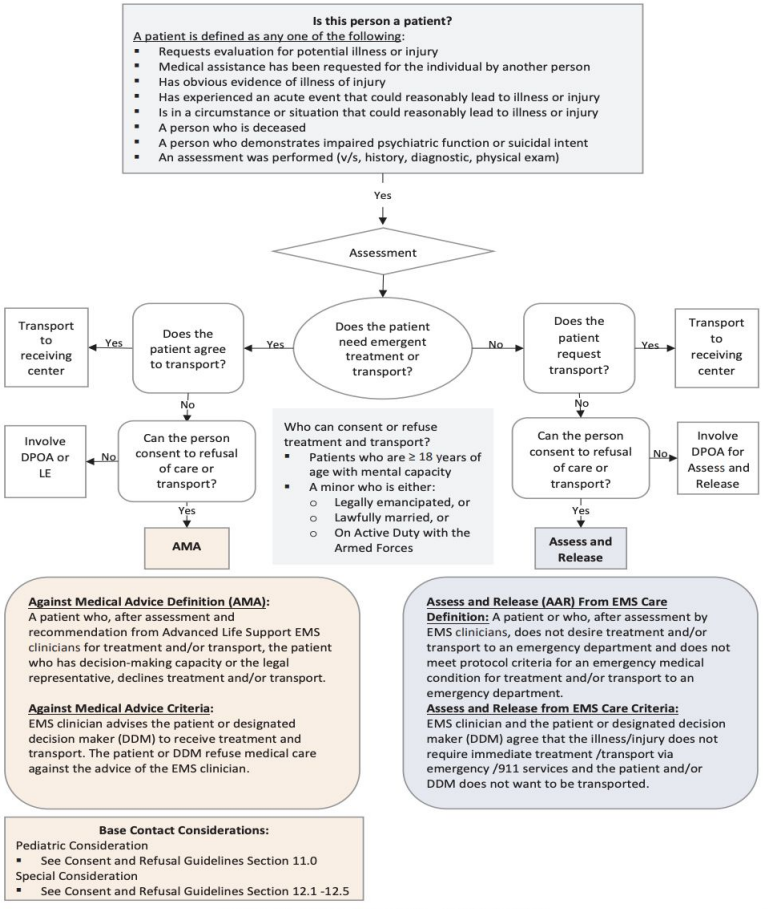
“Now that I know what to do, how do I not get into legal trouble? What should I keep in mind ?”

# Legal Considerations: Part I

1. Consent
    a. Patients who are **unresponsive** or **not competent to consent** may be treated under **implied consent**
    b. In the case of psychiatric emergencies, implied consent is actually muddy-water! **Contact medical direction and follow the ALCO protocol**
        i. ALCO Protocol states: “In order to refuse care, a patient, parent, guardian, or DDM (Designated Decisions Maker) must have legal and mental decision-making capacity by… [exhibiting] no evidence of: Altered Level of Consciousness, Alcohol or drug ingestion that impairs decision-making capacity, Danger to self or others”
    c. In the case of psychiatric emergencies where the patient is a child, and the guardian/ DDM refuses care:
        i. ALCO Protocol States: “Base contact should be made, as well as considering law enforcement involvement to encourage treatment and/or transport.”
    d. In the case of a 5150, (or 5585 for peds patients):
        i. ALCO Protocol States: “An individual under arrest or incarcerated, or on a 5150 is legally capable of consenting or refusing medical care but cannot refuse transport”

## CONSENT AND REFUSAL GUIDELINES

13. CONSENT AND REFUSAL GUIDELINES WORKFLOW:






# Legal Considerations: Part II

2. Refusal of Care huh…

- Note that only **competent** patients can refuse care; as long as they can voice the risks of refusal and understand the consequences of refusing care
- If the patient intends to harm themselves or others, ALCO protocol states that you are allowed to transport without consent!
- When documenting the situation, **USE DIRECT QUOTES!!**
- Involve Law enforcement when necessary

# Legal Considerations: Part III

1. Consent
2. Refusal of Care
3. Involving Police and Medical Direction
    a. Before you restrain a patient **for any reason** you MUST seek medical direction **first!**
    b. Law enforcement personnel should be involved when you need to restrain a patient **or** when you need to transport without consent **or** if there is any threat of violence
    c. Law enforcement not only serve as protection, but they also serve as credible witnesses if needed!
4. False Accusations
    a. Psychiatric patients may be inclined to make false accusations toward you, so remember to document carefully **AND COMPLETELY!**
        i. Document their behavior, statements **in DIRECT QUOTES**, have witnesses if possible
        ii. Have a provider that is the same gender as the patient

# Too Long Don’t Care

- Remember that psychiatric emergencies may result from a psychiatric disorder **or** from a medical condition **or** something physical!
- A psychiatric emergency can place EMT’s at risk (call the cops)
- Physically restraints are **only used** when the patient is a threat to themselves or others
- Behavioral emergencies (very broad term!) can easily involve legal issues of consent and refusal of consent

# Thanks For Not Having A Syncopal Episode

# 05

# Kahoot Time !

KAHOOOOT