Behavioral/ Psychiatric

Note:

- This guideline applies to patients that are being cooperative. Refer to the Agitation and Combativeness Guidelines as needed.
- **Ensuring the safety of EMS personnel is of paramount importance.**
- Behavioral disturbances are often the result of underlying medical conditions that require immediate medical attention, including head trauma, alcohol or drug intoxication, metabolic disease, and psychiatric disorders. Patients in need of medical attention must be transported in an ambulance, not a police vehicle.
- Refer to the patient crisis care plan if one is available and document steps taken and any contact with law enforcement, social services and medical control

Priorities	***Assessment Findings***
Chief Complaint	"Behavioral Disturbance"; "Anxiety"
LOPQRST	Determine onset, duration and progression, triggering events and perception of severity by bystanders. Patient reports: feeling detached or unreal, feeling of losing control or going crazy, feeling faint or light-headed.
AS/PN	Alcohol or drug intoxication, Head trauma
AMPL	Psychiatric medications? Noncompliance? History of schizophrenia or bipolar disorder? History of drug or alcohol abuse?
Initial Exam	Check ABCs and correct immediately life-threatening problems.
Detailed Focused Exam	**Vital Signs:** BP, HR, RR, Temp, SpO_2 **General Appearance**: Elevated mood, apprehensive, appearance of overwhelming panic, trembling or shaking? **Skin:** Diaphoresis? Cool, moist and pale? Warm, dry and flushed? **Respiratory Effort:** Labored breathing? Heavy breathing? **Lung Sounds:** Wheezes, rales, rhonchi or stridor? Decreased lung sounds? **Cardiovascular:** Hypertensive and tachycardic? **Extremities:** Trauma? **Neuro:** Excited, agitated, increased activity and increased intensity of activity? **Psych:** Bizarre thoughts and actions; Paranoia, delusional, confused, clouded consciousness?
Data	SpO2 in all patients (continuous or frequent re-checks); 12-Lead EKG as soon as it becomes practical to obtain one; Blood glucose to rule out hypoglycemia as a cause of the behavioral disturbance.
Goals of Therapy	Reduce symptoms to a point that the patient is more comfortable and better able to participate in their care
Monitoring	BP, HR, RR, cardiac monitoring, SpO_2, $ETCO_2$

EMERGENCY MEDICAL RESPONDER/ EMERGENCY MEDICAL TECHNICIAN

- Scene size-up
- Provide an anxious patient with verbal reassurance and calming.

- It is reasonable to attempt verbal de-escalation, but do not persist if it appears to be futile or making the situation worse.
- Initiate Routine Medical Care once it is safe and practical.
- Obtain blood glucose. If < 60 mg/dL refer to *Altered Level of Consciousness Guidelines*

Give a status report to the ambulance crew by radio ASAP.

ADVANCED EMERGENCY MEDICAL TECHNICIAN/ INTERMEDIATE

- Do not attempt to initiate an IV until the patient becomes cooperative.
- IV normal saline @ KVO
- If signs of hyperthermia or hypovolemia are present, administer normal saline wide open.

Contact Medical Control for the following:

- Additional fluid orders

PARAMEDIC

- Anxiety
    - **Midazolam** 1 – 2 mg (PEDS under age 12, 0.05 mg/kg) IV/IO/IN[1]. May titrate to a maximum of 5 mg.
- Obtain a 12-lead EKG and transmit to receiving facility.
- Monitor vital signs every 5 minutes.

Contact Medical Control for the following:

- Adding **diazepam** 2.5mg-5mg (PEDS (0.15mg/kg) IV/IO/IM -**OR- lorazepam** 1 – 2 mg (PEDS 0.05 mg/kg) IV/IO/IN once or **ziprasidone** (Geodon) 10 – 20 mg IM in addition to midazolam if patients do not respond to the maximum dose of midazolam.
- Additional doses of midazolam

FOOTNOTES:

[1] In the event of a midazolam medication shortage:
a. Lorazepam 1 – 2 mg ADULTS (0.1 mg/kg PEDS) IM/IN/IV/IO or
b. Diazepam 1 – 5 mg ADULTS (0.1 mg/kg PEDS) IM/IV/IO

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