MENTAL HEALTH EMERGENCIES

PATIENT CONTACT AND COOPERATION: Problem behaviors that prevent contact with the patient may be present. If problem behaviors exist that the emergency care provider (responder) is not prepared to deal with, they should call for assistance. For example, if someone is threatening people with a weapon, the responder should summon the police for aid. Once contact has been made with the patient, the evaluation can proceed.

ELICITING COOPERATION: Active listening is the main tool employed in dealing with a problem behavior patient. It can often elicit cooperation from a resistant or violent patient. Properly used, it makes the patient feel understood and instills confidence in the responder. Active listening involves the skills of paraphrasing, perception checking, behavior describing, and feeling reflection.

A problem behavior patient can become uncooperative and even violent at any time. The following list, extracted from articles in Hospital Physician (1971), offers some tips a responder can use in dealing with violent patients:

- ✓ If you are afraid of the violent patient, do not pretend you are not. Your act won't fool the patient. It is better to let the patient know that, despite fear, you are in control of yourself and able to control the patient.
- ✓ Violent patients want limits and will respond when you make clear that you will restrain them and control their violent ways.
- ✓ When talking to a violent patient, stand facing them with your arms crossed. In this nonthreatening position, you can easily deflect blows above or below the belt. Some psychiatrists always talk to violent patients while sitting down. This position can have a calming effect on the patient.
- ✓ Do not try to deal with a violent patient alone in a small room. Both patient and responder need space between them. The patient may have a fear of being touched, and the responder needs room to maneuver, if attacked.

- ✓ Do not sit or stand in the way of the door while interviewing a violent patient. The patient will be less likely to attack if they feel they have a clear exit.
- ✓ Ask the violent patient if he/she owns a firearm and if so, whether it is a pistol, rifle or shotgun. Many psychiatrists feel that the pistol owner or collector is a higher risk than the rifle or shotgun owner.
- ✓ Be especially wary of the self-referred violent patient whose trademark is "If you do not hospitalize me", they are the worst risk in respect to violence. Also be wary of the pseudo-violent patient who presents as extremely tight and rigid and fears losing control. Once sedated, they may scream and carry on, but their body is very relaxed. When they are under control of the medication, they feel free to vent their feelings.

APPROACHING THE PATIENT: Approach the patient in a calm and decisive manner. Make it clear you are there to help and are in control of the situation. Zuni and Barr (1971) compiled the following list of don'ts in handling a psychiatric emergency:

- Ø **Don't** threaten the patient.
- Ø **Don't** openly disagree with the statements of acutely disturbed individuals, listen instead.
- Ø **Don't** make promises which cannot be kept.
- Ø **Don't** joke, laugh or discuss other patients or allow other bystanders to do so in front of the patient.
- Ø **Don't** assume that the patient is consciously manipulating without hard evidence.
- Ø **Don't** take away the patient's pride. Sometimes they may have regained control of themselves, but, both unconsciously and consciously, feel the need to continue the disturbed behavior. This may be because they are surrounded by people who saw them in an agitated state.

- **Don't** assume that the manifestations of the acute emotional disturbance are either in part or fully psychopathic in origin until medical illness has been reasonably ruled out. Many medical disorders can mimic emotional disturbance, such as encephalitis, meningoencephalitis, meningitis, cranial nerve paralysis, postictal state, acute cerebellar symptoms, post-concussive syndrome, Guillain-Barre syndrome, and neuropathies.

When a patient is anxious or violent, they are responding to fantasies they have about themselves in relation to the environment. The more in touch they are with reality the less anxious or violent they will become. A responder can facilitate contact with reality by carefully explaining their procedures and by giving the patient a set of expectations. For example, an injured person showing symptoms of shock may be very anxious and distressed by their circumstances. They may have seen their injury and have the fantasy they are dying. This fantasy would be further confirmed by their experiencing increased perspiration, nausea, weakness, and changes in breathing. A responder can put the patient more in touch with reality by making reassuring statements and explaining the procedures that will follow. This tends to dispel the fantasy that they are dying and reduce the severity of anxiety and shock symptoms as the procedures are carried out. The patient will have replaced their fantasy with a concrete set of expectations. In the same way, a violent patient will often reduce aggressiveness when confronted by a responder who will take charge, set limits and explain procedures.

If a patient is so agitated or violent that all techniques for eliciting cooperation fail, they must be restrained to begin intervention procedures and to prevent injury to themselves, or others.

EVALUATION: The responder's goal in a problem behavior evaluation is to gather information that will be useful to the physician or mental health professional in making a diagnosis. The responder's evaluation will be the basis for deciding which facility the patient is to be transported to. Active listening is the key to attaining a useful evaluation.

Occasionally a visit to an emergency scene by a responder will abate a crisis without hospitalization, but the factors underlying the problem will linger, requiring further attention. The responder should be prepared to provide the patient with a referral to where help can be found on an outpatient basis. This may be the name of the community mental health center, mental health professional, psychiatrist, psychologist, or social worker.

Occasionally, a patient will not voluntarily be helped from a problem behavior that needs in-patient attention. In this event, the patient will have to be involuntarily committed. In the state of Washington, involuntary commitments must be completed by mental health professionals associated with county mental health facilities.

Only through practice and experience can a responder learn to be effective with problem behavior patients.

COMMUNICATING WITH OTHER PROFESSIONALS: Responders will usually communicate with a physician and the department will determine if a mental health professional needs to be involved. If the problem seems to be chiefly psychiatric, it is helpful, to the intake therapist, to have friends and relatives appear at the emergency department after the patient. During a crisis, many important behavior patterns can be identified by the therapist with the patient and significant others in their life. This can be of great benefit to the patient. If the physician determines that the patient needs to be sent to a mental health evaluation and treatment facility, it may be necessary for the responder to stand by and render assistance to the mental health professional. This is usually necessary when the patient is not cooperating.

The responder should be ready to prepare the patient for transfer to the appropriate facility.

As other professionals are contacted, it should be noted that they are interested in information specific to their profession. Communication with another professional is enhanced if the responder is prepared to provide the appropriate information. Below are lists showing information of specific interest to professionals whom responders communicate with regularly:

A. Child Protection Worker

- ✓ Identification: names and approximate ages of abused child, parents, guardians and other children
- ✓ Extent of abuse:
  - ➔ Observed or reported by another (sometimes interfamily squabbles can lead to false complaints about child abuse)
  - ➔ Subjective observation - fear, hollowness of eyes, scars, bruises, etc.
- ✓ Address or directions to child's residence
- ✓ Prior history: Has it happened before?
- ✓ Other observations: Impressions of parents and other family members, evidence of alcohol abuse, etc.

B. Law Enforcement

- ✓ Location at scene
- ✓ Identification of problem person. if available
- ✓ Description of problem person (a physical description quickly enables law enforcement to identify potentially dangerous people when arriving at the scene)
- ✓ Description of problem behavior:
  - ➔A threat to self, others, or property?
  - ➔Description of weapons involved
  - ➔Indications of drug or alcohol abuse
- ✓ Any history of problem person (former mental patient, convict, etc.)

C. Physicians and Mental Health Professionals

- ✓ Identification of patient
- ✓ Age, sex, race, marital status, number of children
- ✓ Chief complaint of patient
- ✓ Acute medical problem, vital signs (especially for physicians)
- ✓ Description of problem behavior, dominating traits, secondary traits
- ✓ Evidence of precipitating circumstances

- ✓ Previous psychiatric care (briefly describe)
- ✓ Evidence of alcohol or drug abuse
- ✓ Present medication
- ✓ If currently in treatment, the name of family physician
- ✓ Brief medical history

LEGAL CONSIDERATIONS: Laws pertaining to emergency medical and/or problem behavior involve child abuse, alcohol, involuntary treatment, confidentiality, Good Samaritan Acts, and liability. These laws vary from state to state. The laws discussed here apply in the state of Washington. The Revised Code of Washington (RCW) 26.44 states if a child or mentally retarded person is physically or sexually abused, abandoned, or isolated from parent because of a crisis; a report of the facts must be made at the local Department of Social Services Child Protection Office or to local law enforcement. Such reports are usually not made directly by responders. This, however, needs to be decided by the individual emergency team. The law requires that after an oral report of the facts is made, a written report needs to follow.

An immediate verbal report shall be made by telephone or otherwise to the proper law enforcement agency or the Department of Social Services and upon request, shall be followed by a report in writing. Such reports shall contain the following information if known:

- ✓ Name, address and age of the child
- ✓ Name and address of the child's parents, stepparents, guardians, or other persons having custody of the child
- ✓ Nature and extent of the child's injury or injuries
- ✓ Nature and extent of the neglected child
- ✓ Nature and extent of the sexual abuse
- ✓ Any evidence of previous injuries, including their nature and extent
- ✓ Any other information which may be helpful in establishing the cause of the child's death, injury or injuries and the identity of the perpetrator or perpetrators (RCW 26.44.040)

Alcohol abuse is frequently a factor in behavior problems. In 1972, the Uniform Alcoholism Act was signed into Washington State Law (RCW 7096A). This law no longer allows treating an intoxicated person as a criminal, except in cases where a criminal act is committed in conjunction with intoxication. Police now treat an intoxicated person as someone who may need help. For example, a police officer who comes in contact with an intoxicated person tries to aid the individual by getting them home. Police officers discourage any activity that may endanger the intoxicated person or others. The officer may determine that the person is incapacitated by alcohol. Incapacitation means the person is incapable of making a rational decision with respect to their need for alcoholism treatment or constitutes a danger to themselves, others, or property. If incapacitated, a person can be involuntarily detained in protective custody for eight hours. The person must then be examined by an alcoholism professional affiliated with community alcohol centers to confirm incapacitation. If so, the law provides that the person can involuntarily be committed to a treatment facility for at least 48 hours. Presently, few facilities exist in Washington State that can manage patients committed for alcohol incapacitation. Therefore, an alcoholism professional usually refers the person to outpatient services and they are released. Sometimes a person can be convinced to voluntarily commit themselves to an in-patient program.

If a patient, as a result of a mental disorder, presents a likelihood of serious harm to themselves or others, or is gravely disabled, a mental health professional can authorize commitment of that patient to an evaluation and treatment facility for a 72 hour evaluation. Also, a peace officer can take a person into custody and place an individual in an evaluation and treatment facility if they, as the result of a mental disorder, present an imminent likelihood of serious harm to themselves or others (RCW 71.05.150).

Juveniles, 13 years of age or younger, can be involuntarily committed with parental consent. Juveniles between the ages of 13 and 17 can be involuntarily committed only through a petition by the person's parent(s), conservator, guardian, or juvenile court. "The petition shall set forth the reasons why commitment is necessary and what alternative courses of treatment have been explored." Juveniles between the ages of 14 and 17

must give their consent for voluntary treatment and also have the consent of their parents (RCW 72.23.070). In a problem behavior emergency, the responder's consulting physician can determine if involuntary treatment is necessary and the appropriate officials can be notified.

Presently, no law exists in Washington State requiring medical personnel to report gunshot wounds or suspicious injuries. It is common practice, however, for medical personnel to inform law enforcement officials of such injuries. Each responding team should develop a policy for these circumstances.

Patients are sensitive to facts about their personal life being known by others. Each patient has a human right to have their personal life facts disclosed only to those persons who have a professional need to know. Most helping professions have ethics regarding patient confidence. In addition, laws have been passed protecting the confidence in patient relationships with physicians and mental health professionals (RCW 5.60.060, 18.83.110). Presently, no laws in Washington protect the confidence in patient-responder relationships.

The Good Samaritan Act protects any person who, while acting in good faith and not for compensation, renders emergency care or transportation for emergency medical treatment (RCW 4.24.300). The law protects from liability if the patient files suit against them. Some responders are not compensated and would be covered by this law.

EMS personnel are protected from liability, while rendering emergency lifesaving service under the responsible supervision and control of a licensed physician, to a person who is in immediate danger of loss of life (In act of attempting suicide)(RCW 18.71.210).

Physicians or hospitals licensed in Washington State are not liable for failure to obtain consent in rendering emergency medical surgical, hospital or health services (18.71.220). Perhaps responders employed by the hospital are protected by this law. Malpractice claims involving a problem behavior patient might likely result from breeches of confidence and the use of physical restraints.