Pediatric Behavioral Emergencies

Cynthia Frankel, RN
Prehospital Care Coordinator
Alameda County EMS

Objectives

- Management strategies & challenges
- Management concepts
- Principles of medication treatment
- Case study

The Call . . .

- You are dispatched to the home of a seven year old male.
- The child is violent, oppositional, defiant, hitting, kicking, and throwing objects.
- He is exploding with rage. He expressed a desire to die because living was "…just too hard!"
- The mother asks you to leave her son alone and not transport him to the hospital.

Initial Assessment

- **Seven year old male child screaming "I want to die, I hate you…I am too much trouble…My head is exploding."**
- **A-B-C's**
  - ✓ **A:** Normal
  - ✓ **B:** Hyperventilation
  - ✓ **C:** Tachycardia

Current Medications

- Risperidone (Risperdal)
  - ✓ .250 mg BID
- Depakote (divalproex sodium)
  - ✓ 125 mg TID
- Periactin (Cyproheptadine)
  - ✓ 4 mg BID
- Concerta (methylphenidate)
  - ✓ 38 mg am dose

Past Medical History

- **Diagnoses - reported by mother**
  - ✓ Bipolar
  - ✓ ADHD with excitability
  - ✓ Obsessive compulsive
  - ✓ Psychotic episodes
  - ✓ Unstable on current medications
- **Previous hospitalizations and suicide attempts**
- **Followed by child psychiatrist and psychologist**
- **Police have been called to home on numerous occasions**

What do you do?

- **Things to consider:**
  - ✓Police assistance
  - ✓5150
  - ✓Restraints
  - ✓Base Physician Consult
  - ✓Transport vs. Refusal of Care

Definition

- **Pediatric behavioral emergency exist when:**
  - ✓ disorder of thought or behavior is dangerous or disturbing to the child or to others
  - ✓ behavior likely to deviate from social norm and interfere with child's well-being or ability to function.

Behavioral Emergencies

- **True psychiatric emergencies in children are rare.**
  - ✓ do not always stem from mental illness
  - ✓ are more likely to stem from situational problems
  - ✓ may be due to other medical problems or injury

Situational Problems

- **Behavioral emergencies may be precipitated by stressful situations:**
  - ✓ Chronic abuse or neglect
  - ✓ Normal emotional upheaval of adolescence
  - ✓ Unplanned pregnancy
  - ✓ Sudden traumatic event
  - ✓ Emotional upheaval but not necessarily involve an emotional disorder

Injuries or Medical Conditions That Mimic Psychiatric Illness

- ✓ Diabetic ketoacidosis
- ✓ Hypoglycemia
- ✓ Brain injury
- ✓ Meningitis
- ✓ Encephalitis
- ✓ Seizure disorders
- ✓ Hypoxia
- ✓ Toxic ingestions
- ✓ Altered mental status
- ✓ Hallucinations
- ✓ Delusions
- ✓ Incoherent speech
- ✓ Aggressive/aberrant behavior
- ✓ Certain medications

Don't Be Fooled…

- **Psychiatric disorders:**
  - ✓ Can present with the appearance of a medical problems
  - ✓ Example: anxiety disorder with a panic attack
    - hyperventilation, tachycardia, diaphoresis, chest pain suggesting a medical emergency.
- **A child with a history of mental illness:**
  - ✓ May present situational or physical problem unrelated to the psychiatric history

Potential Diagnosis

- **Mood Disorders**
  - ✓ Bi-Polar Disorder
  - ✓ Autism
  - ✓ Attention Deficit (Hyperactivity) Disorder ADD/ADHD
- **Schizophrenia**

Bipolar Disorder

- Also called manic-depressive Illness - aberrant behavior during a manic phase
- Can “rapid-cycle” through several moods.
- Under-diagnosed and under-treated in children - Often misdiagnosed
- 1 in 5 kids commit suicide.
- Most mental health professionals believe BP rarely occurs before adolescence

Autism

- Complex developmental disorder
- Evident in the first three years of life
- Difficulties in verbal and non-verbal communications, social interaction, leisure and play activities
- 80% of those affected are male.

ADD/ADHD

- **Hyperactive**
- **Inattentive**
- **Mixed**
- **Impairments:**
  - ✓ language
  - ✓ restricted activities and interests
  - ✓ Social skills

Schizophrenia

- **Hallucinations**
  - ✓ A false perception having no relation to reality. May be visual, auditory, or olfactory. (Seeing, hearing smelling things that aren't there.)
- **Delusions**
  - ✓ A false belief inconsistent with the individual's own knowledge and experience. Patient can not separate delusion from reality. (Delusions may cause him/her to hurt self or others.)
- **Violent behavior**

Pharmacology

- **Drugs used to treat BP:**
  - ✓ Cibalith-S, eskalith, lithane, lithobid (*Lithium*)
  - ✓ Tegretol (*carbamazepine*)
  - ✓ Depakote (*divalproex*)
- **Side effects:**
  - ✓ Excessive sweating
  - ✓ Potential liver problems
  - ✓ Lethal at toxic levels
  - ✓ Headache
  - ✓ Fatigue
  - ✓ Nausea

Pharmacology (cont.)

- **Drugs used to treat schizophrenia:**
  - ✓ Standard antipsychotics:
    - Thorazine (*chlorpromazine*)
    - Haldol (*haloperidol*)
    - Serentil (*mesoridazine*)
  - ✓ Side effects:
    - Weight gain
    - Emotional blunting
    - Tremor
    - Restlessness
    - Fatigue
    - Rigidity
    - Muscle spasm
    - Tardive dyskinesia
  - ✓ Side effects are from cumulative use

Pharmacology (cont.)

- **Drugs used to treat schizophrenia (cont.):**
  - ✓ **Atypical Antipsychotics** (drug/side effects)
    - Risperidone (*risperdol*) : no sedation or muscular side effects
    - Quetiapine (*seroquel*): sedation, least likely to produce muscular side effects
    - Olanzapine (*zyprexa*) : weight gain
    - Clozapine (*clozapine*): most effective, most side effects

Pharmacology (cont.)

- **Drugs Used to treat depression**
  - ✓ **SSRIs:** Prozac *(Fluoxetine);*
    Paxil *(Paroxetine);* Luvox *(Fluvoxamine)*
  - ✓ **Tricyclic AD:** Imipramine *(Tofranil);* clomipramine *(Anafranil);*
  - ✓ **MAOIs:** Seligiline *(Anipryl)*
  - ✓ **Hetercyclic AD:** Serzone *(Nefazodonr);* Bupropion HCL *(Wellbutrin)*
  - ✓ **Miscellaneous:** Effexor *(Venlafaxine)*

Treating Side Effects

- **Dystonic Reactions (#7231)**
  - ✓ Ingestion of phenothiazines
  - ✓ Adminsiter diphenhydramine
- **Tricyclic Antidepressant OD (#7220)**
  - ✓ Widened QRS
  - ✓ Hypotension unresponsive to fluids
  - ✓ Sodium Bicarb
- **These are adult policies. May be used in kids ≥15 – otherwise requires base physician contact.**

Handling a Behavioral Emergency

- **Other EMS policies that may be helpful when dealing with a behavioral emergency:**
  - ✓ Psychiatric Evaluation (#8105)
  - ✓ Refusal of Care (#8040)
  - ✓ Restraints (#8060)
  - ✓ Consent & Refusal Guidelines (#10003)

Handling a Behavioral Emergency (cont.)

- Treat potentially life-threatening medical conditions, do not diagnose psychiatric disorders
- Avoid making judgments or subjective interpretations of the patient's actions

Handling a Behavioral Emergency (cont.)

- **Look for suspicious injuries that indicate:**
  - ✓ Child abuse
  - ✓ Self-mutilation
  - ✓ Suicide attempt
- **Evaluate suicide risk - factors increasing risk:**
  - ✓ Recent depression
  - ✓ Recent loss of family or friend
  - ✓ Financial setback
  - ✓ Drug use
  - ✓ Having a detailed plan

Handling a Behavioral Emergency (cont.)

- **Communicating with an emotionally disturbed child:**
  - ✓ Provide the right environment - approach the child in a calm, reassuring manner
  - ✓ Limit number of people around patient; isolate the patient if necessary
  - ✓ Limit interruptions
  - ✓ Limit physical touch
  - ✓ Engage in active listening
  - ✓ Strive to gain the child's confidence

Back to our case…

- **With the information you have learned today**
  - ✓ What is your assessment?
  - ✓ How would handle the situation?
  - ✓ What options are available to you?

In Conclusion

- Embrace these Families
- Many psychiatric illnesses are new and evolving
- Each child responds differently to psychiatric medications
- Notify the child's mental health professional
- On-going assessment and safety considerations