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
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
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
Drugs Used to treat depression

- **SSRIs:** Prozac *(Fluoxetine)*; Paxil *(Paroxetine)*; Luvox *(Fluvoxamine)*
- **Tricyclic AD:** Imipramine *(Tofranil)*; clomipramine *(Anafranil)*
- **MAOIs:** Seligiline *(Anipryl)*
- **Hetercyclic AD:** Serzone *(Nefazodonor)*; Bupropion HCL *(Wellbutrin)*
- **Miscellaneous:** Effexor *(Venlafaxine)*
Treating Side Effects

- **Dystonic Reactions (#7231)**
  - ✓ Ingestion of phenothiazines
  - ✓ Administer diphenhydramine

- **Tricyclic Antidepressant OD (#7220)**
  - ✓ Widened QRS
  - ✓ Hypotension unresponsive to fluids
  - ✓ Sodium Bicarb

- These are adult policies. May be used in kids $\geq 15$ – 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