# SAEMS
# Behavioral/Psychiatric
## Self Learning Module

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## Purpose

This SAEMS Standing Order Training Module has been developed to serve as a template for EMS provider training. The intent is to provide consistent and concise information to all providers practicing within the SAEMS Region. The content of the Training Module has been reviewed by the Protocol Development and Review Sub-Committee, and includes the specific standing order, resource and reference material, and instructions for completing the Training Module to obtain continuing education credit. One hour of SAEMS continuing education credit may be issued following successful completion of the module.

## Objectives

Upon completion of this self-learning module the EMS participant will be able to:

1. Review basic Behavioral Terminology
2. List the assessment findings for common behavioral disorders
3. Apply the Standing Order appropriately

## Instructions

1. Review the accompanying information, Standing Order and any additional reference material as necessary.
2. Complete the attached posttest and return it to your supervisor or Base Hospital Manager.
3. A SAEMS CE will be issued to providers scoring 85% on the post-test.

## Table of Contents:

**Behavioral Mental Disorder Overview:**

A **mental disorder** or **mental illness** is a psychological or behavioral pattern that occurs in an individual and is thought to cause distress or disability that is not expected as part of normal development or culture. The recognition and understanding of mental disorders has changed over time and across cultures. Definitions, assessments, and classifications of mental disorders can vary, but guideline criteria listed in the DSM IV and other manuals are widely accepted by mental health professionals.

Mental disorders have been found to be common, with over a third of people in most countries reporting sufficient criteria at some point in their life. Mental Health Services for mental disorders may be based in hospitals or in the community.

Mental health professionals diagnose individuals using different methodologies, often relying on case history and interview. Psychotherapy and psychiatric medication are two major treatment options, as well as supportive interventions and self-help. Treatment may be involuntary where legislation allows.

Behavioral emergencies can differ in perception based upon one's view of the situation and the amount of knowledge one has pertaining to the subject matter. Each behavioral emergency is different based upon the patient. Many questions surface when a patient presents with typical or atypical symptoms. Is the patient aware of the disorder? Is the patient newly diagnosed? Is the patient on new psychiatric medications? Is the patient non-compliant with psychiatric medications? Is the patient afflicted with multiple psychiatric disorders? Is the patient suffering from multiple disease processes on top of the psychiatric disorder?

The pre-hospital provider arriving at the scene of the incident needs to feel comfortable addressing and handling the behavioral patient. The safety of the EMS provider as well as the patient is of the utmost importance. Being able to obtain standard information such as a history or asertaining whether the patient has decision making capability can be very tedious with the behavioral or psychiatric patient.

Assessment of the patient begins from the initial arrival on scene while approaching a patient. Cognitive screening is normally obtained throughout the patient encounter and assessment, although the patient suffering from a behavioral or psychiatric episode can make obtaining the most basic of information difficult.

It is imperative that pre-hospital providers understand that with a behavioral patient:

- if the patient wishes to refuse treatment and transport, or
- the EMS provider cannot safely restrain the patient, or
- if law enforcement will not assist or intervene, or
- the patient's condition deteriorates;

the EMS provider needs to contact Medical Direction for assistance based upon the SAEMS Behavioral Emergency Standing Order or needs to follow their Base Hospital's Behavioral policy.

The disorders that will be addressed are the most commonly seen by the pre-hospital provider: Depressive Disorders, Anxiety Disorders, Manic Disorders, Schizophrenia, PTSD, and Dementia.

## Mental Disorder Causes:

Numerous factors have been linked to the development of mental disorders. In many cases there is no single accepted or consistent cause currently established. A commonly held view is that disorders often result from genetic vulnerabilities combined with environmental stressors, which is known as the Diathesis-stress model.

Genetic studies have indicated that genes can often play an important role in the development of mental disorders via developmental pathways interacting with environmental factors. The reliable identification of connections between specific genes and specific categories of disorder(s) has proven difficult.

Environmental events surrounding pregnancy and birth have also been linked to mental disorders as well as individuals suffering from a traumatic brain injury may increase the risk of developing certain mental disorders. There have been tentative inconsistent links found to certain viral infections, substance misuse and to general physical health problems.

Abnormal functioning of neurotransmitter systems have been implicated, including the serotonin, norepinephrine, dopamine and glutamate systems. Differences have also been found in the size or activity of certain brain regions in some cases. Psychological mechanisms have also been implicated, such as cognitive and emotional processes, personality, and temperament and coping style when it comes to causing or exacerbating a mental disorder.

Social influences have been found to play an important role in mental disorders, including abuse or bullying situations and other negative or stressful life experiences. The specific risks and pathways to particular disorders are less

clear, however. Aspects of the wider community have also been implicated, including employment problems, socioeconomic inequality, lack of social cohesion, problems linked to migration and features of particular societies and cultures.

### Medications

A major option for many mental disorders is psychiatric medication. There are several main groups.

**Antidepressants** are used for the treatment of clinical depression as well as often for anxiety and other disorders. There are a number of antidepressants beginning with the tricyclics, moving through a wide variety of drugs that modify various facets of the brain chemistry dealing with intercellular communication. Beta-blockers, developed as a heart medication, are also used as an antidepressant.

**Anxiolytics** are used for anxiety disorders and related problems such as insomnia.

**Mood stabilizers** are used primarily in bipolar disorder. Lithium carbonate (a salt) and Lamictal (an epileptic drug) are notable for treating both mania and depression. The others, mainly targeting mania rather than depression, are a wide variety of epilepsy medications and antipsychotics.

**Antipsychotics** are used for psychotic disorders, notably for positive symptoms in schizophrenia. Although there has not been any evidence of the superiority of newer atypical antipsychotic drugs, they are being prescribed to individuals throughout the world. The prescription of relatively inexpensive, older typical antipsychotic drugs is also used.

**Stimulants** are commonly used, notably for ADHD. Despite the different conventional names of the drug groups, there can be considerable overlap in the kinds of disorders for which they are actually indicated.

There may also be off-label use of medications. There can be problems with adverse effects of medication and adherence.

## Mood Depressive Disorders:

Mood disorders are emotional disturbances consisting of prolonged periods of excessive sadness, severe enough or persistent enough to interfere with daily function and sometimes by decreased interest or pleasure in activities. The exact cause of depression is unknown but probably involves heredity, changes in neurotransmitter levels, altered neuroendocrine function and psychosocial

factors. Diagnostic analysis is based upon the patient history, which includes subjective as well as objective information that is gathered. The treatment of depression has changed dramatically and currently consists of medications, psychotherapy, or both. Very rarely is electroconvulsive therapy utilized.

The term "depression" is often used to refer to several depressive disorders and is often used to describe the low or discouraged mood that results from disappointments or losses. Demoralization is an idiom that is used for describing depression. Depressive disorders can occur at any age, but typically develop during the mid-teens, 20's or 30's.

The exact cause of depression is unknown. Theories include heredity, neurotransmitter level changes and psychosocial factors. Major life stressors, especially emotional separations and losses can precede episodes of depression.

**Major Depressive Episode:** Five or more of the following symptoms are normally present and there is a marked change in functioning for the patient suffering from a major depressive episode. The symptoms are as follows:

1. Depressed mood most of the day, nearly every day, as indicated by either subjective report (feels sad or empty) or observation made by others. Note in children and adolescents the mood can be an irritable mood;

2. Markedly diminished interest or pleasure in all or almost all activities most of the day nearly every day (as indicated by either subjective account or observation made by others);

3. Significant weight loss when not dieting or a weight gain (more than 5% of body weight in a month) or a decrease or increase in appetite nearly every day;

4. Insomnia or hypersomnia nearly every day;

5. Psychomotor agitation or retardation nearly every day (observed by others and not merely subjective feelings of restlessness or being slowed down);

6. Fatigue or loss of energy nearly every day;

7. Feelings of worthlessness, or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self reproach or guilt about being sick);

8. Diminished ability to think or concentrate or indecisiveness nearly every day (either by subjective account or observation);

9. Recurrent thoughts of death (not just fear of dying) or recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

## Anxiety

Anxiety disorders are often debilitating chronic conditions, which can be present from an early age or begin suddenly after a triggering event. They are prone to flare up at times of high stress and are frequently accompanied by physiological symptoms such as headache, sweating, muscle spasms, palpitations, and hypertension, and in some cases lead to fatigue or even exhaustion

Although in casual discourse the words *anxiety and fear* are often used interchangeably, in clinical usage they have distinct meanings; anxiety is defined as an unpleasant emotional state for which the cause is either not readily identified or perceived to be uncontrollable or unavoidable, whereas fear is an emotional and physiological response to a recognized external threat. The term anxiety disorder, however, includes fears as well as anxieties. Indeed, phobias (fears which are "persistent or irrational") constitute the majority of anxiety disorder cases.

Anxiety disorders are often co-morbid with other mental disorders, particularly clinical depression. Studies have also indicated that certain types of anxiety disorders are more likely to be present among those with family history of anxiety disorders.

### Panic Disorders

**Panic Attack** Patients who have a panic disorder suffer from brief attacks of intense terror and apprehension, often marked by trembling, shaking, confusion, dizziness, nausea, and difficulty breathing. These panic attacks, defined by the American Psychiatric Association as fear or discomfort that abruptly arises and peaks in less than ten minutes, can last for several hours and can be triggered by stress, fear, or even exercise; although the specific cause is not always apparent.

In addition to recurrent unexpected panic attacks, a diagnosis of panic disorder also requires that said attacks have chronic consequences: either worry over the attacks' potential implications, persistent fear of future attacks, or significant changes in behavior related to the attacks. Accordingly, those suffering from panic disorder experience symptoms even outside of specific panic episodes.

Often, normal changes in heartbeat are noticed by a panic sufferer, leading them to think something is wrong with their heart or they are about to have another panic attack. In some cases, a heightened awareness (hypervigilance) of body functioning occurs during panic attacks, wherein any perceived physiological change is interpreted as a possible life threatening illness (i.e. extreme hypochondriasis).

**Panic Attack**: Patients suffering from panic attacks suffer from periods of intense fear or discomfort in which four (4) or more of the following symptoms developed abruptly. The symptoms usually peak within 10 minutes and can at times be incapacitating for the patient.

1. Palpitations, pounding heart or accelerated heart rate
2. Sweating
3. Trembling or shaking
4. Sensations of shortness of breath or smothering
5. Feeling of choking
6. Chest pain or discomfort
7. Nausea or abdominal pain
8. Feeling dizzy, unsteady lightheaded or faint
9. Derealization (feelings of unreality) or depersonalization (being detached from oneself)
10. Fear of losing control or going crazy
11. Fear of dying
12. Paresthesia (numbness or tingling sensation)
13. Chills or hot flushes

## Obsessive-Compulsive Disorder

Obsessive-compulsive disorder is a type of anxiety disorder primarily characterized by repetitive obsessions (distressing, persistent, and intrusive thoughts or images) and compulsions (urges to perform specific acts or rituals). The OCD thought pattern may be likened to superstitions insofar as it involves a belief in a causative relationship where, in reality, one does not exist. Often the process is entirely illogical; for example, the compulsion of walking in a certain pattern may be employed to alleviate the obsession of impending harm. In many cases, the compulsion is entirely inexplicable and is simply an urge to complete a ritual triggered by nervousness.

In a minority of cases, sufferers of OCD may only experience obsessions, with no overt compulsions, whereas a much smaller number of patients experience only compulsions.

## Post-Traumatic Stress Disorder

Post-traumatic stress disorder or PTSD is an anxiety disorder which results from a traumatic experience. Post-traumatic stress can result from an extreme situation such as combat, rape, hostage situations, or even a serious accident. It can also result from long term (chronic) exposure to a severe stressor, for example soldiers who endure individual battles but cannot cope with continuous combat. Common symptoms include flashbacks, avoidant behaviors and depression.

## Manic Episode

Mania is generally characterized by a distinct period of an elevated, expansive, or irritable mood state. People commonly experience an increase in energy and a decreased need for sleep. A person's speech may be pressured, with thoughts experienced as racing. Attention span is low and a person in a manic state may be easily distracted. Judgment may become impaired; sufferers may go on spending sprees or engage in behavior that is quite abnormal for them. They may indulge in substance abuse, particularly alcohol or other depressants, cocaine or other stimulants, or sleeping pills. Their behavior may become aggressive, intolerant or intrusive. People may feel out of control or unstoppable. People may feel they have been "chosen", are "on a special mission", or other grandiose or delusional ideas. Sexual drive may increase. At more extreme phases of bipolar I, a patient in a manic state can begin to experience psychosis, or a break with reality, where thinking is affected along with mood. Many patients in a manic state experience severe anxiety and are very irritable (to the point of rage), while others are euphoric and grandiose.

In order to be diagnosed with mania according to the Diagnostic and Statistical Manual of Mental Disorders (commonly referred to as the DSM) a person must experience this state of elevated or irritable mood, as well as other symptoms, for at least one week, less if hospitalization is required.

## Hypomanic

Hypomania is generally a mild to moderate level of mania, characterized by optimism, pressure of speech and activity and decreased need for sleep. Some people have increased creativity while others demonstrate poor judgment and irritability. These patients generally have increased energy and tend to become more active than usual. They do not, however, have delusions or hallucinations. Hypomania can be difficult to diagnose because it may masquerade as mere happiness, though it carries the same risks as mania.

Hypomania may feel good to the person who experiences it. Thus, even when family and friends learn to recognize the mood swings, the individual often will deny that anything is wrong.

**Mixed Affective**

Bipolar disorder can present with a mixed set of symptoms of mania and clinical depression occurring simultaneously (for example, agitation, anxiety, aggressiveness or belligerence, confusion, fatigue, impulsiveness, insomnia, irritability, morbid and/or suicidal ideation, panic, paranoia, persecutory delusions, pressured speech, racing thoughts, restlessness, and rage).

The patient suffering from a bipolar disorder can exhibit a wide range of behaviors and may exhibit three or more of the following symptoms:

1. Inflated self-esteem or grandiosity;

2. Decreased need for sleep (e.g., feels rested after only 3 hours of sleep);

3. More talkative than usual or pressure to keep talking;

4. Flight of ideas or subjective experience that thoughts are racing;

5. Distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli);

6. Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation;

7. Excessive involvement in pleasurable activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments).

## Schizophrenia and Psychotic Disorders

Schizophrenia is a chronic, severe, and disabling mental brain disease. Approximately 1 percent of the population develops schizophrenia during their lifetime and more than 2 million Americans suffer from the illness in a given year. Although schizophrenia affects men and women with equal frequency, the disorder often appears earlier in men, usually in the late teens or early twenties, than in women, who are generally affected in the twenties to early thirties.

Patients suffering from schizophrenia often endure terrifying symptoms such as hearing internal voices not heard by others, or believing that other people are reading their minds, controlling their thoughts, or plotting to harm them. These symptoms may leave them fearful and withdrawn. Their speech and behavior can be so disorganized that they may be incomprehensible or frightening to others. Available treatments can relieve many symptoms, but most people with schizophrenia continue to suffer some symptoms throughout their lives; it has been estimated that no more than one in five individuals recovers completely.

Safety of the pre-hospital care provider is important when dealing with a patient suffering from delusions and hallucinations. Exercising good practice of ensuring that the scene is safe before entering decreases the chances of an accident or attack upon the pre-hospital provider during violent patient episodes.

Research is gradually leading to new and safer medications and unraveling the complex causes of the disease. Scientists are using many approaches from the study of molecular genetics to the study of populations to learn about schizophrenia. Methods of imaging the brain's structure and function hold the promise of new insights into the disorder.

**Schizophrenia as an illness**

Schizophrenia is found all over the world. The severity of the symptoms and long-lasting, chronic pattern of schizophrenia often cause a high degree of disability. Medications and other treatments for schizophrenia, when used regularly and as prescribed, can help reduce and control the distressing symptoms of the illness. However, some people are not greatly helped by the available treatments or may prematurely discontinue treatment because of unpleasant side effects or other reasons. Even when treatment is effective, persisting consequences of the illness, lost opportunities, stigma, residual symptoms, as well as medication side effects may be very troubling and difficult to deal with.

The first signs of schizophrenia often appear as confusing, or even shocking, changes in behavior. Coping with the symptoms of schizophrenia can be especially difficult for family members who remember how involved or vivacious a person was before they became ill. The sudden onset of severe psychotic symptoms is referred to as an acute phase of schizophrenia.

Psychosis, a common condition in schizophrenia, is a state of mental impairment marked by hallucinations, which are disturbances of sensory perception, and/or delusions, which are false yet strongly held personal beliefs that result from an inability to separate real from unreal experiences. Less obvious symptoms, such

as social isolation or withdrawal, or unusual speech, thinking, or behavior, may precede, occur with, or follow the psychotic symptoms.

Some people have only one such psychotic episode; others have many episodes during a lifetime, but lead relatively normal lives during the interim periods. However, the individual with chronic schizophrenia, or a continuous or recurring pattern of illness, often does not fully recover normal functioning and typically requires long-term treatment, generally including medication, to control the symptoms.

**Diagnosis**

It is important to rule out other illnesses as sometimes people suffer severe mental symptoms or even psychosis due to undetected underlying medical conditions. For this reason, a medical history should be taken and a physical examination and laboratory tests should be done to rule out other possible causes of the symptoms before concluding that a person has schizophrenia. In addition, since commonly abused drugs may cause symptoms resembling schizophrenia, blood or urine samples from the person can be tested at hospitals or physicians offices for the presence of these drugs.

At times, it is difficult to tell one mental disorder from another. For instance, some people with symptoms of schizophrenia exhibit prolonged extremes of elated or depressed mood, and it is important to determine whether such a patient has schizophrenia or actually has a manic-depressive (or bipolar) disorder or major depressive disorder. Persons whose symptoms cannot be clearly categorized are sometimes diagnosed as having a schizoaffective disorder.

Characteristic symptoms: Two or more of the following criterion are present:

1. Delusions;

2. Hallucinations;

3. Disorganized speech (frequent derailment or incoherence);

4. Grossly Disorganized or catatonic behavior;

5. Negative symptoms (i.e. affective flattening, alogia or avolition).

**Note**: Only one criterion symptom is required if a patient's delusions are bizarre or the patient's hallucinations consist of a voice keeping up a running commentary on the person's behavior or thoughts, or two or more voices conversing with each other.

**Schizophrenia Subtypes**:

Paranoid Type: A type of Schizophrenia in which the following criteria are met:

- Preoccupation with one or more delusions or frequent auditory hallucinations

- None of the following is prominent: Disorganized speech, disorganized or catatonic behavior, or flat or inappropriate affect

Disorganized Type: This is a type of schizophrenia that the following criteria are met: and all of the following are prominent:

- Disorganized Speech

- Disorganized Behavior

- Flat or inappropriate affect

Catatonic Type: Type of schizophrenia in which the patient has at least two or more of the following:

- Motoric immobility as evidenced by catalepsy (including waxy flexibility) or stupor

- Excessive motor activity (that is apparently purposeless and not influenced by external stimuli)

- Extreme negativism an apparently motiveless resistance to all instructions or maintenance of a rigid posture against attempts to be moved) or mutism

- Peculiarities of voluntary movement as evidenced by posturing (voluntary assumption of inappropriate or bizarre postures) stereotyped movements, prominent mannerisms or prominent grimacing

- Echolalia or echophraxia

**Delusional Disorder**: non-bizarre delusions (involving situations that occur in real life, such as being followed, being poisoned, being admired or loved at a distance, or deceived by a spouse or lover, or having a disease).

**Note**: Tactile and olfactory hallucinations may be present in Delusional Disorder if they are related to the delusional theme

1. Functioning is not markedly impaired and the behavior is not obviously odd or bizarre

2. If the mood episodes have occurred concurrently with delusions or have been brief in relation to the duration of the delusional periods

3. The disturbance is not due to the direct psychological effects of a substance (drug abuse or a medication) or a general medical condition

The following types are assigned based upon the predominant delusional theme:

- Erotomanic Type: Delusions that another person, usually of a higher status, is in love with the individual

- Grandiose Type: Delusions of inflated worth, power, knowledge identity or special relationship to a deity or famous person

- Jealous Type: Delusions that the individual's sexual partner is unfaithful

- Persecurtory Type Delusions that the person (or someone to whom the person is close to) is being malevolently treated in some way

- Somatic Type: Delusions that the person has some physical defect or general medical condition

- Mixed Type: delusions characteristic of more than one of the above types but no one theme predominates

## Dementia

Dementia is not a specific disease. It is a descriptive term for a collection of symptoms that can be caused by a number of disorders that affect the brain. People with dementia have significantly impaired intellectual functioning that interferes with normal activities and relationships. They also lose their ability to solve problems and maintain emotional control and they may experience personality changes and behavioral problems such as agitation, delusions, and hallucinations. While memory loss is a common symptom of dementia, memory loss by itself does not mean that a person has dementia. Doctors diagnose dementia only if two or more brain functions - such as memory, language skills, perception, or cognitive skills including reasoning and judgment – are significantly impaired without an alteration of consciousness.

There are many disorders that can cause dementia. Some dementias can lead to a progressive loss of mental functions such as with Alzheimers Dementia, also

known as AD. Some dementia's can be halted and reversed with appropriate treatment.

With Alzheimer Dementia and many other types of dementia, disease processes cause many nerve cells to stop functioning, lose connections with other neurons and die. In contrast, normal aging does not result in the loss of large numbers of neurons in the brain.

Special Pre-Hospital Considerations

Not all things are created equal and this is evident in patient cognition baselines. Pediatric, geriatric, psychiatric, as well as developmental disabilities patients may be unable to complete a cognitive screen assessment. Assumption of a person's mental ability is not appropriate and documentation as to the patient's mental status and current mental capacity needs to occur to the best of the pre-hospital provider's ability.

It is important to remember that emergency situations create anxiety and confusion and the pre-hospital personnel may encounter difficulties with patients who are excitable or anxious. Extracting the patient from the "charged" environment as well as time, patience and a calming demeanor from pre-hospital personnel can decrease the patient's anxieties.

The pre-hospital provider should ensure the patient's comfort, avoid entering the patient's personal space, be sensitive to the patient's feelings, watch for signs of uneasiness, use appropriate language, and ask open-ended and direct questions while using therapeutic communication techniques.

From the first initial scene size-up to the transfer of patient care, the pre-hospital provider is continually assessing the patient's cognitive status. Each patient is unique and each patient encounter will be slightly different from all others. The pre-hospital provider must be able to quickly adapt to the special requirements of each encounter so that the necessary information can be gathered, creating a seamless yet knowledge-based transfer of care.

# References


DSM-IV-TR, which is endorsed by the American Psychiatric Association.

McCance, K., Huether, S., (1994) Pathophysiology The Biologic Basis for Disease in Adults and Children Second Edition. St Louis, MO: Mosby.

Sanders, M.J., (2005) Mosby's Paramedic Textbook Third Edition. St. Louis, MO: Mosby.

McCance, K., Huether, S., (1994) Pathophysiology The Biologic Basis for Disease in Adults and Children Second Edition. St Louis, MO: Mosby.

Sanders, M.J., (2005) Mosby's Paramedic Textbook Third Edition. St. Louis, MO: Mosby.

Hoyt, S.K., Selfridge-Thomas, J., (2007) Emergency Nursing Core Curriculum Sixth Edition. St. Louis, MO: Saunders Elsevier

Thelan, L.A., Urden, L.D., Lough, M.E., Stacy, K.M., (1998) Critical Care Nursing Diagnosis and Management Third Edition. St. Louis, MO: Mosby

McLaughlin K; Behar E, Borkovec T (August 25, 2005). "Family history of psychological problems in generalized anxiety disorder". *Journal of Clinical Psychology* 64: 905–918.

# SAEMS Standing Order

## BEHAVIORAL EMERGENCY STANDING ORDER

Initiate immediate supportive care:

- Oxygen to keep O2 SAT >90%
- Complete primary and secondary survey as indicated
- Vital Signs including FSBG
- Protect from harming self and others

**INCLUSION**

Use standing orders on patients with these symptoms:

- Suicidal Ideation/Gesturing
- Previous Psychological history
- Acute Psychological Complaint
- Verbalizes danger to self or others
- No identified acute medical needs

**EXCLUSION**

Standing order **should not** be used on patients:

- When use of more appropriate standing order is indicated
- With mixed symptoms
- When an acute medical need is identified

Patient meets criteria for standing order; prepare for transport

**ORDERS**

- Protect patient from harming self and others
- Calm patient with reassuring voice and gestures
- Utilize Law Enforcement for assistance or interventions if necessary
- Transport to appropriate facility
- Restrain as indicated for patient or provider safety
- If restrained, reassess and document neurovascular status of all extremities every 15 minutes
- Contact medical direction for chemical restraint orders as needed

**Contact Medical Direction if**

- **The patient wishes to refuse**
- **The EMS providers can not safely restrain the patient**
- **Law Enforcement will not assist the EMS providers**
- **Condition deteriorates**

Name_____

Agency_____

# Behavioral Standing Order Post Test

Score:_____ Date:_____

Signed By: _____

1. Mania is generally characterized by:
   a. Can exhibit periods of an elevated, expansive, or irritable mood state
   b. Can experience an increase in energy and decreased need for sleep
   c. Attention span is low and may be easily distracted.
   d. Judgment may become impaired and may go on spending sprees
   e. All the above

2. A patient suffering from Schizophrenia Grandiose type will have delusions of inflated worth, power, knowledge, identity or special relationship to a deity or famous person
   a. Yes
   b. No

3. Based upon the SAEMS Standing Order you should reassess a restrained patient and document neurovascular status of all extremities every
   a. 5 minutes
   b. 2 minutes
   c. 10 minutes
   d. 15 minutes

4. A strict form of cognitive screening should be used on all patients never altering the cognitive assessment whether the patient is pediatric or geriatric
   a. Yes, why mess with a good thing
   b. No, not all patients are created equal

5. The SAEMS Behavioral Standing order should not be used on patients:
   a. When use of more appropriate standing order is indicated
   b. With mixed symptoms
   c. When an acute medical need is identified
   d. All the above

6. Assumption of a person's mental ability is not appropriate and documentation as to the patient's mental status and current mental capacity needs to occur to the best of the pre-hospital provider's ability.
   a. True
   b. False

7. Cognitive functioning involves:
    a. The process of transforming, synthesizing, storing and retrieving sensory input.
    b. Information goes in where it should be recognized, learned and retrieved by healthy individuals
    c. High-level functions carried out by the human brain, including comprehension, use of speech, visual perceptions, constructions, calculation ability, attention, memory and executive functions
    d. All the above

8. Cognition can be affected by:
    a. New and/or the lack of medications
    b. Chronic/acute medical illnesses
    c. Traumatic injuries
    d. All the above

9. Bipolar patients exhibit normally all but which behavior:
    a. Inflated self-esteem or grandiosity;
    b. Relaxed and calm
    c. More talkative than usual or pressure to keep talking;
    d. Excessive involvement in pleasurable activities that have a high potential for painful consequences

10. Post-traumatic stress can result from an extreme situation such as combat, rape, hostage situations, or even a serious accident.
    a. True
    b. False

11. During the patient assessment the pre-hospital provider should
    a. Ensure the patients comfort
    b. Be sensitive to the patients feelings
    c. Watch for signs of uneasiness
    d. All the above

12. You are dispatched for a Rescue Nature Unknown and arrive on scene to find a patient in the custody of local law enforcement. The patient is handcuffed lying on the ground. The patient is upset and is screaming obscenities and refuses to cooperate with your line of questions. He just keeps stating he has "chest pain" and "knows the law and that you must take him to the hospital". The patient during transport refuses to answer any and all questions. How would you document the patient findings:

a. Do not document anything as there is no information to document
b. Document the objective data only
c. Document all objective findings, appearance and behavior of the patient, including the refusal to comply with emergency treatment and questions.
d. Score the patient with at least a 3, as the patient knows the "buzz" words to keep him-self out of jail.

13. A common condition in schizophrenia is psychosis

a. True
b. false

14. Based upon the SAEMS Behavioral Standing Order the pre-hospital provider should contact Medical Direction for

a. Patient wishes to refuse treatment and or transport
b. Cannot safely restrain the patient
c. Law enforcement will not assist or intervene
d. All the above

15. _____ are a class of medication used for Anxiety Disorders

a. Stimulants
b. Anxiolytics
c. Antipsychotics
d. Antidepressants

16. A fingerstick (FSBS) is unnecessary to perform on a behavioral patient

a. Yes
b. No

17. The Behavioral Standing Order cannot be utilized for patients with

a. Suicidal Ideation/Gesturing
b. Depression
c. Verbalizes danger to self or others
d. Identified acute medical needs

18. Post Traumatic Stress Disorder (PTSD) is classified under the Depressive Disorders

a. Yes
b. No

19. A patient states they have Major Depressive Disorder, the pre-hospital provider knows that the patient could have:

a. A marked diminished interest or pleasure in all or almost all activities
b. Suffer from insomnia or hypersomnia
c. Feelings of worthlessness
d. Recurrent thoughts of death
e. All the above

20. Stimulants are used for anxiety disorders and related problems such as insomnia.

a. True
b. False

# EVALUATION

Please answer the following questions by marking the appropriate response:

| | | Lowest Worst Least | | | | Highest Best Most |
|---|---|---|---|---|---|---|
| 1. | To what extend did this module meet your needs? | 1 | 2 | 3 | 4 | 5 |
| 2. | There was a balance between theoretical and practical information. | 1 | 2 | 3 | 4 | 5 |
| 3. | The time required was appropriate to the content. | 1 | 2 | 3 | 4 | 5 |
| 4. | The module increased my knowledge and understanding of the topic. | 1 | 2 | 3 | 4 | 5 |
| 5. | References or audiovisuals were adequate. | 1 | 2 | 3 | 4 | 5 |
| 6. | Overall, this program was worthwhile. | 1 | 2 | 3 | 4 | 5 |

7. Additional comments: