De-Escalation in Mental Health Crisis & Episodes

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Disclosures

I have no conflicts of interest related to this presentation

He is a "20"

- Multiple factors may contribute to, or trigger, the onset of a mental health issue, the brain—and neurobiology—is actually the reason patients experience the symptoms observed on mental health emergency calls. Psych calls ARE medical calls.
- Appropriate assessment, medical care and in the moment management are essential for a positive outcome in the short and long term.
- Preventing episodes of crisis that might cause a patient to become vulnerable, unsafe, or a safety risk to others is essential…and may be a key to opening a door to mental health care (Wellness Recovery Action Plan).
- Paramedics and EMS social workers can play a vital role in providing nonjudgmental medical interventions for patients with mental health conditions by understanding both the medical and psychosocial factors contributing to mental health emergencies, and by being familiar with assessment and intervention techniques during patient interactions of all kinds.

And we only have 20!

- Complex topic, only time for quick tips, but consider delving in to more training
- Always rule out a primary medical issue (assumptions and secondary psychosis)
- Most people living with mental health disabilities are functional, and with care, stable. **Avoid Assumptions and reinforcing stigma!**
- Individuals with mental health issues that can cause them to become unsafe are the focus today
- Know that children, older adults, and individuals with disabilities require special consideration
- Psychiatric calls are medical calls!
- Always respond with compassion and non-judgment
- Protocols are critical, and sometimes, so is outside the box thinking
- **211/988** are your friends, call them

Frontal Lobe, we have a problem…

- The largest of the four major lobes of the brain, controls important cognitive functions such as **emotional expression, problem solving, judgment, impulse control, and insight/self-awareness**; it is often the driving force behind behavior challenges observed in patients who present with mental health disorders.
- **Anosognosia**, or lack of insight/self-awareness, causing individuals with mental health disorders to be unaware they have a mental health issue. Medical denial is real, and it is the key to understanding how to help.

Does it have to be so complicated? Yes, it does.

Although mental health disorders are the outcome of neurobiological impacts in the brain, psychosocial, medical, and environmental factors such as the following can contribute to triggering episodes of crisis:

- Home, school, or work stress
- Trauma
- Abuse/exploitation
- Alcohol and/or substance use
- Poverty
- Exposure to violence
- Loss/relationship changes
- Medication changes or discontinuation
- Lack of access to medical care
- Nutrition
- Lack of case management/access to resources
- Lack of social, familial, and/or emotional support
- Other medical conditions

The Truth: https://www.youtube.com/watch?v=b3HW2BYxz5Q

- ***Patients with mental health disorders are generally nonviolent***, however, when in a crisis, especially one involving a loss of reality (psychosis), both the patient and the patient's caregivers are at risk.
- Patients presenting with a mental health disorder who are also impaired by a substance are at a higher risk of perpetrating violence.
- Most patients experiencing a mental health crisis may never get agitated and combative, but it is critical to recognize that a patient may not demonstrate these behaviors initially but could develop them at any point during the patient interaction. **Aim for prevention, be ready for de-escalation**.

Things just got real…

The following symptoms may be a clue that a patient is at risk to become aggressive or violent:

- Agitated delirium—psychomotor agitation, often includes sweating
- Hallucinations-seeing, smelling, hearing, or tasting something that is not real
- Delusions-false beliefs
- Restlessness or unusual physical activity
- Presence of or threat of using a weapon
- Verbal threats
- Yelling or screaming
- Disorientation
- Physical assault-hitting, biting, slapping, kicking
- Evidence of self harm or harm to others, including stated plan to commit these acts

Plan & Protocol

Follow agency protocols, but best practices include:

- Request law enforcement on any scene that has the potential to become unsafe or is not deemed safe. Instinct matters.
- If safe to do so, remove any potentially harmful objects or weapons, or prevent patient access to these items if feasible. Follow agency protocol regarding handling of weapons on scene or on the patient.
- If you are in immediate danger and can safely disengage from the patient and the scene to seek safety until law enforcement arrives, do so.
- If you are in immediate danger and cannot safely disengage from the patient and/or the scene, use de-escalation techniques until law enforcement arrives. **Standby, they are coming next.**
- Follow agency guidelines for use of distress signals if you believe your own life is in danger.
- Utilize Crisis Intervention Training (CIT) or the communication techniques in this presentation to de-escalate the patient and reduce risk as a first line of care.
- Reserve chemical and physical restraints for patients for whom communication de-escalation techniques are not effective in reducing unsafe behavior. Follow agency protocols for use of medications such as ketamine and/or soft restraints.

Help yourself help the patient

- Use a calm and nonaggressive tone of voice.
- Identify yourself and let the patient know you are there to help.
- Speak slowly.
- Use short, direct, and clear sentences.
- Turn down your radio to avoid agitating the patient.
- Look at the patient, but avoid frequent direct eye contact.
- Avoid touching patients without their permission.
- #1 Rule: DO NOT TELL THE PATIENT TO CALM DOWN.
- Tell patients you want to partner with them to help, and they can make decisions with you. In cases where patients do not have the capacity to make decisions, expressing you want to partner with them to help is still appropriate. Avoid language that makes any patient feel forced or coerced.
- Avoid reorientation to reality; instead, let patients know you acknowledge what they believe. Example: *"Mr. G, thank you for sharing with me that you are on your way to fight in a war. That information helps me help you."*
- Avoid abrupt physical movements.
- Do not argue or challenge the patient.
- With patients who are having a hallucination or delusion, it is acceptable to engage them by asking questions about those perceptions. This demonstrates you are trying to help and to listen, which may calm and distract the patient while you provide care. Example: *"Mr. G, I heard you say you are on your way to fight in a war. Tell me about the war."*

More tips…

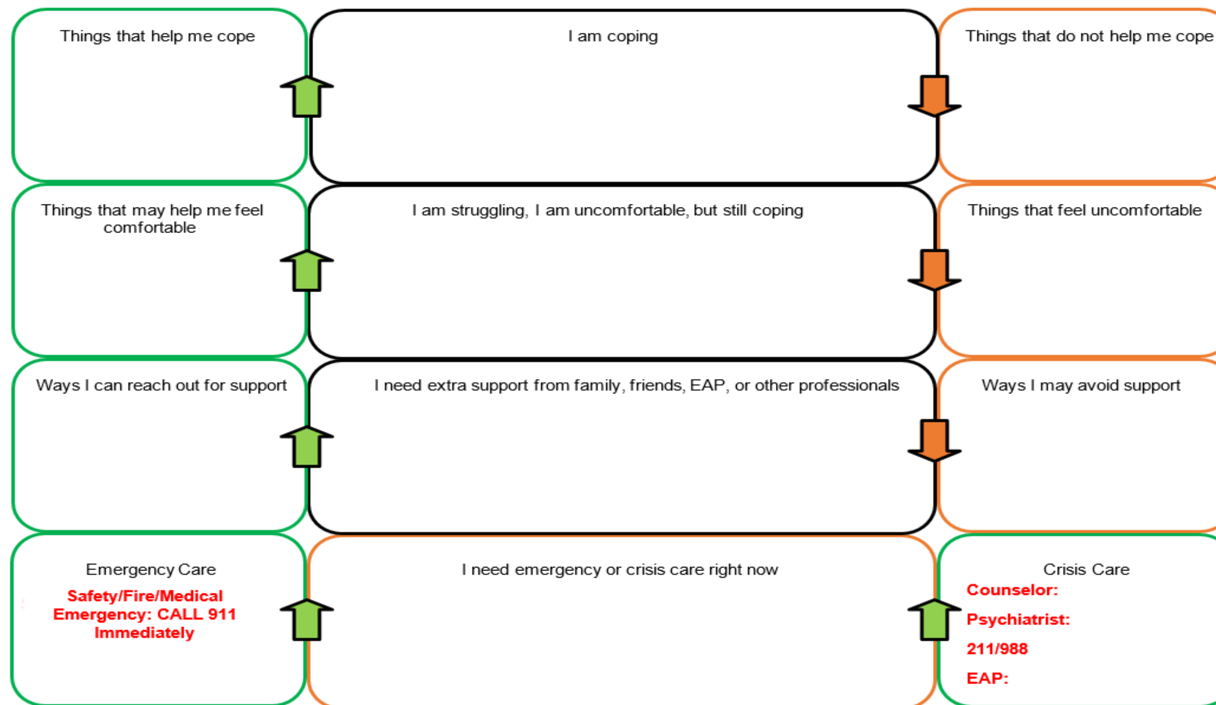
- **Do not threaten them if their behavior does not stop. These patients cannot control their behavior, and this tactic may escalate agitation.**
- **Avoid laughing, or using facial expressions that may indicate sarcasm, such as eye rolling or smirking.**
- **Be honest. If a patient asks a question, answer as directly as possible.**
- **Avoid judgmental and blaming words and statements, such as "If you didn't drink, this would not happen," or "You are crazy right now."**
- **Give patients physical space if they are agitated. Avoid physical confrontation until you are able to de-escalate.**
- **Recognize that because communication is the treatment on scene, these calls take extra time. You might expect to be off scene in 10 minutes for a trauma alert, but for a mental health call you may be on scene for 30-45 minutes before you can safely transport.**
- **Paraphrase: Using fewer words to repeat back what you have heard the patient say.**
- **Summarize: Sum up what the patient has said to you after listening for a period of time.**
- **Reflective listening: Restate what you hear and see, with a focus on how the patient is feeling.**
- **Open-ended questions: Clarify what the patient is thinking or feeling by asking questions that require more than a yes-or-no answer.**
- **I statements: Start your sentences with "I" to take ownership of what you have said and avoid putting the patient on the defensive. Example: *"I heard you say that you are scared of going to the hospital. I can understand why you would feel scared. I am here to help you feel less scared, and I am going to be with you in the ambulance the entire way there."***

Suicide

- **When communicating with a patient who is suicidal, consider these communication strategies:**
- **Be direct and ask patients if they are thinking of suicide.**
- **Ask patients if they have a plan to commit suicide; if they state they do, ask what that plan is.**
- **Ask patients if they have a method to carry out their plan in the home; if so, secure it and/or notify law enforcement if they arrive on scene.**
- **Provide compassionate listening.**
- **Avoid trying to talk patients out of their plan to commit suicide by making statements such as "You**
- **Offer validation. Example: *"I am honored you feel comfortable sharing how you feel with me. We will get through this together."***
- **Explore patients' feelings by asking open-ended questions such as "Tell me about other times you may have felt this way" or "What have you tried to help yourself feel better in the past?"**
- **Keep patients talking until law enforcement or a qualified health provider arrives to discuss voluntary or involuntary admission to a psychiatric facility.**
- **EMTs are sometimes required to manage the initial evaluation and triage of a patient who may be suicidal. Many tools are available to assist with this process. The U.S. Department of Health and Human Services' Substance Abuse and Mental Health Services Administration (SAMHSA) has designed the SAFE-T, a five-step tool that is appropriate for patients of all ages. SAFE-T allows you to:**
  - **Identify risk factors**
  - **Identify protective factors**
  - **Conduct suicide inquiry**
  - **Determine risk level/intervention**
  - **Document**
- **You can download the SAFE-T evaluation tool at www.sprc.org.**

Crisis Resources

Parachute Plan



SAFE-T

SAFE-T

Suicide Assessment Five-step Evaluation and Triage

1
IDENTIFY RISK FACTORS
Note those that can be modified to reduce risk

2
IDENTIFY PROTECTIVE FACTORS
Note those that can be enhanced

3
CONDUCT SUICIDE INQUIRY
Suicidal thoughts, plans, behavior, and intent

4
DETERMINE RISK LEVEL/INTERVENTION
Determine risk. Choose appropriate intervention to address and reduce risk

5
DOCUMENT
Assessment of risk, rationale, intervention, and follow-up

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
www.samhsa.gov

Resources

https://www.nami.org/Support-Education/Publications-Reports/Guides/Navigating-a-Mental-Health-Crisis
https://www.naemt.org/education/ems-safety
https://mhttcnetwork.org/centers/global-mhttc/training-and-events-calendar
https://www.nami.org/Advocacy/Crisis-Intervention/Crisis-Intervention-Team-(CIT)-Programs
https://www.wellnessrecoveryactionplan.com/product/crisis-plan-on-the-go/
https://store.samhsa.gov/product/SAFE-T-Pocket-Card-Suicide-Assessment-Five-Step-Evaluation-and-Triage-for-Clinicians/sma09-4432