Transport of Mentally Ill Patients

Maine EMS personnel are generally called to transport a mentally ill patient in one of two situations:

Emergency Transport
Safety for the patient and the crew is the primary concern in the transport of the mentally ill patient. Personnel should make sure they do a thorough evaluation of the patient to find and treat possible medical causes of the behavior. Refer to the Agitation/Excited Delirium protocol, **Orange 3**.

All diagnostic and therapeutic interventions administered by EMS providers are pursuant to the prescriptive authority of a physician. In certain limited situations, when a patient poses a significant danger to self or others, it may be appropriate to restrain the patient involuntarily. Providers are cautioned to use physical restraint as a last resort, preferably with the assistance of local law enforcement, refer to **Orange 2**. Once the decision is made to restrain a patient, the least restrictive restraint reasonable should be implemented and the patient should remain restrained until arrival at the emergency department, unless it interferes with the delivery of medical care. Only commercially available soft restraints are approved by Maine EMS.

Non-Emergency Transfer
Mentally ill patients who are being transferred usually fall into one of these categories:

Voluntary Committal – These patients have agreed to be transferred to a facility for evaluation and treatment of an underlying mental illness. It is important to get a thorough report on the patient prior to transport to avoid surprises en route. Voluntary committal patients can change their mind during transport. In this case, it is the responsibility of the EMS personnel to discharge the patient at a safe location, preferably at the originating facility. If it is not possible to return the patient to the originating facility, notify local law enforcement to meet you at your location.

Involuntary Committal – Patients who are being committed involuntarily must have committal papers (blue papers) completed prior to transport. Between the hours of 7 a.m. and 11 p.m. a judge has to sign the committal papers. After 11 p.m. and before 7 a.m. the papers do not have to be signed except for Riverview Psychiatric Center (formerly AMHI) – this is known as the “pajama clause”. Make sure that the transporting service is listed correctly on the papers. According to Maine law, the patient must be transported in the least restrictive form of transportation available. Make sure you get a thorough history to determine whether restraints will be necessary. *If the receiving facility refuses to accept the patient after evaluating them, the transporting service is required, by law, to transport the patient back to the originating facility.*

Depression/Suicidal Ideation

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1. Ensure the scene is safe and request law enforcement for patients actively threatening/attempting suicide
2. Assess the patient for need of medical treatment and follow appropriate protocol
3. Establish rapport with the patient by listening carefully and speaking in a non-confrontational manner.
4. Assess the patient
   a. Has a suicide attempt been made? If yes, request ALS
   b. **SAD PERSONS** Scale (report score to receiving hospital)
      1 point for each of the following

      Sex:male
      Age <20 or >44
      Depression
      Previous suicide attempt
      Ethanol abuse
      Rational thinking loss
      Social supports lacking
      Organized suicide plan
      No spouse (divorced, widowed, single)
      Sickness (chronic, debilitating, or severe)

   c. Columbia Suicide Screening (if possible, discuss the following questions with the patient):
      i. Have you wished you were dead or wished you could go to sleep and not wake up?
      ii. Have you been thinking about how you might kill yourself?
      iii. Have you taken any steps towards making a suicide attempt or preparing to kill yourself (such as collecting pills, getting a gun, giving valuables away or writing a suicide note)?
5. Provide constant, 1:1 supervision for the patient
6. Collect items such as toxic substances, alcohol, drugs and medications that may have been taken and transport with patient to the hospital
7. Provide support for family and friends who are present.
8. Obtain information from family and friends and obtain their contact information should the hospital have any questions.
9. Transport the patient to the closest facility that can meet their medical and psychiatric needs

Refer to **Grey 16** for Transport of Mentally Ill Patients protocol
Refer to **Orange 2** for Restraint protocol
Refer to **Orange 3** for Agitation/Excited Delirium protocol

PEARL
A SAD PERSONS Score > 4 or a "yes" answer to any of the Columbia Suicide Screening questions may indicate that the patient requires psychiatric hospitalization. However, **all patients presenting with a psychiatric emergency should be transported to the hospital for evaluation.**

Restraints

In certain limited situations, when a patient poses a significant danger to self or others, it may be appropriate to restrain the patient involuntarily. Providers are cautioned to use physical restraint as a last resort, preferably with the assistance of local law enforcement. Once the decision is made to restrain a patient, the least restrictive restraint reasonable should be implemented and the patient should remain restrained until arrival at the emergency department, unless it interferes with the delivery of medical care. Only commercially available soft restraints are approved by Maine EMS.

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EMT/AEMT

1. Refer to Altered Level of Consciousness Protocol, Gold 5, to establish etiology of agitation.
2. Request law enforcement assistance
3. Request ALS
4. Attempt de-escalation techniques (speak in an honest, non-confrontational tone while avoiding eye contact).
5. Have appropriate personnel available prior to initiating restraints
6. Restrain patients in a lateral or supine position. NEVER leave patients restrained in a prone position. **NEVER** restrain a patient's hands and feet behind them (hog-tying). All applied restraints must be easy to remove should a medical emergency occur.
7. Never place objects on top of patients to restrain them.
8. Restrained patients require 1:1 observation by EMS personnel and require continuous cardiac, pulse oximetry and waveform capnography monitoring, if able to do so.
9. Contact **OLMC** as soon as logistically possible after securing the safety of the patient and providers.
10. Documentation: Document de-escalation techniques untilized prior to physical restraint. Document type of restraints used, how restraints applied, when restraints applied, why restraints applied (patient's behavior and mental status), the agency and individual that applied the restraints, frequent vital signs and CSM checks, education provided to patient and time **OLMC** notified.
11. Restraint devices applied by law enforcement require an officer's continued presence to ensure patient safety and allow for quick removal, if necessary. Law enforcement should accompany the patient in the ambulance.
12. Restrained patients should not be moved in a stair chair device as violent patients cannot properly be restrained in a stair chair and EMS personnel may be easily thrown off-balance by a resisting patient.
13. Restrained patients should be transported to the nearest emergency department that can safely accept the patient.

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PARAMEDIC

14. Refer to Agitation/Excited Delirium protocol, **Orange 3.** Physical restraint is both physically and mentally traumatizing to patients. Consider pharmacologic management, if required, once the patient is physically restrained.

Pearls for Restraints

In conjunction with and support of a joint statement released in October 2020 by the NAEMSP, NASEMSO, NEMSMA, NAEMT and APA, the MDPB strongly supports regular, continuing education focused on the management of behavioral emergencies, implementation of QA/QI processes dedicated to these situations, and fostering local relationships with key stakeholders that encourage local systems of care to support EMS clinicians caring for patients suffering from behavioral emergencies.

Agitation/Excited Delirium #1

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EMT

1. Maintain crew safety; ask for law enforcement assistance, if available
2. Attempt verbal de-escalation using direct, empathetic and calm voice. Present clear limits and options. Respect the patient's personal space. Avoid direct eye contact and assume a non-confrontational posture
3. If altered mental status, check oxygen saturation and perform finger stick blood glucose, if so trained

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4. If blood glucose is less than 60 mg/dL, refer to Diabetic/Hypoglycemic Emergencies protocol, **Gold 6**

PARAMEDIC

5. Perform the Altered Mental Status Scale:

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Score	Responsiveness	Speech	Facial Expression	Eyes
+4	Combative, very violent, out of control	Loud outbursts	Agitated	Normal
+3	Very anxious, agitated, mild physical element of violence	Loud outbursts	Agitated	Normal
+2	Anxious, agitated	Loud outbursts	Normal	Normal
+1	Anxious, agitated	Normal	Normal	Normal
0	Responds to name in normal tone	Normal	Normal	Clear, no ptosis
-1	Lethargic response to name	Mild slowing or thickening	Mild relaxation	Glazed or mild ptosis (<half eye)
-2	Responds only if name is called loudly	Slurring or prominent slowing	Mild relaxation (slacked jaw)	Glazed or marked ptosis (<half eye)
-3	Responds only after mild prodding	Few recognizable words	Mild relaxation (slacked jaw)	Glazed or marked ptosis (<half eye)
-4	Does not respond to mild prodding or shaking	Few recognizable words	Mild relaxation (slacked jaw)	Glazed or marked ptosis (<half eye)

Procedure for AMSS Assessment	Score
1. Observe the patient - if alert, restless, agitated or combative	0 to + 4
2. Say the patient's name in a gentle tone of voice and ask patient to open eyes	-1
3. If no response to voice, continue with routine EMS	-2 to -4

Agitation/Excited Delirium #2

PARAMEDIC

7. If Altered Mental Status Score +1, +2 or +3, consider midazolam 4-10 mg **IM** for patient/EMS provider safety and patient comfort. First dose should be based on patient's size, age, and the circumstances causing agitation
8. If Altered Mental Status Score +4, consider either:
   * Midazolam 4-10 mg **IM** for patient/EMS provider safety and patient comfort. First dose should be based on patient's size, age, and the circumstances causing agitation

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-OR-

*contact OLMC for Ketamine 4 mg/kg **IM**. Ketamine may not be used in patients greater than 65 years old

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9. Monitor and document the following every 5 minutes - ECG, O_2 sat, $ETCO_2$, AMSS, and vital signs

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10. Contact OLMC for dosing questions or if patient requires repeat dosing.

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Pearls for Agitation/Excited Delirium

Agitation - is defined by excessive, purposeless cognitive and motor activity or restlessness, usually associated with a state of tension or anxiety

Excited Delirium - is a sub-category of agitation, with a potential for higher mortality and morbidity. It can be defined by a patient presenting with the following constellation of symptoms (based on the 2009 ACEP White Paper) with frequency in parenthesis:

- Exceptional/abnormal pain tolerance (100%)
- Tachypnea (100%)
- Tactile hyperthermia (95%)
- Unusual strength (90%)
- Police Noncompliance (90%)
- Lack of tiring against restraint (90%)
- Inappropriate clothing for environmental temperature (70%)
- Violent and paranoid behavior
- Rapid development of symptoms
- Rapidly and fluctuating periods of calm and then delirium

These symptoms may be caused by a number of intoxicants, including, but not limited to alcohol, sympathomimetics (cocaine, methamphetamine, MDMA), and dissociative agents (PCP, LSD, dextromethorphan, K2/Spice, Bath Salts, DMT, etc).

Early contact of OLMC is essential for proper preparation of the receiving facility and staff.

Agitation/Excited Delirium #3

Pearls

- Patient who are in a post-ictal state (i.e. have just suffered a seizure) are **NOT** considered to be in excited delirium and should **NOT** receive Ketamine
- Patients should **NOT** receive BOTH Midazolam and Ketamine due to concerns for potential additive affects and respiratory depression

Pearls for Midazolam/Ketamine

Midazolam

- Patients with underlying medical conditions (including COPD/CHF/CAD) as well as patients older than 60 are more likely to suffer adverse effects from midazolam. Consider lower doses in this population.
- WARNING: May cause respiratory depression, arrest, or apnea.
- Assess patients for signs and symptoms of respiratory depression and sedation.
- Administration: **IM** - Administer undiluted deep IM into large muscle.
- Administration: **IV** - Do not administer intra-arterially. Administer by **slow** IV injection over at least 2 minutes using a concentration of 1 mg/mL or a dilution of the 1 or 5 mg/mL concentrations.
- Concomitant use with opioids: **[US Boxed Warning]:** Concomitant use of benzodiazepines and opioids may result in profound sedation, respiratory depression, coma, and death.

Ketamine

- Document the patient's Altered Mental Status Score (AMSS) in the run report.
- Patients with an AMSS less than 4 may be more likely to require airway management when receiving Ketamine, therefore Ketamine is to be used ONLY if the patient is suffering from excited delirium, as measured by an AMSS score of 4.
- Maine EMS Services will be stocking the 100 mg/mL concentration to accommodate the wide dose ranges in the protocol. This is to avoid carrying two very different concentrations and the risk of a serious dose error.
- WARNING: Overdose may lead to panic attacks and aggressive behavior; rarely seizures, increased ICP, and cardiac arrest. Very similar in chemical makeup to PCP (phencyclidine), but it is shorter acting and less toxic.
- Administration: **IM** - Inject deep IM into large muscle mass.
- Administration: **IV** - According to the manufacturer, administer bolus/induction doses over 1 minute or at a rate of 0.5 mg/kg/minute; more rapid administration may result in respiratory depression and enhanced pressor response. Some experts suggest administration over 2 to 3 minutes (Miller 2010).
- **The 100 mg/mL concentration should not be administered IV unless properly diluted with, at minimum, an equal volume of Sterile Water for Injection, NS, or D_5W.**

Alcohol Intoxication/Severe Alcohol Withdrawal, 1

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EMT

1. Assess ABCs
2. Obtain vital signs
3. Assess level of consciousness. Consider alternative diagnosis. Refer to Altered Level of Consciousness Protocol, **Gold 5**.
4. If trained, perform finger stick blood glucose.
5. If blood glucose < 60 or clinical condition suggests hypoglycemia, request ALS and refer to Diabetic/Hypoglycemic Protocol, **Gold 6**
6. **In Acute Alcohol Intoxication** - If the patient has evidence of incapacitating intoxication or acute illness/injury, request ALS.
7. **With any concern for withdrawal** - Question the patient about past withdrawal symptoms. Any patient with a history of hospitalization for alcohol withdrwal, withdrawal seizures or delirium tremens (DTs) should be transported to the Emergency Department.
8. In either **Acute Alcohol Intoxication** or concern for **Alcohol Withdrawal,** ask the patient about the time and amount of their most recent alcohol ingestion, frequency and amount of routine alcohol use, and any co-ingestions such as ethylene glycol (found in antifreeze), ethyl alcohol (AKA ethanol, grain alcohol), methanol (AKA wood alcohol) or other substances.
8. If the patient refuses transport, refer to the Transport Protocol, **Grey 14**

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9. In either **Acute Alcohol Intoxication** or concern for **Alcohol Withdrawal** - for patients requiring transport, consider IV access and fluid bolus if clinically indicated

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PARAMEDIC

10. For **Severe Alcohol Withdrawal** symptoms, contact OLMC for the option of Midazolam 2.5 mg IV or 5.0 mg IM. May repeat x 1 with max cumulative dose of 5 mg IV or 10 mg IM

    a. **Severe Alcohol Withdrawal** symptoms include hypertension/tachycardia AND **two or more** of the following:
        1. *Severe tremors*, even with arms not extended - tested by "arms extended and fingers spread apart"
        2. *Drenching sweats*
        3. *Continuous tactile disturbances* - ask "Have you any itching, pins and needles sensation, any burning, any numbness, or do you feel bugs crawling on or under your skin?"
        4. *Continuous auditory disturbances* - ask "Are you more aware of sounds around you? Are they harsh? Do they frighten you? are you hearing anything that is disturbing to you? are you hearing things you know are not there?"
        5. *Continuous visual disturbances* - ask "Does the light appear to be too bright? Is its color different? Does it hurt your eyes? Are you seeing anything that is disturbing to you? Are you seeing things you know are not there?"
11. If seizure, refer to Seizure Protocol, **Gold 8**

Continued

Alcohol Intoxication/Severe Alcohol Withdrawal, 2

Continued from Previous Page

PEARLS For Alcohol Intoxciation/Withdrawal/Delirium Tremens
Intoxicated patients with any of the following **MUST** be transported to the Emergency Department:

1) **Incapacitating Intoxication:** Inability to maintain airway**;** Inability to stand from seated position and ambulate with minimal assistance; At immediate risk of environmental exposure or trauma due to unsafe location
2) **Acute Illness/Injury:** Abnormal vital signs, Physical complaint that may indicate underlying illness/trauma**,**Seizure, Hypoglycemia, Trauma, Head Injury

Delirium tremens (DTs) is a severe form of alcohol withdrawal that can be life-threatening if not treated properly. DTs usually begin 48 hours after last alcohol consumption and is most severe 4-5 days after last alcohol consumption. Typical duration of DTs is 2-3 days but can last up to 8 days. Untreated DTs has a mortality rate of 37%. In contrast hospitalized patients with DTs have a mortality rate of 1-4%.

Care of the Homeless Individual

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EMT/ADVANCED EMT/PARAMEDIC

1. Approach patient in a non-threatening manner and establish rapport.
2. Patient may be wearing several layers of clothes. Avoid cutting clothes, if possible, as these may be the only clothes the patient has, however do not allow clothes to prevent a full examination of the patient. Be aware of the presence of sharp objects (ie: syringes, knives, weapons, etc.) in pockets and clothing.
3. Be cognizant of patient possessions and attempt to secure patient belongings with a trusted individual if it is not feasible to transport all belongings.
4. Homeless patients are at risk of exposure to environmental elements. Move the patient to a “safe” environment (ie: ambulance) early in the encounter, if feasible.
   a. Once the patient is physically in a private and safe location, consider inquiring about the patient's safety from physical or verbal threats.
5. Be aware of concurrent illnesses that may influence the chief complaint. Homeless indivisuals may lack access to routine medical care predisposing them to the risk for both chronic and acute illnesses.
   a. For example, the pregnancy rate of homeless women is estimated to be twice that of the general population
6. Mental illness and substance abuse occur frequently in the homeless population. Avoid attributing the current chief complaint to these underlying conditions.
7. Head injuries are common in the homeless population. For patient with altered mental status, refer to Altered Level of Consciousness Protocol, **Gold 5** or Head Injury, **Green 11**
8. Individuals suffering homelessness may have many barriers that limit their interest in transport to a hospital. Should the patient refuse transport, refer to the Transport Protocol, Grey *** and consider discussing with OLMC

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