Washington State Department of Health Office of Community Health Systems
Emergency Medical Services and Trauma Section

EMS Guideline
Transport to Mental Health or Chemical Dependency Services

Introduction

The Washington State Department of Health (department) distributes this guideline to assist regional EMS & trauma care councils with developing patient care procedures, local EMS councils with developing county operating procedures and EMS physician medial program directors (MPD) in developing their prehospital patient care protocols.

In 2015 the Washington State Legislature passed RCW 70.168.170 allowing emergency medical services (EMS) to transport patients from emergency scenes directly to mental health or chemical dependency services. Participation of mental health or chemical dependency services is voluntary. Transport to mental health or chemical dependency services is an option for patients and is not mandatory.

The department developed this guideline in consultation with the Department of Social and Health Services, members of the EMS & Trauma Care Steering Committee, representatives of ambulance services, firefighters, mental health providers, and chemical dependency treatment programs. The workgroup was directed by the law to establish guidelines for developing protocols, procedures, and applicable training appropriate to the level of emergency medical service provider.

The guideline was required to consider when to transport to a mental health facility or a chemical dependency treatment program and to include:

- The presence of a medical emergency that requires immediate medical care;
- The severity of the mental health or substance use disorder needs of the patient;
- The training of emergency medical service personnel to respond to a patient experiencing emergency mental health or substance use disorders; and
- The risk the patient presents to the patient's self, the public, and the emergency medical service personnel.

The department appreciates receiving any information regarding experience with this guideline. Please direct comments to hsqa.ems@doh.wa.gov.

What this means for regional EMS and trauma care councils

Regional EMS and trauma care councils shall develop a patient care procedure (PCP) that provides guidance to medical program directors and EMS agencies to operationalize transport of patients to a mental health or chemical dependency treatment facility. The PCP must:

- Direct participating facilities and agencies to adhere to the Washington State Department of Health Guideline for the Implementation of SHB 1721 (guideline);
- Identify health care representatives and interested parties to be included in collaborative workgroups for designing and monitoring programs;
- Direct facilities that participate in the program to work with the medical program director (MPD) and EMS entities to reach consensus on criteria that all facilities and EMS entities participating in the program will follow for accepting patients.
- Include a statement that the facility participation is voluntary;
- Direct the local EMS council and MPD to establish a quality assurance process to monitor programs;
- Direct the local EMS council and MPD to develop and establish a county operating procedure (COP) inclusive of the standards recommended by the guideline and PCP, to include dispatch criteria, response parameters and other local nuances to operationalize the program;
- Direct the EMS MPD to establish a patient care protocol (protocol) inclusive of the standards and screening criteria recommended by the guideline and PCP;
- Direct the MPD to develop and implement department approved education for emergency medical service personnel in accordance with the training requirements of the guideline. Educational programs must be approved by the department.

What this means for local EMS and trauma care councils

Local EMS and trauma care councils must collaborate with the MPD to develop a COP inclusive of the standards in the guideline. The COP must be consistent with state standards and the PCP.

The COP must include:

- A list of approved mental health and chemical dependency facilities participating in the program;
- Destination determination criteria including considerations for transports that may take the EMS service out of its county of origin;
- A list of options for methods of transport and any pertinent timelines for transport to occur;
- Guidance to EMS providers on when to contact law enforcement and any procedures that must be considered during EMS and law enforcement interactions;
- Guidance to EMS providers on when to contact the designated mental health professional (DMHP) and any procedures to be considered during an involuntary hold.

What this means for medical program directors

MPDs must develop a patient care protocol inclusive of the standards and screening criteria in the guideline and PCP. The protocol must be consistent with state standards, PCP, and COP. The protocol should assist EMS providers in the:

1. Determination of medical emergency that requires immediate care;

2. Assessment of the risk the patient presents to the patient's self, the public, and the emergency medical service personnel;
3. Determination of severity of mental health or substance use disorder.

MPDs must develop and implement department approved education for emergency medical service personnel who will respond and transport patients to mental health and chemical dependency facilities. Training must include content that meets the outlined criteria in **Appendix C** of this document.

APPENDIX A

EMS Screening Criteria for Transport to Mental Health Services

INCLUSION CRITERIA:

Facility:

Reference:

RCW 71.05.020 - Definitions
RCW 71.05.153 - Emergent detention of persons with mental disorders – Procedure

Mental health services authorized to receive patients include; crisis stabilization units, evaluation and treatment facilities and triage facilities.

Mental health services who have elected to operate as an involuntary facility may receive patients referred by a peace officer or a patient in involuntary status by a DMHP.

Patient:

- Voluntary with a mental health chief complaint willing to go to an alternative destination.
- Patients with a mental health chief complaint referred by a peace officer.
- Patients with a mental health chief complaint detained under the Involuntary Treatment Act (ITA) by a DMHP. The proper documents must be completed and signed by a DMHP for reimbursement.
- Patients with mental health complaints must have a clear history of mental health problems. No new onset mental health problems.
- The patient's current condition cannot be explained by another medical issue and traumatic injury is not suspected.
- The EMS agency was dispatched via 911.
- Age 18-55 is recommended based on a review of research during the development of the Department of Health guideline. MPDs may adjust this parameter.
- Cooperative and non-combative.
- Normal level of consciousness, no medical issues suspected.
- Suicidal patients may accept voluntary care or may be detained by a peace officer or DMHP.
- HR 50-110 is recommended based on a review of research during the development of the guideline. MPDs may adjust this parameter.

- BP systolic 100-190, diastolic less than 110 is recommended based on a review of research during the development of the guideline. MPDs may adjust this parameter.
- RR 12-24 is recommended based on a review of research during the development of the guideline. MPDs may adjust this parameter.
- Temperature 97-100.3 F is recommended based on a review of research during the development of the guideline. MPDs may adjust this parameter.
- Room air O2 saturation greater than 92 percent is recommended based on a review of research during the development of the guideline. MPDs may adjust this parameter.
- If indicated check blood sugar, 70-300 is acceptable and is recommended based on a review of research during the development of the guideline. MPDs may adjust this parameter.
- Patient has the ability to care for self. MPDs may consider listing other criteria such as activities of daily living (ADLs).

EXCLUSION CRITERIA:

Facility:

- Lack of bed availability
- Intake staff identifies concerns that exceed the ability of the facility to provide adequate care to the patient that requires local hospital emergency department -physician evaluation.
- Facilities may test for alcohol level and establish a cutoff level for acceptance that should not be below 300.

Patient:

- Intentional or accidental overdose
- Any acute trauma other than minor wounds not in need of treatment beyond bandaging.
- Loss of consciousness or seizure within the past 24 hours by patient history.
- Pregnancy
- Anticoagulation. MPDs may specify medications in protocols to consideration.
- Blood sugar out of control over last 24 hours by patient history. MPDs may indicate a specific range or other language to clarify.
- Indwelling tubes, lines or catheters currently being utilized that the patient cannot manage.
- New onset of mental health problems. Mental health problem is not clearly indicated in patient history.
- MPDs and participating facilities must collaborate and determine triage criteria for people with functional and access needs, including developmental delay, traumatic brain injury, organic brain syndrome, dementia, etc.

- Any evidence for acute medical or traumatic problem.

PROCEDURE:

- Scene safety and crisis de-escalation.
- Consider contacting law enforcement to assist EMS with on scene mitigation of suicidal patients who are not voluntary and for agitated or combative patients.
- Ask the patients if they normally take medication for mental health and chronic medical problems. Record medications and dosages if possible.
- Obtain history regarding alcohol and illicit drug use.
- Assess for inclusion and exclusion criteria.
- For patients who meet screening criteria, contact receiving center to determine resource availability. MPDs should consider identifying and including a list of available secondary resources other than the emergency room that can be used if a primary resource is unavailable.
- Contact medical control for approval.
- Secure a safe method of transportation identified and approved by the MPD in COPs or protocols.
- Document all findings and inclusion/exclusion criteria for all person contacts on the patient care report and checklist.
- Patients who meet exclusion criteria or decline alternative destination should be transported to a local hospital emergency department using agency-specific standard operating procedures.
- At time of patient care transfer, the completed inclusion/exclusion checklist should be provided to the receiving facility.
- If at any time the receiving facility determines the patient condition has changed and emergency department evaluation is required, EMS should be re-contacted via 911 dispatch and the reason documented.

APPENDIX B

EMS Screening Guideline for Transport to Chemical Dependency Services

INCLUSION CRITERIA:

Facility:

RCW 70.96A chemical dependency centers, and treatment centers, include sobering centers, and acute and subacute detox centers.

- Facility is identified as a crisis stabilization unit, evaluation and treatment facility, or triage facility that provides chemical dependency treatment services and mental health services.

Patient:

- Voluntary patients with a chemical dependency chief complaint willing to go to an alternative destination.
- Patients with a chemical dependency chief complaint referred by a peace officer.
- Patients with a mental health and/or chemical dependency chief complaint detained under the Involuntary Treatment Act (ITA) by a designated chemical dependency specialist (DCDS). The proper documents must be completed and signed by a DCDS for reimbursement.
- The patient's current condition cannot be not explained by another medical issue.
- The EMS agency was dispatched via 911 or police request.
- Age 18-55 is recommended based on a review of research during the development of the Department of Health guideline. MPDs may adjust this parameter.
- Cooperative and non-combative.
- Normal level of consciousness, no medical issues suspected.
- HR 50-110 is recommended based on a review of research during the development of the guideline. MPDs may adjust this parameter.
- BP systolic 100-190, diastolic less than 110 is recommended based on a review of research during the development of the guideline. MPDs may adjust this parameter.
- RR 12-24 is recommended based on a review of research during the development of the guideline. MPDs may adjust this parameter.
- Temperature 97-100.3 F is recommended based on a review of research during the development of the guideline. MPDs may adjust this parameter.

- Room air O2 saturation greater than 92 percent is recommended based on a review of research during the development of the guideline. MPDs may adjust this parameter.
- If indicated check blood sugar, 70-300 is acceptable and is recommended based on a review of research during the development of the guideline. MPDs may adjust this parameter.
- Patient has the ability to care for self. MPDs may consider listing other criteria such as activities of daily living (ADLs).

EXCLUSION CRITERIA:

Facility:

- Lack of bed availability.
- Intake staff identifies concerns that require local hospital emergency department - physician evaluation.
- Facilities may test for alcohol level and establish a cutoff level for acceptance that should not be below 300.

Patient:

- Intentional or accidental overdose.
- Any acute trauma other than minor wounds not in need of treatment beyond bandaging.
- Loss of consciousness or seizure within the past 24 hours by patient history.
- Pregnancy.
- Anticoagulation. MPDs may specify medications in protocols to consideration.
- Blood sugar out of control over past 24 hours by patient history. MPDs may indicate a specific range or other language to clarify.
- Indwelling tubes, lines or catheters currently being used.
- MPDs and participating facilities must collaborate and determine triage criteria for people with functional and access needs, including developmental delay, traumatic brain injury, organic brain syndrome, dementia, etc.
- Any evidence for acute medical or traumatic problem.

PROCEDURE:

- Scene safety and crisis de-escalation .
- Contact law enforcement for suicidal patients who are not voluntary and for agitated or combative patients.
- Ask the patients if they normally take medication for mental health and chronic medical problems. Record medications and dosages if possible.
- Obtain history regarding alcohol and drug use.
- Assess for inclusion and exclusion criteria.

- For patients who meet screening criteria, contact receiving center for resource availability.
- Contact medical control for approval.
- Secure safe method of transportation.
- Document all findings and inclusion/exclusion criteria for all person contacts on the patient care report and checklist.
- Patients who meet exclusion criteria or decline alternative destination should be transported to a local hospital emergency department using agency specific standard operating procedures.
- At time of patient care transfer, provide the completed inclusion-exclusion checklist to the receiving facility.
- If at any time the receiving facility determines the patient condition has changed and emergency department evaluation is required, EMS should be re-contacted via 911 dispatch and the reason documented.

APPENDIX C

EDUCATION: The following is the minimum suggested content for department approved MPD specialized training that shall be provided to EMS providers participating in transport programs authorized by SHB 1721 legislation and operating within the parameters of the guideline. Education programs must be approved by the department. Education must be provided on initial implementation and in an ongoing manner. MPDs may add content to the minimum recommended standards.

I. Review of the Regulatory Framework
- A. SHB 1721 Legislation and Department of Health Guideline
- B. Regional Patient Care Procedure
- C. County Operating Procedure
- D. Patient Care Protocol

II. Define Terms
- A. Receiving centers
  1. Mental Health Centers
  2. Chemical Dependency Centers
- B. Mental Health Professionals
  1. Emergency Social Worker
  2. Designated Mental Health Professional (DMHP)
- C. Involuntary referral
  1. Peace Officer
  2. DMHP
  3. Detainment Laws
  4. Mandatory reporting

III. Behavioral Health Emergencies and Crisis Response
- A. Crisis Intervention
  1. Crisis recognition/assessment
  2. Securing physical safety
     a. Withdraw from contact until scene safe
     b. Contain situation
     c. Call for adequate help
     d. Call for Law Enforcement
  3. Mitigation
  4. Destination decision making/Implementing an action plan
- B. Principles of crisis intervention
  1. Simplicity
  2. Brevity
  3. Innovation
  4. Practicality
  5. Proximity

6. Immediacy
7. Expectancy

C. SAFER-R
1. Stabilize the Situation
2. Acknowledge that something distressing has occurred
3. Facilitate the person's understanding of the situation
4. Encourage the person to make an acceptable plan of action
5. Recovery is evident

D. History/Assessment Tools
1. SAMPLE
2. OPQRST
3. SEA-3
4. MSE

F. Recognition of Increasing Rage/Risk of Violence
1. Bulging neck veins
2. Reddened face
3. Gritted Teeth
4. Muscle tension around jaw
5. Threatening Gestures
6. Threatening Posture
7. Display of a weapon
8. Clenched Fists
9. Wild or staring eyes

G. Suicide
1. Risk factors
2. Overt and covert clues
3. SADPERSONS
4. Steps to bring a suicidal person to safety
    a. Secure the environment
    b. Develop trust and rapport
    c. Engage in a thorough risk assessment
    d. Develop a greater understanding of the person and issues that led up to the current situation
    e. Explore alternatives to suicide
    f. Select the best option for available alternatives
    g. Develop an action plan
    h. Implement the action plan
    i. Refer to appropriate facility

H. Dementia and Delirium
1. Definitions
2. Distinctions
3. Effect and association with emergent medical disorders
    a. Trauma
    b. Infection
    c. Alcohol and drugs
    d. Toxicology

e. Seizure
f. Stroke
g. Hypoglycemia
h. Metabolic derangements
i. Environmental stressors
j. Endocrine disorders
k. Respiratory failure

I. Alcohol
1. Intoxication
2. Abuse
3. Dependence
4. Withdrawal
a. Seizures
b. Delirium Tremens
c. Wernicke's Encephalopathy and Korsakoff's psychosis

J. Drugs (intoxication and withdrawal)
1. Amphetamines
2. Cocaine
3. Cannabis
4. Hallucinogens
5. Inhalants
6. Opioids
7. PCP
8. Sedatives, hypnotics, anxiolytics
9. Toxidromes
10. Common psychiatric medication side effects

K. Psychosis (schizophrenia and similar disorders)
1. Definitions
2. Association with and mimics of substance abuse and intoxication

L. Mood disorders (depression, mania, Bipolar)
1. Definitions
2. Association with and mimics of medical disorders

M. Anxiety Disorders
1. Definitions
2. Mimics of medical disorders

IV. Review Checklists
A. Inclusion Criteria
1. Patient
2. Facility

B. Exclusion Criteria
1. Patient
2. Facility

C. Procedure
1. Scene management

2. Documentation standards

APPENDIX D

Research Bibliography

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