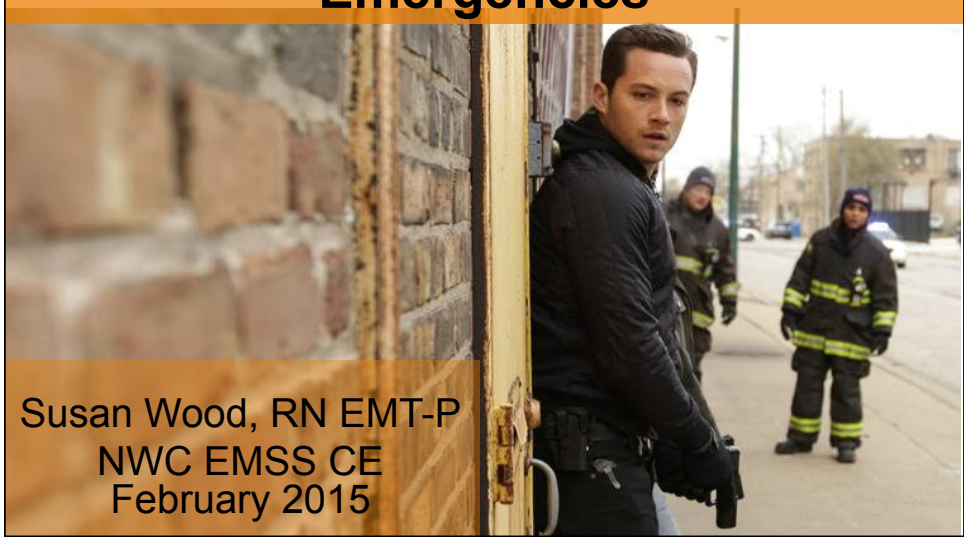
"Perhaps I've lost my Mind"
Drug Overdose and Behavioral Emergencies



Susan Wood, RN EMT-P
NWC EMSS CE
February 2015

Goals for today…

- History & assessment tips to help discover underlying reason for presenting pt's altered mental status (AMS)
- Review most common behavioral emergencies & underlying reason for an AMS
- Legal issues surrounding specific pt conditions
- Update EMS regarding PD's naloxone use

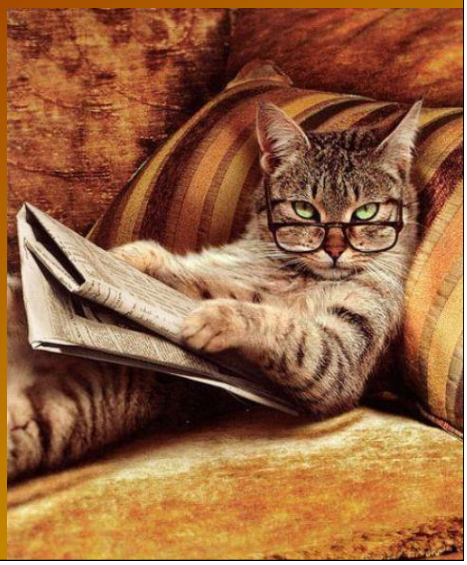
https://www.youtube.com/watch?v=lQLBDGf03z0

Law and Order: SVU
"Regarding Henry"

Psychologist vs. psychiatrist What is the difference?

a ***psychologist*** primarily aids pts through counseling & psychotherapy & is ***NOT*** a medical doctor. May hold a doctoral degree (Ph.D.) & be called "doctor," but is not a medical doctor (M.D.).

– Average training = 8-11 yrs



A ***psychiatrist*** **IS** a medical doctor that in addition to psychotherapy, can prescribe medications & perform medical procedures (ie. electro-convulsive therapy, transcranial magnetic stimulation).

Average

training = 14 yrs

That is not EMS…

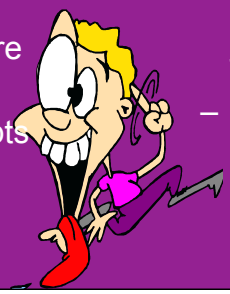
- **EMS must be knowledgeable in a variety of areas including behavioral health.**
- **EMS are not social workers, doctors or lawyers.**
- **The job needs to get done…so what is the best strategy?**

SAFETY

EMS **Patient** **Others**

BEHAVIOR: *A person's observable conduct and activity*

- "Normal Behavior"
  - "What is normal?" Truly no clear definition or ideal model
  - Ideas vary by culture or ethnic group
  - What society accepts at the moment
- "Abnormal Behavior"
  - Deviates from society's expectations
  - Interferes with well being and ability to function
  - Harmful to individual or group



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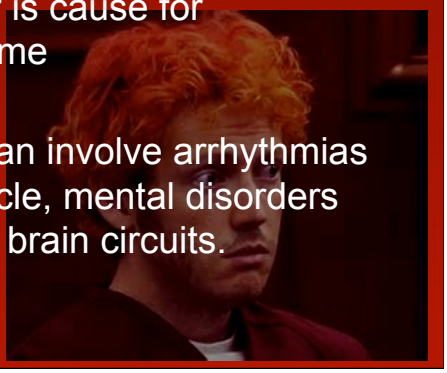
Common *MYTHS* & misconceptions

Abnormal behavior is always bizarre

All mental patients are unstable & dangerous

Mental disorders are incurable

Having a mental disorder is cause for embarrassment and shame

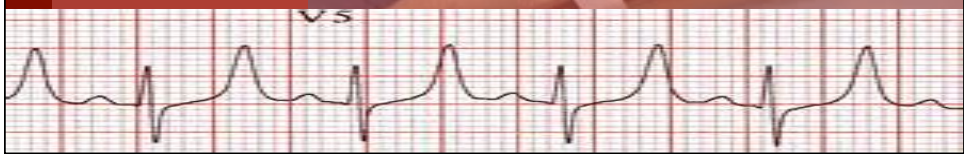


*Just like heart disease can involve arrhythmias or infarction of heart muscle, mental disorders appear to be disorders of brain circuits.

Behavioral event

May be precipitated from an acute or long standing medical event

As a result, this can change behavior of a normally functioning person



What constitutes a behavioral emergency?

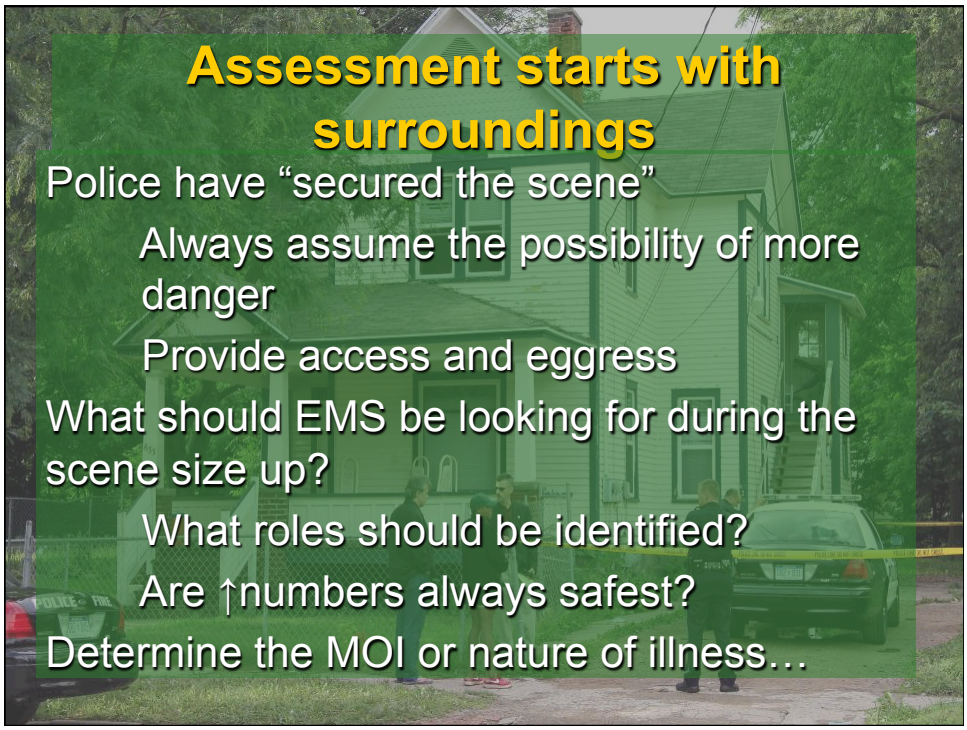
Unanticipated behavioral episode

Behavior that is threatening to patient or others

Requires immediate intervention by emergency responders (police, EMS)

SO WHAT ACTIONS MUST BE TAKEN TO HELP CREATE A SAFER SCENE?

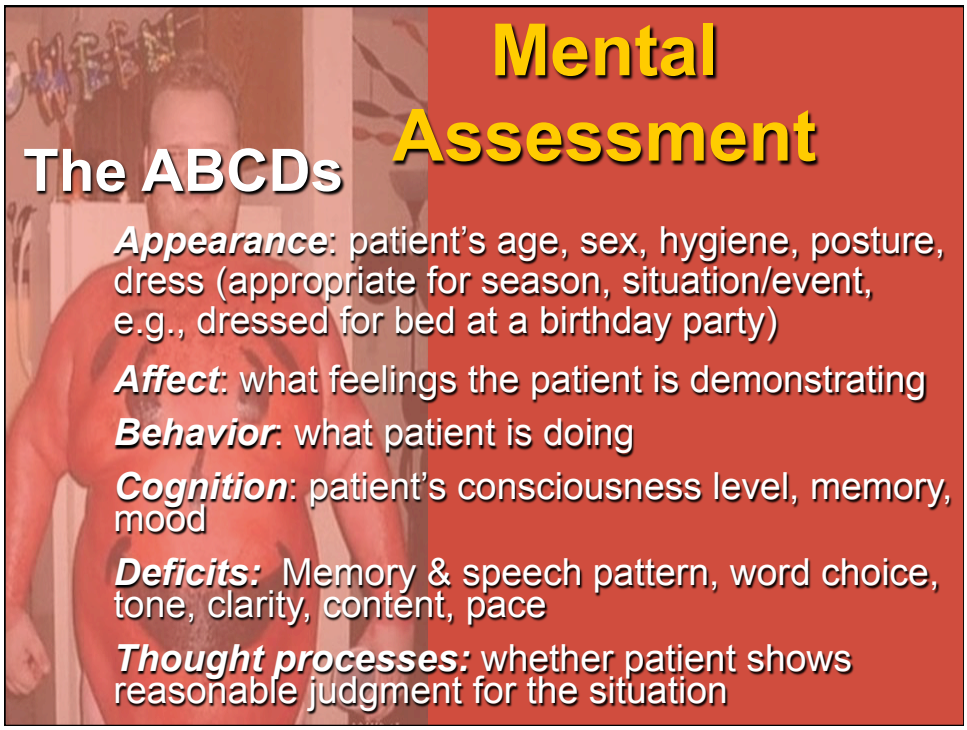
- Suspicion of danger
- Police presence
- Safety in numbers
- Pre-planning selection of roles each provider will play
- Access and egress



Assessment starts with surroundings

- Police have "secured the scene"
  - Always assume the possibility of more danger
  - Provide access and eggress
- What should EMS be looking for during the scene size up?
  - What roles should be identified?
  - Are ↑numbers always safest?
- Determine the MOI or nature of illness…


A good assessment is KEY
Altered Mental Status
Scene size up
Primary assessment
History taking
Treatment Priorities
What should first be ruled out?
Identify underlying etiology


Mental Assessment
The ABCDs
Appearance: patient's age, sex, hygiene, posture, dress (appropriate for season, situation/event, e.g., dressed for bed at a birthday party)
Affect: what feelings the patient is demonstrating
Behavior: what patient is doing
Cognition: patient's consciousness level, memory, mood
Deficits: Memory & speech pattern, word choice, tone, clarity, content, pace
Thought processes: whether patient shows reasonable judgment for the situation

"Establishing rapport"

If the patient has a true psychiatric emergency….How is this accomplished?

What if the patient is:

Delusional

Depressed

Manic

Intoxicated

Angry

Pearls

COMMUNICATE with the pt

Touch & verbal de-escalation

Leave some control in their hands

Set limits

Find common ground

Express concern for the patient

Identify the pts "best interest"

Fact or Fiction

9 out of 10x, a psychiatric patient can be persuaded to get into amb. without force

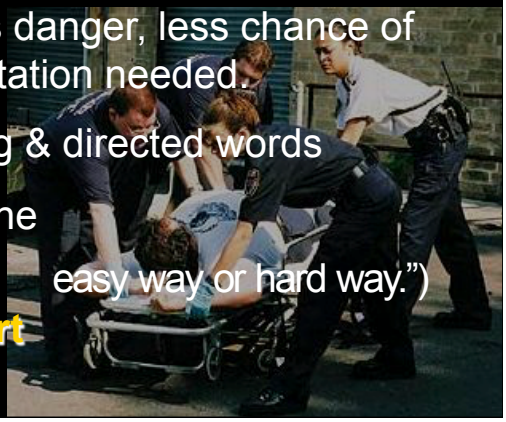
Can take ↑time & effort o/s than might like

Outcome worth it – less danger, less chance of lawsuits, less documentation needed.

Sometimes takes strong & directed words

("We can do this the easy way or hard way.")

…Last resort



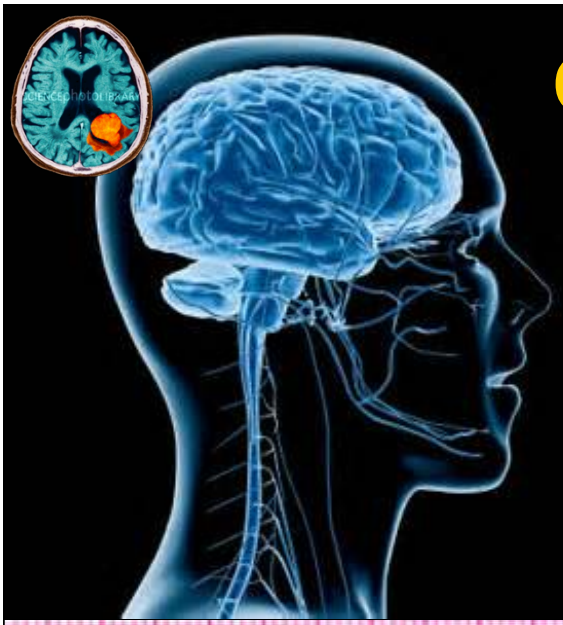
Two primary goals

Recognize life threats *while*
Reducing the stress of the situation

Scene size up
Primary assessment
History taking
Treatment Priorities

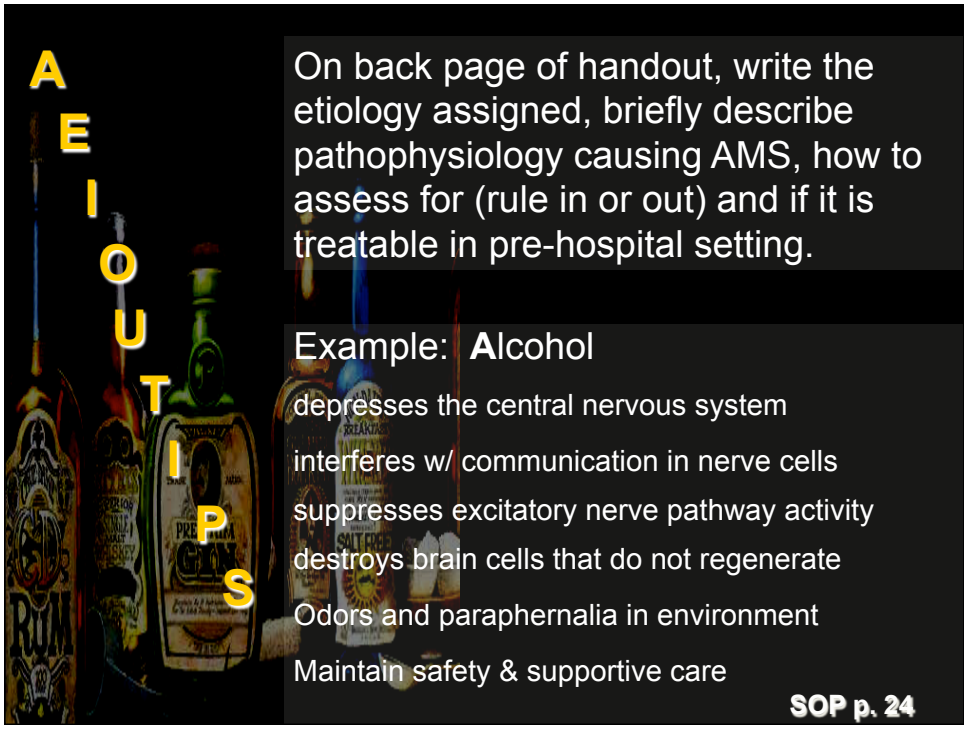
Psychiatric disorders

- Psychotic
- Non-Psychotic
  - Organic
  - Functional



Organic

Organic disorders cause abnormal cognitive function due to organic causes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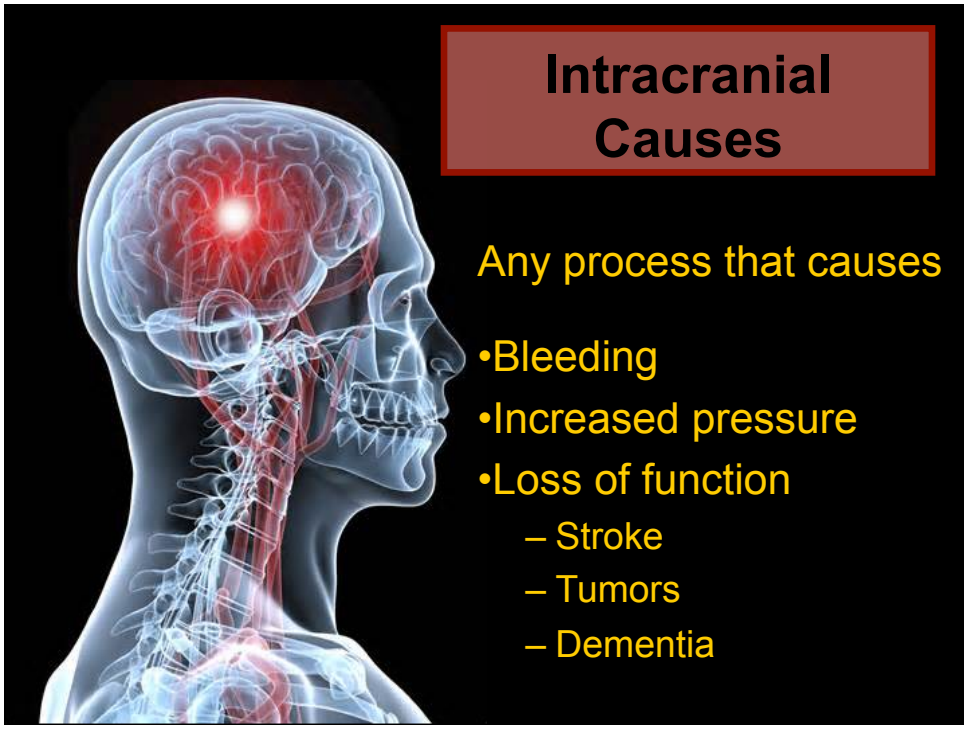
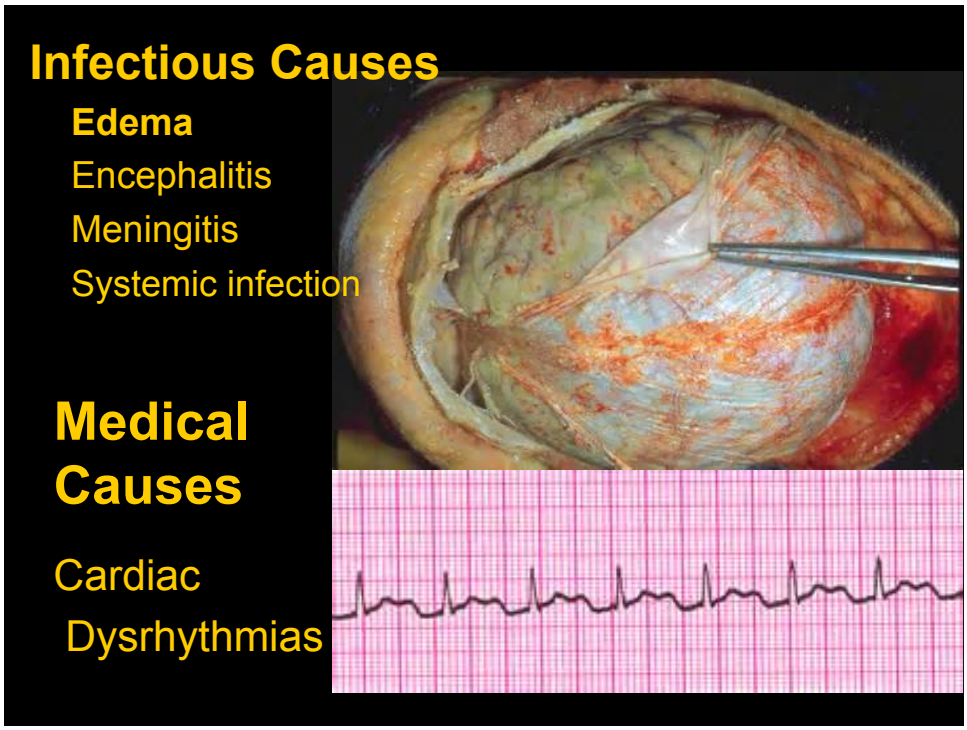
S
On back page of handout, write the etiology assigned, briefly describe pathophysiology causing AMS, how to assess for (rule in or out) and if it is treatable in pre-hospital setting.
Example: Alcohol
depresses the central nervous system
interferes w/ communication in nerve cells
suppresses excitatory nerve pathway activity
destroys brain cells that do not regenerate
Odors and paraphernalia in environment
Maintain safety & supportive care
SOP p. 24


Metabolic Causes
Diabetic emergency
Electrolyte imbalance
Hypoxia
Organ failure
Chronic illness


Intracranial Causes
Any process that causes
•Bleeding
•Increased pressure
•Loss of function
– Stroke
– Tumors
– Dementia


Infectious Causes
Edema
Encephalitis
Meningitis
Systemic infection
Medical Causes
Cardiac
Dysrhythmias

Specific Psychiatric Disorders

- ✓Cognitive disorders
  - – Organic causes such as brain injury or disease
  - – Includes delirium (rapid onset disorganized thought) and dementia (gradual development memory & cognitive impairment)
    - An acute global impairment of brain function, usually transient and/or treatable
    - Although delirium can mimic any major psychiatric disorder, the hallmark is that cognitive (intellectual) functioning is acutely impaired

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Functional psychosis

does not generally cause abnormal cognitive function, although other parts of the mental status exam may show substantial impairment; the functional psychoses include:

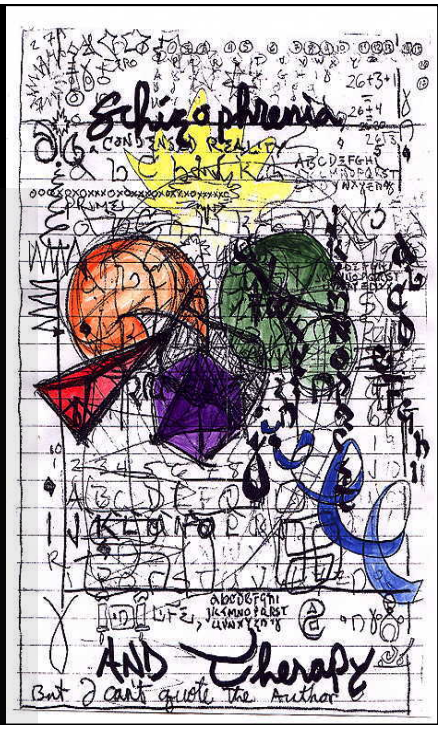
- – Schizophrenia
- – Major affective disorders: mania - major depression, or alternating between them over time

Schizophrenia
(other psychotic disorders)

Paranoid
- Frequent hallucinations
- Delusions of persecution

Disorganized
- Extreme disorders of thought
- Disorganized speech
- Severe social impairment

Catatonic
- Movement disorders



✓Mood disorders

Bipolar

The presence of one or more episodes of abnormally elevated energy levels, cognition and mood (mania) with or without one or more depressive episodes (depression).

Common Bipolar Medications

Mood Stabilizers

(Lithium, Lamictal, Depakote, Trileptal, Tegretol)

- Many mood stabilizers were originally used for seizures
- If pt on these meds ask why they are taking them

Atypical Antipsychotics

(Abilify, Risperdal, Zyprexa, Seroquel, Geodon)

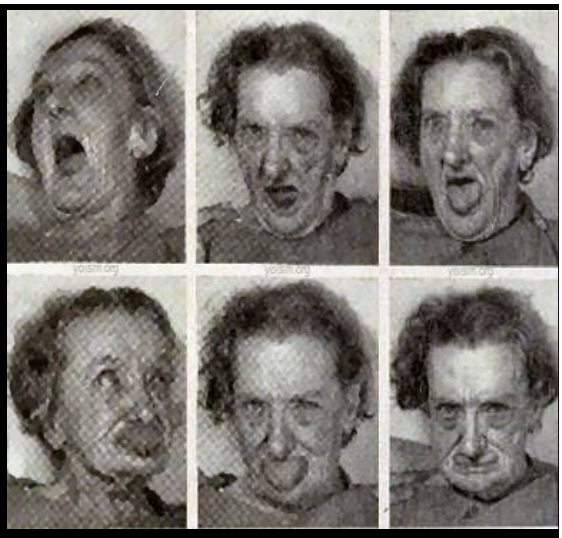
- Linked to obesity & DM II
- Also used for
  - schizophrenia
  - ADHD
  - autism
  - aggression
  - dementia

(don't be surprised, all are used for both children & adults)

Tardive Dyskinesia

Caused from long-term use of antipsychotic drugs

- Degenerative neurologic disorder
- Dopamine pathway suppression in brain by antipsychotic drugs
- Causes repetitive movements of mouth, face
- Rocking
- Repetitive, involuntary motions of extremities



Epidemiology & demographics

15-30% antipsychotic users – on ↑ as antipsychotics gain favor w/ tx.

Management

Consider etiology, especially if 1st "manic" episode.

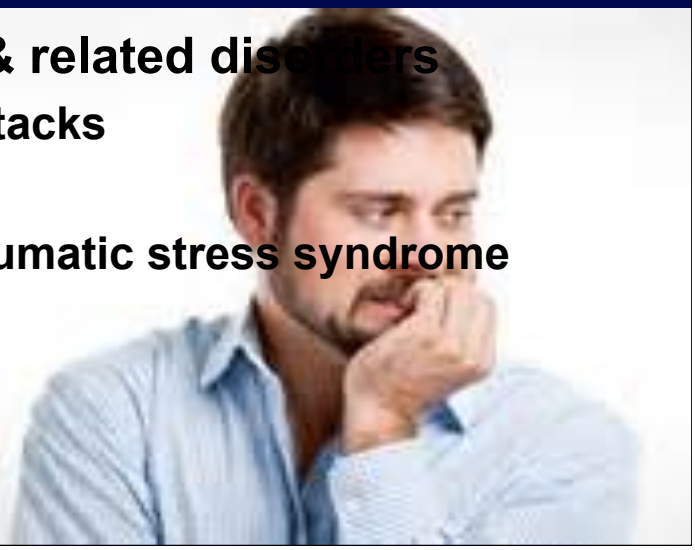
Pts experiencing a manic episode have a tendency to get into trouble, driving recklessly, arguing or picking fights. Resist impulse to feed into loss of control. If patient is not violent, attempt to "talk down".

Keep sensory stimulation to a minimum

Avoid discussion of delusional symptoms

Pearl: Manic pts can be humorous, whereas schizophrenic patients generally cannot.

Psychosocial or situational causes



- ✓**Anxiety & related disorders**
  - –**panic attacks**
  - –**phobias**
  - –**post-traumatic stress syndrome**
  - –**abuse**

A primary anxiety disorder becomes a diagnosis of exclusion

Signs & symptoms:
- tachypnea
- tachycardia
- diaphoresis
- trembling
- palpitations
- SOB
- chest pain

What other patients may complain of these symptoms?

Therefore, what treatment is most appropriate?

Anxiety is a normal response to stress.

However, it can build to a point that fears & worry dominates a person's psychological life & overwhelms the person who then feels helpless & becomes dysfunctional.

Depression

Feeling hopeless

guilt, worthlessness, helplessness

Irritability, restlessness

Lost interest in activities or hobbies

Difficulty concentrating, remembering details, & decision making

Insomnia or excessive sleeping

Overeating or appetite loss

Thoughts of suicide / attempts

Persistent aches, pains, headaches, cramps, or digestive problems unrelieved with treatment

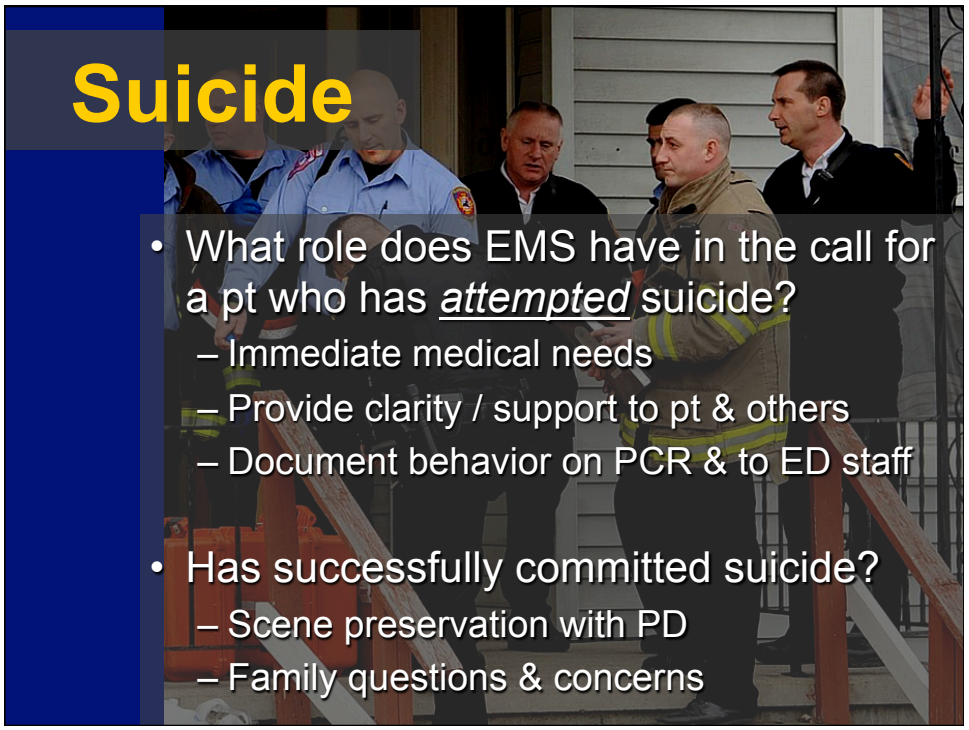
Fatigue & decreased energy

CDC Centers for Disease Control and Prevention
CDC 24/7: Saving Lives, Protecting People™

WHO OR WHAT REPRESENTS THE FACE OF DEPRESSION?

Facts & Stats

- **Suicide crosses all areas regardless of age, sex, race, religion & socioeconomic status**
- **Occurs in every part of country (yes even HI)**
- **Suicide takes the lives of ~38,000 Americans annually (CDC, 2010)**
- **~465,000 pts annually ED visits for self-injury**
- **~1 million persons make suicide attempt annually**

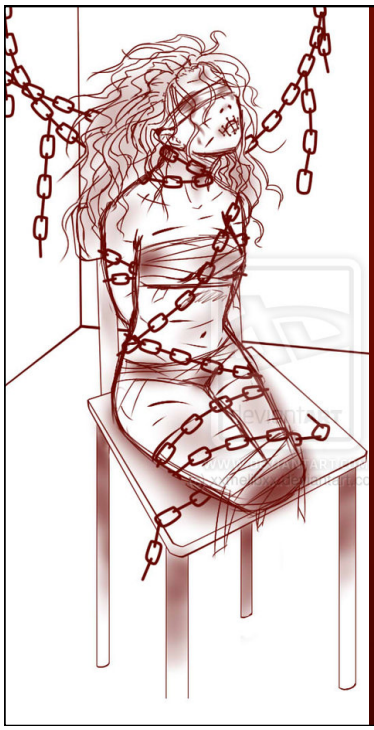


Suicide

- What role does EMS have in the call for a pt who has *attempted* suicide?
  - Immediate medical needs
  - Provide clarity / support to pt & others
  - Document behavior on PCR & to ED staff
- Has successfully committed suicide?
  - Scene preservation with PD
  - Family questions & concerns

EMS can play a significant role in a pts life who is contemplating suicide

Do you believe that??



- The pt must believe that you are there to help them
- Patients who are either contemplating or have attempted suicide, should NOT be allowed to refuse transport
  - Anxiety
  - PTSD (thought of mostly with veterans but more often develops after traumatic event such as rape, torture, car crash, natural disaster, ***work-related***)

Determining imminent danger

- Have you ever thought that life was not worth living?
- Have you ever thought of harming yourself? When?
- Do you have a plan?
- Have you ever tried to kill yourself before?
- A well-organized, thought out plan is more dangerous than one that is non-specific.
- Evaluate lethality of the plan: ↑ lethality = ↑ risk.
- Determine if pt has immediate access to suicide device (ie. are there weapons in the house?)

Management

»Assess for suicidal risk in ALL depressed patients.

»Ask directly about suicidal thoughts. Patients are often relieved when it is brought up, as it gives them *permission to talk about it.*

»Most people suffering from serious depression can be effectively treated on an out-patient basis & can return to routine daily activities w/ symptom relief. Many types of tx available; the type chosen depends on individual & severity and patterns of illness. There are three well-established types of tx for depression: medications, psychotherapy, & electroconvulsive therapy (ECT) (Mackie, 2013).

»It often takes 2-4 weeks for medication such as antidepressants to start taking effect, & 6-12 weeks for antidepressants to have full effect. In some cases, pts may have to try various doses & different antidepressants before finding the 1 or combination most effective.

ACEP

2009 White Paper on excited delirium

The pathophysiology of ExDS is complex & poorly understood. The fundamental manifestation is delirium.

After adequate physical control is achieved, medical assessment & treatment should be immediately initiated. Because death might occur suddenly, EMS should ideally be present & prepared to resuscitate

American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

Imagine making a life altering decision, one that carries significant consequences & have a stranger present to critique your every move.

What feelings would you have?

Upon arrival to scene

1. Ensure the safety of all personnel
2. Address any serious medical needs of pt
3. Establish a rapport
4. Assess the pt
5. Constant supervision of the pt
6. Inventory &/or collect items for hospital eval
7. Transport pt to hospital ensuring safety

**DOCUMENT findings

FACT OR FICTION?

Asking the pt about feelings of suicide if no prior plan was established will put an idea into the pts head.

FACT OR FICTION?

EMS needn't bother asking the pt about pertinent history as they never tell you the truth anyway.

FACT

Anyone at any time can have either physical or emotional situations occur in their lives as a result of personal or work related situations that cause them to feel, overwhelmed, hopeless, confused and emotionally tired.

EMS has a difficult job or treating these pts & it is no surprise that this job may become overwhelming. If this is you, please ask for help from us…

Medications & Non-compliance

Med non-compliance is a common cause precipitating a crisis.

Psychotropic meds can be expensive, make pts feel sleepy, confused, shaky, nauseous, fat, ↓ libido… which is less likely to make pts want to comply.

*Compliance history must be discussed.

✓**Physical symptoms with no apparent physiological cause**

✓**Factitious disorders**
intentional production of signs/symptoms
motivation to assume the sick role
external incentives are absent (ie: avoid police)

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Alcohol

A CNS depressant

A common & favorite mood-altering drug

Affect on body influenced by:

- age
- gender
- physical condition
- amount of food eaten
- other medicines/drugs taken

Toxic drug producing pathological changes in liver tissue (cirrhosis) and can cause death

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~30 % of deaths by suicide involved alcohol intoxication – BAC at or above legal limit

5 substance groups accounted for 96% of primary substances reported

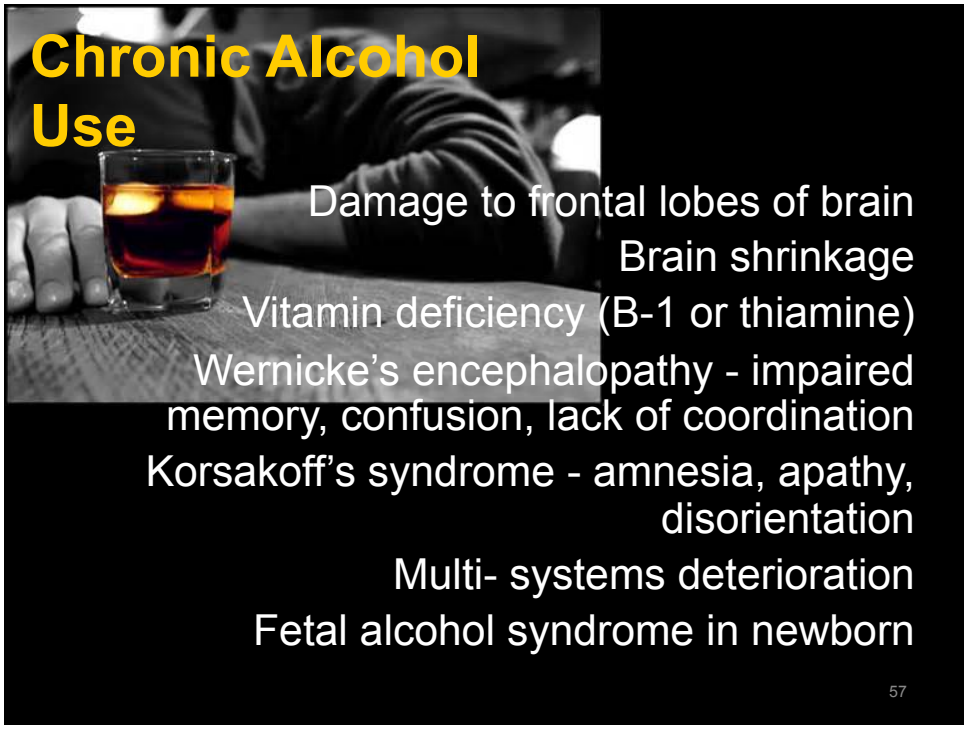
- **Alcohol: 41 %**
- **Opiates: 23 %**
- **Marijuana: 18 %**
- **Cocaine: 8 %**
- **Methamphetamine/Amphetamines: 6 %**

Alcohol

Low dose effects
- relaxed feeling, reduces tension, lowers inhibition
- impairs concentration; slows reflexes
- reduces coordination; impairs reaction time

Medium dose effects
- slurred speech, drowsiness, altered emotions

Higher dose effects
- vomiting
- breathing difficulties
- unconsciousness
- coma


Chronic Alcohol Use
Damage to frontal lobes of brain
Brain shrinkage
Vitamin deficiency (B-1 or thiamine)
Wernicke's encephalopathy - impaired memory, confusion, lack of coordination
Korsakoff's syndrome - amnesia, apathy, disorientation
Multi- systems deterioration
Fetal alcohol syndrome in newborn
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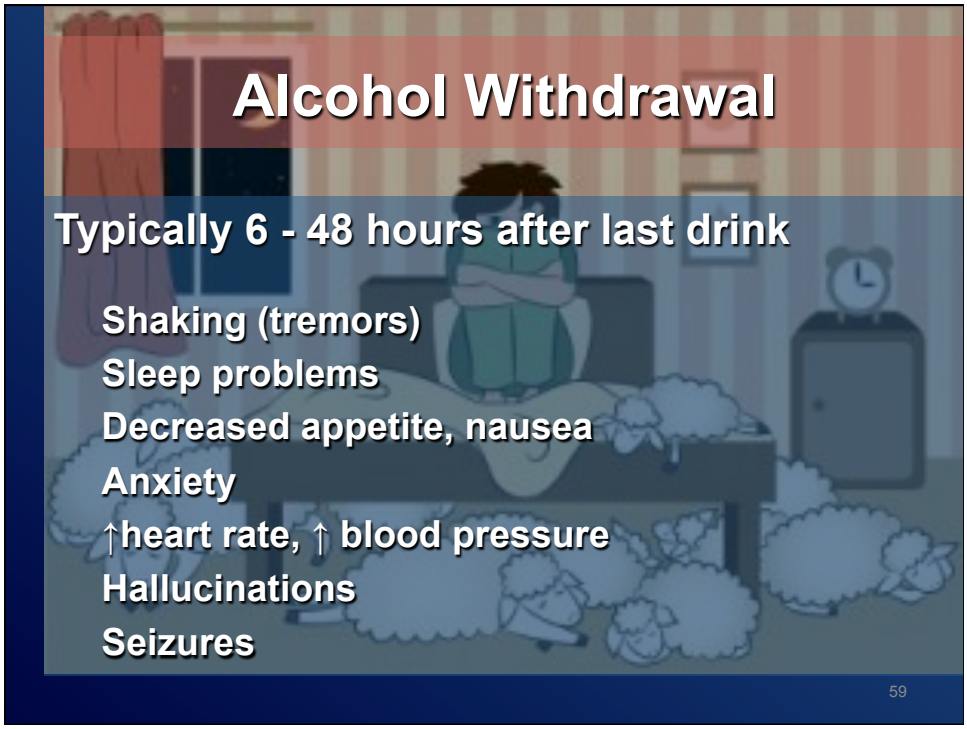
Immediate concerns
• Dehydration
• Hypoglycemia
• Last alcohol intake
• Hallucinations, delusions, tremors
• Significant bleeding
• Trauma even with minimal MOI



Alcohol	Inhalants	PCP
Anabolic steroids	Ketamine	Prescription drugs
Bath salts	Marijuana	Ritalin
Benzodiazepines	Methamphetamines	Rohypnol
Cocaine	Morphine	Stimulants
Dextromethorphan	Nicotine	Synthetic Cannabinoids
Ecstasy	Opiates	Tobacco
Fentanyl	OTC medications	Vicodin
GHB	Oxycontin	
Hallucinogens		
Heroin		

SAMHSA
Substance Abuse and Mental Health Services Administration

Drug Overdoses

People are messing with the craziest things!

Epidemic proportions

Regardless of what the substance ingested, treatment is going to rely heavily on supportive care and presenting symptoms.

SOP p. 27

What class of drug is most often abused currently?

Prescription drugs

Opioid pain relievers
Benzodiazepines

Daily US stat: 114 people die as a result of OD
6,748 are treated in the ED

Deaths from prescription painkillers have reached epidemic proportions

The number of overdose deaths is now greater than those of deaths from heroin and cocaine combined

2010 stat: enough prescription painkillers were prescribed to medicate every American adult around the clock for a month!

Who is…

Most vulnerable?

- More men than women die from overdoses to prescription painkillers
- Middle-aged adults have the highest prescription painkiller overdose rate
- Rural communities
- Whites

Supplying?

Maybe not from June Cleaver, but from parents & friends

Accessibility is essentially free and limitless!

What S & S need immediate care?

↓LOC-
Airway management, aspiration risk, trauma evaluation

Respiratory depression-
Naloxone 0.4 mg IVP/IN/IO/IM

Seizure activity-
Midazolam 2 mg increments slow IVP Q 2 min (max 10mg)
Obtain glucose reading

Opioid Epidemiology

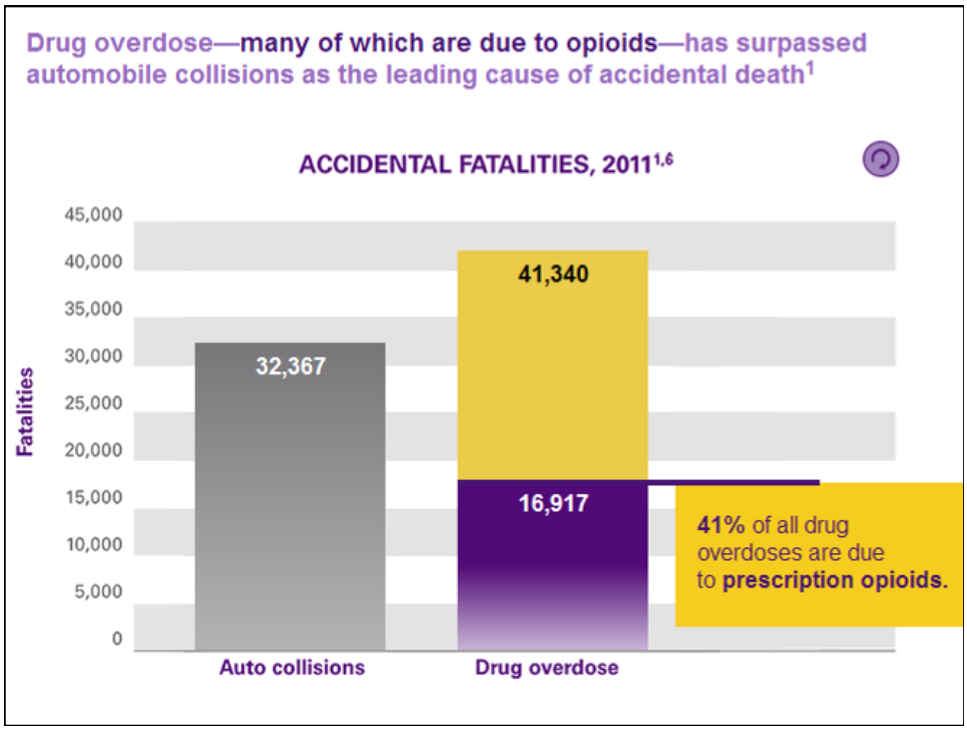
In 2011, there were an estimated 258,482 ED visits involving heroin

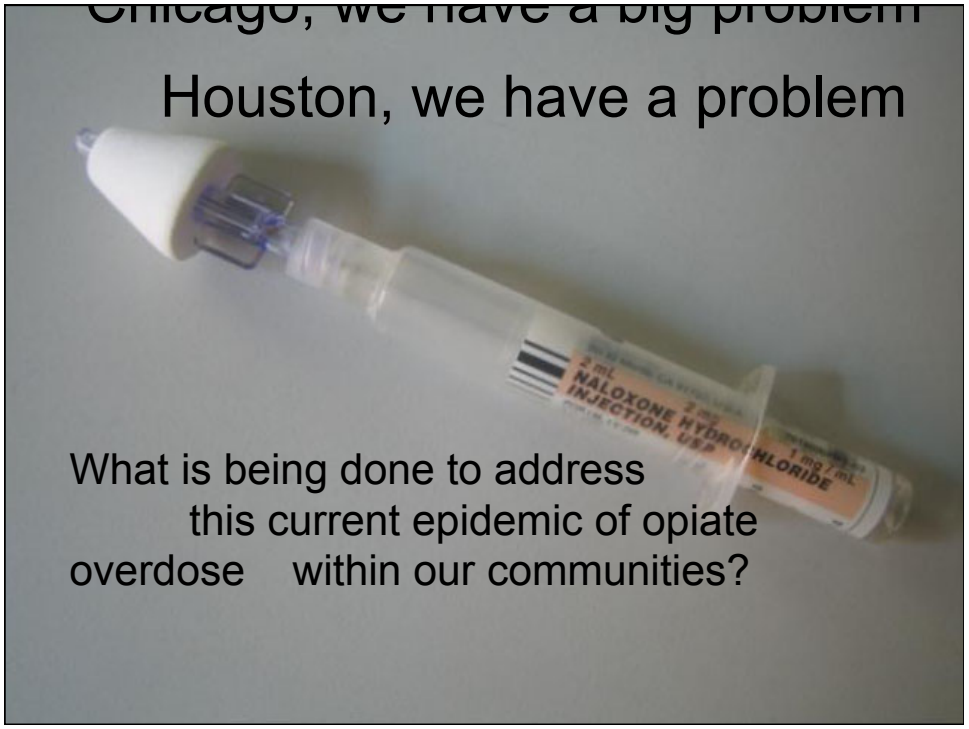
- This represents ~20% of all ED visits related to illicit drugs
- National Survey on Drug Use and Health indicate heroin use is increasing (620,000 past year heroin users in 2011)

In 2011, there were an estimated 488,004 ED visits involving prescription opioids/opiates

- This represents ~39% of all ED visits related to prescription drugs

National Survey on Drug Use and Health





Because EMS cannot be everywhere

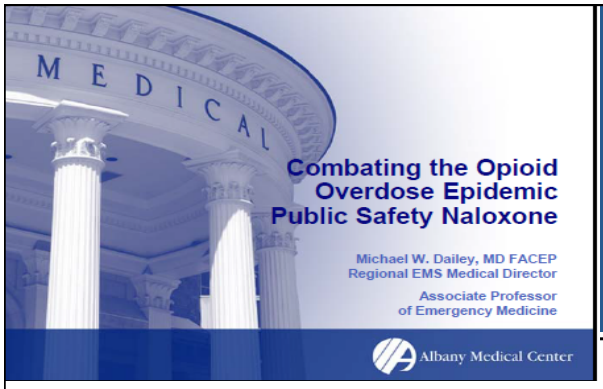
FDA approves new hand-held auto-injector to reverse opioid overdose

First naloxone treatment specifically designed to be given by family members or caregivers

The U.S. Food and Drug Administration today approved a prescription treatment that can be used by family members or caregivers to treat a person known or suspected to have had an opioid overdose. Evzio (naloxone hydrochloride injection) rapidly delivers a single dose of the drug naloxone via a hand-held auto-injector that can be carried in a pocket or stored in a medicine cabinet.

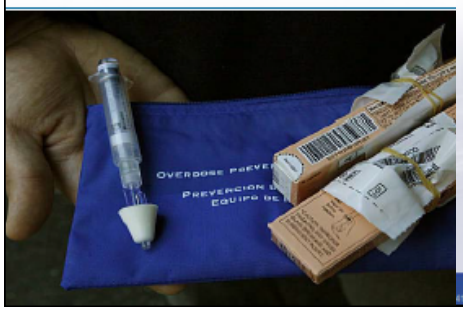
It is intended for the emergency treatment of known or suspected opioid overdose, characterized by decreased breathing or heart rates, or loss of consciousness.

U.S. Food and Drug Administration
Protecting and Promoting *Your* Health



Hot off the presses from NAEMSP

ntranasal Naloxone



Intranasal Administration

- Advantages
  - Nose is easy access point for medication and delivery
  - Eliminates risk of a contaminated needle stick
- Disadvantages
  - Vasoconstrictors (cocaine) prevent absorption
  - Bloody nose, nasal congestion, mucous
  - > 0.5 ml per nostril likely to run off

Albany Medical Center

Dr. Dailey Albany, NY

Intramuscular Naloxone

Naloxone Preparations

- Injectable
  - Less expensive: $1-8 per dose
  - Well-documented efficacy
  - Requires injection, drawing from a medical vial into a syringe
- Intranasal
  - More expensive: $21.00 per dose
  - Less well-documented efficacy
  - Requires assembly of spray device with nasal adaptor and naloxone capsule

NALOXONE VIA PD

IMPORTANT SAFETY INFORMATION

The following is important safety information associated with dosing and administration of EVZIO:

- EVZIO is for intramuscular or subcutaneous use only.
- Administer EVZIO to adult or pediatric patients into the anterolateral aspect of the thigh, through clothing if necessary.
- In pediatric patients under the age of one, the caregiver should pinch the thigh muscle while administering EVZIO.
- Seek emergency medical care immediately after use.
- The duration of action of most opioids is likely to exceed that of EVZIO resulting in a return of respiratory and/or central nervous system depression. Keep the patient under continued surveillance and repeated doses of EVZIO should be administered every 2 to 3 minutes, as necessary, while awaiting emergency medical assistance.
- If the electronic voice instruction system does not operate properly, EVZIO will still deliver the intended dose of naloxone hydrochloride when used according to the printed instructions on the flat surface of its label.

The following precautions should be taken when administering EVZIO:

- Consider other supportive and/or resuscitative measures while awaiting emergency medical assistance.
- Reversal of respiratory depression by partial agonists or mixed agonists/antagonists such as buprenorphine and pentazocine, may be incomplete or require higher doses of naloxone.
- Use in patients who are opioid dependent may precipitate acute abstinence syndrome.
- In neonates, opioid withdrawal may be life-threatening if not recognized and properly treated.
- Patients with pre-existing cardiac disease or patients who have received medications with potential adverse cardiovascular effects should be monitored in an appropriate healthcare setting.
- EVZIO should be used with caution in patients known to be hypersensitive to naloxone hydrochloride.

Choice between IN & injected

Some agencies received grant funding for auto injector which can deliver IM/SQ

Get to Know EVZIO

The first and only FDA-approved naloxone auto-injector

EVZIO is a take-home, hand-held, single-use auto-injector for immediate administration as emergency treatment of known or suspected opioid overdose in settings where opioids may be present. EVZIO is not a substitute for emergency medical care.

If an opioid overdose occurs or is suspected, EVZIO may temporarily reverse the effects of the opioid and help keep the patient breathing until emergency medical assistance is available. Additional doses may be required and other supportive or resuscitative measures may be helpful while waiting for emergency care.

Pre-filled to quickly deliver a single 0.4 mg dose of naloxone hydrochloride	Easy to administer with visual and voice instructions for guidance[1]	Compact in size to facilitate portability and availability in case an opioid overdose emergency occurs	Retractable needle system helps prevent accidental needle exposure

- In 2014, naloxone was administered to pts 432 times

Correct dose for naloxone administration is?

System Review- naloxone

Doses given

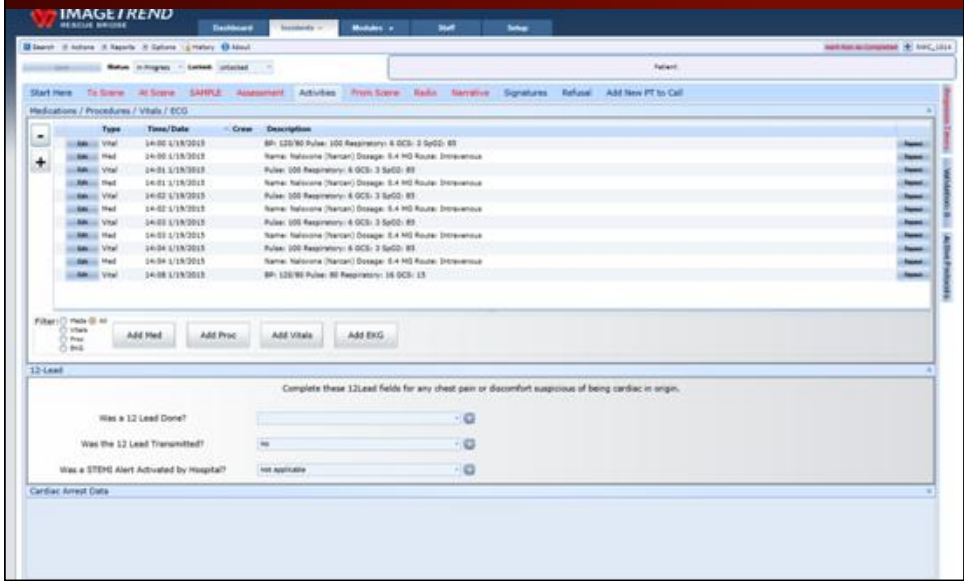
0.2mg, 0.4mg, 0.5mg, 0.8mg, 1mg, 1.2mg, 1.6mg, 2mg

If possible opiate toxicity, w/ AMS + RR <12

0.4 mg w/ repeating to 2mg

SOP p. 24

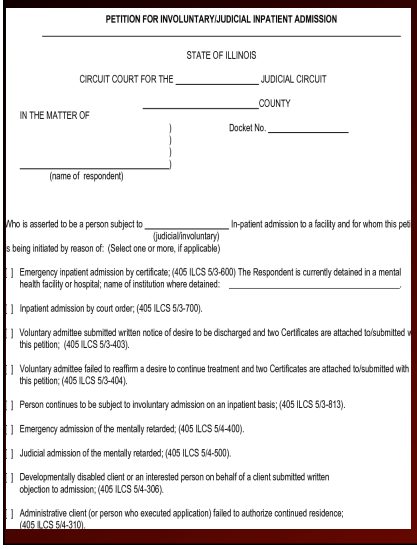
Each dose is a separate entry



And now, the most requested topic….

Psychiatric Petitions

What's a Petition



PETITION FOR INVOLUNTARY/JUDICIAL INPATIENT ADMISSION

STATE OF ILLINOIS

CIRCUIT COURT FOR THE _____ JUDICIAL CIRCUIT

_____ COUNTY

IN THE MATTER OF) Docket No. _____

)

)

_____)

(name of respondent)

Who is asserted to be a person subject to _____ In-patient admission to a facility and for whom this peti
(judicial/involuntary)

is being initiated by reason of: (Select one or more, if applicable)

[ ] Emergency inpatient admission by certificate; (405 ILCS 5/3-600) The Respondent is currently detained in a mental health facility or hospital; name of institution where detained: _____.

[ ] Inpatient admission by court order; (405 ILCS 5/3-700).

[ ] Voluntary admittee submitted written notice of desire to be discharged and two Certificates are attached to/submitted w this petition; (405 ILCS 5/3-403).

[ ] Voluntary admittee failed to reaffirm a desire to continue treatment and two Certificates are attached to/submitted with this petition; (405 ILCS 5/3-404).

[ ] Person continues to be subject to involuntary admission on an inpatient basis; (405 ILCS 5/3-813).

[ ] Emergency admission of the mentally retarded; (405 ILCS 5/4-400).

[ ] Judicial admission of the mentally retarded; (405 ILCS 5/4-500).

[ ] Developmentally disabled client or an interested person on behalf of a client submitted written objection to admission; (405 ILCS 5/4-306).

[ ] Administrative client (or person who executed application) failed to authorize continued residence; (405 ILCS 5/4-310).

- A paper form.
  - Someone feels someone else is in danger to self / others & requires involuntary psychiatric tx.
- Does not "commit" someone.
  - Allows ER MD to evaluate, seek certificate for involuntary admission.
- If a judge does not approve the certificate from the ER doc, nothing happens.
- Is signed by witness to get the process rolling… it's not the end of the process.

Petition for EMS Purposes

Ensure legal transport from place of origin to hospital ED for evaluation with or without consent

Assists ED staff in keeping the pt through evaluation

These are our only goals…thus **Policy E-1**

Page 3 states:

#3-"A petition form should be completed for all patients…"

Mental Health Code 405 ILCS 5

Defines a minor as any person < 18 years

However, allows certain permissions for specific circumstances at age 12 and 16.

Being a legal document, it is ALWAYS going to be open to interpretation

3 lawyers will often have 4-5 opinions!

BEST PRACTICE: fill one out

Pediatric Psych Patients

Parents have legal authority for minors, so if they say they go, they go.

No argument. (or at least you hope so).

What if the parents say no or change their mind during the interaction, but EMS feels strongly that the minor needs a medical evaluation?

OLMC has the authority for assuming legal protective custody under Child abuse and neglect Act. (petition not needed)

Pediatric Psych Patients

EMS still needs to document all behavior and statements by the patient and witnesses, just like in an adult psych situation whether in the PCR or petition.

Pearl: This is a legal situation and many people will review the PCR-document well!

405 ILCS 5/3-606

Sec. 3-606. “A peace officer may take a person into custody & transport to a mental health facility when the peace officer has reasonable grounds to believe that the person is subject to involuntary admission & in need of immediate hospitalization to protect such person or others from physical harm. Upon arrival at facility, the peace officer may complete the petition under Section 3-601. If the petition is not completed by the peace officer transporting the person, the transporting officer's name, badge number, and employer shall be included in the petition as a potential witness as provided in Section 3-601 of this Chapter.”

When Do They Have to Go?

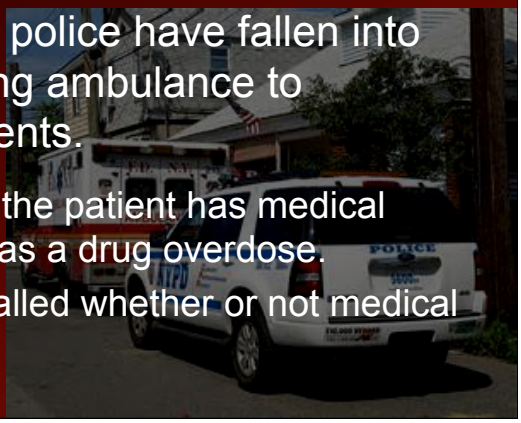
Patients who…

- display an inability to make a rational judgment
- pose a threat to themselves or others

…will be treated & transported despite their desire to refuse.

So Who Has to Take Them?

- Illinois law says police can take pt. into custody & transport them to hospital for mental health reasons.
- Unfortunately, some police have fallen into habit of always calling ambulance to transport psych patients.
  - This makes sense if the patient has medical complications, such as a drug overdose.
  - But we tend to get called whether or not medical issues are involved.



Who Can Fill Out a Petition?

- Whomever witnesses dangerous or suicidal behavior can fill out petition.
  - Family members
  - Bystanders
  - Police
  - EMS
- Sometimes people are reluctant to sign petitions, because they feel like they are responsible for "committing" someone.
- Sometimes police don't want to fill out petitions because they don't understand the process or have been incorrectly told it's our problem.
- So: if paramedics are the only witnesses to the behavior willing to fill out a petition, then they should do so… for the sake of their patient.

Patients who don't need to go

Adult psychiatric patients who are…

- Alert
- Oriented,
- Answer questions appropriately
- And are no danger to themselves or others

…have the right to refuse care.

Must sign refusal like anyone else, MS must be completely documented on PCR with OLMC contact approval.

How to Fill Out a Petition for Involuntary Admission

- **Page 1:**
- Fill out the name of the person (and spelling counts).

  You will then circle the person is subject to ***involuntary*** admission.
- Then place an **X** next to the appropriate box, most commonly: *Emergency admission by certificate.*

Page 2

1. Place the patient's name on the top line. (spelling counts)

Then place at least 1 **X** next to one of the 3 appropriate boxes:

For suicidal/homicidal pt, mark:

- ❑ "*a person with mental illness & who because of his or her illness is unable to provide for their basic needs so as to guard themselves from harm… "*

For ALL individuals, mark:

- ❑ *"in need of immediate hospitalization for the prevention of such harm."*

For pts who are incapable of caring for themselves due to mental illness, such as schizophrenia, mark box stating:

- ❑ *"an individual who is mentally ill and who because of his or her illness is unable to provide for his or her basic physical needs……"*

Page 2 (continued)

2. On the next few lines put *your narrative*, the things that were stated, the actions that were noted, etc.

- *be specific* -On this date at such a time, the pt, (name) was…

3. On section where you list witnesses, put full name (or "unknown") & address of witnesses to actions & statements in your narrative. Include your station address & phone number.

4. Also mark 3 boxes that state you ***do not have a legal interest in this matter; do not have a financial interest in this matter; am not involved in litigation with the respondent*** *(unless of course you do, or you are).*

Page 3

1. In this section you will place full name & address of any witnesses, ex. Family members, friends, guardians, etc., that were present with pt when events took place.

2. ***IF*** a police officer takes the patient into custody or detains pt into ambulance, mark *yes* & get *officer's name, badge number & department he/ she works for.*

3. The last section of this form to be filled out is where individual dates & signs form as well as put department address, phone number & date/ time report filled out.

EASY as 1,2,3!

…3 pages of course…but it is a legal document that is giving you permission to transport with or **WITHOUT** their consent.

Ask Dr. O!

These were the questions asked 5 years ago and answered.

Assume a patient is decisional and we have no evidence or reason to believe that pt is in need of transport, but the medical control (OLMC) says we need to transport and patient is refusing. If attempts to convince pt to go are unsuccessful, should the hospital staff be filling out a petition?

This is a difficult situation. When EMS communicates with OLMC, they need to carefully state the circumstances and details. If EMS truly believes that there is no evidence that the person is a threat to himself and no one is providing a petition, that should be communicated to OLMC. Specifically ask on what basis the pt should be transported? EMS does operate under medical direction – whether on-line or off line. If, after explaining the situation, OLMC is still requesting transport, the ordering physician is responsible for his/her decision and completing a petition. EMS should document the physician's name in the PCR. Call the hospital EMSC and make sure the call recording is pulled for archiving in case the pt decides to pursue legal remedy.

In many domestic cases, we run into "he said/she said" situations. While these are usually focused on "taking sides", they sometimes result in trading accusations. "He's saying I want to kill myself. He's the one who is constantly overdosing." In cases where all we have is the statements and they are equally reliable, are we to treat both people as patients?

Each case is unique, but in essence, yes. If both parties want to petition the other, then we now have two patients and need to transport both, in two different vehicles, as long as we have petitions completed.

Who is responsible for chasing the patient when he runs?

EMS is not responsible for chasing patients. That being said, we are responsible for exercising due caution in protecting the safety of the patient. If we anticipate the need to transport a patient involuntarily, we need to do everything possible to effect a safe transport – this may include physical and/or chemical restraint. Having more personnel in the form of police or additional EMS personnel is always a good idea.

Ward of State (Little City - a residential facility for the disabled): If a pt is a ward of the state do we need a petition? Severely mentally disabled – attacks staff – non verbal? Meds altered? Harm to self/others?

The mentally disabled in a health care facility should have a petition completed by the staff of the facility, if the reason for transport is of a behavioral nature.

If a patient, after convincing, is willing to voluntarily go to the hospital, do we still have to fill out the "Involuntary" Petition Form? Of course, the narrative has to be detailed and specific. If so what do we do when asked whether it is judicial or involuntary on the form?

If we have first hand knowledge of attempted or potential self-harm, we should complete a petition, even if the patient is coming voluntarily. Patients can change their minds on arrival at the hospital and may not be held there with out a petition. All petitions that we complete are "involuntary"; "judicial" refers to court-ordered evaluations.

Resources

suicidepreventionlifeline.org

1-800-273-TALK (8255)

http://ilffps.org

QUESTIONS?