Treatment Protocol: BEHAVIORAL / PSYCHIATRIC CRISIS **Ref. No. 1209**

Base Hospital Contact: Required for all patients with agitation requiring midazolam.

1. Perform initial assessment of scene and patient situation for safety ❶

2. Attain law enforcement (LE) assistance prior to approaching a patient if a weapon is visualized or the patient threatens violence or for potential assistance with application of an involuntary psychiatric hold ❶❷

3. Approach patient with caution, assess for agitation and use verbal de-escalation as needed *(MCG 1307, Care of the Psychiatric Patient with Agitation)* ❸

4. Evaluate for medical conditions, including those that may present with psychiatric features ❹

5. Initiate basic and/or advanced airway maneuvers prn
   Prepare in advance to support ventilations prn for any patient who receives midazolam sedation ❺

6. Administer **Oxygen** prn *(MCG 1302)*

7. Pre-plan approach to physical restraint; apply restraints when indicated *(Ref. No. 838, Application of Patient Restraints)* ❻

8. Manage ongoing agitation based on patient's condition

9. For COOPERATIVE PATIENTS:

   Olanzapine 10mg Oral Disintegrating Tablet (ODT); given once *(MCG 1317.32)*

10. For UNCOOPERATIVE PATIENTS who pose a potential safety risk to self and/or EMS personnel:

    Consider **Midazolam 5mg (1mL) IM/IN/IV** ❺❼
    CONTACT BASE concurrent with administration
    With Base orders may repeat q5 min prn, to a maximum total dose of 20mg

11. For SEVERE AGITATION WITH ALOC who pose an IMMEDIATE RISK to self and/or EMS personnel:

    Administer **Midazolam 5mg (1mL) IM/IN/IV** ❺❼, repeat prn x1 in 5 min, or
    Administer **Midazolam 10mg (2mL) IM/IN** ❺❽
    May administer 5mg with repeat prn or 10mg single dose considering size of patient and level of risk, maximum 10mg prior to Base Contact

    CONTACT BASE for additional sedation
    With Base orders may repeat up to a maximum total dose of 20mg

    Normal Saline 1L IV rapid infusion
    Reassess after each 250mL increment for evidence of volume overload (pulmonary edema); stop infusion if pulmonary edema develops

12. Initiate cardiac monitoring on all patients in restraint and/or post-sedation *(MCG 1308)* ❺❾
    Pre-position monitor prior to sedation; continuously monitor airway and breathing peri- and post-sedation
    Assess for dysrhythmia or interval widening

13. **CONTACT BASE** for QRS > 0.12 sec or heart rate < 50 to discuss need to administer **Sodium Bicarbonate 50mEq (50mL) IV** ❿

14. If patient's skin is hot to touch or has a measured fever with suspected hyperthermia (i.e., measured temperature greater than 39C or 102F), initiate cooling measures

15. Establish vascular access prn *(MCG 1375)*

    Check blood glucose prn ⓫
    If glucose < 60 mg/dL or > 400 mg/dL treat in conjunction with *TP 1203, Diabetic Emergencies*

16. Evaluate for physical trauma; if present treat in conjunction with *TP 1244, Traumatic Injury*

17. Evaluate for possible suicide attempt ⓬⓭
    For potential overdose, obtain patient and bystanders information about ingestions and treat in conjunction with *TP 1241, Overdose/Poisoning/Ingestion*

18. If concern for suicidal intent in persons not on a 5150/5585 hold and refusing voluntary treatment or transport, **CONTACT BASE** (*MCG 1306*)

19. Evaluate for acute mental health and/or substance abuse crises ⓭
    Obtain relevant clinical history regarding patient's current psychiatric diagnoses, psychiatric and other medications, and any recent alcohol or recreational drug ingestions
    Obtain and document relevant third party or collateral data [13]

20. Patients who respond to verbal de-escalation or are treated only with olanzapine for agitation, and are now cooperative, and who meet criteria in *Ref. No. 526, Behavioral/Psychiatric Crisis Patient Destination* and *Ref. 526.1 Medical Clearance Criteria Screening Tool for Psychiatric Urgent Care Center*, may be transported by Basic Life Support (BLS) or law enforcement (LE) to the MAR or to a Psychiatric Urgent Care Center.

21. Patients, evaluated by EMS personnel not yet approved for alternate destination transport, who receive olanzapine for agitation and are otherwise stable, and do not have an emergency medical condition, may be transported by BLS or law enforcement to the MAR only.

SPECIAL CONSIDERATIONS

❶ Scene safety includes the assessment for the presence of firearms or weapons, including observations and direct inquiry with the patient and any available/relevant third parties (e.g., family, caregivers, or witnesses). If a weapon is found on the scene, EMS personnel should notify all members on the scene, and contact law enforcement (LE) immediately.

❷ Psychiatric, including mental health and substance abuse, emergencies are medical emergencies, and as such are best treated by EMS personnel. Those patients with psychiatric emergencies presenting with agitation, violence, threats of harm to self or others, or criminal activity are best managed by an EMS and LE co-response.

❸ Always attempt verbal de-escalation first and avoid applying restraints to patients who do not present a threat to self or EMS personnel (*Ref. No. 838, Application of Patient Restraints)*

❹ Many medical causes of psychiatric symptoms exist:

- Agitation *(see MCG 1307)*
  - Acute pain
  - Head trauma
  - Infection
  - Encephalitis or Encephalopathy
  - Exposure to environmental toxins
  - Metabolic derangement
  - Hypoxia
  - Thyroid disease or other hormone irregularity
  - Neurological disease
  - Toxic levels of medications
  - Alcohol or recreational drugs: intoxication or withdrawal
  - Exacerbation of a primary psychiatric illness
  - Autism Spectrum Disorder
- Psychosis
  - Delirium
  - Chronic neurological disease (dementia, seizures, parkinsonism, brain tumor)
  - Steroid use, other medication reactions
  - Alcohol or recreational drugs: intoxication or withdrawal
- Mania
  - Delirium
  - Thyrotoxicosis
  - Alcohol or recreational drugs: intoxication or withdrawal
- Anxiety
  - Respiratory disease
  - Cardiac disease
  - Thyroid disease
  - Toxic levels of medications
  - Alcohol or recreational drugs: intoxication or withdrawal
- Depression
  - Reaction to medication
  - Chronic disease or chronic pain

Hormonal variations
Subclinical / clinical hypothyroidism
Alcohol or recreational drugs: intoxication or withdrawal

❺ Medications used for pharmacologic management of agitation may cause respiratory depression; administer only when necessary for the safety of the patients and/or EMS personnel. Apnea can occur suddenly and with little warning. Resuscitation equipment (oxygen and bag-mask ventilator) should be positioned near the patient and readily available prior to sedation. Every individual who receives restraint and/or midazolam pharmacologic management should be continuously monitored (including capnography when available) and transported for additional clinical assessment and treatment.

❻ Use of restraints in severely agitated patients is associated with an increased risk of sudden death. Avoid using restraints in patients who do not present a threat to self or to EMS personnel. Monitor patients closely when restraints are applied. Never secure or transport a patient in restraints in prone position.

❼ The IM or IN route is preferred unless an IV has been previously established.

❽ Patients who are larger in size (e.g., ≥100kg) and/or pose a greater risk for harm due to their level of agitation and violence may require the higher dose of midazolam for adequate sedation. Patients in need of sedation who are smaller, frail, elderly or already exhibiting signs of fatigue should preferentially be treated with a 5mg dose, repeating if necessary, to reduce risk of oversedation and potential for apnea.

❾ Patients who are agitated while in physical restraint and have the potential for injury due to the degree of agitation, should receive medication by EMS personnel to reduce agitation with continued monitoring for respiratory depression, in accordance with *Ref 838, Application of Patient Restraints*.

❿ Several drugs that may cause agitation and present similarly to a psychiatric crisis may also cause life threatening cardiac arrhythmias after intentional or accidental overdose. These arrhythmias are often preceded by prolonged QRS intervals (> 0.12 sec) or bradycardia. Cocaine intoxication is strongly associated with severe agitation and may also produce cardiac effects similar to Tricyclic antidepressant (TCA) overdose (widened QRS progressing to malignant arrhythmia). These patients may require a large dose of sodium bicarbonate to prevent sudden cardiac death. Consult Base Physician immediately to discussion administration of Sodium Bicarbonate; may repeat x1 if QRS remains > 0.12 sec after initial sodium bicarbonate. Treat in conjunction with *TP 1241, Overdose / Poisoning / Ingestion*

⓫ Agitation may be present after a seizure, or in the setting of hypo/hyperglycemia. Consider checking glucose early if the patient is a known diabetic or demonstrates clinical evidence of hypoglycemia, but only if safe to do so.

⓬ It is important to assess for any evidence of suicide attempt. If there is concern for overdose, ask the patient or bystanders to provide information on agents used (specifically what, when, and how much). Collect and transport any medication vials, or additional pills). This will assist in determining necessary antidote treatment and monitoring at the hospital. This information is often lost, if not obtained immediately on scene.

⓭ Patients with acute mental health or substance abuse crises may not be capable or willing to provide reliable information; therefore, it is important to obtain third party collateral information about the patient's condition (e.g., from family, caregivers, witnesses), including names and contact information for persons knowledgeable about the patient's illness, treatment and medications.