Washington State Department of Health
Office of Emergency Care Systems

EMS Guideline
Transport to Behavioral Health Facilities

Introduction

The Washington State Department of Health (department) developed this guideline to provide direction to regional emergency medical service (EMS) & trauma care councils for developing patient care procedures, local EMS councils with developing county operating procedures and EMS physician medical program directors (MPD) in developing their prehospital patient care protocols for EMS transport to behavioral health facilities.

For the purposes of this document the term behavioral health facilities are inclusive of mental health and substance use disorder (SUD) facilities and services.

In 2015 the Washington State Legislature passed RCW 70.168.170 allowing EMS to transport patients from emergency scenes directly to mental health or chemical dependency facilities. Behavioral health facility participation is voluntary. Transport to behavioral health facilities is an option for patients and is not mandatory.

Additionally, as directed by the Legislature, 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, behavioral health providers, and substance use treatment programs. The workgroup was directed to establish guidelines for developing protocols, procedures, and applicable training appropriate to the level of emergency medical service provider. This document serves as these guidelines.

In 2023 the Washington State Legislature passed RCW 71.24.916 establishing 23-hour crisis relief centers and directed the department to establish rules which included standards for determining medical stability of patients before EMS drop-offs at these facilities. The department has updated this document to contain inclusion and exclusion criteria for EMS transport to 23-hour crisis relief centers.

The guideline required the following to be consider when transporting to a behavioral health facility:

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

Questions regarding this guideline can be directed 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) as defined in WAC 246-976-010 that provides guidance to EMS MPDs and EMS services to operationalize transport of patients to a behavioral health facility.

The PCP must:

- Direct participating facilities and agencies to adhere to the Washington State Department of Health Guideline for the implementation of the EMS Transport to Behavioral Health 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 MPD and EMS services 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 as defined in WAC 246-976-010 that includes the standards in this guideline. The COP must be consistent with state standards and the Regional EMS & Trauma Care Council PCP.

The COP must include:

- A list of approved behavioral health 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 crisis responder (DCR) and any procedures to be considered during an involuntary hold.

What this means for medical program directors

MPDs must develop a patient care protocol (protocol) as defined in WAC 246-976-010 consistent with the standards and screening criteria in this guideline. The protocol must be consistent with state standards, Regional EMS & Trauma Care Council PCPs, and COPs.

The protocol should assist EMS providers in the following:

- Determining when a medical emergency requires immediate care;
- Assessment of the risk the patient presents to the patient's self, the public, and the emergency medical service personnel; and
- Determination of severity of behavioral health emergency.

MPDs must develop and implement department approved education for emergency medical service personnel who will respond and transport patients to behavioral health facilities.

MPDs establish parameters for EMS providers and may collaborate with participating facilities in their area to determine the following:

- Receiving facilities within their county;
- Acceptable age range for transport;
- Acceptable vital sign ranges inclusive of level of consciousness, heart rate, blood pressure, respiratory rate, temperature, room air O2 saturation, and blood sugar levels;
- Triage criteria for people with functional and access needs, including intellectual developmental disability, traumatic brain injury, organic brain syndrome, dementia, etc.
- Procedures for uncooperative or combative patients (if applicable);
- Clinical criteria for alcohol intoxication appropriate for acceptance; if using an alcohol level cutoff, the maximum allowable should be no lower than 300;
- Self-care criteria which may include criteria such as activities of daily living (ADLs); and
- Criteria for indwelling lines, tubes, and catheters that patients cannot manage themselves.

EMS should only transport patients to behavioral health facilities when the following criteria are met:

- The EMS agency was dispatched via 911;
- The receiving facility is a licensed behavioral health agency, behavioral health hospital, residential treatment facility, or diversion centers / sobering centers approved by the MPD and identified in the MPD protocols and COP;
- The receiving facility has bed availability;

- EMS Provider uses their judgement based on MPD protocols; and
- The patient meets the following inclusion and exclusion criteria.

Inclusion and exclusion criteria are outlined in **Appendix A** of this document. EMS procedure for MPD consideration related to EMS transport to behavioral health facilities in **Appendix B**. Training must include content that meets the outlined criteria in **Appendix C** of this document.

APPENDIX A

EMS Screening Criteria for Transport to Behavioral Health Facilities.

Reference:

RCW 71.24.025- Definitions
RCW 71.05.020 - Definitions
RCW 71.05.153 - Emergent detention of persons with behavioral health disorders – Procedure

Inclusion Criteria

The patient must:
- Have a behavioral health chief complaint;
- Be willing to go to an alternative destination, referred by a peace officer or being detained under the Involuntary Treatment Act (ITA) by a DCR;
  - For ITA proper documents must be completed and signed by a DCR for reimbursement.
- Have vitals that fall within the acceptable range;
- Fall within the acceptable age range for transport;
- Be cooperative and non-combative, unless otherwise specified in MPD protocols; and
- Can care for self as specified in MPD protocols.

Exclusion Criteria

The patient must not:

- Be suspected of having another medical issue that requires medical evaluation in an emergency department;
- Have any evidence of acute physical trauma, other than minor wounds, that require medical evaluation;
- Have intentionally or accidentally overdosed on substances that require medical care or monitoring at an emergency department (e.g. acetaminophen, aspirin, tricyclic antidepressants, or metformin);
- Have impending childbirth, pregnancy with complications, or suspected to be in third trimester pregnancy;

- Have new onset of behavioral health problems if greater than age 65; identified by exhibiting symptoms such as delusions, hallucinations, or bizarre behavior in absence of substance use, age may be lowered by MPD based on MPD protocol;
- Have indwelling tubes, lines, or catheters the patient cannot manage, unless otherwise specified in MPD protocols;
- Have had unexplained loss of consciousness (other than from suspected opioid overdose) or seizure within the past 24 hours by patient history;
- Have an alcohol level above the acceptable cutoff in accordance with the MPD protocols; and
- Have a condition that exceeds the ability of the facility to provide adequate care to the patient that requires local hospital emergency department physician evaluation.

Appendix B

EMS procedure for MPD consideration related to EMS transport to behavioral health facilities.

Procedure:

- Prioritize 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 behavioral health and chronic medical problems. Record medications and dosages if possible.
- Obtain history regarding substance use.
- Assess the inclusion and exclusion criteria.
- Contact receiving center based on MPD protocol to determine resource availability for patients that meet the screening criteria.
- 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 based on MPD protocol.
- 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, checklist and leave patient care report per standard procedure.
- Patients who meet exclusion criteria or decline transport to an alternative destination should be transported to a local hospital emergency department using agency-specific standard operating procedures.
- EMS should be re-contacted via 911 dispatch if, at any time, the receiving facility determines that the patient conditions changed, and an emergency department evaluation is required.

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 RCW 70.168.170 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 to include definitions
- A. RCW 70.168.170 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. Behavioral Health Centers
  2. Substance use Centers
- B. Behavioral Health Professionals
  1. Emergency Social Worker
  2. Designated Crisis Responder (DCR)
- C. Involuntary referral
  1. Peace Officer
  2. DCR
  3. Involuntary Treatment Act
  4. Mandatory reporting
  5. Include types of documentation and required signatures

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
        1). Contain situation
        2). Call for adequate help
        3). 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

E. 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

F. Suicide
   1. Risk factors
   2. Overt and covert clues
   3. SAD PERSONS
   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
         1). Refer to appropriate facility

G. 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. Enviro-behavioral stressors
j. Endocrine disorders
k. Respiratory failure

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

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

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

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

L. 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

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