GETAC Medical Director's Position Statement on Mental Health Emergencies and Their Effect on EMS and EDs

Context

Patients with a variety of mental health conditions including depression, bipolar disorder, schizophrenia, substance abuse frequently find themselves in crisis and unable to manage their diseases on their own. Additionally, they may engage in self-destructive behavior that puts themselves or others at risk for harm. As a result, they often come in contact with Emergency Services at the crossroads of health care and law enforcement. Sometimes they seek help voluntarily while at other times family, friends or bystanders will contact either EMS or law enforcement seeking help for them or protection from their behaviors.

Scope of Current Problem

1. Patients with mental health disorders often consume a disproportionate percentage of EMS resources.
2. The traditional 911 response consisting of a lights and sirens response by an ambulance, fire trucks and police officers may have little to offer the patient and often exacerbates the patient's condition.
3. Mental health emergencies often result in prolonged scene times that remove resources from the system, making them unavailable for other emergencies.
4. Mental health patients, including substance abuse and self-destructive behavior, often make up a large percentage of system "high utilizers" with multiple calls for the same issue over a prolonged period of time.
5. In most systems, the only help EMS can offer is transport to an Emergency Department.
6. For patients with mental health issues only, i.e. no concomitant medical problems, the average ED is ill-equipped to meet the patient's needs. The patient's most often have extended stays in the ED while awaiting transfer to a mental health facility with the ability to help these patients.
    a. These extended stays almost always exacerbate the patients underlying condition, frequently necessitating chemical sedation, which may make their ultimate treatment more difficult.
7. There is a shortage of beds available to accept patients with acute mental health crises. This shortage has turned EDs into a poorly functioning waiting room.
    a. As long as the psychiatric patient, for whom the ED has nothing of value to offer, remains in an ED room, that room (and the nursing, physician and staff resources caring for them) are unavailable to care for other medical patients, thus worsening already overcrowded ED waiting rooms.

8. In-patient psychiatric facilities often require a "medical clearance" exam which is intended to assure the patient does not have a medical disease which is either causing the acute psychiatric disturbance or an exacerbation of an unrelated medical problem that the facility would not be able to treat.
    a. This "medical clearance exam" is ill-defined and seems to change from event to event.
9. Texas law does not currently allow non-law enforcement personnel to hold a patient against their will if they have decision-making capacity, even if the patient is a clear threat to themselves or others.
    a. Medical personnel have an obligation to report these events and can be held liable in civil court for not forcibly restraining these patients.
    b. Medical personnel often feel they have an ethical obligation to restrain these patients but also feel they are unable to without risking civil liability for false imprisonment or battery.
    c. EMS personnel are often asked to transport a suicidal patient against their will to an ED for 'medical clearance' but without a LEO placing the patient under arrest.
        i. This creates a conflict for them because they don't have the legal ability to restrain a patient without the LEO present.

Position

It is the position of the Medical Directors Committee of GETAC that stakeholders:

1. Work with local and regional mental health in-patient facilities to create a standard definition of medical stability.
    a. This definition should include any testing requested and should be explicit about what the exam should include.
2. Work with professional associations representing in-patient psychiatric facilities to get-acceptance of "medical stability" according to the above definition.
3. Determine if there are medically stable patients who, with appropriate medical direction, could be transported directly to in-patient psychiatric facilities or other non-ED facilities (sobering centers, crisis intervention centers).
4. Work with professional organizations representing law enforcement agencies to draft legislation authorizing emergency detention of patients at risk of harming themselves or others by non-law enforcement personnel