Yukon-Kuskokwim HEALTH CORPORATION

Clinical Guideline

Involuntary Psychiatric Admissions

This guideline only applies to medically stable patients.

Patient in village.

- Health aide sends RMT for potential Involuntary Psychiatric Admission.
- Provider instructs health aide to contact BH on call if not done already.
- If patient has medical concerns, provider manages as appropriate (e.g. NAC for acetaminophen overdose, hemorrhage control for wounds).
- RMT provider can sign title paperwork or talk to BH about who should sign.
- Patient brought to Bethel with escort. (See box.) BH arranges travel.

Patient in Bethel.

Behavioral Health coordinates transfer to Bethel ED, MC-105 (T-47), and escort by Bethel Police.

Escorts

- Must be sober and responsible and ensure patient arrives safely. May be TPO/VPO or Trooper.
- If patient is a minor, try to get legal guardian as escort to sign documents and assist with placement if needed.

Contact

- BH Emergency Services: x6499
  - Tiger Connect BH Emergency (not under roles)
- Psychiatry: Tiger Connect role Psych Inpt On Site

Is patient intoxicated?

Yes → MC-105 (T-47) maintained until alcohol level <80.

No → ED provider evaluates patient.

Work-up

As there is no medical indication for routine lab work on psychiatric patients, provider may decline to obtain lab work and document reasoning. The following may be considered:

- CBC, CMP
- UDS: result can be followed by DES/inpatient unless newly psychotic patient with concern for acute drug intoxication
- EtOH (BAL or serum)
- APAP/salicylate levels if suspected ingestion or history
- UA if age >65

Definitions

- MC-100: Petition for Order Authorizing Hospitalization for Evaluation. Must be confirmed by a judge.
- MC-105: Notice of Emergency Detention and Application for Evaluation, often referred to as "Title 47." May be completed by law enforcement or physician.

Is the patient any of the following?

1. Threat to self
2. Threat to others
3. Gravely disabled

Yes

- MC-105 (T-47) is maintained.
- ED provider performs appropriate work-up (see box) and determines when patient is medically stable.
- BH or psychiatry provider evaluates patient and completes MC-100.
- If BH evaluation will be delayed and ED / NW provider are in agreement patient warrants admission on psychiatric hold, BH evaluation may occur after admission.

Admission

- Hospitalist admits patient to hospital using BH Inpatient Admission order set along with general admission orders.
- Hospitalist writes H&P, addressing both psychiatric and medical conditions.
- When patient is medically stable, hospitalist signs patient over to psychiatry service:
  - Hospitalist documents in a note that patient is cleared for transition to psychiatry service.
  - Hospitalist confirms plan with charge nurse and psychiatry service verbally or via Tiger Connect.
  - Hospitalist places communication order "The patient is transferred to psychiatry service."
  - Hospitalist does not need to round on patient any longer but may choose to remain involved as needed and may be re-consulted for concerns.

Medications to Treat a Combative Patient

(Use ED T-47, Psychiatric Disorder Power Plan.)

- Olanzapine 5-10 mg IM/PO Q30 minutes up to max daily dose 60 mg.
- Haloperidol 2.5-10 mg IM/PO Q30 minutes, max daily dose 100 mg.
- Diphenhydramine 25-50 mg IV/IM/PO Q4-6h.
- Lorazepam 2-10 mg IV/IM/PO Q30 minutes, titrate to effect. No max dose. Avoid in intoxicated patients due to risk of respiratory depression.
- Ketamine 0.1-2 mg/kg IV Q10 minutes, max 2 mg/kg total dose.
- Ketamine 1-5 mg/kg IM Q30 minutes, max 5 mg/kg total dose. Consider for temporary control when other medications have failed or if immediate sedation is needed to prevent harm to patient or staff.

CAUTION: There is a risk of respiratory depression with all sedative medications, especially in the setting of alcohol use. Start with 1-2 agents and titrate. Do not add additional medications until prior medications are given time to work. All patients receiving sedative medications must be on continuous pulse-oximetry when they are no longer combative. 1:1 monitoring is required due to ligature risk. Consider ET CO_2 monitoring.

No

- MC-105 (T-47) is allowed to lapse.
- Behavioral Health evaluates patient and works with provider to determine disposition, which may include home with a safety plan, CRC, or voluntary admission to Inpatient Unit.

Services at YKHC

- Behavioral Health (BH): Masters level clinicians (MSW, LPC, etc.) who provide consultation services and are physically present in the hospital. They field calls from patients, assist Pyschiatry in determining whether a patient needs involuntary hospitalization, and coordinate the logistics for where psychiatric patients go. They do not have legal authority to place psychiatric holds and do not have admitting privileges. **It is ultimately a physician's responsibility to determine suitability of psychiatric hold and appropriate disposition.** Non-physician providers may evaluate and treat these patients and maintain existing T-47s. If a new T-47 needs to be initiated, a physician must sign off on it.
- Psychiatry: All inpatient psychiatric care (including discharge or transfer to a higher level of care) is provided by a psychiatric physician or an advanced practice psychiatric provider under direct supervision by a psychiatric physician. Psychiatry will manage all patients on the psychiatry service, will be responsible for all patients on Title 47 commitments with the aid of BHES, and will also provide consultation for psychiatric patients on the Inpatient Unit.
- Inpatient Hospitalists: Family medicine physicians who admit patients, stabilize medical problems, and transfer to psychiatric service when medically stable. Hospitalist determines whether a patient has medical concerns requiring active ongoing inpatient management (e.g. infection, electrolyte abnormality, alcohol withdrawal). If medical problems, hospitalists remain primary service of record until active medical problems are resolved, writing daily progress notes, placing orders, and billing as usual with psychiatry consulting. If no medical problems, hospitalist may immediately sign patient over to psychiatry service. They can defer all psychiatric management to psychiatry service or collaborate with psychiatry team in rendering diagnoses and ordering medications. This should be communicated clearly both in the note and via direct conversation with psychiatry service.

This guideline is designed for the general use of most patients but may need to be adapted to meet the special needs of a specific patient as determined by the medical practitioner.
Approved by Clinical Guideline Committee 5/15/23. Click here to see the supplemental resources for this guideline. **If comments about this guideline, please contact Travis_Nelson@ykhc.org or Kaia_Pearson@ykhc.org.**