

Section 12 Orders

CS-001038

I. SCOPE / PURPOSE

The following policy and procedure encompasses the transfer of individuals under M.G.L. 123, §12 ("Section 12"). The need for Section 12 transport and admission is determined based on either direct observation or by conferring healthcare professionals. Section 12 transfers are necessary when the patient's condition has made them inappropriate for their current surroundings, and they need to be transferred to a facility for evaluation or treatment, and the patient is unable to make that decision independently.

II. POLICY

It is Armstrong's policy to function in the best interest of the patient and comply with the transfer orders as indicated by the form AA-3 "Application for and Authorization of Temporary Involuntary Hospitalization" as issued by the Massachusetts Department of Mental Health (aka. "Section 12 form", "Section 12 order" or "Section 12 paperwork").

III. PROCEDURE

- A. The Section 12 forms are filled out based on clinical presentation at the time of patient's assessment by a Physician, Registered Nurse, Licensed Psychologist, Judge or Police Officer ("Licensed Provider"). The patient's condition may change from the time they are assessed to the time an EMT crew arrives to transport them. Patient compliance and affect at the time of EMS arrival DOES NOT change the clinical decision made by the licensed professional at time of assessment and the patient must be transferred under the orders on the Section 12 form.
- B. EMS providers must transport the patient to the receiving facility listed on the Section 12 form and no other facility.

NOTE The only exception to this rule is if the patient develops a serious medical condition requiring immediate treatment during transport. In that situation, diversion to the closest appropriate facility is permissible. EMTs should contact the Communications Center to inform them of the situation; the Communications Center will then inform the receiving facility of the delay in transport.

- C. The Section 12 Form
 1. The patient's name must be filled in on the Section 12 form by the party that is issuing the paperwork. The EMS provider is not allowed to complete the patient's name.
 2. If the information on the form is incorrect, or in the wrong location, the EMS provider should request that the issuing party cross out the information with a single line, initial the cross out, and write the correct information above the cross out or on the correct line.
 3. The date section must be completed on the Section 12 form.
 4. Section 12 forms must be signed by a Physician, Registered Nurse, Licensed Psychologist, Judge or Police Officer. The EMS providers cannot render a clinical diagnosis opposing that of the Licensed Provider that signed the Section 12 form.

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5. The original Section 12 form is transported with the patient from the issuing facility to the receiving facility and left at the receiving facility.

In the event that the original is not available at the pick-up location, the crew must confirm with the dispatcher that the Communications Center has received a completed copy of the Section 12 paperwork. When confirmed, the crew can complete the patient transport to the facility indicated on the Section 12 form.

It is the responsibility of the *issuing party* to also fax a copy of the Section 12 orders to the receiving facility, and secure the original with the receiving facility as soon as feasible. When requested, Armstrong Communications personnel can send a copy of the Section 12 order to the receiving facility.

6. A copy of the Section 12 order must be retained by the EMS crew at the completion of the transfer if a copy has not already been faxed to the Communications Center. The EMS crew must submit the Section 12 order with their paperwork at the end of each shift. All Section 12 orders will be directed to and filed in the Communications Center.

D. Safety Procedures

The safety of Armstrong EMS crews is of the utmost importance, as is the safety of the patient. Crews should adhere to MA Pre-Hospital Statewide Treatment Protocols 2.4 and 2.5 regarding adult and pediatric behavioral emergencies - attached to this document as Appendix A - in order to ensure the safest outcome for all involved. The protocol includes, but is not limited to: scene safety, general assessment, and use of restraints.

- E. All questions concerning a Section 12 transport should be directed to the on duty Field Operations Manager or Director of Clinical Services and or designee.

IV. RESPONSIBILITY

- A. **EMS Crew** - The EMS crew assigned to a Section 12 patient transport must obtain, or verify with the Communications Center, the existence of a completed Section 12 order. The EMS crew must transport the patient to the indicated facility, complete all necessary PCR documentation, and submit a copy of the Section 12 order at the completion of the transfer. All crews are expected to be alert and vigilant to the unique needs of the psychiatric patient, while acting in a professional and courteous manner at all times.
- B. **Communications Center** - When a Section 12 order is sent directly to the Communication Center from an outside party, the dispatchers should verify that the order has been filled out completely and then arrange for transport according to Armstrong dispatching procedures. They should indicate to the EMS crew that the Section 12 is in their possession, and when necessary, they should fax copies to the receiving facility. ALL copies of Section 12 orders will be filed in the Communications Center
- C. **Senior Clinical Manager** - The Senior Clinical Manager will be the primary point of contact for all questions concerning the treatment of Section 12 patients. The Director will be responsible for training crews on Section 12 procedures and informing crews as changes to the procedures are made by OEMS or other regulatory agencies.

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CONTACT / DEPARTMENT: Clinical Services

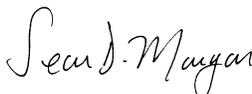
CAAS SECTION: 201.02.01

REFERENCES: M.G.L. 123 §12; Massachusetts Department of Mental Health Form AA-3
“Application for and Authorization of Temporary Involuntary Hospitalization”
MA STP 2.4 & 2.5 – Behavioral Emergencies (attached as Appendix A)

REVISION LEVEL: 05

REVISION DATE: SEPTEMBER 21, 2022

REVIEW SCHEDULE: ANNUAL

APPROVED BY: 
Sean Mangan
Director of Operations

Behavioral Emergencies Adult & Pediatric

2.4

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1.0 Routine Patient Care, followed by:

1. One EMT should manage the patient while the other handles scene control, but no EMT or First Responder should be left alone with the patient.
2. Avoid areas/patients with potential weapons (e.g., kitchen, workshop), and avoid areas with only a single exit; do not allow patient to block exit.
3. Keep environment calm by reducing stimuli (may need to ask family/friends to leave room, ask patient to turn off music/TV). Transport in a non-emergent mode unless the patient's condition requires lights and sirens.
4. Respect the dignity and privacy of the patient.
5. Make eye contact when speaking to the patient.
6. Speak calmly and in a non-judgmental manner; do not make sudden movements.
7. Maintain non-threatening body language (hands in front of your body, below your chest, palms out and slightly to the sides).
8. Establish expectations for acceptable behavior, if necessary.
9. Ask permission to touch the patient before taking vital signs, and explain what you are doing.
10. Assess the patient to the extent that they allow without increasing agitation, maintain a safe distance from a violent patient.
11. Stop talking with patient if they demonstrate increased agitation; allow time for them to calm down before attempting to discuss options again.
12. Provide reassurance by acknowledging the crisis and validating the patient's feelings and concerns; use positive feedback, not minimization.
13. Determine risk to self and others ("Are you thinking about hurting or killing yourself or others?").
14. Encourage patient to cooperatively accept medication in the form of oral disintegrating tablets (ODT) transport to the hospital for a psychiatric evaluation and treatment.
15. Consider asking friends/relatives on scene to encourage patient to accept transport, if needed; but only if they are not a source of agitation.
16. Ask law enforcement or Online Medical Control to complete a MDMH Section 12 application for uncooperative patients who acknowledge intent to self-harm or harm others, but do not delay transport in the absence of this document.
17. Use restraints in accordance with 2.5 Behavioral Emergencies: Restraint if de-escalation strategy fails and the patient is a danger to him/herself or others.

Acute risk factors for violence include:

- Male gender
- Homicidal or violent intent or plans
- Intoxication or recent substance use
- Actions taken on plans/threats
- Unconcerned with consequences
- No alternatives to violence seen
- Intense fear, anger, or aggressive speech/behavior
- Specified victim (consider proximity, likelihood of provocation)

Protocol Continues

Medical Protocol 2.4

2.4 Behavioral Emergencies Adult & Pediatric

← Protocol Continued

Medical Protocol 2.4

EMT/ADVANCED EMT STANDING ORDERS

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- Routine Patient Care
- Position patient to ensure breathing is not impaired, especially if in soft extremity restraints.
- If trained and approved to do so, administer **Olanzapine** 10 mg ODT; or
- Risperidone** 2mg ODT; (refer to **Protocol 6.16 Oral Antipsychotics**)

PARAMEDIC STANDING ORDERS

ADULT STANDING ORDERS

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- Haloperidol** 5 mg IM; and/or
- Midazolam** 2-6 mg IV/IO/IM/IN
- Ketamine** 4mg/kg IM only, to a maximum dose of 400mg IM only, as a single dose.

NOTE: In patients >70 years of age, limit medication to half these doses.

PEDIATRIC STANDING ORDERS

- Midazolam** 0.1mg/kg IV/IO/IM/IN, to maximum dose of 6 mg.



Medical Control may order additional doses of above medications

Haloperidol is preferable for psychotic patients; but do not administer to patients with a history of seizures or prolonged QT intervals.

Haloperidol should be administered by **INTRAMUSCULAR** injection ONLY

Massachusetts Department of Public Health Office of Emergency Medical Services
Statewide Treatment Protocols version 2022.1

Behavioral Emergencies: Restraint Adult & Pediatric 2.5

OVERVIEW

In accordance with M.G.L. c. 111C, §18, the following guidelines may be followed to restrain a patient only when the patient presents an immediate or serious threat of bodily harm to him/herself or others.

Adults (or emancipated minors as defined in A/R 5-610) who are competent with the functional capacity to understand the nature and effects of their actions and/or decisions have the right to refuse treatment and/or transport. Do not restrain these individuals.

Procedures:

1. Follow 2.4 Behavioral Emergencies.
2. Use the least restrictive method that assures the safety of the patient and others.
3. Use only soft restraints (leather restraints only if made with soft padding inside).
4. Remind law enforcement that for ambulance transport, patients who are handcuffed must have handcuffs in front (not behind) or to the stretcher and that the key must be readily available for removal; if needed.
5. Apply restraints in a way that allows for airway, breathing, and circulation assessment.
6. Never restrain a patient in a prone position or use equipment that forms a "sandwich" around the patient.
7. Have a minimum of four (4) trained personnel coordinate the restraint effort and consider involving parents if patient is a child.
8. Secure the patient so that major sets of muscle groups cannot be used together, restraining the lower extremities to the stretcher first around the ankles and across the thighs with soft restraints and stretcher straps.
9. Restrain the patient's torso and upper extremities with one arm up and one arm down with soft restraints and stretcher straps; do not impair circulation.
10. Consider cervical-spine immobilization to minimize violent head/body movements.
11. Pad under patient's head to prevent self-harm.
12. Secure backboard or scoop stretcher (if used) to ambulance stretcher.
13. Transport OB patients in a semi-reclining or left lateral position.
14. Monitor/record vital signs every 5 minutes, ensuring patient's airway remains clear.
15. Consider placing a non-rebreather mask (use only at 15 lpm) or a face mask (NOT a P100/N95) on the spitting patient's face.
16. Unless necessary for patient treatment, do not remove restraints until care is transferred at the receiving facility or condition has changes to necessitate removal.
17. Notify receiving facility and tell them that patient is restrained.
18. Document restraint use details in the patient care report, including:
 - a. reason for restraint use
 - b. time of application
 - c. type(s) of restraints used, in addition to cot straps
 - d. patient position
 - e. neurovascular evaluation of extremities
 - f. issues encountered during transport
 - g. other treatment rendered
 - h. police and/or other agency assistance

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Medical Protocols 2.5