

Guidelines for sedating psychiatric patients flawed

Dr Dagg contends that the air transport guidelines for psychiatric patients are flawed on several counts and need to be rewritten.

Paul Dagg, MD, FRCPC

I am writing in response to the recent article, “Criteria for sedation of psychiatric patients for air transport in British Columbia” in the *BCMJ*.¹ The article, although helpful in clarifying expectations of the ambulance service with respect to level of sedation, in fact reinforces many of the problems that we encounter on a regular basis in transporting people with psychiatric illness within the province of BC when distances require the use of air ambulance.

At Hillside Centre, we provide tertiary psychiatric care in our PICU, adult, and geriatric programs for people from throughout the northern and southern interiors of BC. We also run the Behavioural Stabilization and Assessment Program for the BC Neuropsychiatry Program, providing services for patients from throughout the province. By virtue of our providing tertiary services we provide care for people who cannot be cared for in general hospitals in their home community, so often have to transport people both to our facility for treatment, and back to their home hospital once they have stabilized or improved. As a result we regularly use both ground and air ambulance services to move

our patients both at times when they are markedly distressed and at times when they are much more stable.

Providing safe transportation for people with severe psychiatric illness who are acutely unstable is very difficult and safety of the patient and the air crew is essential, but there are several problems in Dr Wheeler’s article that need to be addressed.

Probably the biggest problem is that the consultation process described in the article to develop new guidelines consisted only of six transport advisors meeting and reviewing the literature, which is unfortunately very scanty. There was no outside consultation and, in particular, no psychiatrist or, in fact, anyone with expertise in mental health was involved in the discussion.

One of the fundamental difficulties in the recommendations might have been avoided if this consultation had occurred, and that is the reference to psychiatric patients in the guidelines as if people with mental illness are a homogenous group with identical needs, contrary to other guidelines in the literature.² The guidelines created identify anyone labeled as *psychiatric* as being high risk for transfer, regardless of diagnosis, and recommends the same approach to sedation for flight. There is no attempt to stratify risk or needs within this broad group of people, which in turn creates huge potential for confusion and misuse of medications. A person with dementia who is being transferred for

assessment to a psychogeriatric facility is seen as “a psychiatric patient,” whereas the same person being transferred to a neurological service is not. A person who has a treated depressive disorder, returning to his or her home hospital prior to discharge, perhaps to assume a responsible job on leaving hospital is seen by air ambulance staff as having the same risk of aggressive behavior as someone who is acutely psychotic. Given how common psychiatric illness is, even among people reading this journal, the application of the term “psychiatric patient” and the implication that this is someone who can easily lose control in an aircraft is stigmatizing and of no value in determining risk.

The guidelines also make no distinction for where the individual is in the course of illness—whether he or she is in an acute relapse or not, implying that people with mental illness are always at risk. We constantly face expectation by air ambulance staff that our patients are as sedated when they leave our hospital after treatment as when they arrived even if they have experienced a significant recovery. We have even had the experience where a patient transferred to us from a medical ward for treatment with minimal sedation was expected to have a greater degree of sedation for the return flight after treatment, as the patient was then labeled as psychiatric, having stayed on a psychiatric unit.

Continued on page 22

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Guidelines reflect philosophy of respect for psychiatric patients

Dr Wheeler defends and explains the guidelines he says were created to give psychiatric patients the same access to care as medical patients.

Stephen Wheeler, MD

I have had an opportunity to review Dr Dagg's thoughtful response to the article published in the October 2009 issue of the *BCMJ*, "Criteria for sedation of psychiatric patients for air transport in British Columbia." I feel that I have to respond to some of the points that he raised.

I will respond to his last point first, that is that the guidelines stigmatize psychiatric patients. The whole point of developing these guidelines was to accommodate psychiatric patients so they can be transported by air ambulance the same as medical patients. However, the risks associated with doing this are not negligible, therefore the need for the guidelines. These guidelines are an attempt for the BC Ambulance Service (BCAS) to transport psychiatric patients safely. If we cannot do this then we will not be able to transport psychiatric patients by air and we feel that this would be the ultimate stigmatization. I would like to point out the guidelines are not just for psychiatric patients, but are applied to medical patients who have an altered sensorium. BCAS is a world leader in its philosophy toward psychiatric patient transports. I challenge Dr Dagg to find an air service that provides a better service for psychiatric patients than BCAS.

Dr Wheeler is the medical director of the BC Ambulance Service Air Ambulance Program.

Dr Dagg's criticism that no psychiatrists were involved in the development of these guidelines might appear to have some merit; however I would like to mention the credentials of the physicians who developed them. All six transport advisors who make up the provincial transport advisor team contributed to these guidelines. All six physicians are board certified emergency physicians practising at the Royal Jubilee Hospital in Victoria. The Jubilee Emergency Department has within it a psychiatric emergency facility. Up to 20% of our patients have a psychiatric condition. All of the transported advisors are knowledgeable and experienced in dealing with acute psychiatric conditions. The role of the transport advisor is not the same as the treating psychiatrist. Our goal is to have a stabilized patient who can be safely transported. We understand that our recommendations may not help treat the chronic psychiatric problem; we leave that to the psychiatrist and family physician. The transport advisors are familiar with the transport environment, having flown with the crews on multiple occasions. They understand what is required for a safe transport. Therefore they are the best suited to determine what guidelines are needed for a safe transport.

We fully understand that some patients will have a prolonged sedation beyond the time it takes to transport them and that other physicians will be managing these patients during this

time. However we have to balance the risks. As mentioned in the article the transport advisors call on all psychiatric transports and each case is considered individually. A small frail patient will receive less medication than a large agitated patient. It is impossible to know beforehand which patient will become agitated—hence the broad criteria for sedation—but the amount of sedation may be tailored to the patient.

Finally, successfully treated patients do not, and should not, return home by air ambulance. Successfully treated medical patients being discharged from tertiary care centres are not transported by air ambulance unless they are being readmitted into a local hospital. As pointed out in the article, other methods of transport are available for these treated patients: they may go home with family either by private vehicle or commercial airline. In this regard psychiatric patients are exactly the same as medical patients.

I doubt Dr Dagg and I will ever fully agree on every issue related to the air transport of psychiatric patients, but the dialogue helps develop an understanding of each other's concerns. **BCMJ**

Continued from page 20

Certainly an individual who is acutely psychotic is at risk of aggressive and disruptive behavior that could put an air crew at extreme risk, but we know in fact that being male and having a history of substance abuse is at least as much a risk factor for aggressive behavior, yet many people with both these risk factors are transported for nonpsychiatric reasons without special rules for sedation.

The guidelines also refer to certification under the Mental Health Act as implying a need for a high degree of sedation, but this too reflects a lack of understanding about the Mental Health Act and the role of certification. Many individuals with relapsing illness live in the community where they are free to work, parent, operate motor vehicles, and engage in other safety-sensitive activities under certification by the Mental Health Act if that is deemed necessary by their treating physician to help prevent substantial deterioration in their psychological health as part of a comprehensive treatment plan.

One of the most puzzling recommendations in the article is the “three medication rule,” whereby the group determined that using three medications, including an antiemetic, a benzodiazepine, and an antipsychotic medication, was an appropriate approach to sedation of people with mental illness, regardless of diagnosis and without any evidence to support that recommendation. This is particularly troubling as the use of multiple medications with vague indication puts the patient at risk of significant complications, including delirium or other side effects like akathisia, which can make agitation worse. Dimenhydrinate, which is recommended in the article, has a very high incidence of delirium, especially in the elderly,³ and haloperidol similarly carries a significant risk of akathisia,⁴ which may very well appear in flight, given the timing of the medications suggested.

Routine use of these medications in individuals without a history of motion sickness or of psychosis adds little therapeutic benefit and significantly increases the risk of toxicity.

Most patients who require air transport to or from a tertiary facility are already in hospital and already on a variety of medications. The blanket application of a three medication approach without reference to existing medications is not medically sound. In our experience this often results in patients already on one or even more antipsychotic medications, already at high dose (as their treatment resistance is a reason for their transfer), receiving high doses of a high potency antipsychotic like haloperidol intramuscularly in addition to various sedative medications. At this point the patient’s dopamine receptors are already likely fully occupied, so the addition of a drug like haloperidol in this case does absolutely nothing other than increase the risk of side effects and toxicity. Banerjee and colleagues⁵ reviewed eight cases of sudden death in psychiatric patients in 1995 in the UK and concluded that “the risk of sudden cardiotoxic collapse in response to neuroleptic medication given during a period of high arousal should be widely publicized,” reminding us that there is risk with medications used to treat psychiatric patients and their use must be rational and guided by diagnosis and individual circumstance.

The unfortunate decision of the BC Ambulance Service (BCAS) to develop new guidelines for transportation of people with mental illness without consulting anyone with expertise in mental illness has had several unfortunate consequences, the main one being that physicians who need to get help for their patients in another centre continue to feel forced into a blanket application of a medication policy that has no basis in evidence, does not take into account existing medications, puts their pa-

tients at undue risk, and does not help with the difficult transfers that we do need to make. The article in the *BCMJ* in my opinion adds little clarity and only feeds into stigmatization and labeling of people with mental illness. At this stage the BCAS needs to start over again, and this time, consult both with psychiatrists who have expertise and experience relevant to the management of acutely ill people with mental illness, and with family physicians and emergency physicians in small communities throughout BC who need appropriate and effective treatment guidelines to help them get their patients the help they need.

References

1. Wheeler S, Wong B, L’Heureux R. Criteria for sedation of psychiatric patients for air transport in British Columbia. *BC Med J* 2009;51:346-349.
2. Bristow A, Toff NJ. A report—recommended standards for UK fixed wing medical transport systems and for patient management during transfer by fixed wing aircraft. *J Royal Soc Med* 1992;85:767-771.
3. Campbell N, Boustani M, Limbil T, et al. The cognitive impact of anticholinergics: A clinical review. *Clin Interv Aging*, 2009;4:225-233.
4. Gao K, Kemp DE, Ganocy SJ, et al. Antipsychotic-induced extrapyramidal side effects in bipolar disorder and schizophrenia: A systematic review. *J Clin Psychopharmacol* 2008;28:203-209.
5. Banerjee S, Bingley W, Murphy E. Deaths of detained patients: A review of reports to the Mental Health Act Commission. Mental Health Foundation (London), 1995. **BCMJ**