A. Obtain relevant history:
   1. Previous psychiatric hospitalization, when and where?
   2. Where does patient receive psychiatric care?
   3. What medications does that patient take (include prescription, over-the-counter, herbals)
   4. When is the last time the patient actually took their medications?
   5. Has the patient been using illicit drugs or otherwise “self-medicating”?

B. Calm the patient/verbal de-escalation. Sit down, speak calmly, avoid judgmental statements

C. Evaluate the patient’s general appearance and vital signs

D. EMS Providers must remember that aggressive, violent behavior may be a symptom of medical conditions such as, but not limited to:
   1. Head trauma
   2. Alcohol / drug related issues
   3. Metabolic disorders (i.e., hypoglycemia, hypoxia, environmental exposure etc)
   4. Psychiatric / Stress-related disorders

E. Contact Medical Control and advise of patient condition

F. Transport patient to appropriate facility
   1. Pregnant psychiatric patients of any age shall be transported to an obstetrics-capable hospital.
   2. Non-pregnant pediatric (under 18 years) psychiatric patients shall be transported to a pediatric psychiatric capable hospital (i.e. Akron Children’s Hospital)
   3. If exceptions need to be made consult online medical control.

G. Contact law enforcement for assistance with violent patients

NOTE: RESTRAINTS (physical and chemical) MAY BE USED TO PROTECT THE PATIENT, RESPONDERS AND BYSTANDERS.

H. All patients who are not making rational decisions should be transported for medical evaluation. They lack medical capacity to refuse care. See Transport Policy.
   1. Threats of suicide; overdose of medication, drugs or alcohol; and/or threats to the health and well-being of others are NOT considered rational.
A. Soft restraints are to be used only when necessary in situations where the patient is potentially violent and may be a danger to themselves or others.

B. Patient health care management remains the responsibility of the EMS provider. The method of restraint shall not restrict the adequate monitoring of vital signs, the ability to protect the patient’s airway, compromise peripheral neurovascular status or otherwise prevent appropriate and necessary therapeutic measures.

It is recognized that the evaluation of many patient parameters requires patient cooperation and thus may be difficult or impossible to complete.

C. All restraints should have the ability to be quickly released, if necessary.

D. Restraints applied by law enforcement (i.e., handcuffs) require a law enforcement officer to remain with patient to adjust the restraints as necessary for the patient’s safety. This policy is not intended to negate the need for law enforcement personnel to use appropriate restraint equipment to establish scene control.

E. Patients shall NOT be transported in a prone position to ensure adequate respiratory and circulatory monitoring and management.

F. Restrained extremities should be monitored for pulse quality, capillary refill, color, motor function, and sensory function at the time of restraint application and every 5 minutes thereafter.

G. Restraint documentation on the Patient Care Report shall include:
   a. Reason for the restraint
   b. Agency responsible for restraint application (i.e., EMS, police)
   c. Documentation of cardiorespiratory status and peripheral neurovascular status at least every 5 minutes.

A. Chemical restraint should be used in conjunction with physical restraints in controlling the violent / agitated patient so as to minimize the risk of injury to themselves and/or others. Physical restraint may actually make excited delirium worse. Physical restraint alone should never be used; it should always be a bridge to/buy time for chemical restraint with Ketamine or Midazolam.

B. Try to determine if the patient’s behavior is due to psychiatric emergency, drug / alcohol intoxication, environmental exposure, or head injury.

C. Attempt to determine the patient’s allergies. Administer midazolam (Versed) 2.5 mg IV/IM/IN. May repeat once in 5 minutes if agitation persists.

D. All patients requiring any form of restraints – physical or chemical – must have vital signs, respiratory status and level of consciousness monitored and documented every 5 minutes.
E. Apply cardiac monitor and pulse oximeter if able.

**ADULTS:**
A. IF a psychiatric/behavioral emergency is present and patient remains agitated:
   1. Administer **Ketamine** 2 mg/kg IM or 1mg/kg IV if available.
   2. As an alternative to Ketamine, administer Midazolam 2.5 mg IV/IM/IN. May repeat once in 5 minutes if agitation persists.
B. IF Excited Delirium is suspected, use Ketamine or Midazolam per excited delirium protocol.

**PEDIATRICS:**
C. On rare occasion, you may encounter a young child with agitation and/or violent behavior. Such acting out in this age group is more commonly due to psychosocial stressors, disruption of the school or familial environment, or underlying psychiatric or developmental problems rather than drug use. An 8 year-old is much more likely to tear the house apart because of underlying psychiatric illness (e.g. ODD) or home life stressors than methamphetamine use.
D. Stay calm and be as non-threatening as possible. Get down on the child’s level – take a knee to speak to the child if it is safe to do so.
E. Provided that they are reasonably calm, collected and able to be of assistance, family is your greatest asset. Involve them early and provide the child reassurance.
F. IF a psychiatric/behavioral emergency is present and patient remains agitated:
   1. Administer Midazolam 0.05-0.10 mg/kg IM FIRST. Max dose 2mg IM.
   2. If agitation persists, administer Diphenhydramine 1 mg/kg IM SECOND. Max dose 25 mg IM.
   3. Do **not** use Ketamine in the field on agitated children.

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**EXCITED DELIRIUM**

**GENERAL CONSIDERATIONS**
A. An important consideration for EMS in the pre-hospital management of the extremely combative patient is the condition known as Excited Delirium. These patients are generally extremely agitated and present with bizarre and potentially violent behavior.
   1. A stereotypical case would be the middle-aged male who, after stripping naked, is a bloody mess from breaking out all of the windows in his house and is now running through traffic or wandering aimlessly in an unusual location (e.g. PCP).
B. Law enforcement officers are often called upon to confront and control these patients. Some patients may fall victim to a phenomenon known as sudden, unexpected, in-custody death if excited delirium goes unrecognized and untreated. Many standard law enforcement techniques have taken the blame for these deaths over the years, including pepper spray, prone positioning post-restraint, and most recently, the TASER.
C. The components of Excited Delirium are:
   1. Bizarre behavior
   2. Nonsensical speech
   3. Constant motion
4. Paranoia
5. Attraction to shiny objects / lights / glass
6. Superhuman strength
7. Decreased pain sensation
8. Hyperthermia, tachycardia, hypertension, often dilated pupils

D. It is not unusual for an Excited Delirium patient, once they are subdued, to “crash” and exhibit
difficulty breathing, hyperthermia, unresponsiveness, or other signs and symptoms of a
medical emergency. Without prompt intervention and treatment, a certain number of these
patients may progress to sudden, unexpected, in-custody death. Be prepared for this to
occur, despite your aggressive interventions!

The current explanatory theories behind these deaths and the things EMS providers need to be
aware of are:

1. Underlying Health Problems - put the patient at an increased risk of sudden death
after such extreme exertion.

2. Illicit Stimulant Intoxication - Long term abuse and/or acute severe overdose of illicit
stimulants such as cocaine, PCP, bath salts, or methamphetamine can result in
Excited Delirium-type behavior and can lead to metabolic acidosis.

3. Metabolic Acidosis - These patients tend to be functioning at a very high metabolic
rate. They will eventually “burn out” and suffer an unsurvivable metabolic acidosis,
which will lead to end-organ damage and death.

4. Sympathomimetic overload – Patients tend to have hyperpyrexia (elevated body
temperature, though their “fever” is not necessarily from an underlying infection),
tachycardia, hypertension, and often dilated pupils.

5. Psychiatric Illness - Certain psychiatric illnesses or conditions can lead to a hyper
manic state and again cause metabolic acidosis (e.g. bipolar disorder,
schizophrenia).

6. Ventilation Problems - The primary means by which the body corrects metabolic
acidosis is through (hyper)ventilation. It is debatable, but many believe that certain
restraint devices or positions limit adequate ventilation and may exacerbate
metabolic acidosis.

**TREATMENT**

A. Patients who are in a state of Excited Delirium are at risk for sudden death and require
medical intervention. To prevent the sympathetic overdrive from killing them, the patient
must be sedated with benzodiazepines (e.g. Versed) to stop the hyperactive “fight or flight”
response that will lead to neurologic excitatory-toxicity and death. Remember that physical
restraint alone can worsen the patient’s condition. “Chemical restraint” with medications is
key.

B. Even with aggressive interventions, you must be prepared for the patient to suddenly “crash”
and become dyspneic and/or unresponsive. Be ready to support ventilation and resuscitate
from respiratory or cardiac arrest.

C. Patients who are potentially in a state of Excited Delirium should be transported expeditiously
to an ED for evaluation and treatment by a physician.
A. KETAMINE
For adult patients with profound agitation that poses a risk to the patient and providers, administer Ketamine 4 mg/kg IM or 2 mg/kg IV if an IV is available.
   a. It is prudent to back away after ketamine has been administered for several minutes until the medication has taken effect. Onset: 30 secs IV, 3-4 min IM. Ketamine dosing does not “stack”/is not cumulative. Once patient is sedated, giving them more only increases side-effects; it will not make them “more sedated”. You must wait until it wears off.
   b. Be prepared to suction the airway and/or assist with ventilation with BVM
   c. Administer 500 ml normal saline bolus.

B. MIDAZOLAM/VERSED
Excited delirium is essentially a sympathetic overdrive, and responds best to benzodiazepines such as Midazolam/Versed that slow the sympathetic system down. Ketamine is a dissociative that will “pause” the excited delirium problem, not stop it. When the Ketamine wears off, the patient may wake up just as agitated as before.

Therefore, either in place of Ketamine, or in addition to Ketamine, administer Midazolam 5 mg IV/IM/IN to treat excited delirium. May repeat once in 5 minutes. Onset: 3-5 min IV
   a. If using Midazolam in addition to Ketamine, recommend giving the Midazolam as the patient is starting to wake up from the Ketamine. This will both keep them sedated for safe transportation and help stop the underlying excited delirium
   b. Be prepared to suction the airway and/or assist with ventilation with BVM
   c. Administer 500 ml normal saline bolus.

C. Medications should be administered cautiously in frail or debilitated patients. Lower doses should be considered.

C. TASERED PATIENT

A. TASERED PATIENT ASSESSMENT
A. The Taser device is designed to transmit electrical impulses that temporarily disrupt the body’s central nervous system. Its Electro-Muscular Disruption (EMD) technology causes an uncontrollable contraction of the muscle tissue, allowing the taser to physically debilitate a person, typically regardless of pain tolerance or mental focus.

B. Assessment of a patient who has been “hit” with a taser shall include evaluating:
   1. Possible underlying medical condition for aggressive / agitated behavior (e.g. hypoglycemia, hypoxia, environmental exposure etc.)
   2. For the presence of any injuries sustained after being tasered
   3. Any injuries from the taser barb

C. Be aware of and suspect injury in the following at risk patients:
   1. Patients exhibiting Excited Delirium
   2. The elderly
   3. Pregnant patients
   4. Patients with known heart disease, pacemaker, and/or AICD
D. Be aware of and suspect injury with high risk barb strikes to the following areas:
   1. Eye
   2. Open mouth
   3. Neck
   4. Genitals
   5. Large blood vessels in the groin
   6. Bone

   **TREATMENT**

   A. Tasered patients do not necessarily require transport. Current medical literature does not support the routine medical evaluation of an individual after Taser application, with some exceptions. Those that should be transported are:
      1. Patients from the at risk group
      2. Patients with a high risk barb strike
      3. Patients with significant, underlying, predisposing medical condition
      4. Patients who sustained a significant injury after being tasered
      5. If unable to remove barb
      6. Advanced EMTs and Paramedics should apply the cardiac monitor and obtain rhythm strip for patients with irregular pulse, palpitations, elderly, cardiac disease history and/or Excited Delirium

   B. Treatment for patients that require transport includes:
      1. Medical attention for their specific condition(s)
      2. Remove barb and bandage sites
      3. Refer to Behavioral Emergencies Protocol as indicated for restraints
      4. Cardiac monitor (Advanced EMT and Paramedic)
      5. Transport

   C. Treatment for patients NOT requiring transport includes:
      1. Remove barb and bandage sites
      2. Tetanus immunization inquiry and recommendation - If last tetanus immunization was more than 10 years ago, patient should receive another immunization within 2-3 days
      3. Appropriate documentation of assessment and treatment on Patient Care Report and release of patient to the custody of the specific law enforcement agency
**BEHAVIORAL EMERGENCIES**

- Assess and manage ABC’s
- Obtain relevant history
  - Previous psych hospitalization?
  - Where patient receives psych care?
  - What medications does the patient take? When was their last dose?
  - Any illicit drug use?
- Evaluate patient condition
- Monitor vital signs
  - Hypoperfusion (BP < 100 systolic)
- Reassure patient
- Transport patient to appropriate facility
- Contact law enforcement for assistance with violent patients
- Consider use of restraints – see restraint protocol
- All patients who are not making rational decisions should be transported for medical evaluation (i.e., threat of suicide, overdose, drugs or alcohol, and threats to the health or well-being of others)

**EXCITED DELIRIUM:**

- **Chemical restraint for mild to moderately agitated patient:** Administer **midazolam (versed)** 2.5 mg IV/IM/IN may repeat once in 5 minutes if needed
- **Chemical restraint for profoundly agitated patient (excited delirium):** Administer **midazolam (versed)** 5 mg IV/IM/IN may repeat once in 5 minutes if needed
- Apply cardiac monitor and pulse oximeter if able

- **Chemical restraint for mild to moderately agitated patient:** Administer **ketamine** 2 mg/kg IM or 1 mg/kg IV
- **Chemical restraint for profoundly agitated patient (excited delirium):** Administer **ketamine** 4 mg/kg IM or 2 mg/kg IV
- Administer 500 ml normal saline bolus

**THE COMPONENTS OF EXCITED DELIRIUM ARE:**

- Bizarre behavior
- Nonsensical speech
- Constant motion
- Paranoia
- Attraction to shiny objects/light
- Superhuman strength
- Decreased pain sensation
- Hypothermia
- Tachycardia
- Hypertension
- Often dilated pupils

**Patients who are potentially in a state of excited delirium should be transported expeditiously to an ED for evaluation and treatment by a physician.**

**Treatment of excited delirium includes the administration of ketamine to “pause” the event and midazolam, to slow the sympathetic response.**

**Key**

- Basic EMT
- Advanced EMT
- Paramedic
- Med Control
- Soft restraints are to be used only in situations where the patient is potentially violent and may be a danger to themselves or others.
- Health care management remains responsibility of the EMS provider.
- All restraints should have the ability to be released quickly.
- Patients shall not be transported in prone position.
- Restrained extremities should be monitored every 5 minutes for:
  - Pulse quality
  - Cap refill
  - Color
  - Motor function
  - Sensory function
- Documentation includes:
  - Reasons for restraint
  - Agency responsible for restraint application
  - Cardiorespiratory status every 5 minutes
  - Peripheral neurovascular status every 5 minutes

Physical restraint should only ever be a bridge to chemical restraint.

**KEY**

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<td>Med Control</td>
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**Physical Restraints**

- **Mild-Moderate Agitation**
  - Administer midazolam (Versed) 2.5 mg IV/IM/IN
- **Profound Agitation** (Excited Delirium)
  - Administer midazolam (Versed) 5 mg IV/IM/IN
  - Apply cardiac monitor and pulse oximeter if able

**Ketamine**

- **Mild-Moderate Agitation**
  - Administer ketamine 2 mg/kg IM or 1 mg/kg IV
- **Profound Agitation** (Excited Delirium)
  - Administer Ketamine 4 mg/kg IM or 2 mg/kg IV

**Pediatric Agitation**

- **1st Choice:** Administer midazolam (Versed) 0.05-0.10 mg/kg IM, max dose 2 mg
- **2nd Choice (if #1 insufficient),**
  - Administer diphenhydramine (Benadryl) 1 mg/kg IM, max dose 25 mg