Medical Control Guideline: Care of the Patient with Agitation

DEFINITIONS:

Agitation: A hyper-aroused state (ranging in severity from anxious and cooperative to violent and combative) in which the individual exhibits excessive, repeated, and purposeless motor or verbal behaviors (e.g., pacing, fidgeting, clenching fists or teeth, prolonged staring, picking at clothing or skin, responding to internal stimuli such as hallucinations, threatening or carrying out violent acts).

Agitated Delirium: A state of agitation, excitability, and aggression associated with stimulant abuse, substance abuse and/or psychiatric disorders which leads to physiologic changes, such as hypertension, hyperthermia, diaphoresis, and cardiovascular instability. Also commonly referred to as “Excited Delirium”.

Delirium: An acute change in mental state due to an underlying medical condition characterized by confusion, disorientation, reduced awareness of the environment, and disordered thinking.

Autism Spectrum Disorder: A disorder diagnosed in childhood, but continuing into adulthood, with a wide range of severity involving difficulty with social communication and interaction, repetitive patterns of behavior, and narrowed interests or activities. Some patients have very little ability to communicate, or comprehend verbal and nonverbal communication, while others may communicate and are intelligent. Individuals are often sensitive (fearful/reactive) to environmental stimulation and depend on routines.

Bipolar Disorder: An episodic illness in which patients experience periods of elation or “high” mood (mania or hypomania), and periods of depression. Manic episodes are characterized by decreased sleep, lots of energy, rapid speech and ideas, impulsive and reckless decision-making (e.g., buying expensive objects, quitting a job, going on sudden unplanned trips) and an inflated view of oneself (grandiosity).

Delusion: A false belief that is firmly held despite objective and obvious contradictory proof or evidence. Delusions can be dangerous when the patient has a fixed idea that causes them to act violently.

Dementia: An illness generally diagnosed in older adults, associated with progressive cognitive decline including memory loss and an inability to carry out tasks or basic functions (i.e., driving, using a phone, dressing/grooming). The condition ranges in severity with some patients having little ability to speak, communicate, to those with less severe forms may be able to communicate well and manage their own care needs.

Major Depressive Disorder: An episodic illness in which a person feels profound sadness, a lack of enjoyment, and other symptoms that may include impairments in sleep, energy, appetite, motivation, concentration, and socialization. These patients often feel hopeless and are especially likely to think about or try to commit suicide.

Disorganized behaviors: A set of behaviors or actions that do not appear to accomplish anything meaningful (e.g., laughing to self, lying motionless and unresponsive to people around them, pacing or repeatedly sitting/standing without any clear reason, staring at the wall, or object with a blank expression). They can be seen with a variety of conditions including psychosis, autism, dementia, and mania.

Disorganized Speech: A speech pattern that is extremely difficult to follow, such as garbled or non-sense speech, telling a story that jumps illogically from one topic to the next, making up new words, or highly repetitive speech (e.g., muttering to self with repetitive phrases).

Hallucinations: Patients experience sensing things that other people cannot hear, see, or smell (infrequent). Most commonly this means a patient is “hearing voices” or “seeing things”. This can be dangerous if the patient is experiencing hallucinations that command them to harm themselves, other people, or carry out dangerous acts. Hallucinations can be a symptom of psychosis or drug intoxication, but can be associated with other conditions like mania, depression, dementia and delirium.

Iatrogenic escalation: Escalation of a patient’s agitated state caused by EMS / healthcare personnel either inadvertently, or deliberately, by acting in ways that the patient does not expect or desire (e.g., restricting a patient’s freedom to move (cornering the patient), taking away patient belongings or invalidating, confronting, arguing with, or intimidating a patient).

Intellectual Disability: A range of disability from mild to severe, characterized by significant limitations in intellectual functioning (learning, reasoning, problem solving, planning) and adaptive behavior (everyday social skills like communication, and practical skills like living independently).

Paranoia: A state of suspicion or mistrust of people or institutions, such as hospitals/healthcare personnel, law enforcement or security.

Psychosis: A state where a person loses contact with reality. Common diagnoses or terms of psychotic illness include: “Schizophrenia”, “Psychotic disorder”, “Acute psychotic episode”, “Schizoaffective disorder” (a combination of schizophrenia and bipolar disorder), “delusional disorder”. The symptoms of a psychotic illness are commonly: hallucinations, delusions, paranoia and/or disorganized behaviors and speech.

Self-injurious behaviors: Behaviors or violent acts directed at oneself, occurring in many psychiatric disorders which may include depression or bipolar disorder, psychosis, drug abuse, and personality disorder (patients are often trying to distract themselves from extreme emotional pain they feel). (Also referred to as: Non-suicidal self-injury)

PRINCIPLES:

1. Psychiatric emergencies, including those related to mental health and substance abuse, are medical emergencies, and as such are best treated by EMS personnel who are trained, equipped, and experienced to evaluate and manage medical patients.

2. A proportion of prehospital psychiatric emergencies involve acute behavioral agitation, violence, threats of harm to self or others, or criminal activity. Such patients are best managed by an EMS and law enforcement (LE) co-response.

3. The overarching goal in management of acute behavioral agitation is to help the patient regain control over their behaviors so that they can participate in their evaluation and treatment.

4. EMS personnel should maintain the patient’s dignity to the extent possible, including use of the least restrictive method of restraint or intervention to facilitate clinical patient assessment, medically indicated treatment, and safe transport to a hospital.

5. Agitation has varying presentations on a spectrum, ranging in severity from anxious and cooperative to violent and combative. The patient may not have the ability to understand the situation or the dangers of their behavior or comply with directions because they lack insight and/or self-awareness.

6. The potential causes of agitation are numerous and varied and can include medical and/or psychiatric and/or substance abuse conditions. Agitation can also be unrelated to a medical/psychiatric condition, in such cases agitation may be used by a person "instrumentally" as a means of achieving a goal.

7. Physical restraint and pharmacologic management of agitation when providing EMS care are primarily indicated to protect a patient, the public, and other EMS personnel from injury.

8. The decision for EMS personnel to utilize medication management to treat agitation is a critical health care decision. (Note: "chemical sedation" or "chemical restraints" are not preferred terms)

9. Persons who lack decision-making capacity, or unaccompanied minors, are assessed and treated with implied consent (Ref. No. 834 – *Patient Refusal of Treatment/Transport and Treat and Release at Scene*).

10. LE officers, whenever available, should be involved in cases in which a patient poses a threat to themselves, the public, and/or EMS personnel.

GUIDELINES:

1. Initial Approach to Scene Safety:
   A. Evaluation of the agitated patient should start from a safe and sensible distance *(See MCGs 1307.1 and 1307.2)*.

   B. If EMS personnel are in danger of harm, they should retreat to a safe location and await the arrival of LE.
      i. Safety is paramount and at no time should EMS personnel jeopardize their safety by engaging with an agitated patient unless they feel that they have the knowledge, tools, and skills to do so.

   C. The first EMS and/or LE responders should organize their approach by identifying a lead who is responsible for communicating with the patient and coordinating the actions of the rest of the team.

   D. If there is no safe option for retreat, EMS personnel who are being physically attacked may defend themselves as permitted by local law. EMS personnel should not show aggression or retaliate against the patient.

   E. The goals of EMS care are to determine whether the patient is a candidate for verbal de-escalation (the preferred first step in managing agitation), if physical restraint is indicated, if pharmacologic intervention is indicated, and ultimately to provide an assessment for acute medical and psychiatric conditions.

   F. The flowchart in *MCG 1307.1* describes the initial approach to the scene of an agitated patient.

2. Verbal De-escalation:

   A. All EMS personnel shall be trained, capable, and competent in verbal de-escalation techniques, (e.g., using the "ERASER" mnemonic, see *MCG 1307.2*).

   B. The use of appropriate de-escalation techniques should take precedence and be attempted prior to physical restraint and/or administration of pharmacologic management, whenever possible and clinically appropriate.

   C. EMS personnel should not directly question or confront a patient's psychotic symptoms (e.g., hallucinations, delusions, paranoia, or behaviors) as it may worsen the patient's agitation.

   D. EMS personnel should remain self-aware and not allow themselves to react to provocative patients because this can lead to iatrogenic escalation of agitation.

3. Assessment of Agitation:

   A. EMS personnel shall attempt to perform an appropriate patient assessment to identify and manage clinical conditions that may be contributing to a patient's agitated, combative, or violent behavior. The table in *MCG 1307.3* describes potential clinical scenarios where a patient presents with agitation and provides guidance on use of verbal de-escalation.

4. Pharmacologic intervention may be required for the safety of the patient, EMS personnel and/or public when verbal de-escalation techniques are ineffective (*TP 1209 or 1209-P, Behavioral/Psychiatric Crisis*).

5. Use of Restraints:

   A. If determined that the patient is not an appropriate candidate for verbal de-escalation (i.e., after failed attempts at verbal de-escalation, or acute medical situation requires immediate intervention) or when managing a patient who re-escalates to agitated behavior after verbal de-escalation, physical restraint may be required in conjunction with pharmacologic management (*Ref. No. 838, Application of Patient Restraints*).

6. Co-Response with Law Enforcement:

   A. At all times, EMS personnel should act as an advocate for the safety, medical monitoring, and clinical care of the patient.

   B. In some situations, it may be necessary for LE to apply restraint techniques or interventions (e.g., handcuffs or flex cuffs, herein referred to as LE restraint).
      a. Patients requiring ongoing care and/or EMS transport that are in LE restraints shall be managed in accordance with *Ref. No. 838, Application of Patient Restraints*, with preference for discontinuing LE restraint in favor of EMS approved restraint interventions when appropriate.

   C. Patients who are in LE custody or who are under arrest must always have a LE officer present or immediately available during EMS transport.