Monroe Livingston Region Program Agency

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To: All EMS Providers

From: Jeremy T. Cushman, MD, MS, EMT-P
Regional Medical Director

Date: May 13, 2013

Re: Advisory 13-03: Policy 9.3 – Management of Psychiatric and Violent or Potentially Violent Patients

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Attached please find updated Policy 9.3 "Management of Psychiatric and Violent or Potentially Violent Patients." This policy replaces that of a similar name dated December 28, 2009. This document provides important guidelines on important definitions and the physical restraint procedures to be used for violent or potentially violent subjects and should be reviewed by all personnel.

With the support of the University of Rochester Division of Prehospital Medicine, The Office of the Monroe County Medical Director, and Monroe County EMS, Fire, and Law Enforcement Agencies, an educational vodcast have been created to provide awareness of the violent subject, the recognition of Excited Delirium Syndrome, and the physical and chemical restraint techniques to be considered in the management of these patients. The training is not mandatory, but highly encouraged. In order to be eligible for one (1) hour BLS CME, the provider must watch the video and complete the post test. The link for this training, "Excited Delirium Syndrome: EMS Provider Edition" can be found here. This training demonstrates the recommended restraint techniques and similar training on this subject has been delivered to all Monroe County and City of Rochester Law Enforcement Officers as well as the Monroe County Emergency Communications Department. The Law Enforcement and ECD versions are available for use by neighboring jurisdictions and are located on the MLREMS website as well.

At this time, ALS providers are expected to continue to use Protocol 2.8 – Behavioral Emergencies, for the protocol doses of midazolam to be used when considering chemical restraint. This protocol is attached as a reference.

With any questions, please do not hesitate to contact the Regional Program Agency.

9.3 MANAGEMENT OF PSYCHIATRIC & VIOLENT OR POTENTIALLY VIOLENT PATIENTS

PURPOSE

This guideline is intended to define standards to assure that both the psychiatric patient and the caregiver are safe during transport to the hospital. This will also outline the techniques that may be used for the management of violent and potentially violent patients.

DEFINITIONS

A psychiatric patient is defined as a person encountered by EMS personnel with an actual or potential psychiatric problem.

Mental Illness: A disorder in which individuals experience periodic problems with feeling, thinking, or judgment to such an extent that the person afflicted requires care, treatment, and rehabilitation. Mental illness may be acute, time limited, chronic, lifelong and may occur at any time in an individual's life.

Emotionally Disturbed Person: An individual who is in severe crisis, displaying behavior that may include irrational behavior, suicidal ideation, or other bizarre behavior that may be brought on by depression, intense anger, or anxiety.

9.39 Hospital: A hospital licensed pursuant to NYS Mental Hygiene Law (NYSSMHL), section 9.39 that maintains adequate staff and facilities for the observation, examination, care, and treatment of person(s) alleged to be mentally ill. 9.39 hospitals in Monroe and Livingston County include Strong, Rochester General, Unity, and St. Mary's.

Generalized Signs & Symptoms
The following guidelines are generalized signs and symptoms of behavior that may suggest mental illness, although EMT's and Paramedics should consider other potential causes, such as underlying medical conditions (diabetes); reactions to narcotics/alcohol; or temporary emotional disturbances that are situationally motivated. The EMT or Paramedic should evaluate the following related symptomatic behavior in the total context of the situation when making judgments about an individual's mental state and need for intervention.
Mentally ill and/or emotionally disturbed persons may show signs of:

(1) Strong and unrelenting fear of persons, places, or things. The fear of people or crowds (agoraphobia), for example may make the individual extremely reclusive or aggressive without apparent provocation.
(2) Demonstration of extremely inappropriate behavior(s) for a given context. For example, people who are observed yelling to themselves in a public place.
(3) Becoming easily frustrated in new or unforeseen circumstances and the demonstration of inappropriate or aggressive behavior(s) in dealing with the situation.
(4) In addition to the aforementioned, a mentally ill/emotionally disturbed person, may exhibit on or more of the following characteristics:

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(a) Abnormal memory loss related to such common facts as name, home address (although these may be signs of other physical ailments such as brain injury or Alzheimer's disease).
(b) Delusions: the belief in thoughts or ideas that are false, such as delusions of grandeur ("I am God"). Paranoid delusions, ("Everyone is out to get me"), or somatic delusions: the belief that one suffers from extraordinary physical maladies that are not possible.
(c) EMS personnel should be alert to the fact that just because a patient appears to suffer from somatic delusions (e.g., believing their heart was stolen), does not mean that there are not serious physical symptoms worthy of assessment, such as cardiac arrhythmias.
(d) Hallucinations of any of the five senses (e.g., hearing voices commanding the person to act, feeling ones skin crawl, etc.)
(e) Extreme fright, anxiety, or depression

The Mental Hygiene Law
Section 9.41 of the NYS MHL allows a *law enforcement officer* to place in custody and transport to a 9.39 hospital, any person who appears to be mentally ill for evaluation if:

(1) The individual displays a substantial risk of physical harm to other persons as manifested by homicidal or other violent behavior, by which others are placed in reasonable fear of serious physical harm.
(2) The individual displays a substantial risk of physical harm to him/herself as manifested by threats or attempts at suicide or serious bodily harm.
(3) The individual exhibits other conduct demonstrating that he/she is dangerous to him/herself. They may include, but are not limited to: the person's refusal or inability to meet his/her essential need for food, shelter, clothing, or health care, provided that such refusal or inability is likely to result in serious harm if there is not immediate hospitalization.

Pursuant to section 22.09 of the NYS MHL, and individual who is intoxicated or impaired because of known or suspected alcohol and/or substances in their body, may be placed in the custody of a police officer and brought to a hospital facility under the NYS MHL, for immediate treatment, observation, and care if:
The person who appears to be incapacitated by alcohol and/or substances to the degree that they are unconscious, incapable of making a rational decision with the respect to the need for emergency treatment, or there is a likelihood to result in harm to the person or to others, may be taken to a general hospital to receive emergency treatment.

EMS RESPONSE GUIDELINES

When dispatched to a psychiatric emergency, the EMS crew must always consider their safety first. The following are general response guidelines to psychiatric-type calls:

- Based on dispatch information, a crew may always exercise the option to stage near the scene, instead of staging in quarters. (Notify the respective dispatcher of your staging location).

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- The general response to all staging areas is non-emergent. Response can be upgraded if you receive information that you are cleared into the scene and the reported patients' condition warrants an emergent response.

- The responding unit should consider requesting a paramedic, if not already available, to reports of a "violent medical", to allow chemical restraint to be applied as per protocol. If the patient does not need chemical restraint and has no other indications for advanced interventions, that patient may be released to BLS for transport, following all applicable MLREMS protocols.

(1) Responders should apply the following techniques on every call to promote their safety and the safety of those around them:
    (a) Have two means of communication with their respective dispatch center at all times.
    (b) Ensure that location changes are reported to their respective dispatch center
    (c) Be aware of an exit route from the scene
    (d) Have a plan for an alternate source of cover or concealment
    (e) Request that dogs and other potentially hostile animals be secured
    (f) Scan the scene for improvised weapons
    (g) Be alert of the body language of all persons on the scene

(2) Scene Safety: Often law enforcement will enter the scene first to assess the scene safety prior to the ambulance crew arriving. However, there may be situations whereby staging may not be prudent. This may include a situation where the psychiatric patient is reported to be unresponsive.

    Patient contact may be delayed in the responders believe the scene may be unsafe, based on either dispatch information or a scene size-up. EMS units should stage out of sight from any potentially hostile incident and notify their respective dispatch center of their staging location.

    If patient contact is delayed due to a potentially dangerous environment, it should be reported to their respective dispatch center and documented on the PCR with both the reason and the time.

    If EMS providers are already on the scene and the situation becomes hostile, the providers should exit the situation to a safe area, until law enforcement can establish a safe scene.

(3) In order to execute an involuntary transport, a sworn law enforcement officer must place the patient under Mental Hygiene Arrest (MHA), as outlined above. There is no middle ground: either the patient is under arrest or they are not. A "voluntary" MHA is a misnomer.

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If a patient with a psychiatric condition wishes to voluntarily go to the hospital:

(a) A patient may go to the hospital voluntarily and request a psychiatric evaluation, however, in most circumstances, when law enforcement is involved, the MHA will be completed if the patient meets the criteria, regardless if the person is not under MHA. They can revoke their decision to go to the hospital at any time during the transport.

(b) If the patient changes their mind and cannot be convinced to continue to the hospital, the crew is obligated to allow the patient out of the ambulance as soon as it is safe to do so. Notify law enforcement to your location so that a determination can be made as to the disposition of the patient. At no time is the crew to attempt to restrain the patient who is not under MHA.

(4) Responders are reminded that verbal statements made to the patient can help deescalate the situation. The following are some standard approaches that should be used in all situations with distressed individuals:

(a) Use the phrase, “slow down” to encourage the individual to calm down. Using the phrase “calm down” can often have a paradoxical effect. For example, “could you please slow down a bit? I want to understand what you are saying and it’s hard to understand you when you are speaking so fast.”

(b) Use empathy as much as possible. Empathetic statements let the patient know you understand what is upsetting them. Once a patient feels “heard,” there will be better rapport and more cooperation. To be empathetic:

- Listen carefully to what the patient is saying
- Pay particular attention to the emotion(s) he/she is experiencing
- Communicate with the patient. For example: “I can understand how angry that makes you,” “That really is painful, isn’t it?” or “That’s a lot to deal with.”
- Rather than confronting the delusions (e.g., “you can’t possibly be living without a heart”) or feeding into them, (e.g., “yes, we’ve seen other individuals who have had their heart stolen”), an empathetic approach will be much more effective. For example: “It sounds like your chest feels empty to you” and/or “that must be really scary.”

(5) If the patient is under MHA, apply the following guidelines:

(a) If the patient is not already handcuffed upon arrival of EMS:

- The medic and arresting officer must evaluate the potential for the patient to become violent and determine the need for restraints.
- If the patient has displayed any acts of violence, threatened violence, displayed any violent tendencies, or the arresting officer requires the patient be in handcuffs during transport, the patient should be restrained using the standard restraint procedure, as outlined in section 6, (Patient Restraint Guidelines), below.
- If both the medic and arresting officer agree that no restraints are warranted, the patient may be transported on the gurney using the standard gurney straps only (restraints are not required). All straps must be used.

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- If the arresting officer requires what is often called a “courtesy cuff” (one cuff on the patients wrist, one cuff on the gurney), the patient should be fully restrained using the standard restraint procedure outlined in section 6, (Patient Restraint Guidelines), below.

(b) If the patient is already handcuffed behind the back upon arrival of EMS:

- Evaluate the patient for potential for violence.
- Engage the arresting officer(s), discussing their assessment of the patients’ mental condition.
- There may be rare instances whereby removing the handcuffs of a patient already cuffed would not be in everyone’s best interest. Should that be the case, the arresting officer and the medic should have a discussion regarding options:
    1. The use of chemical restraint should be considered following MLREMS protocol.
    2. Removal of the cuffs and restraining would be after the patient has been adequately sedated.
    3. Transport with handcuffs left in place.
    4. A patient can NEVER be transported in the prone position.
    5. Transport using a mean other than EMS.

(6) Patient Restraint Guidelines:

(a) When practical, and prior to restraining a patient, explain to the patient and patient’s significant other(s) the reason for restraint use. Maintain constant, direct supervision of the restrained patient.

(b) Patients should be restrained on a backboard in a supine position. Patients should be restrained using a soft restraint (such as a cravat, spiral gauze, or commercial soft restraint). Place a webbed belt around the patients’ thighs and chest; however, these belts must not restrict chest expansion. One hand is to be secured to the backboard slot (on the same side as the limb being restrained), above the patients’ head. The other hand will be secured to the backboard slot at the patients’ side (on the same side as the limb being restrained). All limbs should be restrained.

- When placing the patient on the long board:
    (a) Apply thigh strap above the knees
    (b) Apply soft restraints to both wrists
    (c) Remove one hand from handcuffs
    (d) Ideally, secure the left arm to the backboard above the patient’s head
    (e) Apply chest strap as high up on the chest as possible
    (f) Re-tighten all straps, check all limb restraints
    (g) Assure breathing is not compromised with strap placement
- If necessary, the patients’ ankles can be secured with cravats or gauze to the lower slots of the backboard. Handcuffs or plastic bands should be replaced with gauze or cravats if feasible.
- If handcuffs are requested by law enforcement, whenever possible the patient should be readily available at all times to allow removal.

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(c) Once restraints are applied, the EMS provider must regularly reassess vital signs, and circulatory, motor, and sensory status distal to the restraints. Restrained extremities must be monitored for constriction, ischemia, or other signs of injury. The patients' medical status must be continuously monitored. **The patient must never be left alone.**

(d) If the patient is restrained using the accepted restraint guideline and the EMS provider feels comfortable with transporting the patient, the arresting officer may follow the ambulance to the hospital. If the medic is not comfortable transporting the patient alone, the arresting officer should be requested to ride along in the patient compartment. Note that the officer may at their discretion decide to ride in the ambulance even if the EMS provider does not request it.

(e) If there is any disagreement the medic and arresting officer with regard to the proper method of safe transport in the ambulance, or the request of the officer to ride along, the EMS provider should request their superior, as well as the appropriate law enforcement supervisor.

(f) If the patient is spitting, it is appropriate to apply a "Spit Sock" or surgical mask. The EMS provider must constantly monitor the patient's airway, respiratory status, and level of consciousness.

(g) Documentation is expected to include the following:

1. Steps taken to control patient prior to use of physical restraints, including the reasons restraints were needed and why less restrictive measures were unable to be utilized.
2. Baseline skin color and integrity prior to application of restraints.
3. The time restraints were applied.
4. Pertinent observations, including vital signs, and any changes in behavior.
5. Name of police agency, and if possible, name of police officer.
6. A patient evaluation should be documented every 5 minutes for restrained patients, or every 15 minutes for stable, non-restrained patients.

Approved January 21, 2013

2.8 BEHAVIORAL EMERGENCIES

CRITERIA

Any patient who demonstrates potentially violent behavior regardless of underlying diagnosis, who continues to resist against appropriately applied restraints, and needs facilitation of physical restraint. In all cases, consider staging until law enforcement is present.

CAUTION

Agitation may signal a physiologic deterioration of the patient and accompany hypoxia, hypoglycemia, cerebral edema, or other medical problems. Treatment of medical disorders should always be done prior to any chemical restraint.

1. Assess mental, emotional, and physical status thoroughly including all other potential causes of aggressive behavior. Other causes should be treated first, which may be sufficient to resolve the aggressive behavior.

2. Attend to medical or trauma needs as per protocol.

No patient will be transported without law enforcement presence if his or her emotional or mental status poses a threat to patient or crew safety.

Follow 'Management of Violent and Potentially Violent Behavior' procedures (Policy 9.3). If unable to manage with physical restraints, consider chemical restraints below.

EMT STOP
EMT-I STOP

3. If patient is at immediate risk of harming themselves or others:

   Midazolam (Versed) 2.5 mg IV/IM/IN. May repeat once to total dose 5 mg IV/IM/IN.
   Contact Medical Control following administration.

ABSOLUTE ONLINE

4. If patient remains immediate risk of harming themselves or others after first 5 mg:

   Midazolam (Versed) 2.5 mg IV/IM/IN (repeat doses per Medical Control)