2008 Council Resolution 21: Excited Delirium

Council Action: **AMENDED AND ADOPTED**

Board Action: **ADOPTED**

Status: **Completed**

SUBMITTED BY: Pennsylvania College of Emergency Physicians
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Purpose:

To establish a multidisciplinary group to study “excited delirium” and make clinical recommendations.

Fiscal Impact:

Budgeted expenses for staff labor and approximately $580 for task force conference calls.

Background:

WHEREAS, “Excited Delirium” is a term applied to certain hyperadrenergic patients (mostly afflicted with mental illness, drug effects, or both) in the out-of-hospital and hospital environments that may be predisposed to the risk of sudden death during physical or electrical restraint (TASER), by drugs, physiologic derangements, or underlying unknown cardiac disease; and

WHEREAS, ACEP’s expertise is with such patients in all such environments; and

WHEREAS, Such patients sometimes die during or shortly after attempts to bring them under control, such as physical restraint or electrical shock (TASER), whether by police, EMS, or Emergency Department (ED) personnel; and

WHEREAS, There are questions whether the syndrome exists or whether its associated deaths are even related to restraint efforts; and

WHEREAS, Such patients are commonly encountered in the ED as well, with multiple methods of physical and chemical restraint advocated, none of which have been universally agreed upon; and

WHEREAS, Modern methods of chemical sedation may provide quick and easy control of such patients that may save their lives, in both the out-of-hospital and hospital environment; therefore be it

RESOLVED, That ACEP undertake the lead to establish a multidisciplinary group of involved and concerned out-of-hospital (police, EMS), professional medical, and other appropriate organizations or individuals to:

1. define the existence of “excited delirium” as a disease entity (or not);
2. define identifying characteristics that help establish the diagnosis and risk for death; and
3. define preferred methods of control and treatment to minimize patient and caregiver risks so that the patient may be successfully managed in a medical environment.

This resolution requests ACEP to establish a multidisciplinary group to study “excited delirium” and make clinical recommendations. Excited delirium is a term used to describe a person who is experiencing extreme agitation, paranoia, and aggression with extraordinary strength and appears to be numb to pain. The media have used the term as a cause of death for individuals in police custody who exhibit combative agitation and delirium, usually with drug and/or alcohol intoxication, who dies suddenly, frequently after a violent struggle requiring the use of a TASER or physical restraint.

The Diagnostic and Statistical Manual of Mental Disorders (DSM) IV, a classification system for mental disorders and the International Classification of Diseases (ICD), a worldwide statistical disease classification system for all medical conditions including mental disorders published by the World Health Organization do not recognize excited delirium as a medical or psychiatric diagnosis. DSM IV includes criteria for delirium due to a medical condition, substance intoxication or withdrawal, or not otherwise specified.

The symptoms of excited delirium as a cause of death was first described in American psychiatric literature in 1849 by Dr. Luther Bell and is known as Bell’s mania. Symptoms were described as occurring over days or weeks. In 1981, the term excited delirium was used in the *Annals of Emergency Medicine* in a Case Report describing a patient who presented to the ED with anxiety and became increasingly agitated, confused, combative and violent. Upon autopsy the patient was found to have retained a ruptured finger cot of cocaine. In 1985, an article in the *Journal of Forensic Science* described seven cases of cocaine induced psychosis and sudden death in recreational cocaine users. Five of the seven deaths occurred in police custody. Symptoms were described as an acute onset of an intense paranoia, unexpected strength, hyperthermia, a high pain tolerance and violent bizarre behavior resulting in forcible restraint.

There have been occurrences highlighted in the media concerning the use of force on individuals who exhibit the signs of excited delirium that have resulted in death. Some cases involved the use of Tasers, pepper spray, and/or physical restraints with accusations that unreasonable force or that the way the patient was restrained (“positional asphyxia”) caused the individual’s death. A study of 18 cases of excited delirium sudden deaths after struggle and physical restraint witnessed by EMS personnel from 1992-to 1998 was conducted to determine factors associated with these deaths. During the study period a total of 196 other individuals with excited delirium were also restrained with wrist and ankles bound and attached behind the back. The factors identified were: excited delirium, hobble restraint, prone position, forceful struggle against restraint, stimulant drug use (78%), autopsy evidence of chronic disease (56%), obesity (56%), known chronic cocaine use (45%), pepper spray (33%), and Taser (28%). “…Other than excited delirium requiring restraint with struggle during restraint, there were no risk factors found present in every case.”

Vincent J. M. DiMaio MD Chief Medical Examiner in Bexar County Texas in his book, *Excited Delirium Syndrome: Cause of Death and Prevention* and describes the excited delirium syndrome primarily associated with illegal stimulant drugs. Details of medical and legal investigation of deaths due to the condition, risk factors, prevention and the role of first responders are discussed.

A recent article in the *Journal of Emergency Medical Services*1 calls for EMS to take the lead in the development of protocols that address patient restraints by pre-hospital providers with local law enforcement and mental health professional involvement. Training and preparation is seen as critical to minimize the potential for patient or rescuer harm with protocols and training addressing the use of verbal defusing, and physical and chemical restraints.

Stragegic Plan Reference:

Promote Quality Care and Patient Safety

Prior Council Action:

None

Prior Board Action:

None

Council Action:

Reference Committee C recommended that Amended Resolution 21(08) be adopted.

RESOLVED, That ACEP **study:** undertake the lead to establish a multidisciplinary group of involved and concerned out-of-hospital (police, EMS), professional medical, and other appropriate organizations or individuals to:

1. define the existence of "excited delirium" as a disease entity (or not);
2. define identifying characteristics that help establish the diagnosis identify the **presentation** and risk for death; and
3. define preferred methods of control and treatment to minimize patient and caregiver risks so that the patient may be successfully managed in a medical environment; and be it further

RESOLVED, That ACEP develop and disseminate a white paper on findings to appropriate entities (e.g. EMS, law enforcement).

The Council adopted Amended Resolution 21(08) on October 26, 2008.

RESOLVED, That ACEP **study:** undertake the lead to establish a multidisciplinary group of involved and concerned out-of-hospital (police, EMS), professional medical, and other appropriate organizations or individuals to:

1. define the existence of "excited delirium" as a disease entity (or not);
2. define identifying characteristics that help establish the diagnosis **identify the presentation** and risk for death; and
3. define preferred **current and emerging** methods of control and treatment to minimize patient and caregiver risks so that the patient may be successfully managed in a medical environment; and be it further

RESOLVED, That ACEP develop and disseminate a white paper on findings to appropriate entities (e.g. EMS, law enforcement).

Testimony:

Testimony was divided regarding the support for the resolution. Speakers suggested that, due to the absence of a defined standard or evidence, ACEP should consider developing a white paper. Those opposed stated that a policy on excited delirium would have unintended consequences for EMS and law enforcement. Several expressed concerns that the resolution as originally written was too prescriptive and does not allow the College the flexibility to address this issue before establishing a multidisciplinary group.

Concern was expressed regarding 1) the lack of scientific evidence for the development of a policy statement that would establish a standard of care; 2) the risk and liability incurred by a practitioner should they not elect to follow the policy; and 3) formation of a task force is premature prior to the adoption of the above resolves.

Board Action:

The Board adopted Amended Resolution 21(08) on October 30, 2008.

RESOLVED, That ACEP study:

1. the existence of "excited delirium" as a disease entity (or not);
2. characteristics that help identify the presentation and risk for death; and
3. current and emerging methods of control and treatment; and be it further

RESOLVED, That ACEP develop and disseminate a white paper on findings to appropriate entities (e.g. EMS, law enforcement).

References:

1. Bledsoe BE, Phillips D. Holding back: issues in patient restraint. *JEMS*. 2007;32(5):75-85.

Implementation Action:

A task force was appointed. The task force report was approved by the Board in October 2009. The report was distributed to the 2009 Council and assigned to Reference Committee C for comments. No comments were offered on the report. The report has had limited distribution as it is being considered for publication in emergency medicine journals. The report will be given wider distribution and added to the ACEP Web site once a decision has been made regarding publication.

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