

Patient Care Guidelines EMSaiStack Version 1.0 2026

National EMS Model Compliant

3J BEHAVIORAL EMERGENCIES

PATIENT CARE GOALS

- Identify and manage potential life threats associated with a behavioral emergency.
- Safely manage patients with behaviors potentially dangerous to themselves or others.
- Use physical and chemical restraints only to the level necessary to ensure effective control and safe transport of patients.
- Provide frequent reassessment of physically and chemically restrained patients.

EMT

1. If safe to do so, assess the patient and provide initial care, including oxygen, if needed, as per **1B General Assessment and Care**.
2. During initial assessment and care, identify and address primary or secondary behavioral problems that may be due to emotional, psychosocial, mental, or physiological causes.
3. Recognize that behavioral problems may present secondary to a number of medical or traumatic conditions that are potentially life threatening, including hypoxia, head trauma, stroke, drug or alcohol use, hypoglycemia, or situational stress. Identify causes and provide specific treatments as needed.
4. Verbal de-escalation is the first method to employ in managing the patient and defusing the situation. Attempt communication, calming/soothing techniques, reorientation and active listening first, rather than force, to gain permission to assess, provide care, and transport patients experiencing behavioral emergencies.
5. Physical restraints, holds and devices can be employed for patients who meet the restraint criteria.
 - Physical restraint devices include: buckle guards, padded leather or soft restraints, spinal immobilization equipment, hand cuffs, or any other devices and supplies primarily applied to control behavior or to prevent escape. Stretcher safety straps or seat-belts are not considered restraint devices for the purposes of this guideline.
 - The type and number of restraint devices employed should be appropriate to the patient's condition and adequate to impede the patient from easily getting off the stretcher.
 - When using physical restraints, holds and devices, subdue and secure combative patients using physical holds in as humane a manner as possible, avoiding the use of submission holds or other extreme tactics as a means to maintain control.¹
 - Treat patients with respect during all phases of management.
6. Transport Position. Physically restrained patients should be transported on the stretcher in a supine or semi-sitting position. Use left lateral recumbent position, if possible, for patients who must be transported on their side. No prone restraint positions should be used during transport.
 - Additional physical restraints should be deployed as needed to provide a margin of safety for the crew and patient.
 - Keep stretcher straps and other restraint devices clearly visible at all times, and inspect

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them periodically to ensure their integrity.

7. For patients with suspected hyperactive delirium with severe agitation:
 - Obtain a baseline temperature, if possible, and, if the patient is or appears to be hyperthermic, begin cooling procedures during transport.
 - Check blood glucose level.

AEMT

8. Establish vascular access (IV, IO) as needed per 1B General Assessment and Care.
9. For patients with suspected hyperactive delirium with severe agitation:
 - Establish vascular access and administer IV fluids for rehydration.
 - Establish 2 large bore IV/IO with normal saline.
 - Administer normal saline 1 liter IV/IO bolus (20 mL/kg pediatric); repeat once if hypotension or hyperthermia persists.

PARAMEDIC

10. For patients with suspected hyperactive delirium with severe agitation:²
 - Carefully monitor ECG and vital signs, including SpO₂ and EtCO₂ when possible, for possible progression to cardiovascular collapse. This monitoring is especially important for the patient who suddenly becomes quiet and stops resistance.
 - All patients with hyperactive delirium with severe agitation require transport and hospital intervention. This condition may contribute to unexpected sudden deaths of restrained individuals.
11. Treat hypoglycemia per **3G Hypoglycemia**.
12. Chemical Restraint. The goal of chemical restraint is to control excessive agitation and struggling, reduce the patient's level of exertion and oxygen demand, ensure safety for patients and providers, prevent injury, and avoid aggravation of other medical conditions. Frequently monitor vital signs of all patients receiving chemical restraint. Use the minimum level of sedation needed to control behavior and minimize alteration of the patient's level of consciousness.

ADULT	PEDIATRIC (up to 40 kg or 14 years of age)
<u>For routine agitation³</u> 1. Administer lorazepam 1 to 2 mg IV/IO slowly, diluted with an equal volume of IV fluid and titrated to effect. May repeat dose once in 15 minutes, if needed. Maximum total dose is 4 mg. OR Administer lorazepam 1 to 2 mg IM, undiluted. May repeat dose once in 15 minutes, if needed. Maximum total dose is 4	<u>For routine agitation³</u> 1. Administer lorazepam 0.1 mg/kg IV/IO slowly, diluted with an equal volume of IV fluid and titrated to effect. May repeat dose once in 15 minutes, if needed. Maximum total dose is 4 mg. OR Administer lorazepam 0.1 mg/kg IM, undiluted. May repeat dose once in 15 minutes, if needed. Maximum total dose is 4

Patient Care Guidelines EMSaiStack Version 1.0 2026

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ADULT	PEDIATRIC (up to 40 kg or 14 years of age)
mg. 2. Be prepared to support ventilations. <u>For moderate agitation⁴</u> - Administer haloperidol⁵ or droperidol 5 mg IM. May repeat once in 15 minutes if needed. - For suspected dystonic reactions⁶ to haloperidol or other antipsychotic medications, administer diphenhydramine 50 mg IM or IV slowly. <u>For severe agitation⁷</u> - Administer haloperidol⁵ or droperidol⁵ 10 mg IM. If inadequate response after 15 minutes, administer an additional haloperidol⁵ or droperidol⁵ 5 mg IM. - For suspected dystonic reactions⁶ to haloperidol or other antipsychotic medications, administer diphenhydramine 50 mg IM or IV slowly. - May use lorazepam 1-2 mg IM/IV as secondary sedative. Repeat in 15 minutes if inadequate response. For hyperactive delirium with severe agitation² - Administer haloperidol⁵ or droperidol⁵ 10 mg IM; may repeat 10 mg IM once after 15 minutes. - OR administer ketamine 4 mg/kg IM (maximum 400 mg) or 1-2 mg/kg IV/IO slowly. Be prepared to manage the airway. - Lorazepam 1-2 mg IM/IV may be added as a secondary sedative only if the response is inadequate; [contact Medical Control] before combining agents. - Treat hyperthermia with cold packs to axilla and spray patient with water and fan to promote heat loss. - Obtain 12-lead ECG to assess for hyperkalemia. - If cardiac arrest develops proceed to 2B Cardiac Arrest, the appropriate cardiac arrest algorithm (2C VF/VT or 2D	mg. 2. Be prepared to support ventilations. <u>For moderate agitation⁴</u> - Administer haloperidol⁵ or droperidol 0.05 mg/kg IM (maximum 5 mg). May repeat once in 15 minutes if needed. - For suspected dystonic reactions⁶ to haloperidol or other antipsychotic medications, administer diphenhydramine 1 mg/kg (maximum 50 mg) IM or IV slowly. <u>For severe agitation⁷</u> - Administer haloperidol⁵ or droperidol 0.1 mg/kg IM (maximum 10 mg). If inadequate response after 15 minutes, administer an additional haloperidol⁵ or droperidol 0.05 mg/kg IM. - For suspected dystonic reactions⁶ to haloperidol or other antipsychotic medications, administer diphenhydramine 1 mg/kg (maximum 50 mg) IM or IV slowly. - May use lorazepam 0.1 mg/kg IM/IV as secondary sedative. Repeat in 15 minutes if inadequate response. <u>For hyperactive delirium with severe agitation²</u> [Contact Medical Control for orders.]

Patient Care Guidelines EMSaiStack Version 1.0 2026

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ADULT	PEDIATRIC (up to 40 kg or 14 years of age)
PEA/Asystole) and perform 7G High Performance CPR ; consider sodium bicarbonate 1 mEq/kg for suspected hyperkalemia.	

DOCUMENTATION KEY POINTS

- Detailed description of the patient's behavior used as a basis for employing restraints.
- Methods used to gain control of the uncooperative patient.
- Method(s) and effectiveness of physical and chemical restraints employed.
- Frequently record assessments of distal circulation and motor-sensory (CMS) status of restrained extremities.
- For chemically restrained patients, initial and repeated assessments of vital signs, including level of consciousness.
- Involvement of law enforcement, Medical Control, medical practitioners, or court orders in deciding to use restraints or in exercising involuntary transport of patients.
- Position of the patient during transport.

NOTES

- ¹ Whenever possible, allow law enforcement officers to take the lead in gaining control of uncooperative and combative patients. For safety, always use a sufficient number of personnel.
- ² Hyperactive delirium with severe agitation is a syndrome characterized by extreme agitation and hyperactivity, hyperthermia, sweating, insensitive to pain, and exceptional strength and endurance without apparent fatigue. It may include confusion, hostility, aggression, paranoid delusions, hallucinations, and incoherent speech and shouting. Be suspicious of this syndrome in hyper-excited patients who appear hyperthermic, or who required multiple conducted electrical weapon (CEW) strikes or CEW strikes combined with considerable physical restraint to subdue. This syndrome is often associated with the use of cocaine, methamphetamine, PCP, and LSD, but it may be purely psychogenic in origin.
- ³ Patients experiencing routine agitation present with agitation and combativeness but are not in a state of hyperactive delirium with severe agitation or severe agitation. These patients generally do not require the use of physical restraints.
- ⁴ Patients experiencing moderate agitation present similarly to those with routine agitation, but usually require the use of at least 1-point or 2-point light physical restraints.
- ⁵ **Haloperidol and droperidol: These medications are not indicated** for use in patients less than 6 years of age; contact Medical Control for these patients. It is not to be administered IV for any patient due to risk of over sedation and extrapyramidal reactions. Additionally, caution should be taken when administering to patients older than 65. If used in the older patient, reduce the doses indicated by 50%.
- ⁶ Extrapyramidal reactions include dystonic reactions and/or akathisia. These may actually be adverse effects of **haloperidol** or **droperidol** and may be mistaken for worsening of the patient's behavioral status. Dystonic reactions are involuntary muscle contractions that may affect the neck, jaw,

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National EMS Model Compliant

tongue, eyes, or torso areas. The muscle contractions are often accompanied by pain, anxiety, diaphoresis, and tachycardia. Laryngospasm may occur, endangering the airway. Dystonic reactions are treated with [diphenhydramine](#). Akathisia is motor restlessness and anxiety, which often presents as squirming, pacing, complaints of jitteriness, or feeling like "jumping out of one's skin".

⁷ Patients experiencing severe agitation usually require 4-point physical restraints.