Excited Delerium

New study on ExDS shows police can train for this

By Joel Johnston

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I was involved with an International Special Panel Review of excited delirium for the US-based National Institute of Justice (NIJ) last year. It was made up of a diverse group of law enforcement personnel, medical practitioners and researchers. What has become clear is that we can take tangible steps and implement protocols to reduce the risk of unintended outcomes when these rare circumstances present themselves.

Ever since the Braidwood Commission of Inquiry on Conducted Energy Weapon Use, many politicians, their ministries and law enforcement governing bodies have taken the official position that 'excited delirium' does not exist. As a result, it is not (and in some cases cannot) be addressed in training – nor is it captured in standardized use of force response reporting.

Some of the Braidwood findings were constructive but others contradicted the body of knowledge on this subject at that time and have been the catalyst for emotionally charged debate across Canada and beyond. This article is an effort to help the reader navigate these muddy waters so as to do your own fact-checking and perhaps better discern between reality and the "mud" of conspiracy theories and media bias.

Braidwood found:

Based on the presentations of psychiatrists, other mental health professionals and emergency medicine physicians, I concluded that:

• Police officers are called upon, with increasing regularity, to deal with emotionally disturbed people who display extreme behaviours, including violence, imperviousness to pain, superhuman strength and endurance, hyperthermia, sweating and perceptual disturbances.

• Such emotionally disturbed people are often at an impaired level of consciousness; may not know who they are or where they are; may be delusional, anxious, or frightened; and may be unable to process or comply with an officer's commands.

• This cluster of behaviours is not a medical condition or a diagnosis. They are symptoms of underlying medical conditions that, in extreme cases, may constitute a medical emergency.

• The officer's challenge is not to make a medical diagnosis but to decide how to deal with the observable behaviours, whatever the underlying cause.

• It is not helpful to blame resulting deaths on "excited delirium," since this conveniently avoids having to examine the underlying medical condition or conditions that actually caused death, let alone examining whether use of the conducted energy weapon and/or subsequent measures to physically restrain the subject contributed to those causes of death.

• The unanimous view of mental health presenters was that the best practice is to de-escalate the agitation, which can best be achieved through the application of recognized crisis intervention techniques. Conversely, the worst possible response is to aggravate or escalate the crisis, such as by deploying a conducted energy weapon and/or using force to physically restrain the subject. It is accepted that there may be some extreme circumstances, however rare, when crisis intervention techniques will not be effective in de-escalating the crisis, but even then there are steps that officers can take to mitigate the risk of deployment.

Although Braidwood influenced a significant number of inquiries, it wasn't the final word on this critical medical issue – nor was it intended to be. In fact, the commissioner affirmed that further research was required to shed light on many unclear issues – including excited delirium. Nonetheless, the inquiry report has profoundly affected public policy and public opinion. While it is clearly a misunderstood issue, dismissing its existence is not only problematic but both dangerous and negligent. It is particularly troublesome because of the immense influence that the media appears to have had on public perception.

Folks who rely on the news media for information seem to robotically align with the misinformed or inclined media position on the subject. The failure of the public, politicians and law enforcement governance bodies to recognize excited delirium as a real syndrome puts people at risk every day – and relegates these situations to criminal or public safety issues to be dealt with by police, rather than as the medical crises which they are. While this is understandable with regard to the public to some extent, it is inexcusable for our elected officials and administrators.

Ignoring the problem has significant costs: continued loss of life; personal toll on the deceased's family and involved law enforcement officers; extensive and costly investigations into what may be preventable death; years of expensive litigation and diminished public confidence in law enforcement – leading to an unhealthy divide between law enforcement and the public they serve.

Sadly, recent editorial commentaries, such as those in *The Globe & Mail* (Jan. 4 2012) and the *Calgary Herald* (Jan. 6 2012), have the capacity to do even more damage in placing already at-risk subjects at even greater risk. They do so by advocating a position of denial, based on ignorance and/or motivated by political expedience. This position – that excited delirium is a term made up by law enforcement to "distract from the true cause of death and to justify police use of force," is neither credible nor defensible. Unfortunately, it continues to be perpetuated by those with a variety of other agendas.

The situation would be laughable if there wasn't so much at stake. Why, in the interest of enabling a safer and more effective approach to dealing with these difficult situations, is it so difficult to consider the notion that this may, in fact, be a "dynamic" in certain law enforcement

encounters with the public? Instead the *Globe* and *Herald* criticize Alberta Provincial Court Judge Heather Lamoureux for recommending that emergency responders be trained to more capably recognize and readily implement a collaborative response in an effort to promote the best possible outcome: saving lives.

{Editorial: *Delirious over delirium* (Copyright *The Globe & Mail*)}

Canada does not need a national delirium over "excited delirium." This supposed cause of many deaths in police custody, including those involving the use of Tasers, was laid to rest after the exhaustive Braidwood inquiry following the 2007 death of the Polish immigrant Robert Dziekanski.

Why then has an Alberta judge ruled that Gordon Bowe, tasered and restrained by several officers, died from "excited delirium syndrome"? Why is Judge Heather Lamoureux of Alberta Provincial Court proposing everything from the training of police dispatchers in diagnosing "excited delirium" to the creation of a countrywide "excited delirium" database?

"Excited delirium" (overheating and wild behaviour) is a blind alley, not a recognized medical condition. It is a convenient way to avoid tough scrutiny of police practices that may contribute to death.

Mr. Braidwood, a retired appeal court judge, spent two years and oversaw two inquiries, one on the overall safety concerns around the Taser and one on Mr. Dziekanski's brutal death after being Tasered five times by the RCMP at the Vancouver International Airport. He spoke to experts in emergency medicine, cardiology, electrophysiology, pathology, epidemiology, psychology and psychiatry. Judge Lamoureux did not refer in her seven-page ruling to Mr. Braidwood's 1,000-plus page reports.

Mr. Braidwood concluded that "excited delirium" is not a medical condition. By contrast, delirium is a recognized cognitive and brain dysfunction that is a symptom of an underlying medical condition. This is not just semantics; it points to the real problem – dealing with a sick individual without killing him.

"It is not helpful to blame resulting deaths on 'excited delirium,' since this conveniently avoids having to examine the underlying medical condition or conditions that actually caused death, let alone examining whether use of the conducted energy weapon and/or subsequent measures to physically restrain the subject contributed to those causes of death."

Mr. Bowe was on cocaine and acting wildly in a dark house. The Tasering and heavy-handed restraint by Calgary police may or may not have been justified – though the judge should have questioned "kicks to the side of Mr. Bowe's body."

Any policy built around "excited delirium" would be an irrational response to such a death. Judges and policy-makers should read Mr. Braidwood's reports.

{Editorial: *Delirious fatality report* (Copyright *Calgary Herald*)}

The fatality report into the death of Gordon Bowe adds ammunition to the argument that public inquiries too often become a waste of time and money.

Provincial Court Judge Heather Lamoureux's recommendations are curious, in that they are almost entirely built around the theory that excited delirium is a legitimate medical condition, an assertion that's controversial and widely disputed. She concluded Bowe, 40, died as a result of excited delirium syndrome, which she says was brought on by cocaine use and not from the deployment of a Taser gun, used by Calgary police trying to subdue him.

Her nine recommendations in the seven-page report almost all deal with developing protocols around excited delirium, treating it as a legitimate condition without reference to the controversy or debate in the medical community. She calls for mandatory training of emergency response workers, police and dispatchers in identifying excited delirium and wants a national database established, where police chiefs across Canada would "record and share information relating to death associated with excited delirium."

There's another school of thought that warns the controversial diagnosis of excited delirium is a distraction from the true cause of the medical condition that caused the death and is used to justify use of force by police.

The exhaustive Braidwood inquiry into the Taser death of Polish immigrant Robert Dziekanski heard overwhelming evidence that, while delirium is real, excited delirium is "NOT a valid medical or psychiatric diagnosis." Moreover, it "provides a convenient post-mortem explanation for in-custody deaths where physical and mechanical restraints and conducted energy weapons were employed."

Just a year ago, another provincial court judge in Halifax, who presided over an 11-month inquiry and wrote a far more comprehensive 460-page report, to Lamoureux's seven pages, reached conclusions similar to Braidwood's.

Provincial Court Judge Anne Derrick rejected excited delirium as the cause of death of a man Tasered repeatedly by police. She warned: "This case should sound a loud alarm that resorting to 'excited delirium' as an explanation for a person's behaviour and/or their death may be entirely misguided."

Excited delirium is not listed in the *Diagnostic and Statistical Manual of Mental Disorders,* the medical community's bible for diagnosing psychiatric illness. Even an independent report commissioned by the RCMP criticized the term and concluded it is sometimes used as an excuse to justify using a Taser.

All that aside, asking police officers to diagnose the mental state of an agitated suspect in the midst of a crime scene places too much responsibility on those who are not trained psychiatrists.

John Dooks, president of the Calgary Police Association, offers another perspective. Dooks supports any tools that can help better educate and train officers, so that they are able to identify

the symptoms described as excited delirium, regardless of whether or not excited delirium is a legitimate medical condition.

We agree there are physical attributes that are common in all of these cases that police would do well to understand and recognize. When these symptoms present themselves, police should refrain from using stun guns on the suspects and call for medical help immediately. A public inquiry isn't needed to reach that conclusion.

Here is a sampling of troubling comments from Canadians responding to the above editorials:

• *"Police brutality" and "excessive force" are not recognized medical conditions either, but unlike "excited delirium" they do exist and can be fatal.*

• *"Excited delirium " as a cause of death?! What a load of politically correct but evasive tripe! A drunk ran you over – and you die – "from excessive bleeding." Your fault – don't bleed so much next time a drunk driver smashes you into the pavement. I give up!*

• *How else would the government, police, prosecutors, lawyers and judges keep an avenue open for themselves of getting out of trouble when they did something wrong? The NEW mental state is required to keep the system from accounting for itself!*

• *Excited delirium sounds like something taken out of an 18th century medical text. Right up there with vapours from the swamps causing disease or prescribing 'blistering' for what ails you.*

• *This is not untypical of Alberta judges, some of whom think they have the knowledge to extemporaneously decide what is a medical condition based on junk science. Keep in mind Alberta is the "no Charter zone" of Canadian legal systems.*

• *So, if excited delirium is an actual medical condition, why do people – well, men actually (95% of cases) and black men the majority at that – only die from this condition following an encounter with authorities where force was used?*

In addressing the media position and the baseless and uninformed comments it inspires, it's important to dispel a number of myths associated with the issue of excited delirium syndrome (ExDS) and law enforcement:

Myth One -

Excited delirium is not a recognized medical term.

In the interest of validation, they continue to repeat that it isn't in the standard medical or psychiatric reference texts such as the Diagnostic and Statistical Manual of Mental Disorders – Fourth Edition (DSM-IV) or the World Health Organization's International Classification of Diseases (ICD-9).

While technically that remains a correct statement, what is inaccurate is the claim that it is still not a medically recognized term.

It has gained acceptance in the medical community in recent years. Both the American College of Emergency Physicians (ACEP) and, perhaps as important, the National Association of Medical Examiners (NAME) have recognized it – the very physicians most likely to encounter this phenomenon during, pre-mortem and post-mortem. Additionally, the DSM has always had multiple references to delirium and agitation. Similarly, the ICD-9 contains the following codes which match the signs and symptoms of ExDS:

• 296.00S Manic Excitement

• 293.1J Delirium of Mixed Origin

• 292.81Q Delirium, drug induced

• 292.81R Delirium, induced by drug

• 307.9AD Agitation

• 780.09E Delirium

• 799.2AM Psychomotor Excitement

• 799.2V Psychomotor Agitation

• 799.2X Abnormal Excitement

Myth Two -

Excited delirium is a term made up by law enforcement or Taser International

Excited delirium has consistently been related to deaths from events that never involved the police – many psychiatric in nature. In fact, restraint related deaths of mentally ill patients can be traced back to 1650 (1), more than 100 years before the birth of Sir Robert Peel, the man credited with creating modern policing.

The ExDS phenomenon was further documented in the 1800s by Dr. Luther Bell, primary psychiatrist at the McLean Asylum for the Insane in Massachusetts, as it was observed in the psychiatric setting where people with mental illness and extreme behavioural problems were institutionalized.

By the 1950's these observed problems and behaviours seemed to decline drastically due to the discovery and use of anti-psychotic pharmaceutical therapy. However, with the decline of "mental institutions" in the 1980's these problems began to manifest in the real world, as psychiatric out-patients ceased to self-medicate. This was exacerbated by the dramatic increase

in stimulant drug use. This was when police first began encountering ExDS. The term 'excited delirium' was coined in 1985 by Dr. C.V. Wetli and Dr. D.A. Fishbain in their publication, "Cocaine-induced psychosis and sudden death in recreational cocaine users."

Myth Three -

Excited delirium is always fatal.

North American law enforcement personnel have many years of experience of dealing with ExDS subjects. They come to our attention most frequently because of the violent, agitated, destructive, unpredictable, behaviour that they display. In many cases emergency medical services are able to respond and sedate the subject once they have been restrained.

In other cases they respond and successfully treat victims of ExDS-related cardiac arrest. These out-of-hospital subjects would normally be transported into custody or to hospital and have survived. Some flee before law enforcement or emergency medical responders even arrive on scene – some survive and others do not.

Other subjects suffer fatal cardiac arrest with law enforcement and emergency medical responders on scene. Police are sometimes called to hospitals to assist medical staff unable to control subjects exhibiting signs of ExDS so they can be treated – as there can be no treatment without first gaining control. The syndrome has become of increasing concern to emergency physicians and other primary health care professionals, who believe that earlier recognition, intervention and proactive management may result in fewer ExDS-related deaths.

Myth Four -

Law enforcement should not be attempting to diagnose a medical condition.

However, there is a distinct difference between an underlying diagnosis and discerning indicators of a condition. It is important to again note that law enforcement use of the term 'excited delirium' is not intended to convey a diagnosis.

Police and other pre-hospital personnel have no ability to differentiate between the underlying processes. However they have a critical need to be able to recognize this type of presentation as being different from a goal-oriented, coherent yet violent individual since one requires urgent medical intervention and the other does not. The medical community most affected by ExDS and the interested researchers have recognized the condition, now we as law enforcement and the public need to accept that the phenomenon exists so that we can respond to it appropriately and more effectively. Period.

Myth Five -

First responders can do it all.

The notion that first responders (who always operate in non-clinical settings) are capable of achieving "the unanimous view of mental health presenters (at the Braidwood Inquiry) – to de-escalate the agitation through the application of recognized crisis intervention techniques" is naïve and unrealistic.

It appears that recent research has identified a lack of empirical evidence or relevant research into the effectiveness of de-escalation strategies and crisis intervention techniques (2). The current rush to implement them in training in some Canadian law enforcement circles seems to be being done with the same lack of caution with which police have been accused of doing when adopting recent force response options.

This is where recognizing the syndrome is most critical. Incoherent, irrational people in the midst of a medical crisis that, left unabated, may kill them need to be controlled so that they can be treated as quickly as possible. They are not usually receptive to the communication process. Windows of opportunity for control must be exploited when they first appear – because they may never present again. Police understand the value of crisis intervention techniques and tactics – but understanding when and where to apply them is equally as important as how to apply them.

Myth Six -

It is all about police covering up.

There is no appetite to define excited delirium syndrome for the purpose of "blaming in-custody deaths on it." The sooner this argument against moving forward is put to rest, the sooner all emergency responders will be able to more safely and effectively deal with the problem. Jurisdictions that have it right on the excited delirium syndrome issue have made documented saves of people in its throes – situations that may have otherwise resulted in in-custody deaths.

Instead of burying our heads in the sand on this issue, let us move forward and recognize the existence of the state of excited delirium syndrome, much the way sudden infant death syndrome (SIDS) and acquired immune deficiency syndrome (AIDS) were recognized after much debate – in the interest of saving lives.

The first step is recognition

Without protocols, unintended outcomes cannot improve. Recognition is the first step. There are a number of North American jurisdictions who have taken a proactive approach to dealing with ExDS.

The NIJ panel recognized that perhaps the most important aspect of these early and pilot protocols is the cooperative nature of the response and training required to ensure such a response capability exists.

First and foremost, these situations need to be treated as a medical crisis, not a criminal situation. ExDS is a medical problem masquerading as a police call – this changed thinking in some communities has led to the development of innovative cooperative responses. The first response

has become a multi-disciplinary effort, not just law enforcement. Some communities have protocols enabling coordinated response training with dispatchers, emergency medical personnel (EMS & fire), law enforcement and emergency department medical staff.

A preliminary protocol

The common protocol steps the panel recognized – identify ExDS, rapidly control, sedate and transport to a medical facility – generally adhere to the American College of Emergency Physicians (ACEP) Excited Delirium Task Force white paper report.

While the panel acknowledged response protocols will continue to evolve and improve with experience and research, its consensus is that overall, these response protocols are appropriate. In the long run, they may prove to be insufficient but will likely do no harm. Some jurisdictions have also established documentation practices for these protocols, not described in the white paper, but which the NIJ panel also recommends:

- Clear identification of ExDS cases based on common signs and symptoms (indicators) of the syndrome;
- Rapid control of the individual with adequate law enforcement personnel;
- Sedation by emergency medical personnel immediately after the subject comes under police control;
- Transport of the subject to a medical facility for follow-up treatment and evaluation; and documenting the case.

While the panel report has provided some clarity on ExDS, research continues into the syndrome, underlying causes and responses. In conjunction, data being collected by some agencies will help provide even more clarity to the syndrome and improve our collective response so that we can save lives as we continue to protect the public we serve.

First and foremost we need to formally recognize the existence of excited delirium syndrome and establish clear protocols for dealing with it. We need to engage in a multi-disciplinary, comprehensive training effort to ensure that a competent, collaborative response to these rare situations is achievable. Best practices have been identified. The choice is ours.

THE AUTHOR

Joel A. Johnston is a 27-year veteran senior operational police sergeant working in Vancouver's Downtown Eastside and BC's former provincial use of force & ERT coordinator. An ERT and crowd control unit veteran, he was a member of the RCMP National Working Group and US NIJ International Panel of Experts on ExDS. A Simon Fraser University graduate, a Sandan in traditional Shotokan karate and a court-certified use of force subject matter expert, he has contributed to for the past 17 years. The opinions in this article are solely his own and do not represent any official position of offices held.

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