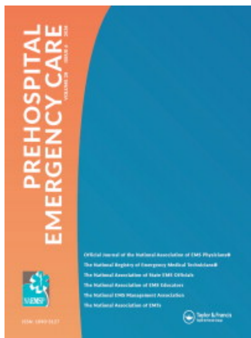

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Consensus Statement of the National Association of EMS Physicians International Association of Fire Chiefs and the International Association of Chiefs of Police: Best Practices for Collaboration Between Law Enforcement and Emergency Medical Services During Acute Behavioral Emergencies

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Abstract

Emergency Medical Services (EMS) and law enforcement (LE) frequently work as a team in encounters with individuals experiencing acute behavioral emergencies manifesting with severe agitation and aggression. The optimal management is a rehearsed, coordinated effort by law enforcement and EMS providing the necessary interventions to address behaviors that endanger the patient, the responders, and the public. The purpose of this document is to provide guidance and direction in the shared responsibility of managing and caring for a person displaying behavioral instability with irrational, agitated, and/or violent behavior. This is a discussion of the roles of law enforcement, 911 call centers (hereafter referred to as the Emergency Call Centers or "ECCs"), Fire, and EMS. A coordinated and unified response enhances the safety and effective management of potentially serious situations posed by individuals experiencing such acute behavioral emergencies. This paper provides the framework for an approach endorsed by NAEMSP, IACP, and the IAFC.

Keywords: agitated patients, emergency medical services, patient restraint, death in custody

Introduction and statement of purpose

Emergency Medical Services (EMS) and law enforcement (LE) frequently work as a team in encounters with individuals experiencing acute behavioral emergencies manifesting with severe agitation and aggression. The optimal management is a rehearsed, coordinated effort by LE and EMS providing the necessary interventions to address behaviors that endanger the patient, the responders, and the public.

The National Association of EMS Physicians (NAEMSP®), the International Association of Fire Chiefs (IAFC) and the International Association of Chiefs of Police (IACP) brought together a group of representatives in early 2023 to discuss this issue and to draft consensus statements on best practices for the collaboration of LE, EMS, and Fire to preserve the safety of all people. This group consists of physician and non-physician members of each organization, some of whom belong to more than one association.

The purpose of this document is to provide guidance and direction in the shared responsibility of managing and caring for a person displaying behavioral instability with irrational, agitated, and/or violent behavior. This is a discussion of the roles of LE, 9-1-1 call centers (hereafter referred to as the Emergency Call Centers or "ECCs"), EMS, and Fire. A coordinated and unified response enhances the safety and effective management of potentially serious situations posed by individuals experiencing such acute behavioral emergencies. This paper provides the framework for an approach endorsed by NAEMSP, IACP, and the IAFC.

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For the purpose of this paper, EMS is defined as clinical care delivered by any type of agency including, but not limited to, fire-based, private, volunteer, public utility, third service, military, and hospital-based. Law enforcement broadly includes all law enforcement officers (LEOs) including local, county, state, and federal LEOs and other agents performing LE duties for a community.

A mission statement was agreed upon to guide the discussions:
To promote collaboration among LE, EMS, and Fire at multidisciplinary scenes and foster a team understanding of the roles, responsibilities and training of all disciplines to maximize the health and safety of all community members and public safety professionals.

This work acknowledges the 2021 Position Statement from the NAEMSP, NASEMSO, NEMSMA, NAEMT and APA entitled ***Clinical Care and Restraint of the Agitated Patient by Emergency Medical Services Practitioners (1)*** which provides an important foundation for the broader discussion of the multidisciplinary collaboration occurring daily in our communities in the preservation of life and safety.

Law enforcement, EMS, and Fire have co-responded to events in which a lack of communication and coordination contributed to delays or suboptimal care. Such tragic outcomes have resulted in legislation limiting the practice of EMS medicine and the criminal prosecution of EMS

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clinicians and LE officers. While events that gain national attention are very rare, they nonetheless cast a pall on these professions, affecting morale, retention and recruitment.

We believe that LE, EMS, and Fire need to act swiftly to review local policy and practices surrounding these shared scenes. Focus should be on proactive education and training, communication and handoff strategies, integrating each discipline's unique role as well as the time-dependency in the provision of medical care.

We emphasize the following principles (1):

Primary Goal: To protect agitated, combative, or violent individuals from injuring themselves while simultaneously protecting the public and emergency responders from harm.

Agency Protocol: Every EMS agency should have specific protocols for dealing with agitated, combative, or violent patients. Protocols should address the interface with LE.

Assessment/Clinical Treatment: EMS clinicians must quickly evaluate the situation and render appropriate care.

Dignity: EMS clinicians must maintain the individual's dignity to the greatest extent possible including using the least restrictive method of restraint that ensures their safety as well as that of others present.

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Optimal collaborative management of high-risk incidents

An individual whose behavior is deemed to represent an immediate threat of violence will typically involve LE, either as the first-responding public safety entity or in response to a request from EMS or Fire. Regardless of the underlying cause of the behavior, LE will assess the threat posed and apply their training, skills, tools, and techniques to control the threat using the least restrictive method that is appropriate for the situation.

The effective management of these situations requires very close coordination between LE and EMS, a point which cannot be over-emphasized. Once the immediate threat has been mitigated and the scene is deemed safe, EMS clinicians must provide timely medical assessment and treatment of the individual. The EMS clinician should assess for the possibility of metabolic derangements as a cause or result of the event as well as for injuries sustained before or during the interaction. In addition, the individual should be monitored closely for the presence or progression of any acute, time-sensitive, or life-threatening condition(s). The EMS clinician, in collaboration with LE officers, should also consider the transition from restraints and positioning used in policing to medical restraints and positioning, if the situation allows.

Processing of the call by Emergency Call Center (ECC)

Numerous models exist for ECC staffing. Many systems employ separate positions for "call taking" and for "dispatch." This model allows for the gathering of additional information by the call taker as well as the provision of pre-arrival instructions, while simultaneously sending a

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response appropriate for the information obtained by the call-taker. In some jurisdictions, there may be more than one ECC and handoffs may occur which require continued coordination between the ECCs. Regardless of the model used, there should be a policy on how calls involving extreme behaviors are processed when violence has occurred or seems likely.

There are four potential sources of the call to the ECC. The patient may be the caller, or it may be someone else who has some knowledge about the patient (family member, medical provider, neighbor). The call may come from a third party, someone driving by, for example, and is just calling it in. The call may be a call for additional assistance from EMS or LE on scene. Policies and training should address each of these reporting scenarios.

The amount and type of information will be different for each of these types of 9-1-1 activations. The following information should be obtained, if possible:

- Specific description of the behavior
- Name of the individual
- Age and gender
- Physical description of the individual
- Whether there is a known weapon or weapons at the scene
- Whether the individual may be under the influence of drugs and/or alcohol
- Whether there is a history of violence with the individual
- Whether there is a history of chronic drug or alcohol abuse.
- Whether the individual or anyone else has been injured

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- Other individuals at risk in the environment, including the number of individuals, approximate age(s) and any known or suspected injuries
- Suicidality and credibility of threat
- Prior call history
- Depending on the resources of the ECC, additional information may be available.

The ECC should have guidelines on who has primary responsibility once the information is obtained, and the call is categorized. This will depend on local resources but could include, for example, LE, LE and EMS, a mental health team, or other combinations.

NextGen dispatch solutions as well as current add-ons to ECC computer assisted dispatch systems are increasingly making scene audio and/or video available. In cases where this technology exists, means for sharing with LE and EMS should be established.

Crisis intervention teams and 9-8-8 suicide and crisis lifeline

Crisis intervention teams may be an option in the management of acute behavioral emergencies in which there is no indication of violence or conditions requiring assessment for coexisting medical conditions or traumatic injuries. These teams generally consist of mental health professionals who may be augmented by an EMS clinician, substance use professional, or a social worker. Some call centers may employ mental health clinicians with crisis experience

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to de-escalate and manage the crisis without a response if appropriate. The National 9-8-8 Suicide and Crisis Lifeline may also be a resource.

Scene threat assessment

As in all emergency responses, life safety is the first priority during a behavioral emergency. To accomplish this goal, an initial assessment of the scene must be performed, typically by LE. During this scene size-up, observations include the types of behavior displayed by an individual, the presence of physical injuries, and the involvement of any weapons. Through these observations, officers may determine overall scene safety prior to on-scene EMS arrival.

The threat level can change very rapidly. Scene safety is not the sole responsibility of LE; all responders need to be continually cognizant of scene dynamics and respond appropriately to minimize life safety issues for all involved.

De-escalation

All emergency personnel should have baseline training in de-escalation techniques. Open, two-way communication with patients and LE should be established early by EMS whenever possible. Communication between LE and EMS could include EMS taking over primary communication with the patient while LE creates distance to allow for patient communication with EMS to occur. (The description of specific tools and techniques unique to the EMS

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environment is described in detail in the 2021 Position Paper (1). The reader is referred to this document for additional information on this topic.)

Self-preservation

De-escalation and self-preservation must go hand-in-hand. All personnel on scene should have basic training on self-preservation techniques.

Lifesaving is everyone's duty

While EMS can deliver advanced clinical care, it is incumbent upon LE to provide immediate, basic life-saving care (for example CPR, hemorrhage control, naloxone administration, etc.) to the individual.

Life-saving education and training may vary by LE agency. Regardless, it is strongly encouraged for LE to be trained – and have recurrent training – in basic life-saving care.

Duty to Act/Just Culture

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We endorse the Duty to Act/Just Culture model. All responders must be able to express concerns for the safety of an individual or a responder, and all responders must be receptive to these concerns.

There must be an awareness of the potential for bias such as anchoring bias, ascertainment bias, and confirmation bias. We must make a conscious effort at an independent assessment of the individual. The goal is to optimize the individual's safety with the minimal use of force or restraint, yet still provide for the safety of first responders and bystanders.

Subject or patient?

An underlying medical cause of unusual behaviors should be considered. For example, hypoglycemia (low blood sugar) may result in agitated or other bizarre behavior. These causes of acute behavioral emergencies can be addressed medically with decreased risk to the individual, bystanders, and responders on scene.

Medical evaluation

When called upon, EMS has a duty to evaluate and treat all patients in a timely fashion. In these instances, the treatment clock starts when the scene is deemed safe.

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The potentially competing priorities of LE and EMS also need to be recognized and addressed as part of conjoint education and training to ensure collaboration in the assessment and any required clinical treatment of these individuals.

Optimally, LE should give a short, objective summary to EMS on the circumstances of the encounter. This summary should include the reason for the encounter, pertinent observed behaviors, medical history that may have been volunteered by the individual or bystanders, descriptions of any use of force and/or the use of less lethal weapons that may have been employed, as well as any other potential sources of trauma.

Some encounters may have been of short duration with minimal physical involvement whereas others may have been of longer duration or with higher levels of physical interaction. Regardless of the length or intensity of the interaction, EMS clinicians should be vigilant in assessing the medical needs of the individual. However, as with any EMS patient, not all will require emergency transport or evaluation in a hospital setting. Alternative destinations may be appropriate to consider in specific situations.

Emergency medical services must have access to the patient for clinical assessment, which may require transition from LE positioning and restraints to medical positioning and restraints. Law enforcement may provide input on the threat posed by transitions so that the team can collaborate to arrive at the safest solution that allows for the provision of any needed clinical care.

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Foremost is the need to identify and treat a potentially life-threatening medical condition, including, but not limited to, hypoxia, hypoglycemia, metabolic derangements, hyperthermia, cardiac conditions, and trauma. The EMS clinicians must also be cognizant of possible toxidromes as a potential cause of the patient's behavior, which may require immediate treatment.

Restraints and patient positioning

Individuals may display variable degrees of anxiety, agitation, combativeness, or extreme hostility requiring physical restraint by LE officers and/or EMS. At the earliest possible time, the patient should be placed in the safest possible position.

In situations not responsive to de-escalation and/or physical restraint, EMS may consider pharmacologic management when the patient appears to be exhibiting a dangerous metabolic burden from the magnitude and duration of a continued struggle. **A decision to utilize pharmacologic management shall be made solely by EMS based upon their independent patient assessment and in strict accordance with EMS protocols and medical director oversight**. All patients receiving this type of therapy should have monitoring of heart rhythm, blood pressure, oxygen saturation and end-tidal CO2 by EMS clinicians trained to recognize and treat potential side effects of the administered agent.

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The successful outcome in these situations requires ongoing interdisciplinary communication. This communication is critical not only for responder safety, but also for the effective clinical management of an individual with a medical condition that could result in sudden deterioration or even death.

As expanded upon from the position statement on Clinical Care and Restraint of Patients by Emergency Medical Services Practitioners (1), we endorse the following:

"Physical Restraint: Restraint protocols should address the type of physical restraints and techniques that are permissible for use by EMS practitioners. Any physical restraint device used must allow for rapid removal if the patient's airway, breathing, or circulation becomes compromised. Rigid restraints, such as handcuffs, should not be used by EMS providers. If the patient is handcuffed by law enforcement officers, consideration should be made to transition to the least restrictive restraints that are safe for the patient and responders. Physical restraint devices that are easily removed by practitioners without a key are preferred. However, if a patient is restrained in devices that require a key, the key must accompany the patient during treatment and transportation.

Prohibited Techniques: Restraint protocols should identify restraint techniques that are expressly prohibited for use by EMS clinicians. Patients must not be restrained in a position with hands and feet tied together behind their back or restrained with techniques that compromise the airway or constrict the neck or chest. During transport on a stretcher or other

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transport device, patients must not be restrained in a prone position nor under backboards or mattresses…"

Transport

In some cases, LE may choose to transport the individual either to a medical facility or directly to a facility for legal remand. In these situations, it is important – when indicated – that EMS be utilized as a resource in these decisions. Although EMS clinicians may be asked by LE to evaluate an individual prior to transport to a detention facility, they should not provide a medical "clearance" without a complete clinical assessment. Some of these individuals require advanced medical assessment and interventions not available to EMS.

In situations when EMS is transporting, LE and EMS should ensure there are sufficient personnel with the appropriate scope of practice to address medical contingencies and continue any required physical restraint during transport. The monitoring and care in this setting should be delineated by EMS agency protocols and policies.

Transition of care at destination

As with any transition of care, EMS must accurately report the events leading up to the patient's presentation. Vital information that should be relayed to the staff includes a description of the patient's behavior, any physical measures utilized by LE (including, but not

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limited to, subject control and apprehension techniques (SCAT), chemical irritants, electrical conduction devices, batons, and restraints), the patient's response to these measures, physical exam findings, vital signs, medications and physical restraints utilized by EMS, and any known past history (including, but not limited to, behavioral health diagnosis, cardiac or respiratory conditions, and suspected ingestions). In addition to verbal communication during the transition of care to the receiving staff, EMS clinicians should also complete written documentation of the patient interaction in a timely manner.

Importance of appropriate documentation.

Documentation is crucial for both LE and EMS agencies when managing acute behavioral emergencies. Detailing proper care, communication, accountability, and continuity of treatment to improve a patient's outcome will minimize potential medical and legal complications

Post Incident Analysis (PIA)

After a complex, multiagency interaction, we recommend that a PIA be performed. This should be done as a medical quality improvement activity and should be protected by applicable peer-review protection statutes.

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The widespread introduction of LE and EMS body-worn cameras, fixed municipal video monitoring, as well as the videos inevitably obtained by bystanders, will increasingly provide an immediate record of medical care at scenes in which LE and EMS collaborate. If available, pertinent video should be shared to the extent that it informs on the potential to improve future collaborative care. Medical information must be screened for compliance with HIPAA rules, but pertinent medical findings from the field and hospital should be shared if the information may be beneficial.

Conclusion

The management of an individual with an acute behavioral emergency, manifesting with severe agitation and aggression, requires successful collaboration of LE, EMS, and Fire. A rehearsed, coordinated effort amongst the potential responding agencies is fundamental to the best outcome for all involved. This requires interagency and interdisciplinary communication, pre-planning and training well before an event occurs.

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1 Kupas, D. F., Wydro, G. C., Tan, D. K., Kamin, R., Harrell, A. J., & Wang, A. (2021). Clinical Care and Restraint of Agitated or Combative Patients by Emergency Medical Services Practitioners. *Prehospital Emergency Care*, *25*(5), 721–723. https://doi.org/10.1080/10903127.2021.1917736

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