Welcome to the National Criminal Justice Training Center webinar, Excited Delirium Syndrome: Early Diagnosis Often Saves Lives, presented today by John Wallschlaeger. My name is Greg Brown, and I'm a program manager with the National Criminal Justice Training Center. And I will be moderating for you today.

Today's presentation is part of the webinar series for the Bureau of Justice Assistance Comprehensive Opiate, Stimulant, and Substance Abuse programs, and the Indian Alcohol and Substance Abuse program for Coordinated Tribal Assistance Solicitation, Purpose Area 3 grantees and non-grantees focused on responses to alcohol and substance abuse-related crime. This project is supported by a grant awarded by the Bureau of Justice Assistance Office of Justice Programs, US Department of Justice. The opinions, findings, conclusions, or recommendations expressed in this webinar are those of the contributors, and do not necessarily reflect the views of the Department of Justice.

With that, let's try our first poll question. This is simply a simple question to find out who's joining us today. Please launch the first poll question. The question is, which of the following best describes your role? Your choices are probation/parole/community corrections, law enforcement, victim services, child welfare, and/or advocacy center staff, or treatment provider, mental health or substance abuse, and finally, an other category.

Probation and parole and community corrections, about 18% of our audience today. Law enforcement, about 38% of our audience. Victim services, child welfare and/or child advocacy center staff, 23%. Treatment providers-- that includes mental health or substance abuse treatment providers-- about 6%, and 15% are other, John.

I'm pleased to introduce to you our presenter today. John Wallschlaeger is an associate with the National Criminal Justice Training Center, and served 21 years in law enforcement before retiring from the Appleton Police Department in 2015. John specializes in mental health training for law enforcement and crisis intervention teams.

Also joining us today is Kevin Mariano, who will also be providing his expertise on today's webinar. Kevin has over 20 years of law enforcement experience, and served as the Chief of Police with the Pueblo of Isleta Police Department for over seven years. Kevin is currently a project coordinator with the National Criminal Justice Training Center. John and Kevin, thank you for joining us today. John, I will now turn the time over to you.

Thank you, Greg. We are, of course, here today to talk about excited delirium. And the definition, as defined by Morrison and Sadler, is a state of extreme mental and physiological excitement, characterized by extreme agitation, hyperthermia, hostility, exceptional strength, and endurance without apparent fatigue. That will move us to our very first poll question. Do you think you have encountered a person in an excited delirium state, yes, no, or unsure?

And as you can see from the results, about 52%, over half the audience, has experienced, has encountered a person in this state. About 25% have not, and about 23% are unsure, John.

Very good. So in simple terms, excited delirium is the sympathetic nervous system in total activation , okay? Chemicals get pumped into the body, and a primal fight or flight response kicks in. The body can only function this way for a limited period of time. Imagine it like having your car in park and pressing the accelerator to the floor. You know that that motor is only going to hold up so long. Okay, and that engine is eventually going to find a weak point. And that's the same thing that happens inside the body.

Some other terminology with regards to excited delirium might be sickle cell sudden death, agitated delirium, cocaine psychosis, metabolic acidosis, exertional rhabdomyolysis, positional asphyxia, sudden custody death. I think we can all agree that something exists.

Some of the causes for excited delirium are mental illness. Also included would be stimulant drug use or long-term drug abuse, sudden cessation of drugs-- and that could be psychotropic medications that are prescribed for mental illness. If a person stops taking them suddenly, that could cause that kind of a reaction. Hallucinogenic agents-- and you'll see a video on that later-- new drugs, and alcohol withdrawal. That's oftentimes referred to as the DTs. And that can include the delirium.

So cause and what it looks like. The causes of excited delirium or agitated state vary. Subjects' presentations, though, are usually very similar. In fact, it often can read just like a script when you look at the event afterwards. The key thing is the lack of training that leads to failure to recognize what's happening.

So the sudden custody death is an unintentional death that occurs while the subject is in custody. Such deaths usually take place after the subject has demonstrated bizarre or violent behavior and has been restrained. There is often no obvious cause of death found during the autopsy. And I can assure you, no agency really wants to have a sudden in-custody death.

The history of these sorts of things, these sudden deaths go back to the 1800s. And there, they were

prescribed as a peculiar form of delirium. Then in the early 1900s, there were deaths that were occurring in psychiatric hospitals. Okay? They might have been called institutions or other names, but they were oftentimes defined as exhaustion due to mental excitement.

In 1946, they more clearly identified it, and they put it as a sudden exhaustive death in excited maniacs. There wasn't any treatment, by the way, back in those days to deal with this excited delirium, and death was a common outcome. A study in 1952 described the onset symptoms, the same symptoms that we're seeing today. So the problem really continues. We see it in some mental institutions, in some nursing homes and hospitals, or other places where restraint is necessary.

Hey, John, this is Greg.

Yes.

I think you might be talking about this, but what's really changed in the '80s? I've heard people talk about deinstitutionalization as being one of the major contributors. Perhaps you're going to get to that and talk a little bit more about it.

Sure, that's a great question, Greg. What has changed is the development of the psychotropic medications that are administered in the hospital settings. Haldol is a common one that we hear. Ketamine is another one that is actually even a little bit more popular these days to treat excited delirium. But those drugs didn't really come into play until the '50s. And that's what made it safe for hospitals to actually release those patients, because they had their psychotropic medications and they were able to then function fairly normally, without experiencing that risk of excited delirium.

Now, we have, in the more modern era, since the '70s, had a re-emergence of this type of death. And that will be more commonly caused by stimulant drug use or abuse. And we also recognize it where somebody maybe is, again, living with mental illness and have prescribed medications, and for whatever the reasons, they have stopped taking their medications, and that triggers that reaction.

So how can excited delirium kill? Well, the body can only do so much before it literally gives out. Under normal conditions, the brain sends a signal to the body to stop or calm down as it nears exhaustion. We've all been there, okay? For a person that's experiencing excited delirium, they don't get that signal. They don't get that safety mechanism. And they override it, and they push totally past it to a total state of exhaustion, which, again, can be a fatal medical condition that would be very difficult to reverse.

The importance, of course, is recognizing these behaviors as they start so that you can activate EMS,

because when you see it, you'll recognize it. You'll understand it is a medical emergency. So some of the behaviors include bizarre, violent, aggressive behavior. And not necessarily directed at you, but oftentimes at inanimate objects, such as glass or mirrors. I've certainly seen that.

A person usually is overheating. They have excessive sweating, and their body will just-- you can just see it is overheating. Oftentimes, that's what leads to the public disrobing. Sometimes completely, sometimes partially. There have been instances where people have broken into a place and they're discovered in a shower, taking a shower, sometimes with their clothes on, sometimes off, in their attempt to cool themselves.

We also had one in Appleton where a man went into the river in an attempt to cool himself. Extreme paranoia also comes as a sign, and incoherent shouting or guttural, animal-like sounds with very heavy, pressured speech. You'll hear that in the video that we show. Go ahead.

Can I ask a question? How often, and maybe if you could talk a little bit about what are the most common kind of misreads from law enforcement and first responders that haven't had this kind of training or are aware of excited delirium disorder? How are they misrecognized? How might we be responding that isn't helpful?

Well, when you look at the initial slide there of behaviors, an officer, if they're called or if they observe this, somebody taking their clothes off, somebody breaking glass, having violence towards objects, they might think that they're under the effects of drugs or alcohol, okay? So initially, that would not necessarily jump out as being excited delirium. It's just that when they start to look at the rest of the signs and symptoms that they then are able to connect the dots that it's something more than that.

Some of those other things would be this really irrational physical behavior. It might be that there have been instances where the person is eating their feces and smearing it all over their body. That's obviously really irrational physical behavior. They have that hyperactivity. There is a sense when they have their eyes extremely wide open that gives them kind of a bug-eyed look. And then their fight or flight response, their sympathetic nervous system is not controllable. And so they will start and stop and do things that, again, are irrational.

They also might display unbelievable strength, punching through walls or bending things that you just would not think possible. And they seem very undistracted or unfazed by any type of pain that they might be experiencing, as well. So a typical 911 call will be a man perhaps standing in the street

partially naked, acting, again, very unusual. The person will usually try to resist if an officer were to engage them quickly.

And if a struggle would incur, then more officers would get involved. We in the police business oftentimes refer to that as the polyester pig pile, because that type of swarm is one way to get control of someone. But usually, a lot of times, people get hurt. Then when physical restraints get applied, then, all of a sudden, you see that struggle continue. It escalates, and then the person might be transported. But unfortunately, what happens then is that there's this apparent resolution, where the subject slips into calm or maybe even unconsciousness.

Oftentimes-- and I can say from experience-- there are people that fake that pretty well, and they want to see what your reaction will be. And so that's why an officer might think that the person is faking. Then you look at labored or shallow breathing, and sadly, again, because it's undetected, an unexpected death. And when the death occurs, even in the care of paramedics or at a hospital, resuscitation fails, oftentimes because those dominoes have fallen just too far.

John, we have a couple of questions or comments from people, and I wondered if you could comment on those. The first one is an officer who's been on the street quite a bit says it sounds like PCP or intoxicants, similar to some of the behavior we might see on the street. And then the other comment was, have bath salts contributed to this, to see a rise in this disorder or these kinds of behaviors?

We can say yes to both of those. And you know, the angel dust, the PCP can also trigger delirium. And the use of bath salts, of K2, we have an attachment to this training, which is a list of videos that a person can go see later. And a couple of examples-- one that says Riverside Cemetery-- is bath salts or K2. And so for sure it can be brought upon by drugs, okay? But it's not always going to be that, but that is a distinct possibility, yes.

Thank you.

You bet. So what is the history of sudden custody death and police tactics? Because let's face it, it's kind of like the hot potato, whoever gets left with it gets the prize, right? And so for law enforcement, if we transport someone to jail and then the person dies at the jail, the jail gets blamed, Okay, if they're in the police custody and they die, the police get blamed. If they're at the hospital, the hospital gets blamed. But in reality, oftentimes in excited delirium, this is something that was probably occurring all through that chain of custody.

So in the '70s and '80s, they wanted to put it on chokeholds being the cause of death. In the '80s and

'90s, they were looking at hog ties, where the legs are secured. And also, for people that are left perhaps on their stomach, where it's positional asphyxia. In the '90s, the thought was that the pepper spray was the thing that was causing the deaths. And since the development of the taser in the 2000s, the taser was oftentimes blamed, the electronic control device was blamed for the death. Because it's difficult to detect that this is the cause, excited delirium, oftentimes that blame is still out there as being the cause.

Some of the excited delirium cases that are increasing are because, as some of our viewers have mentioned K2 and bath salts, PCP, cocaine, methamphetamines. Those are street drugs. Sadly, during this pandemic, we've certainly seen more of some of those activities going on. We have also a significant rise in people with mental health disorders that are not necessarily fully connected to their medical care. And that makes it difficult right now getting access to medications, for example, getting to the doctor so that you can get your prescription renewed. That's a challenging thing. Okay, so we are seeing more incidents along these lines. And the problem, honestly, is probably going to get worse before it gets better.

So in-custody deaths, many that die in custody suffer from one or more medical conditions that can contribute to their mortality. Some may have a high level of drugs in their body. Some may have a mental health crisis. We've certainly seen-- and this is post-mortem-- we've seen people that had both. Okay, they were self-medicating their mental health challenges with street drugs. And so their condition became very challenging. And when they were confronted and restrained, death can result.

The important thing is early recognition. The aspect-- and I think I did see in the roster, I think I saw that there were a few dispatchers in the listing of attendees. Dispatcher training is really critical. Okay, the dispatchers-- and you'll hear that in the video that we show-- the key questions need to be asked during that call. Okay, and we're getting to that in a moment. They want to gather that, and then they want to repeat those words that are used to describe the condition of the individual. And it might even lead to a simultaneous dispatch of EMS and law enforcement, which could actually save time.

So you can imagine the call coming into dispatch, and they say there's this guy acting strange and he's running in circles. That doesn't really tell us a whole lot, just a little bit about his behavior. But you want to try to ask a little bit more. You want to draw out more of the behavior. You know, what do you mean by strange? Everyone's got a little definition difference there.

What specifically is the individual doing? And if they're using things like strange, well, is it bizarre? Is it

violent? Is it aggressive? You know, if someone were to start shadowboxing with a tree. Okay, that would be a good description. Okay, if they're starting to smash something, like glass or windows, that would be violence towards objects that you'd want to describe.

The incoming call to dispatch would include, you know that attack or breaking of glass, the overheating, the public disrobing, the paranoia, you know, someone that's really looking around and acting just really aggressive, the incoherent shouting or grunting, animal-like noises-- you'll hear that in the video that we show-- and then the unbelievable strength. Again, undistracted by any type of pain they might be experiencing, and very irrational. Go ahead.

John, I was just going to say, someone asked about what if someone's behaving in a claustrophobic way? All of a sudden they are experiencing or describing symptoms of being claustrophobic. Is that something to pay attention to?

Well, that could be an anxiety attack. Okay, that maybe is triggered by something that's going on. Some people truly do have claustrophobia, or fear of tight spaces, you know, and so that could be more of an anxiety attack, you know if they're not overheating, if they're not directing anger towards something. But it's still is a mental health crisis. And so it would still be something about trying to calm the individual before going hands on, if you can avoid that.

Thank you. And one other kind of related question. A question came in about how might traumatic brain injuries or brain imbalance-- I'm thinking they're talking maybe about some kind of psychological disorder-- how are those people represented in this, and is there any research on that, if those are contributing factors or things to be concerned about?

The two types of mental illness-- and it is coming up on a slide, the very next one, actually-- that it's been most commonly observed would be bipolar disorder and schizophrenia. And someone with a traumatic brain injury might be more prone to regular seizures, more so than they would delirium. But I'm not going to say it's impossible, but it's more likely somebody that lives with bipolar disorder or schizophrenia, more so than someone with a TBI.

But a person with TBI, depending upon where their head injury occurred, okay, certainly could do irrational things. Somebody that goes through the windshield of a car, for example, in a car accident, that frontal lobe is going to be damaged, and that is your command center. That's where your inhibitions are. And a person that has that part of their brain damaged might make bad decisions, might make more poor choices. But not necessarily more prone to something like excited delirium.

Thank you.

OK. So the caller would want to be questioned about if there is a drug history, and if they happen to know what type of drug they were using. You know, how much they used it, how often they used it, you know, were they are chronic user. And again, in this video that you'll see, the dispatcher asks about that, and the mother indicates that he used to smoke pot, marijuana, but she's not aware that he's gone on or moved on to any other drugs.

So there also is a question of asking if there is a history of mental illness or psychiatric illnesses. Okay, and again, bipolar disorder, schizophrenia are the two more common ones. They might also be asked if the person is known for taking prescription medications, okay? They might have a seizure disorder, where they would normally take medications to treat that seizure disorder. Okay, and again, if they are not taking it because maybe it's not available or they didn't have it with them or they have just totally stopped taking them, that could be a factor.

And of course, one thing that's really important, too-- and this is something to often take to the emergency room-- is if it is a sudden onset. That is a very common thing, is it is not slow in coming on. This is usually fast in coming on. And if it's a sudden onset. Okay, that's definitely going to be something-- something is going on, something right now is happening, and be along with the medications or lack thereof.

So I think we have another poll. In your jurisdiction, do you have 24-hour access to mental health professionals that can respond with you to the scene or provide support services? Answer yes, no, or unsure.

So John, the answer to the question do you have 24-hour access to the poll results is 46% said yes they do, 30% said no, and 24% were unsure.

All right. Well, that's great to have the mental health or even medical professionals, who are-- oftentimes, EMS is getting a little bit more training in that area-- to have them be able to provide support on the street at the call. I can recall in crisis intervention training having an officer that was from Germany, and he came to America to live here. And he's in law enforcement. And I asked him how their protocols are in Germany, and he said, well, the doctor is on the ambulance. So they always had that level of response. Okay, and he said it made our jobs a lot easier. So maybe that's something that we can look forward to in how we move forward.

So if you suspect someone has excited delirium, you want to, of course, give out those behaviors in

detail, as described by the caller. You don't want to just put it out as a welfare check. You want to put it out as something more than that. You want to try to get a patrol supervisor to respond, if possible, and inquire about EMS. It's not always automatic for a dispatcher-- they may not have the authority to automatically dispatch EMS or fire. They might have to actually have a supervisor or a patrol supervisor, for example, approve that.

And you want to ask about priority response. A siren or the flashing lights could actually enhance, okay, or accelerate the person's behavior. Okay? It might further agitate them. And you want to advise if EMS should approach or if they should stage near the call. And you'll hear many of these things in this video that we're going to show. And of course, if you can keep the caller on the line, that's even better because situations change, and we want to be ready for that.

What should the officers do? Well of course, as soon as they start to see the signs and symptoms, they want to get EMS on the way. Okay, there's absolutely nothing wrong with getting EMS rolling so that you have them coming, instead of maybe making it an afterthought. Okay, there've been many tragic stories about that. You want to avoid confrontation if at all possible. And again, you'll see that in this video.

And you want to contain or isolate that subject as best you can without going hands-on until you're ready to go hands-on. Okay, verbal de-escalation is really important. There's no necessarily any benefit in yelling at the individual. Try talking to them, without getting too close, of course, but you want to redirect. You want to redirect them.

You know, stay away from traffic. Come over here, come on over here into this grassy area. And sometimes, you get compliance. You don't really know for sure, but you certainly want to attempt that. And if push comes to shove, you want to have as many backup officers as possible for your plan B so that, in the event things don't go right, you've got plan B to work with.

So the reality is these bizarre, violent behaviors will often require confrontation and restraint. The restraint oftentimes that makes the problem worse, but without restraint, the EMTs, the medical emergencies cannot treat it. Okay, the person would be too violent. There would be too much risk of injury for everyone. So you have to eventually do the restraint.

That physical control, okay, you can expect will trigger that fight or flight. Rarely have I ever seen it or known it to occur where they go into the freeze mode, okay, but the fight or flight usually is what happens. And you want to get that fight over quickly, again, using a taser if one is available, or some other type of ECD, or the swarm technique.

Okay, pain compliance will not work. Okay, the person is usually oblivious to the pain. And you want to have EMS protocol and transport to the hospital. You want them ready so that, when you do get them in custody, they can move in, scoop them up, and you want to take them to the hospital. Not to the jail, but to the hospital. You want to get that medical clearance.

So we're going to play the video. And just to set it up a little bit, this occurred in Appleton several years ago now. And you'll hear the caller talking to the subject's mom. And she came home and discovered him. And she doesn't have really a complete explanation. You'll hear the dispatcher looking for, again, more information. You'll hear a supervisor recognizing the symptoms that are being described in the call, and his reaction to those things. So now we will put our faith in technology and start this first video.

[PHONE RINGING]

Outagamie 9-1-1.

Hi. Something's wrong with my son. I don't know whether he got-- he's 29. I don't know whether he got onto something. He's very strange.

OK, does he need an ambulance? What are you reporting?

I don't know. He's just talking and talking, and saying he's going to die, and he's making-- like he's on something. I don't know. I don't know.

[SCREAMING IN BACKGROUND]

You hear that?

Does he live there?

Huh?

Does he live there?

Yes.

Has he been drinking?

I just got home a little while ago and took a shower. He was sleeping. I think he must've--

Does he use drugs?

He used to. He hasn't for years. He used to do marijuana. He hasn't for years. I don't know whether-- I don't know. I don't know what's happening.

I mean, he keeps yelling and says he's dying. Does he say anything else?

No, he just says I'm dying, Mom, I'm dying, Mom. And he's sitting there naked. He certainly doesn't do that in front of his mother.

[SCREAMING IN BACKGROUND]

OK, we are dispatching help, OK?

Yeah.

I want you to tell me if he does anything else.

Yeah, he's just kind of sitting on the floor screaming.

[SCREAMING IN BACKGROUND]

But you don't know if he's used any drugs?

I don't know.

OK.

It sure looks like it, but I don't know.

[SCREAMING IN BACKGROUND]

[INAUDIBLE]

[SCREAMING IN BACKGROUND]

9128 and 9218.

9128.

9218.

[INAUDIBLE] complaint. RP's 29-year-old son is acting strange. He's yelling, and does currently not have any clothes on. No weapons. Unknown intoxicants, unknown drugs. He's screaming that he is dying, he's breathing heavily, and has no clothes on. Code 3.

[INAUDIBLE]

Go ahead.

[INAUDIBLE] non-emergency at this point, just a staging area. Give them the behavior signs we have at this point. I'll be on as well.

Can you talk to your caller and just see if he has any past drug history or mental illness history?

9102. The only thing the RP's aware of is he used to use marijuana years ago.

OK. I'm in the area.

10-4.

Hi, it's OK.

As I'm not.

It's OK.

As I'm not.

It's OK.

As I'm not. This is the last heartbeat.

It's OK, it's OK. I understand.

Is it gonna die? But I'm going to, is it gonna die? But I'm going to--

You're OK.

--is I'm going to die.

91 to restrict traffic.

But I'm going--

It's OK. What is his name? Tim?

--to die.

Tim, we need to go to the hospital.

But I'm going to--

9102, have Gold Cross come up to the address. 1033 at this point.

But I'm gonna hear the heartbeat of me saying--

What's his first name again?

Tim.

--oh, I'm going to die.

Tim. Tim.

But I'm going to lay down on the ground--

Can you lay down for me?

--as I'm going to die, but--

Tim.

--I'm going to--

Tim.

--not, and you will understand now, and isn't that fucking weird? But I'm going to--

Tim.

--is I'm going to die, but I'm going to look around--

Tim.

--as if I'm going to die. Shivers are going to kinda go running up my side.

Tim, it's OK. Ma'am, ma'am, ma'am. Get those-- let's put the clothes away, OK? This is a reaction to something, OK? We'll get him to the hospital.

[END PLAYBACK]

At this point, you can see that they're just really sizing up the situation. Dave Nichols is captain when this video, or rather, this presentation was done, but he was a bit of a black cloud. And he had a way of being in the right place at the wrong time. So as it turns out, of course, it was absolutely the right time for this gentleman, because he recognized exactly what was going on.

So he was gathering resources. He had the EMS come up and stage. Okay, and he had, as you'll hear, officers go and cover the backside, okay in the second half of this video. And then they talk about how they want to restrain him. A little-known-- unknown fact is the EMS people that responded, Gold Cross Ambulance Service that is owned by the hospitals in the area, and they use a lot of part time people. And it just so happens that the people that were on the rig that day had not gotten the training.

Okay, but we knew the training well enough. We had been training on excited delirium since 2005, and so we could coach them very easily through the process. So now I'll start the second video.

[VIDEO PLAYBACK]

It's ready?

Yeah.

OK.

They're at the site [INAUDIBLE]

All right. All right, let's move.

Said she saw mushrooms in the yard, so--

Just get on his legs. Lay across his legs there. You want to go on a-- you want to go on a board with him, and then strap him, and then get him out, or what do you think?

I think if we can wrap him in this blanket.

I just don't want him to get free if he--

Yeah. That's right.

Yeah.

Uh, I'm gonna get the scoop stretcher? We can do that.

Sure. As long as we can secure him to--

--the strap. Plenty--

Please and I tap my hand. Please and I tap my hand. Please and I tap my hand. Please and I tap my hand and I--

No, it's OK. Don't fight it.

Please and I tap my hand I fought. Please and I tap my hand I fought. Please and I thought.

We're going-- we're going to get you to the hospital--

Please and I taught!

Relax.

Please, and I last I time I shook it, I taught my-- please, by-- please, please, please. Please, please, please, please, please.

[RAPID BREATHING]

[INAUDIBLE]

Yeah, that's fine.

[GIBBERISH]

No, I'm serious. No, I'm serious. About the--

Like I said that-- like I said if you're--

No, I'm serious!

It's OK.

I'm serious! I'm fucking serious [INAUDIBLE]. No, I love you, Enzo.

It's OK. It's all right. It's all right. We're doing good. We're doing-- we're doing good. We're doing good.

Don't kill me. Don't kill me.

Nobody's going to hurt you.

[INAUDIBLE]

Nobody-- nobody's going to hurt you. Nobody--

[SCREAMING]

Just relax. Lay your head back and relax, Tim. Tim, lay your head back and relax.

[INAUDIBLE] shoulders.

Just we're good, we're good. Tim. Tim, you're all right. Push.

Tim, you're going to hurt yourself.

Tim, put your head down.

I don't want to die, though.

You're not going to.

But seriously.

We're going to go to the hospital, bro.

Seriously, though.

We're going to go to the hospital.

No. [GIBBERISH] No. This is what I'm going to do.

Did that break loose?

[GIBBERISH] gonna die though!

Tim, relax.

Tim, Tim, relax. It's OK. Yes it is.

It's not OK.

It's OK.

It's not OK.

It will be OK. You've got to calm down.

It's not OK.

You gotta calm down. You gotta calm down.

This is gonna die.

No you're not.

This is gonna die.

We're going to the hospital.

This is gonna die. This is gonna die.

We're going to the hospital, Tim. Relax.

No, no. This is gonna die, though. This is gonna die, though.

Remember, your mom's all worried about you. Try to relax and we can help you.

Mom! Don't let them kill me! I love you but this is gonna die though!

OK.

This one! All the meat I've eaten, I forgive myself.

Are we good on those arms?

This is gonna be a minute.

Satisfied?

Mom!

I mean--

Mom, Mom, Mom!

Should I do a handcuff also loose in case--

You're questioning is-- liar. Liar!

All right.

Liar! Liar! Lie all you want! Lie all you want!

Let's get him out of here.

Broke his back with a shovel. Broke his back with a shovel, grab a shovel. We have a shovel in the back yard. Grab a shovel and poke his back out. Mom, grab a shovel, poke his--

You got it? Yep.

They're going to kill you.

[END PLAYBACK]

So you can tell from the video he was exerting a lot of pressure against those straps for the cot. The EMS people originally thought they would-- because the living room was kind of crowded with furniture that they would walk him out. And Captain Nicholas knew that that was probably not a good idea. When that-- they got him in restraints, they didn't want to run the risk of him getting out of those restraints.

And maybe you could also see in the video how the sweat was soaking into the straps that were across his chest. OK, again, the profuse sweating. There are instances of people that actually eviscerated their stomach muscles from their stomach lining wall when they were exerting in an ambulance experiencing excited delirium. They tore the muscles away from the stomach wall while they were doing that.

Okay, again, totally oblivious to it. Not really understanding what they were doing while they were

doing it. So I don't know if we've gotten any further questions with regards to the video,okay, but the important thing is to know that you want to get them transported as soon as you have them into custody. And you want to take them to a medical facility.

Okay, it isn't about taking them to jail, all right? He was given a dose of Haldol on scene, and then he was given two more doses of Haldol at the emergency room. And two hours later, when he came to, okay, he did not remember any of it. And he did not recall anything that he did. He didn't experience any pain, but I'd be willing to bet that he was probably sore or stiff the next day from exerting himself as much as he had.

It's good if you radio ahead to the hospital or call them to let them know that you're bringing in someone with suspected excited delirium so that security and safety precautions can be taken care of before you arrive, okay? And if at all possible, I think EMS would probably prefer that an officer ride in the back of the ambulance. And so that would be my suggestion.

Let me just back up for a second, John, and I think that one of the places to kind of start with this is we were going to talk with Kevin a little bit about any special training for your dispatchers, Kevin, when you were with the Pueblo of Isleta in addressing the excited delirium kinds of cases that come in or calls that come in. And then how did your staff-- yeah, how did you staff support dispatching officers in the field?

Yeah, thank you, Greg, and hello everyone there. And again, I'm Kevin Mariano, project coordinator with the National Criminal Justice Training Center. And yes, so when I was there as the chief, we actually were able to provide some training, whether it be online or in-person training, to train all the staff from dispatchers to the officers and others that were going to be working, whether it be as the call takers, or someone that's out in the field. But we were actually able to work closely with individuals that were dealing with whether it be mental health illness or excited delirium to actually develop a position where we were able to create this position because of the issues that just kind of came upon us. Was kind of surprising with some of the things that were happening within the community.

But the position itself there was to help the officers out in the field, and this position was particularly identified as a police officer case manager. And what this position was created for was to assist those individuals who were dealing with mental health issues and other issues related to that to assist the officers where they didn't have to be tied up on a call if it came down to transporting the individual to a facility. And it was real good to have the training for all the staff there and the officers, because they

were able to identify individuals who were dealing with some type of mental health issue and all.

And what this particular physician would do is they would actually create a referral out to the program that would assist this individual with some ongoing treatment services. So we were able to actually partner up with some other local health providers not only within the community, but outside the community that we could rely on 24 hour, seven days a week services to send these individuals to. And lucky enough that we were able to actually kind of get some bed space at times to help transporting and put the individuals in there where they received their treatment services.

But we knew that at the time, that you know that obviously jail detention wasn't going to be the positive outcome for the individuals, but we were actually able to work with the individuals to provide some type of treatment services as a start to help open them-- helping them get back onto being really good community members and so forth. But with the position, it changed to where a referral was referred into the behavioral health program-- the local behavioral health program for follow-up. And as that was going, we were actually able to move into merging with our reentry individuals that they were able to assist our police officer case manager with some cases that they were working on. So obviously treatment, and training, and all was really helpful to the officers and staff who were working with individuals with mental health issues. Back to you there, Greg.

Yeah, thanks, Kevin. Thanks for that response. John, any comments on what Kevin had to say about his response in Isleta?

You know, I think having the awareness is the number one goal. Okay, that people know that this can occur, and if it does occur, what you're going to do. And I think you have to have, like in Kevin's case, you have to have a plan A and a plan B. And because you don't really know what is going to happen next, and nobody certainly wants for someone to die in custody. And it's a difficult situation to forecast.

Thanks, John. One of the questions we have, have you heard about crisis intervention or triage centers? And if so, can you talk a bit about why they've come about, and what they can do in these situations? And I'll pair that with one of the comments as I'm reading through the comments. We had an officer respond and say, you know, on these kinds of calls, sometimes I get tied up for three, four, five hours on these calls trying to figure out what to do with a person who's demonstrating some of these symptoms. Can you comment on those two pieces?

I sure can. So in some larger communities-- but it's not really limited to larger communities necessarily-- that they have developed a crisis triage center. And really, I always say, you know, I

think I died and went to heaven. Because that would be the ultimate if we had a standalone psychiatric crisis center that could receive walk-in clients through the front door and emergency law enforcement clients to the rear. And could have medical staff in addition to psychiatric staff, and a person could get the attention-- the immediate attention that they often deserve.

Okay, I say that because the emergency room is oftentimes our point of entry to the mental health system of care, but you're competing when you get to the emergency room with all kinds of other emergencies. Okay, broken bones, car accidents, heart attacks. And because oftentimes the emergency rooms are limited, okay, they're going to have to put out the hottest fire just like we do.

Okay, and so that is a challenge. And yes, as one of our participants said, they can be stuck on that call for a long time. And if you have a standalone psychiatric crisis center, oftentimes you can hand that patient off, and then you don't have to stay. And so it frees up resources. Certainly that arrangement can be made at an emergency room as well as long as the hospital has their own security and they have enough of it to be on standby in the event that somebody is needed.

But yes, you can find yourself tied up on the call, and oftentimes you might end up having to stay until that person is medically cleared. And that could take a few hours. For this case, the man that you saw in the video, that was Psilocybe mushrooms that he had gotten through the mail. And so he was on a psychedelic, and that was going to take a little while for that to clear. And so yes, you could find yourself at the hospital for that time.

That's great, and thanks for the explanation. That's been several questions in the question box, which is, was it determined what Tim was on?

Yep, mushrooms. They went with mom and you know, checked, because we wanted to know what it could possibly be. And mushrooms were found in his bedroom, and mom did not know how long he'd been using those or when he got them. So she really didn't have any prior knowledge to that experience.

So that's what it was in that case, and the other video that I mentioned in the list of documents for video resources, the one that says Riverside Cemetery, that one was K2. And it's just as bizarre of behavior, disrobing. But thankfully, again, got compliance because we didn't rush the person. We didn't trigger their sympathetic nervous system response.

Your question there about the officer being tied up, and this was one of the concerns that we had with-- we came into a situation where we had officers, and depending on the size of your agency

department, sometimes you're kind of stretched with the officers being in the field. So we were having some calls that we were tying up officers, and that was one of the reasons for creating this position where it was identified as the police officer case manager.

But that officer was able to actually come in and, well, was on call pretty much 24/7 to assist the officers in the field. And they would be assigned to that person that they're dealing with throughout the whole call, whatever time it took. So it helped out the officers in the field when we actually created the position itself there.

That's great, Kevin. John, I know that these questions are kind of popping in. I wanted to make sure that we're close to being done with the final presentation, and then we'll move into the formal question and answer period, and I've got more for you. So I'll turn it back over to you for a second and then come back with questions and answers.

Great. So, you know one of the things as you transport to the hospital, you know, you've got EMS there. Some people have asked during these presentations, well, what if it isn't excited delirium? The fact is, you have nothing to lose, okay? So they got an ambulance ride. Worst case scenario is they lived another day.

Okay, but if it had been excited delirium and you had not activated EMS, you very likely would have that in-custody death. And again, once those dominoes start falling, it's very hard to reverse that circumstance. And that early intervention, the administering of Haldol or ketamine, again, whatever your medical director authorizes, whatever your paramedics are trained with, okay, they have to start doing those things quickly. Okay, and they can't do that until you have that person safely in custody.

So I think that wraps up the presentation portion, Greg.

OK, thank you, John. We're now going to move to the question and answer portion of the webinar. If you have questions about today's webinar, please submit them now via the question box in the GoToWebinar control panel. Questions are seen by webinar staff only, and confidentiality will be maintained.

So John, with that, I have several questions that I've been pulling as we've been talking as you've been giving your presentation. One of the questions was related to Tim, and do you know how long his excited delirium situation lasted and stayed pretty critical? And what can people expect in those kinds of situations?

I think that if I recall correctly, his excited delirium was probably about an hour in length to the point

where then it was being chemically controlled through the use of the Haldol. Again, they gave him some on scene, and then they administered two more doses in the emergency room. And so it took quite a while for them to fully bring him out of that you know, drug-- maybe drug overdose might be one way to look at it.

And so he had about an hour's worth, maybe a little bit more. And we're thankful that they have on the rig those medications. Of course, Narcan is very common as a drug that we now carry in law enforcement, homeless shelters, places like that. We're not going to have Haldol, but the ambulance rigs will. And so we're getting better prepared for these types of events.

Thanks, John. Someone asked, why have a police officer in the ambulance? What's the importance of that and the rationale behind that?

Well, you've got to imagine that the paramedic technician, and there's only going to be one in the back, is busy monitoring vitals, perhaps following other procedures that the hospital is going to dictate. And so they really can't be distracted by him maybe exerting himself against his straps. You know, one of the comments, and you maybe have heard it in the video, is, is that strap going to break?

And Dave, Captain Nichols said, you know, why don't we put a handcuff on one of the wrists in the event he does come loose that we can handcuff it, then, to something else. And so I think that that is probably to make the EMS technician feel more comfortable in focusing on what they need to do, and we are there to protect both the person that's being strapped down as well as the ambulance staff. So that's why that is suggested. It's not always possible, okay, but if it is possible it's a good idea to do it.

Thanks, John. We've got a couple more questions. One of the questions was, are corrections staff in your experience trained to help address this in facilities, or does it require hospitalization? And kind of related to that, does the CIT training that people are getting around the country, does it help with figuring out best responses in your community to dealing with people with excited delirium or similar kinds of disorders?

OK, so first of all, corrections needs to have the awareness so they can see the onset. We had an excited delirium that occurred in the jail, but the subject had swallowed his drugs, okay, his crack. Okay, and what happened is as that got into his bloodstream, he went into a state of delirium.

But they saw it in the early onset, and they activated EMS. That person's going to have to be transported. You know maybe there are some jail facilities around the country that have full time

medical staff that can intervene, but in most cases, it's going to be activate EMS and figure you're going to transport that person out of the jail. But the important thing is that the corrections staff need to have that training.

With regards to CIT training, excited delirium is commonly incorporated into the curriculum. Okay, and I can only really speak about Wisconsin for certain. Okay, and that's with regards to both the corrections training and law enforcement training. But the whole goal of having CIT Is the community collaboration that it comes together to bring that training and to collaborate to do early interventions.

In other words, if mental health has a client that doesn't show up for his monthly injection, a CIT officer should be notified so that the CIT officer can do an early intervention and get that person reconnected to mental health services. In the past, without CIT, that person would have just been checked off as a missed appointment. And whatever happens happens. And the question is, why do we want to wait for that? We don't.

Okay, so having that community collaboration means we start talking about different scenarios, things like excited delirium, that could occur. And we collaborate in advance to develop good protocols and responses. So yes, they do go hand in glove with the CIT training.

So thank you, John. That's actually a really good segue into another question we received, which is, basically we're a small department with two officers on duty at a time, and the nearest hospital's an hour away. It sounds like maybe putting something together like CIT training and bringing the professionals together to problem solve and look at resources might be a good idea for jurisdictions that have challenges like that.

Yes, there are counties in Wisconsin that do not have any hospitals. Okay, everybody that they encounter that has a medical emergency is going to be transported to the next county over, and those drives are, you know, like the question, you know, you're looking at about an hour. You can still have a protocol in place, and obviously the goal is to get EMS coming sooner, okay-- as quickly as possible because you have that longer transport time.

So again, it is about building the partnerships, having crisis, having the dispatch center, and having you know, each county-- in most states, each county has a medical director. And having those meetings and doing a tabletop exercise. What are we going to do if we have this incident occur? What is going to be the best protocol?

There are states that rely on even air ambulance, helicopter for example, because you can't get there quick enough by car. But by air ambulance, by helicopter, you can. And so in some places, they actually have done those table type exercises and concluded that an aviation response is the best way to deal with it. So yes, talking about it before it happens is the best way to do it.

Thanks, John. We had a question, if you encounter someone like this, is it common in departments to have in their protocol to use Narcan first or while EMS is responding because we don't know what's causing it? Will that cause any harm, or is that a direction that departments are--

Well, I'm not a medical professional, so I really can't speak to trying the Narcan first. We know that Narcan is relatively safe. They're lower dose, and, you know, certainly officers have been recipients of Narcan when they think that they may have come in contact with some type of substance and they're having a reaction.

And so it doesn't harm you to have it, but I guess I would not fall back on that as being a primary response. I think I would get EMS coming and wait for EMS's arrival if possible, okay? If the person were to you know, collapse, then I think as a last ditch effort maybe perhaps you would consider using the Narcan. But you know, the Narcan that's issued to law enforcement is really supposed to be for law enforcement, so I'm not going to try to second guess what your policies or your procedures are. I think that is a great question for the medical director in your region.

So as people are developing responses to potentially excited delirium or similar kinds of cases, having that collaboration through a CIT or other partnerships, getting some guidance from the medical people about what might be the best evidence-based best practice protocol is the place to go?

Yes.

Thanks. So we have a few more questions. Let's see here. One of the questions was-- back to Tim's scenario-- was the conversation the officers were trying to engage with, Tim, was that helpful when someone's in a psychotic or excited delirium state, or is it not helpful, or the recommendations around that?

You know, it seemed to work, right? It didn't necessarily make any sense, but it seemed to work. And it also, you know, as it turns out, certainly showed that law enforcement was doing what they could do. You know sadly, I mean, if Tim had expired or died from this, the body camera video would show that law enforcement was supportive. And that's what certainly the goal is.

And it's funny, but, you know, when he suggested that he was going to lay down on the floor, you know, that probably was quite a relief to Dave that he was willing to do that without Dave having to direct him to the floor. Okay, and so that all worked out very well. So I don't think that having those conversations is bad. You really don't know how much they're hearing, how much their, you know, auditory exclusion could be starting to overcome them. But I still think it's good to go ahead and have those conversations, yes.

Thanks, John. Question, are there implications for policies that are connected to use of force with respect to responding to excited delirium and the medical response that you indicated? So are departments struggling with that and how to respond? Do you have any comments on that?

That is a great question. Okay, and that is one that I have encountered in doing these trainings. And I had a lieutenant who said that-- from another agency-- who said, well, you know, I'm sorry, but if we use a taser, we have to take them to jail. And I asked him, you know, how come? He said, well, that's how we have it written in policy is that deployment of a taser is a use of force, and it would result in criminal charges.

And I said, well, think about what the taser is. I said, it's an electronic control device. I said, if you are electronically controlling this individual so that you can safely take him into custody for medical treatment, I said, you know, I think you could skip the arresting part. Okay, and so honestly, the lieutenant, he said they had never really thought about it. And so I sent him to Appleton Police Department use of force, because we do talk about in the policy we talk about the ECD as a control device.

Okay, and they very quickly amended their use of force, and so that is a great question. That's totally spot on. Because again, we may have seemed that we're really using it to get somebody into custody for an arrest, but in fact, we might be getting them in custody for medical emergency response. So that's a great question, and the policy could easily be amended to cover that.

And John, is that something that people were to email NCJTC or you, do you have some sample policies or best practices out there that you could share with departments?

I most definitely can do that. Whichever place they email, if it comes to me, I can certainly provide some sample policies to cover that, yes.

Thank you. We have a question coming in about can officer contact actually trigger an excited delirium episode, and precautions around that, being aware of that?

Well, I guess the question is, would it accelerate it? You know, the triggering is already happening chemically, okay? And, it's just to what level that person's sympathetic nervous system is going to engage. Okay, is that throttle just going to be halfway down, or is it going to go all the way to the floor?

And we know that from experience that once you go hands-on and you go to restraint, okay, that usually puts that gas pedal down to the floor, okay? But having calm conversations, having you know, a nonviolent posture, not closing in too closely, prematurely, okay? Those things definitely delay that triggering of the sympathetic nervous system.

And the person, you know, if you don't press them, they may actually just pass out, you know, at that point. Again, the dominoes are already started to fall. So there's really not any way externally for us to look at that individual and say, well, he's got about three minutes left. Okay, we're not going to know, but we know that we'd used calm talk and we avoid cornering the individual until it's time to go hands on where the plan A and plan B being EMS is ready to assist.

And so yes, to a certain degree, we can trigger it. But probably not through conversation, okay? Maybe yelling, screaming, that type, yes. That could trigger it. But engaging them in discussion, trying to calm them down, I don't that's going to make anything worse, and I think that our experience is that only thing that makes it worse is when we go hands on.

Thank you, John. We have a question. In a government study, I read recently that officers were trained to physically restrain people with excited delirium by placing them in a prone proposition with pressure on their upper back. To speak quietly, is this still being trained, and is this the best response?

I'm not familiar with that training protocol. I know that when we certainly utilize a taser to get someone into custody, we are going to, you know, handcuff them to restrain them. But we are also then put them into the recovery position and usually have them seated. And then we're going to get them onto a cot, and they're usually going to be on their back. Okay, and so I'm not familiar with a medical protocol that described that sort of thing with pressure on the back like that.

Thanks, John. And for the person who asked that question, if you'd like to send us that site, send it to the NCJTC email. We'll certainly look into that and get you a more comprehensive response. So John, I think I have another question for you, which is, when a person's in this state, are they in control of their behaviors? And are those who assault officers or others typically violent people, or is this directly related to the excited delirium?

I don't think that they have complete and total control. In other words, they're kind of along for the ride. They might be able to have some sort of control, but in most cases they don't recall the event. And so my thought is that a lot of it is just is a sympathetic nervous response. And whatever is going on inside their head, they may not have any control over that.

Thanks. And another question is, is this more of a male disorder than a female disorder?

I've never seen any evidence of that. But I'll be honest, I've never seen or read any reports of any females in excited delirium. I know that in the psychiatric hospitals they had both male and female, but it was predominantly male in the hospital setting. But the patients were predominantly male.

So that's a great question. I've never seen a study that indicated if one sex was more prone to having it than the other. It's a great question.

Thanks, John. And a question about do we see more excited delirium kinds of cases in homeless populations, maybe because of substance abuse or mental illness? Can you comment on that?

Sure. Well, since I've retired, I actually work with the homeless population. And I think that there is a possibility that we could see more. The homeless population doesn't necessarily have as good of a system of care. Yow know, they don't generally have a family doctor. They don't generally eat as well as the average person does.

So they have a lot of health challenges, which to me would mean that if they had an incident of excited delirium it would probably have a greater risk of being fatal than the average person. But, you know, yes, a high percentage of people that live with homelessness live with psychiatric disorders such as PTSD and depression. But, you know, I can't think of any right now in the Appleton area. All of the people that we had excited delirium cases with were housed. They were not homeless. And so surprisingly, I guess, no. I don't think that they have a higher risk.

Thank you. And I think a final question, does excited delirium disorder, does this happen in children? And if so, what age of onset and similar kinds of symptoms is the question.

I think that there is certainly a possibility of it happening in children. The brain starts to mature by the time we are in our late 20s and early 30s, and we most commonly see the average age of mental illness emerging at around 14 years of age. So, you know maybe young adults, adolescents. I'm sure chemically it's possible that it could happen in younger children, but I've not ever encountered again, a record that that's the case. But I would think that all of the elements are there for it to occur.

Thanks, John. I think we're going to close out the question and answer portion. I wanted to throw it back to you and Kevin for any final comments.

I want to thank everyone for participating and for the great questions. You know, Kevin, you know, how you were able to get that community collaboration to problem solve things like that, that's a great example of collaborating to solve problems.

Thank you, Greg and John. A lot of good questions were asked and all that. And if there's anything else that we can do, please contact the National Criminal Justice Training Center. But as far as what we were able to develop where I was working at, it was really a lot of support not only in using the police department, but other programs as well as kind of getting that buy-in from these other programs and how they're going to support the program.

And we were actually able to develop a mental health plan for the officers to use out in the field. And the case manager, officer case manager, was able to use this form to as a referral to refer out to other programs that we're going to be assisting along the way here. But a lot of time and effort developing this was really grateful for what was accomplished and all that. But something that really worked in the community and really helped out quite a bit with mental health and excited delirium.

But thank you to all, and stay safe, and back to you, Greg.

Thanks, Kevin. I want to thank everyone. This is going to conclude our question and answer portion.

In closing, we'd like to share brief information on additional training and technical assistance opportunities. NCJTC is a training and technical assistance provider for a coordinated Tribal Assistance Solicitation Purpose Area 3 grantees and non-grantee tribal agencies focused on implementing system-wide strategies to address crime issues related to alcohol and substance abuse in tribal communities. We are also a TTA provider assigned to assist tribal comprehensive opiate, stimulant, and substance abuse program grantees focused on developing, implementing, or expanding comprehensive efforts to identify, respond to, treat, and support those impacted by illicit opiates, stimulants, and other drugs of abuse.

TTA services for both programs include customized on-site and virtual training, regional trainings, conferences, webinars, peer to peer support, on-site or virtual meeting facilitation, written resources, community planning, justice system collaboration, and sharing grantee best practices. For additional information on general TTA services, links to the featured offerings, and to request TTA, please visit our program website as it's shown on the screen for more information.

Please follow the on demand link to view upcoming webinars and our robust library of webinar recordings and self paced online training opportunities. Another valuable resource is the COSSAP resource center. A screenshot of the COSSAP resource center is shown here, along with a web link.

Featured resources include funding opportunities, COSSAP grantee site profiles with a data visualization tool, information about demonstration projects, peer to peer learning, and recordings of all previous webinars covering a range of substance use disorder related topics and strategies. Of particular significance is the ability to request training and technical assistance, or TTA, whether you are a COSSAP grantee or not. The COSSAP TTA program offers a variety of learning opportunities and assistance to support local, tribal, and state organizations, stakeholders, and projects in building and sustaining multidisciplinary responses to the nation's substance abuse crisis.

For more information, you can contact COSSAP program at cossap@iir.com. Thank you again to our presenter, John, and to Kevin for your excellent presentation today and sharing your time and expertise. Thank you all for attending, and have a wonderful day.