Provincial Clinical Practice Guidelines

G01: Behavioural Emergencies

BC Emergency Health Services

Provincial Health Services Authority

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Related Policy	Least Restraint
Date	January, 2026
Purpose	To provide a consistent procedural approach to the management of Medical Behavioural Emergencies
Scope	Applies to all British Columbia Emergency Health Services (BCEHS) clinical staff
Setting	Pre-hospital assessment and treatment
Population	Paediatric and adult patients
Author	BCEHS Practice and Learning Department
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Disclaimer

The content of this guideline is expressly intended for use by qualified BCEHS clinicians when performing duties during the delivery of patient care, and on behalf of BCEHS.

Introduction

The purpose of this Clinical Practice Guideline (CPG) is to outline recommendations for the management of patients experiencing a behavioural emergency by paramedics and Emergency Medical Responders operating within the British Columbia Emergency Health Services (BCEHS). This CPG applies to both paediatric and adult patients. It is not directly applicable to the inter-facility transfer (IFT) of behaviourally compromised patients but shares the same fundamental concepts that govern the principles of least restraint, consent and decision-making capacity.

Behavioural Emergencies

Behaviour that places the patient, the EMR/paramedic and other first responders or the public at immediate risk of harm.

These guidelines address the following:

- Assessment of the patient experiencing a behavioural emergency,
- The severely agitated patient,
- Medical management principles for behavioural emergencies,
- Guidelines for de-escalation techniques,
- Definitions of restraint,
- The legal framework and policies guiding the management of the patient with a behavioural emergency,
- Guidelines for the application and use of restraints in clinical practice.

Assessment of the patient experiencing a behavioural emergency

It is important to recognise that when responding to an event where a patient is experiencing a behavioural emergency, an initial behavioural risk assessment of the situation should be conducted to determine the potential harm to the EMR/paramedic, patient, or bystanders.

The use of standard terminology and a risk assessment that can be understood by all responders is important to maintain continuity, safety and clear communication between all public service agencies on scene. An assessment should only involve the observation of the patient's behaviour and response to de-escalation efforts. Potential causes and attempts to diagnose should not occur at this stage.

In the context of behavioural emergencies, "agitation" refers to a state of excessive psychomotor activity and/or heightened excitability, often accompanied by restlessness, irritability, and potentially violent behavior.

Rapid decision-making, differences in training and the need for communication between medical and non-medical agencies pose unique challenges within the dynamic pre-hospital environment, making the direct application of sedation and agitation scales impractical. The use of a rapid **Level of Agitation Assessment** can be carried out using an observational-based approach that does not require patient cooperation or participation.

Level of Agitation	Behaviour
Severe	Violent, aggressive, danger to self and others Attacking objects or people Not redirectable Not responsive to verbal de-escalation
Moderate	Physically or verbally threatening No danger to self Extremely active Difficult to redirect
Mild	Agitated Signs of overt physical and verbal activity Redirectable
Calm	No agitation Non-threatening

The severely agitated patient

A patient presenting with a severe level of agitation represents a high-risk situation requiring a coordinated response that prioritises medical treatment as well as responder and public safety.

An **Agitated Medical Emergency (AME),** previously called Excited Delirium Syndrome (ExDS) is an extreme form of behavioural emergency. This syndrome is characterised by **severe agitation** and often presents with physical hyperactivity, hyperthermia, exceptional strength, endurance, disordered thought and extreme aggression.

The **cardinal features** of an AME are:

1. **Pain tolerance.**
2. **Constant or near-constant activity.**
3. **Lack of awareness of surroundings and first responder presence.**
4. **Exceptional strength.**
5. **Rapid breathing.**
6. **Not tiring despite heavy physical exertion.**
7. **Naked/inappropriately clothed.**
8. **Sweating profusely.**
9. **Hot to the touch (i.e., tactile hyperthermia.**
10. **Aggression towards inanimate objects (e.g., windows, glass).**

This is a **medical emergency** and as such the agency of jurisdiction is BCEHS. This is an important distinction, as severely agitated and aggressive patients will require some use of force both in the prehospital and in-hospital setting. Although infrequent, these are potentially volatile events that require a coordinated, medical and law enforcement response to achieve assessment, treatment and transport.

The patient experiencing an AME has an increased risk of metabolic and physiologic collapse which may result in sudden and/or unexpected death.

A detailed initial medical assessment of a patient exhibiting combative, agitated and/or violently aggressive behaviour may not be possible. In these circumstances paramedics should not approach the patient without the presence of law enforcement.

If law enforcement has not yet arrived, the decision to remain on scene should be agreed upon by both paramedics and first responders. (*see Paramedic Safety at Scene*)

Plan your approach to the patient to ensure you have a safe exit route so you can leave the area promptly if necessary

Do not approach a patient that has a weapon or access to a potential weapon

Request assistance from law enforcement if a weapon is present or if you are threatened or are concerned about your safety

If deemed unsafe to remain, EMRs and paramedics should:

- relocate to a safe area away from the hazard and remain staged.
- Contact dispatch and/or supervisor to advise them of the situation and your assessment of the hazard.
- Await the arrival of law enforcement.
- Confirm it is safe to approach before re-engaging with the patient.

(*see Right to refuse unsafe work*)

Only if/when it is safe to conduct, patient assessment should include the following:

- Credible history of the event from reliable sources such as family, care givers and others who may be present at the scene
- Past medical history
- Social history
- History of drug/alcohol use
- Physical assessment
- HR, RR, BP,
- Temp, BG, SpO_2

Medical management principles

EMRs and Paramedics should assess for an underlying medical component to the exhibited behaviour and consider the potential for life-threatening causes.

Medical conditions including hypoglycaemia, hypoxia, hypercarbia, head trauma, encephalopathy, meningitis, encephalitis, seizures, electrolyte abnormalities, acute delirium, and dementia
Acute Mental Health conditions including anxiety, schizophrenia, bipolar disorder, anti-social personality disorder, depression, and psychotic disorders.
Substance Toxicity from substances such as hallucinogens, stimulants, alcohol, ketamine, LSD, or other drug toxicity
Situational such as overwhelming stress, grief, or pain.
Behavioural disorders which may include an exacerbation of an existing intellectual disability, impulse control disorders, neurodivergence such as autism or ADHD, and acquired brain injury.

Factors that should be considered include:

- Abnormal vital signs
- Focal neurological findings
- Decreased awareness of surroundings
- Difficulty maintaining attention
- The absence of obvious triggers
- First time event

Paramedics and EMRs remain responsible for the treatment of underlying conditions even if the patient is in restraints. The absence of abnormal findings should not lead the EMR or paramedic to make a conclusion that it is safe for law enforcement to transport the patient.

The focus **must be** on ensuring safe **ambulance** transport to a medical facility for further assessment and diagnosis as the clinical condition of a patient experiencing a behavioural emergency can change quickly. Frequent and ongoing assessments **must be** performed when considering the need to maintain any form of restraint for the purpose of transport.

Attempts to apply de-escalation should be a collaborative approach between law enforcement and medical personnel. However, **the behaviour of the patient and scene safety will dictate which agency performs critical incident de-escalation**.

The principles of management should include the use of the following **de-escalation** techniques where possible:

- Respect personal space
- Do not be provocative
- Establish verbal contact
- Be concise
- Identify wants and feelings
- Listen closely to what the patient is saying
- Identify areas upon which to agree
- Set clear boundaries and limits
- Offer choices and optimism
- Evaluate the outcome of de-escalation

If verbal de-escalation fails to achieve an appropriate response, the EMR or paramedic needs to consider the use of restraint to achieve ongoing treatment and safe transport.

Once initiated and in place, restraints may be continued in the absence of law enforcement for the purposes of safety during transport.
Remember: The clinical condition of a patient experiencing a behavioural emergency can change quickly. Frequent assessments and clinical judgement should be applied when considering the need to maintain any form of restraint during and for the purpose of transport.

Definitions

Restraint is a physical, mechanical, pharmacological, seclusion or environmental measure used to control the physical or behavioural activity of a person or a portion of their body.

Least Restraint is the use of the least restrictive restraint for the shortest duration of time and only when all other options have been exhausted.
(*see Least Restraint Policy*)

Physical Restraint is the act of using one's body to physically restrain or impede another person's movement.

EMRs and Paramedics should only apply physical restraint as a last resort to defend themselves against unpredicted harm.

Mechanical Restraint is a method of restraint involving the use of authorized equipment. A mechanical restraint restricts the freedom of movement or access to one's own body that it is attached to, adjacent to, or worn by the patient and that the patient cannot remove.

EMRs and Paramedics should not initiate any mechanical restraint without the presence of law enforcement when in the prehospital environment unless personal safety requires them to do so.

Environmental Restraint is any barrier or device that limits the movement of an individual and thereby confines an individual to a specific geographical area or location.

Pharmacological Restraint is a pharmacological agent given to control sudden aggressive or violent behaviour representing a serious risk of harm to self or others.

When a drug is used to treat specific medical or psychiatric symptoms and is part of a treatment plan, it is not considered a restraint.

The application of a medication to the restrained patient for comfort and pain relief is not considered a form of pharmacological restraint.

Medication administered by the paramedic to provide sedation is a form of pharmacological restraint and must be considered as a component of a least restraint approach

Substitute Decision Maker (SDM) is defined under the Health Care Consent Act as the person(s) authorized to give or refuse consent to treatment on behalf of a person who is incapable with respect to that treatment. Prior documentation is not required to determine an SDM, and the Act provides priority in the order of: spouse, adult child, parent, adult sibling, grandparent, adult grandchild, adult relation by birth or adoption, close friend, immediate relation by marriage ("in-laws").

Legal framework

The principle aim of management of a patient with an MBE is to reduce the risk of harm to the patient or others by using the least restrictive means possible.

The use of restraints may only occur within the following legal framework in the absence of:

- Patient with decision-making capacity and their consent,
- Patient with impaired decision-making capacity and the consent of the patient's substitute decision maker,
- Patient with impaired decision-making capacity and imminent risk of harm; **no consent required.**

Capacity to consent is determined based on the capacity to fully understand the treatment and possible consequences of treatment. Informed consent and discussion of rationale for treatment should be documented.

Where consent is being sought, paramedics have a duty to take reasonable steps to be satisfied that the patient or substitute decision maker has understood the appropriate information, particularly where there is a language barrier, emotional issues, questions of mental function, or a history of trauma.

Paramedics are entitled to presume capacity unless there are reasonable grounds to believe otherwise (e.g. something in a patient's history or behaviour raises questions about their capacity to consent to the treatment).

Minors: The capacity to consent is based on maturity, not chronological age. A minor is considered capable of consenting or refusing

treatment (**mature minor)** if the physical, mental and emotional development of the minor will allow for a full appreciation of the nature of the consequences of the decision. (*see: Consent of "Minors": Infants Act*)

BCEHS Policy considerations

In accordance with the **BCEHS Least Restraint Policy**, restraints must only be used in the following situations:

Under the Mental Health Act, at the direction of a Physician

When a patient has been apprehended by the police or similar legal enforcement.

In circumstance when considered necessary to maintain public or personal safety or when a paramedic's safety is in question.

When a safety issue is identified prior to transport and the patient is capable and willing to provide their consent to restraint for the duration of the journey.

BCEHS supports a philosophy of least restraint that recognizes the individuality of the patient, the patient's right to freedom of movement, and the patient's right to self-determination.

Placing a patient into mechanical restraints represents a significant suspension of their rights and as such paramedics must ensure that such action is justifiable.

A restrained patient must not be placed nor transported in the prone position. (*see: BCEHS OPS 220 Positioning of Restrained Patients Before and During Ambulance Transportation*)

Paramedics should be aware of the potential for medical complications if physical restraint and incorrect positioning are used before and during ambulance transport.

Restrained patients are also at risk of injury from direct pressure on areas of their body and the physical exertion they expend while struggling against restraint.

The use of pharmacological restraint may lessen the need for mechanical restraints and is therefore aligned with the BCEHS Least Restraint Policy.

When considering the use of restraints, paramedics are asked to weigh their decisions against the principle of beneficence (doing good) and non-maleficence (avoiding harm) to ensure the patient's well-being.

Paramedics should also consider the social and cultural impact of restraint on a patient and their family and have regard for the following concepts and philosophies of care within both BCEHS and the wider healthcare system:

Trauma informed practice should be incorporated into all patient care situations with the intent of understanding the prevalence, impact and roll that trauma may have on a patient's emotions and behaviour. An understanding of the ways in which trauma changes an individual's neurobiology, emotional regulation and capacity for adaptive social functioning is specifically relevant when faced with behaviours associated with restraint.

Cultural safety is a patient-centered approach that aims to create a safe and respectful environment for all patients. It involves recognizing and addressing power imbalances that exist between the healthcare provider and the client. Restraints create an automatic power imbalance once applied.

Cultural Humility requires the care provider to acknowledge themselves as a learner when it comes to understanding the patient's experience.

Child/youth centred care relies on treatment that is developmentally appropriate and focuses on individualised care that involves the child/youth as an active participant in the decision-making process whenever possible.

Family/caregiver focused care is based on the philosophy that care involves a partnership between the patient and their family (the recipients of care) and those delivering care.

Guidelines for the application and use of restraint in clinical practice.

BCEHS recognises that the decision to restrain a patient is complex and challenging and, can create an ethical and clinical practice dilemma for those providing patient care. This can have an emotional impact for paramedics, who are asked to make this decision in emergent situations without full knowledge of patient's history or underlying causes of the behaviour.

The over-arching principle in all restraint use is to provide a safer environment in which care can be provided while protecting the patient, providers and public from further harm.

Proper documentation is crucial when using restraints and is essential for ethical and legal protection. BCEHS requires ALL patient encounters to be fully documented

General Principles:

- Create a safe environment for the patient,
- Remove bystanders and unnecessary persons,
- Create a reactionary gap of a minimum of two arm's lengths distance between you and the patient,
- Demonstrate safe body language,
- Proceed with verbal de-escalation.

The volatility of the scene is unpredictable, and the Paramedic may or may not be the most appropriate point of verbal contact for the patient.

Consider as part of the management plan:

- Verbal de-escalation may already have been initiated - only one responder should establish and maintain verbal interaction,
- When available, the use of a mobile integrated crisis response (MICR) team who can assist with a behavioural management and mental health crisis,
- When appropriate and available, utilize the services of a **BCEHS Indigenous Cultural Advisor**
- Request ACP and/or CCP back-up to support ongoing care and sedation. **All sedated patients must be conveyed to an emergency department for observation**.
- Maintain communication with the BCEHS Clinical Hub for ongoing consultation with:
    - Paramedic Specialist,
    - CCP-Advisor, ITT-Advisor,
    - EPOS.
- **Comprehensive documentation:**
    - Observed behaviour,
    - Clinical assessment findings,
    - Reasons for restraint,
    - Alternative interventions attempted,
    - Restraint procedure and duration,
    - Patient's response to the restraints
    - Vital signs and interventions.
- Advanced notification to receiving facility:
    - Patient's behaviour,
    - Reason for restraint,
    - Type of restraint.