Excited Delirium, Ketamine Use and Death During Police Restraint

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As medical director for AAPL, I represent AAPL on the American Psychiatric Association's Council on Psychiatry and Law (CPL). CPL performs many functions for the APA including writing Position Statements and Resource Documents. CPL is also asked to provide consultation for other APA groups including the Assembly. At times CPL is asked to provide input to APA Government Relations regarding legislation that might be relevant to the APA.

In April 2021 CPL was informed that APA had been asked to give input to proposed legislation from Colorado Representative Joe Neguse's office to ban the non-hospital use of ketamine during arrest and detention for federal offenses. Representative Neguse has filed the bill in the House of Representatives as the Ketamine Restriction Act. (1)

The bill was generated after the death during arrest of 23-year-old Aurora, Colorado resident Elijah McClain in August 2019. Mr. McClain, a black man, was 0.3 miles away from his home when someone called 911 saying a person who was wearing a ski mask was walking down the street, was waving his arms and "looked sketchy." Several police officers arrived. There was no evidence of a crime and no weapon. Within one minute police attempted to restrain Mr. McClain using handcuffs and then bilateral carotid holds. Paramedics were called. Mr. McClain was in obvious medical distress. The paramedics protocol allowed them to administer ketamine after they diagnosed excited delirium in the field, without consultation with a physician. Paramedics than administered 500 mg of ketamine. Although Mr. McClain weighed 140 pounds at autopsy, paramedics administered a ketamine dose for a 200-pound person, 50% more than should have been administered based on the protocol and body weight. Mr. McClain went into cardiac arrest and died several days later. (2)

Ketamine is a dissociative anesthetic that is an analog of PCP. It is sometimes recommended in the emergency medicine literature, but not the psychiatric literature, to treat acute agitation. UpToDate gives the following caveats for ketamine use in such situations: "While the use of ketamine for agitation is increasing, caution is needed until higher-quality evidence confirms the safety and effectiveness of this approach," and "Evidence suggests that ketamine can provide more rapid sedation than benzodiazepines and haloperidol, but its use may be associated with more complications including the need for endotracheal intubation." (3)

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The concept of excited delirium entered the literature in 1985 when Wetli and Fishbain first used the term in an attempt to explain sudden death in users of cocaine. (4) In 2009 the American College of Emergency Physicians published a white paper on their organization's Task Force on Excited Delirium. The Task Force Consensus Opinion was that Excited Delirium was "a real syndrome of uncertain etiology. It is characterized by delirium, agitation, and hyperadrenergic autonomic dysfunction, typically in the setting of acute on chronic drug abuse or serious mental illness … The risk of death is likely increased with physiologic stress. Attempts to minimize such stress are needed in the management of these patients. Ideally, any necessary law enforcement control measures should be combined with immediate sedative medical intervention to attempt to reduce the risk of death. Sedation with various medications, including ketamine was a recommended treatment." (5)

Excited delirium has been used to explain in-custody deaths during police restraint and after Taser use. (6) Excited delirium is taught by police trainers as causing subjects to cause greater risk of physical harm to police officers because, "the usual tactics to detain a subject often don't work and the potential exists for the struggle to be elongated" and that persons with excited delirium are "far more violent than drunk subjects." (7)

EMS protocols around the country allow paramedics to administer ketamine in the field, without direct medical supervision after making a diagnosis of excited delirium. EMS services in Aurora, Colorado had such a waiver with many caveats including that agitation that is not thought to be "due to an underlying medical or psychological etiology" should be managed by police and that EMS personnel should not "engage in restraining people for law enforcement purposes." (Ref. 2, p. 67) Despite this caveat, ketamine was used to sedate Mr. McClain.

Citing an inadequate initial investigation that cleared responding police officers and EMTs, the Aurora City Council commissioned an independent investigation. The results of the investigation were highly critical of police behavior and found as well that the paramedics who administered ketamine did so without attempting to appropriately assess Mr. McClain and injected an inappropriately high dose of ketamine. (8)

In contrast to the American College

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of Emergency Physicians position both the APA (after extensive discussion by CPL) (9) and the AMA (10) have endorsed policy statements stating that current evidence does not support excited delirium as an official diagnosis; that denounce attempting to justify police use of excessive force solely by an excited delirium diagnosis; and that state drugs like ketamine should not be used exclusively in a law enforcement setting as an intervention for an agitated individual without a legitimate medical reason and without appropriate supervision.

Mr. McClain's family has sued the City of Aurora and others in Federal Court under 42 U.S.C. § 1983 alleging multiple civil rights violations (Ref. 2, pp. 74-102). The case is currently in settlement negotiations.

After investigative reporting by the *Hartford Courant* in 1998 inpatient medical and psychiatric seclusion, physical and chemical restraint practices came under close scrutiny. (11) Although initially resisted by practitioners, the increased regulation and oversight generated from the investigations led to improved inpatient practice and better patient care. (12) I hope that the increased scrutiny of ketamine used as a chemical restraint by paramedics in the field will also lead to regulations that will improve patient outcome and eliminate in-custody deaths in restraint.

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Committees: The Backbone of AAPL

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Those who have read issues of this Newsletter in recent years may have a fair idea of how the organization works. Articles by the President, Executive Director, Medical Director, and Newsletter Editor not infrequently include discussions of the mechanics of AAPL's operations, or descriptions of components such as the Executive Council. AAPL Committees have been mentioned, and members encouraged to join, in those articles and in other pieces in these pages as well (see the Fellows' Corner in this issue, for example). Yet some may still be unclear about AAPL's Committee structure. What are these Committees, and what exactly do they do?

The first thing to understand about AAPL Committees is that they are actually of three types, as specified in AAPL's bylaws: Standing, Special, and Administrative/Member Services. The Standing Committees are critical for the day-to-day operations of the organization. They are the Budget, Education, Ethics, Membership, and Nominating Committees, along with the International Relations Program. The Committees falling in the Administrative and Member Services category include the Association of Directors of Forensic Psychiatry Fellowships, the Bylaws Committee, the Awards Committee, and the Rappeport Fellowship Committee, as well as the Editorial Board of AAPL's *Journal*.

The purpose of each Standing or Administrative Committee can be understood simply by looking at its title. In addition to them there are the Special Committees, which have now grown to 31. Most of these cover subtopics of interest within the field of forensic psychiatry, although a couple, such as the Maintenance

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