The Acutely Agitated Patient

(Project BETA and how it might just help you deal with patients better)

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UNIVERSITY *of* CALIFORNIA, SAN DIEGO
MEDICAL CENTER

A personal note…

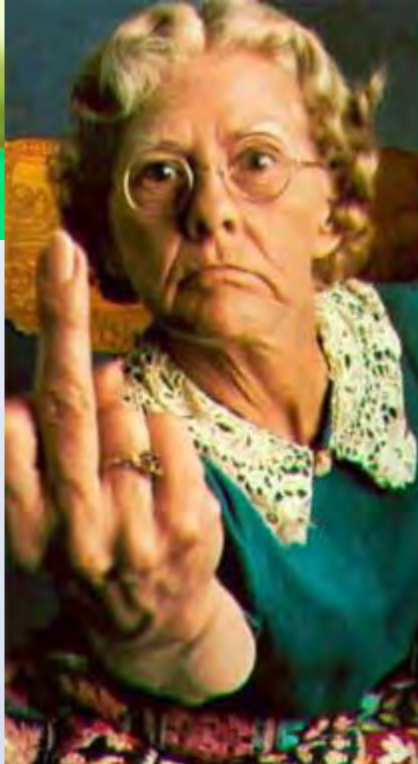
54.5%

There are no financial relationships with any drug mentioned in this talk.

American Association for Emergency Psychiatry

Agitation in the ED

The agitation you might see…



So how should we treat agitated patients?

Project BETA

- In October 2010, AAEP embarked on Project BETA.
  - Challenge: to develop new guidelines that were effective, safety-minded, and in best interests of the patient.
  - Over 35 emergency psychiatrists, emergency medicine physicians, mental health clinicians, nurses, and patient advocates participated.
  - Mission was to develop and disseminate guidelines that represent **B**est practices for the **E**valuation and **T**reatment of **A**gitation.

Project BETA

Available for **free** reading/download:

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Western Journal of Emergency Medicine

A Peer-Reviewed Professional Journal

BEHAVIORAL EMERGENCIES: BEST PRACTICES IN EVALUATION AND TREATMENT OF AGITATION

1 **Overview of Project BETA: Best practices in Evaluation and Treatment of Agitation** (Editorial)
GH Holloman Jr, SL Zeller

3 **Medical Evaluation and Triage of the Agitated Patient: Consensus Statement of the American Association for Emergency Psychiatry Project BETA Medical Evaluation Workgroup** (Review)
K Nordstrom, LS Zun, MP Wilson, V Stiebel, AT Ng, B Bregman, EL Anderson

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26 **The Psychopharmacology of Agitation: Consensus Statement of the American Association for Emergency Psychiatry Project BETA Psychopharmacology Workgroup** (Review)
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35 **Use and Avoidance of Seclusion and Restraint: Consensus Statement of the American Association for Emergency Psychiatry Project BETA Seclusion and Restraint Workgroup** (Review)
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GW Currier, D Litts, P Walsh, S Schneider, T Richardson, W Grant, W Triner, N Robak, R Moscati

51 **Impact of the Mental Healthcare Delivery System on California Emergency Departments** (Original Research)
A Stone, D Rogers, S Kruckenberg, A Lieser

PERSPECTIVE

57 **Life in the Inner City**
SD Docherty

CAL/AAEM California Chapter · CALIFORNIA ACEP · ACOEP The American College of Osteopathic Emergency Physicians

Through **PubMedCentral** or Bing
"Agitation BETA"

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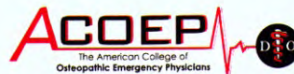
CALIFORNIA ACEP

AMERICAN COLLEGE OF EMERGENCY PHYSICIANS

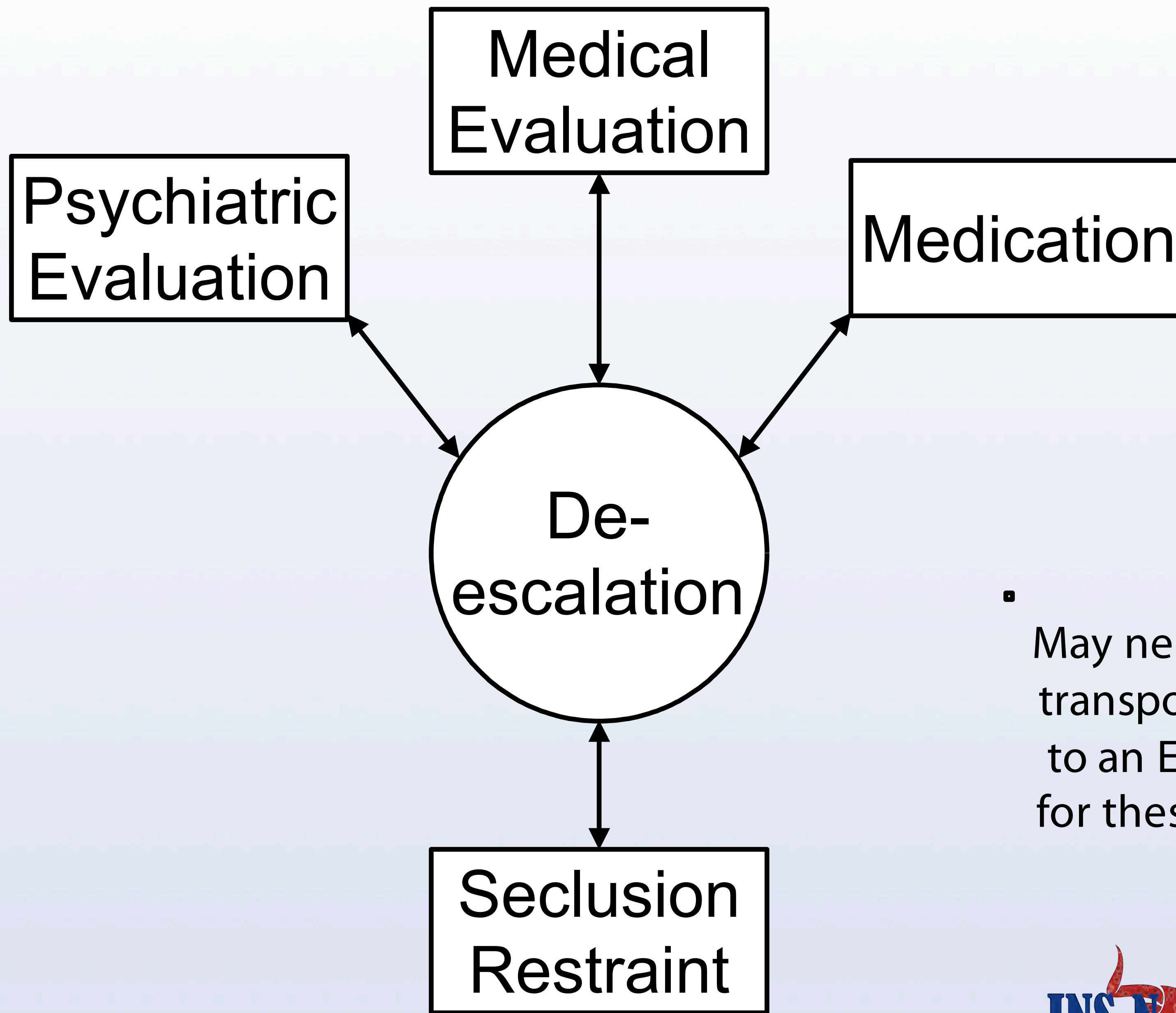


Project BETA articles are among the most downloaded articles in the history of the *Western Journal of Emergency Medicine*.

Stories about Project BETA have appeared in *Emergency Medicine News*, *Psychiatric Times*, *Psychiatric News*, and many other publications.

Selected Guidelines

- **Use verbal de-escalation**
- **Staff should be appropriate for the job**
- **Oral medications instead of IM**
- **Reduce seclusion & restraint**



- May need transport to an ED for these!

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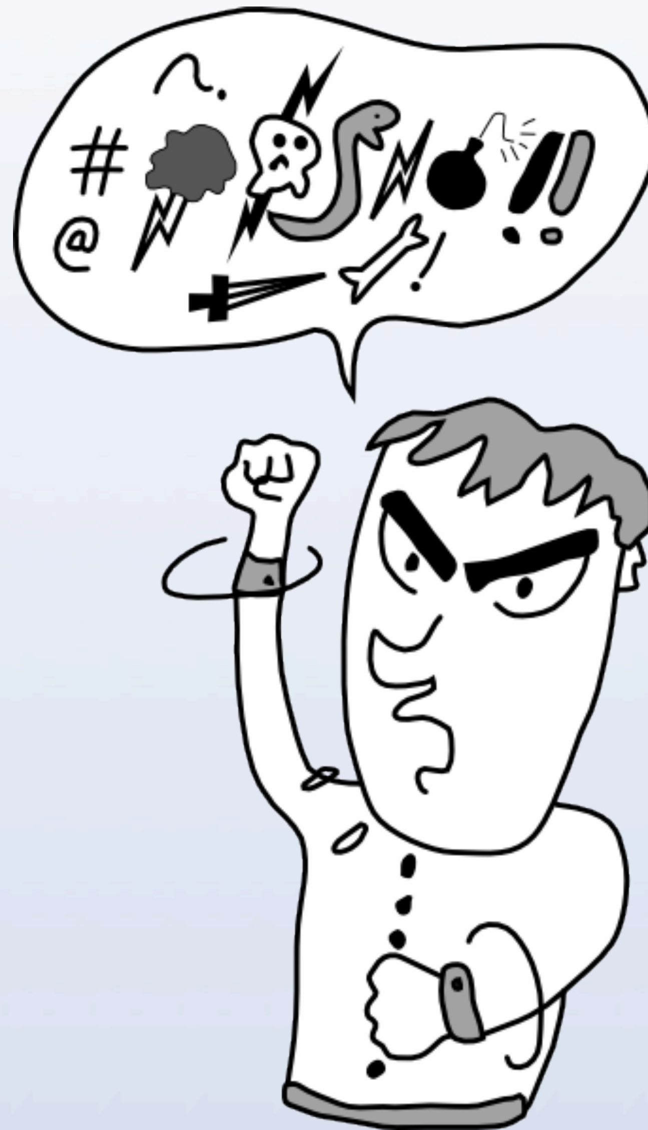
National Academy of Infusion Therapy
Dallas, TX November 6-8

Guideline: verbal de-escalation



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Verbal De-escalation

- Goal is to help the patient regain control
  - While engaging in verbal de-escalation, clinician observations & medical judgment must drive management
  - Successful de-escalation is the key to avoiding seclusion/restraint
  - Most injuries to staff occur during restraint

BETA recommendations: verbal de-escalation

I You shall be non-provocative:

- calm demeanor, facial expression
- soft-spoken with no angry tone,
- empathic - genuine concern
- relaxed stance- arms uncrossed..
  …hands open..knees bent

II You shall respect personal space

- 2x arms length
- Normal eye contact
- Offer a line of egress
- expand space if paranoid
- Move if told to do so

III You shall establish verbal contact:

- tell them who you are,
- establish you are keeping them safe,
- you will allow them no harm
- you will help them regain control
- ONE COMMUNICATOR

Richmond JS, et al. Verbal de-escalation of the agitated patient: Statement of the American Association for Emergency Psychiatry Project BETA de-escalation workgroup. West J Emerg Med. 2012; 13(1):17-25.

BETA recommendations: Verbal de-escalation

IV You shall be concise:
- use short phrases or sentences
- repeat yourself, repeat yourself
- Get the patient's attention..don't confuse

V You shall identify their wants and feelings

VI You shall lay down the law:
- set limits
- offer choices; propose alternatives
- establish consequences
- use positive reinforcements

VII You shall listen:
- Don't argue
- Don't up the ante
- Listen and agree
- Check understanding

VIII You shall agree or agree to disagree

IX You shall have a moderate show of force and be prepared to use it

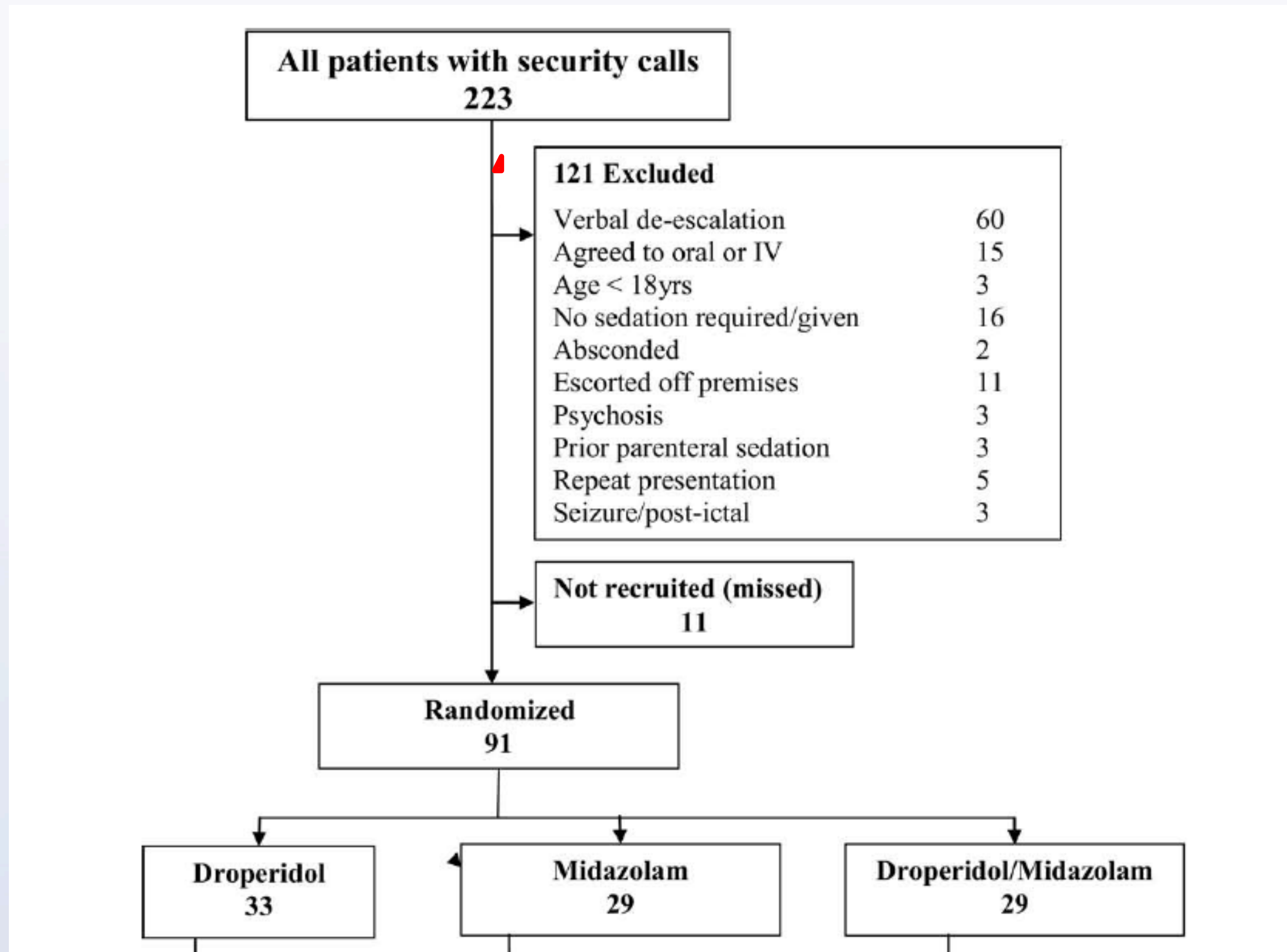
X You shall debrief with patients and staff

Richmond JS, et al. Verbal de-escalation of the agitated patient: Statement of the American Association for Emergency Psychiatry Project BETA de-escalation workgroup. West J Emerg Med. 2012; 13(1):17-25.

Courtesy of Scott Zeller, MD

Do verbal techniques work for all patients?

Do verbal techniques work?



Isbister GK, et al. Randomized controlled trial of intramuscular droperidol versus midazolam for violence and acute behavioral disturbance: The DORM study. Ann Emerg Med. 2010; 56392-401.

Case study:
So what about this guy?

- Ethics
  - If a patient a danger to themselves/others and incapable of making decisions, may medicate involuntarily
  - Otherwise, this is assault
- Practicality
  - If severely agitated, they're probably too agitated to start an IV safely
  - You'll need other people to hold them down

Case study

- Must be urgently deescalated
  - Verbal de-escalation while security being called
  - Should be offered medication orally first

- Medical evaluation
  - Since signs of overt trauma
  - Should be transported in safest way (for him & staff) possible

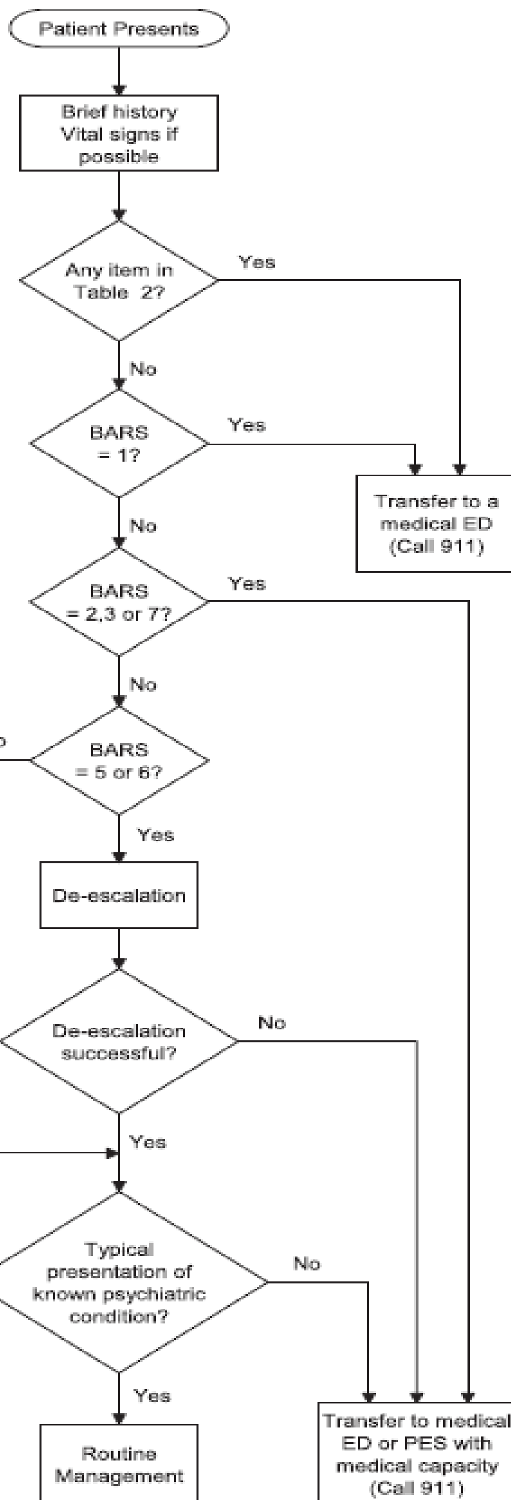


Table 1. Behavioural Activity Rating Scale.[4]

1 =	Difficult or unable to rouse
2 =	Asleep but responds normally to verbal or physical contact
3 =	Drowsy, appears sedated
4 =	Quiet and awake (normal level of activity)
5 =	Signs of overt (physical or verbal) activity, calms down with instructions
6 =	Extremely or continuously active, not requiring restraint
7 =	Violent, requires restraint

Table 2. Findings that require immediate evaluation by a clinician.

Symptoms
Loss of memory, disorientation
Severe headache
Extreme muscle stiffness or weakness
Heat intolerance
Unintentional weight loss
Psychosis (new onset)
Difficulty breathing
Signs
Abnormal vital signs: pulse, blood pressure, or temperature
Overt trauma
One pupil larger than the other
Slurred speech
Incoordination
Seizures
Hemiparesis

Nordstrom K, Zun LS, Wilson MP, et al. Medical evaluation and triage of the agitated patient: Consensus statement of the American Association for Emergency Psychiatry Project BETA Medical Evaluation Workgroup. West JEM. 2012; XIII(1):3-10.

Guideline: Staff should be appropriate for the job: Attitudes

- Inadequate education/preparation
- Societal attitudes/personal biases
- Organizational climate
- Safety concerns
- Crowding
- Caregiver lack of confidence in skills & experience
- Lack of guidelines

ENA: Care of psychiatric patient in the emergency department. https://www.ena.org/practice-research/Aresearch/Documents/WhitePaperCareofPsych.pdf. Accessed July 5, 2015.

Staff Attitudes about Suicide

- " Suicidal behavior appears to elicit mostly negative feelings among staff members…"
  - If not acknowledged and properly handled…may lead to premature discharge…justified by statements 'he is not really suicidal'"
  - "It is important task for staff members is to contain and work through negative feelings towards patients."

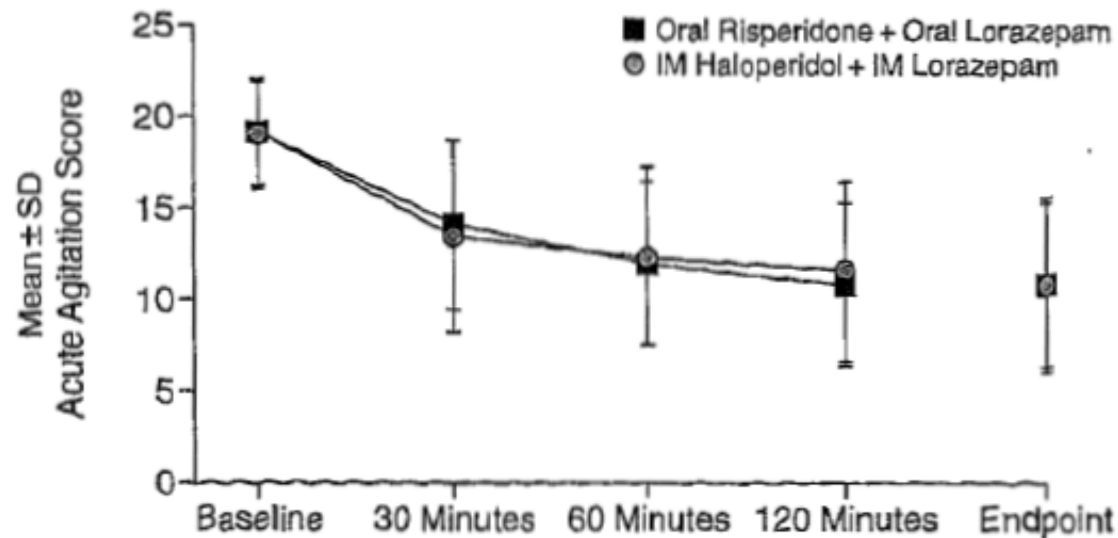
Rossberg, JI, Frills, S: Staff members emotional reactions to aggressive and suicidal behavior of inpatients. Psychiatr Serv. 2003;54(10):1388-1394.

Guideline:
Oral over IM when possible

BETA recommendation: oral medications over IM when possible

- Control agitation as rapidly as IM
  - despite slower time to peak plasma concentrations
- No risk of needlestick
- Less risk of oversedation
- (probably) fewer side effects

Oral medications work quickly



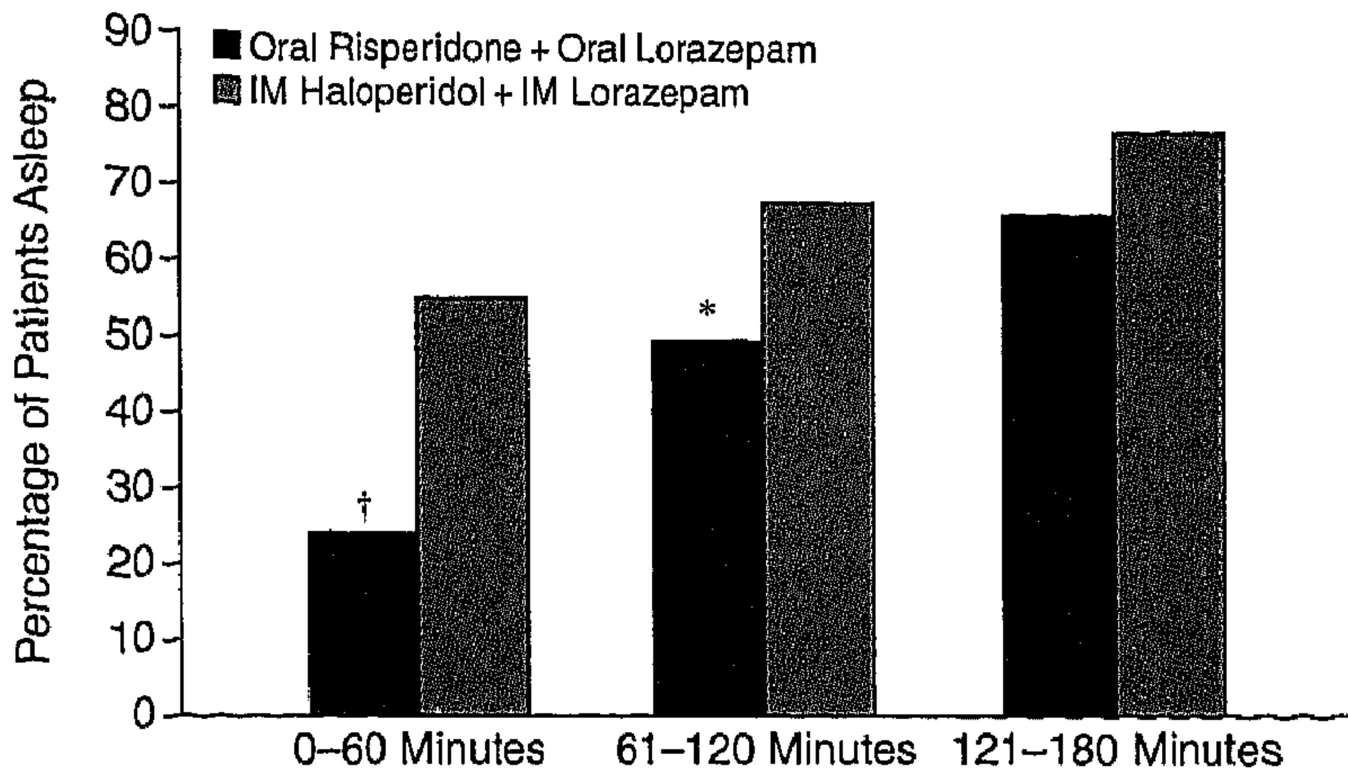
Currier GW, et al. Acute treatment of psychotic agitation: A randomized comparison of oral treatment with risperidone and lorazepam versus intramuscular treatment with haloperidol and lorazepam. J Clin Psychiatry. 2004; 65; 386-394.

Oral meds work just as quickly

Author	Trial design
Currier, et al. (2004)	Prospective, parallel group, randomized, rater-blinded. Multi-center.
Currier, et al. (2001)	Prospective, nonrandomized, rater-blinded, double -arm. Informed consent not required, but willing to accept oral meds.
Hatta et al. (2008)	Pseudorandomized, open-label, flexible dose, Multicenter. Informed consent after treatment, but willing to accept oral meds.
Hsu et al. (2010)	Prospective, randomized, rater-blinded.
Kinon et al. (2004)	Prospective, randomized, double blind, multicenter.
Lejeune et al. (2004)	Open-label, active controlled, Multicenter. Patients allowed to choose their own group.
Lim et al. (2010)	Prospective, randomized, open-label, rater-blinded.
Normann et al. (2006)	Prospective, open-label study. Since observational only, no informed consent required.
Pascual et al. (2007)	Naturalistic, prospective, open-label. Informed consent after treatment, but willing to accept oral meds.
Turczynksi et al. (2004)	Naturalistic, prospective, unblinded, open-label, multicenter, nonrandomized. Willing to accept oral meds.
Veser et al. (2006)	Prospective, randomized, placebo-controlled, doubleblind.

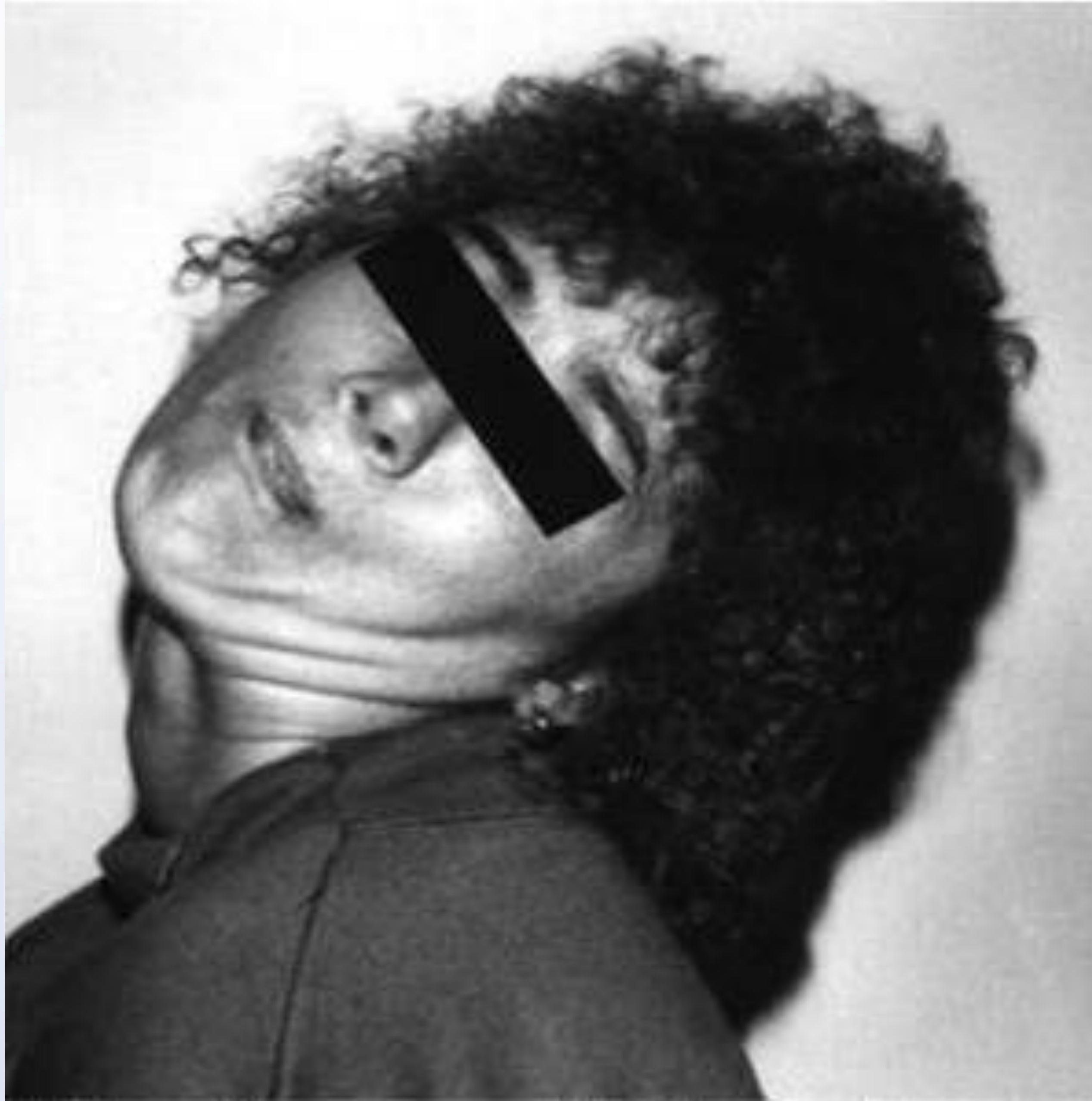
Gault TI, Gray SM, Vilke GM, Wilson MP. Graded Evidence-based Medicine Summaries for the Journal of Emergency Medicine (GEMS for JEM): Are oral medications effective in the management of acute agitation? J Emerg Med. 2012;43(5):854-9.

Figure 6. Percentage of Patients Receiving Oral or Intramuscular (IM) Treatment Who Were Sleeping for the First Time at 0 to 60, 61 to 120, and 121 to 180 Minutes After Admission



*p < .05 vs. IM treatment.
†p < .001 vs. IM treatment.

Currier GW, et al. Acute treatment of psychotic agitation: A randomized comparison of oral treatment with risperidone and lorazepam versus intramuscular treatment with haloperidol and lorazepam. J Clin Psychiatry. 2004; 65; 386-394.



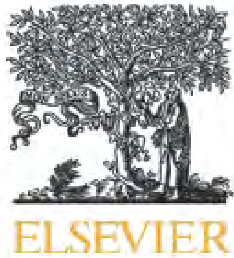
Slide courtesy of www.medscape.com

BETA recommendation: IM SGA over FGA

- Similar efficacy
  - Haloperidol can cause dysphoria; patients often complain of the way it makes them feel later
  - Fewer side effects (unless EtOH)
  - Probably less sedating than haloperidol/lorazepam

Lambert M, et al. Subjective well-being and initial dysphoric reaction under antipsychotic drugs—concepts, measurement and clinical relevance. Pharmacopsychiatry. 2003; 36(suppl 3):S181–S190.

Karow A et al. What would the patient choose: subjective comparison of atypical and typical neuroleptics. Pharmacopsychiatry. 2006;39:47–51.



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journal homepage: www.elsevier.com/locate/ajem

The American Journal of Emergency Medicine

Original Contributions

Lengths of stay for involuntarily held psychiatric patients in the ED are affected by both patient characteristics and medication use

Michael P. Wilson, MD, PhD [a,b,*], Jesse J. Brennan, MA [a,b], Lucia Modesti, MD [b], James Deen [a], Laura Anderson [a], Gary M. Vilke, MD [a,b], Edward M. Castillo, PhD, MPH [a,b]

[a] *Department of Emergency Medicine Behavioral Emergencies Research (DEMBER) lab, University of California San Diego, San Diego, CA*

[b] *Department of Emergency Medicine, University of California San Diego, San Diego, CA*

Accepted Manuscript

Prolonged Length of Stay in Emergency Department Psychiatric Patients: A Multivariable Predictive Model

Mark B. Warren MD, Ronna L. Campbell MD, PhD, David M. Nestler MD, Kalyan S. Pasupathy PhD, Christine M. Lohse, Karen A. Koch MSN, RN, Eduard Schlechtinger, Scott T. Schmidt DO, Gabrielle J. Melin MD, MS

The American Journal of Emergency Medicine

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Accepted date: 26 September 2015

2015
Infusion Therapy
vember 6-8

Precautions when using SGAs

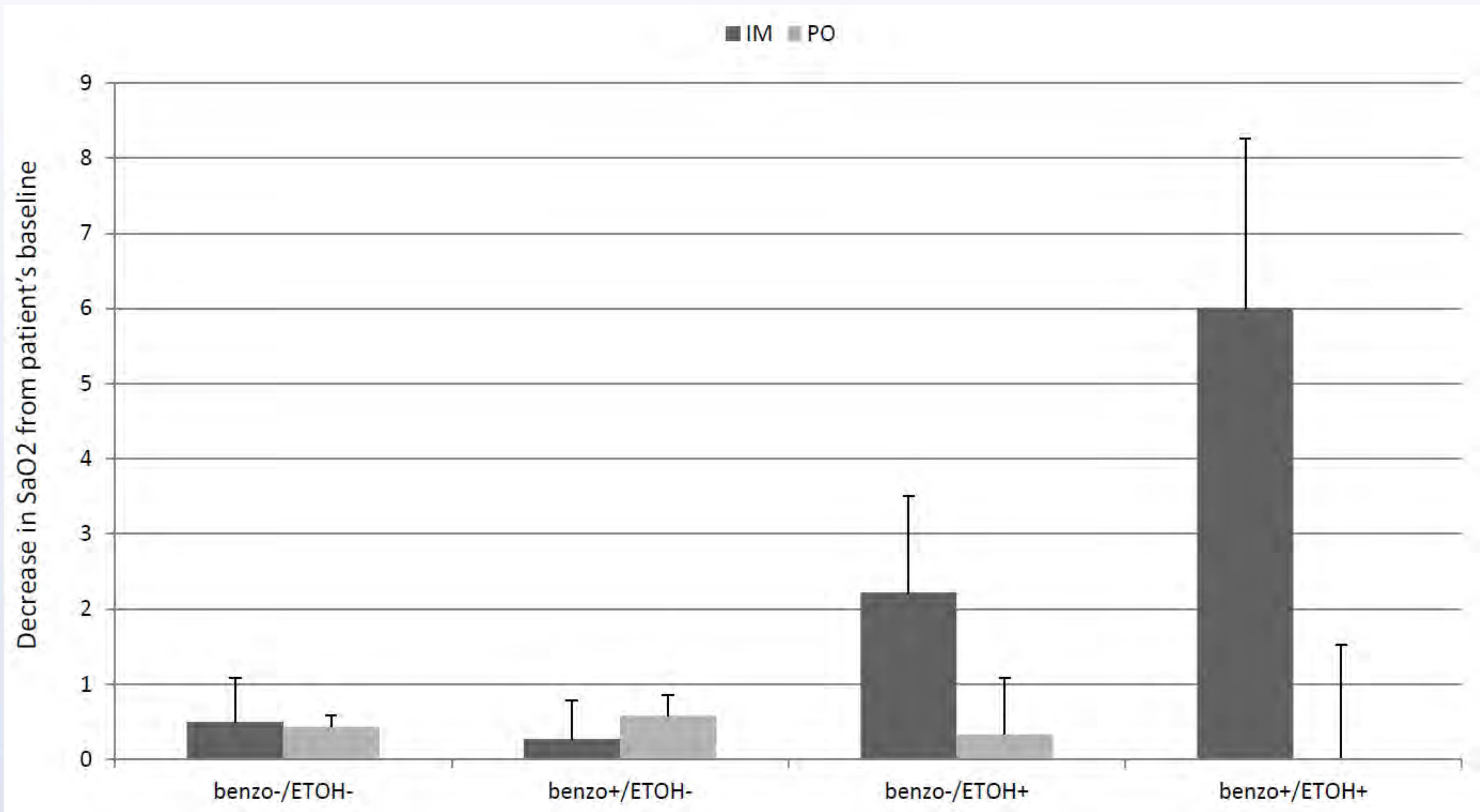
- If EtOH+, may be associated with decreased oxygen saturations if given IM
  - Olanzapine + benzos
  - Ziprasidone + benzos
  - Likely okay if given orally

Wilson MP, MacDonald KS, Vilke GM, Feifel D. A comparison of the safety of olanzapine and haloperidol in combination with benzodiazepines in emergency department patients with acute agitation. J Emerg Med. 2012; 43(5), 790-797.

Wilson MP, MacDonald KS, Vilke GM, Feifel D. Potential complications of combining intramuscular olanzapine with benzodiazepines in agitated emergency department patients. J Emerg Med. 2012; 43(5), 889-896.

Wilson MP, MacDonald KS, Vilke GM, Feifel D. Intramuscular ziprasidone in the emergency setting: Influence of alcohol and benzodiazepines. J Emerg Med. 2013; 45(6):901-908.

Oral meds have fewer side effects with EtOH



Wilson MP, Chen N, Vilke GM, Castillo EM, MacDonald KS, Minassian A. Olanzapine in emergency department patients: Differential effects on oxygenation in patients with alcohol intoxication. Am J Emerg Med. 2012; 30(7):1196-1201.

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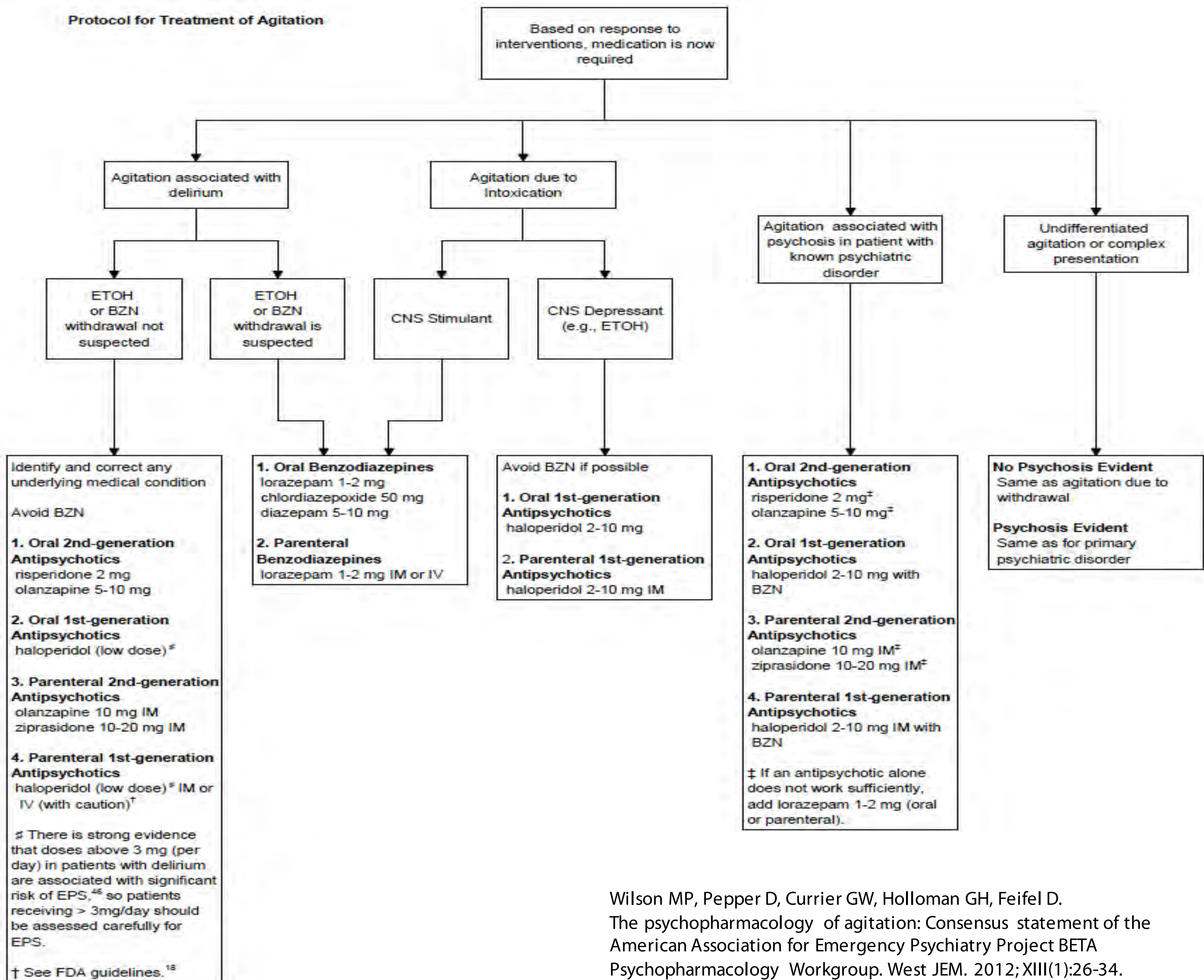

Wilson MP, Pepper D, Currier GW, Holloman GH, Feifel D. The psychopharmacology of agitation: Consensus statement of the American Association for Emergency Psychiatry Project BETA Psychopharmacology Workgroup. West JEM. 2012; XIII(1):26-34.

Guideline: reduce restraints

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So why are we talking about restraints?

(Isn't a restrained patient a safe patient?)

- Most mental health advocacy groups have called for less coercion in treating mental health patients
  - In particular, calls for little or no restraint use by:
    - American Psychiatric Association
    - American Psychiatric Nurses Association
    - American Academy of National Alliance for the Mentally Ill
    - Mental Health America
    - the American Association of Community Psychiatrists
    - the National Association of State Mental Health Program Directors

Restrained patients use more resources

- JC requires written policies in place
  - About evaluation
  - About reevaluation

- JC requires continuous monitoring of restrained patients
  - this requires additional staff

"We're all out of Novocain, so we need to restrain your arms and legs."

Restrained patients stay longer

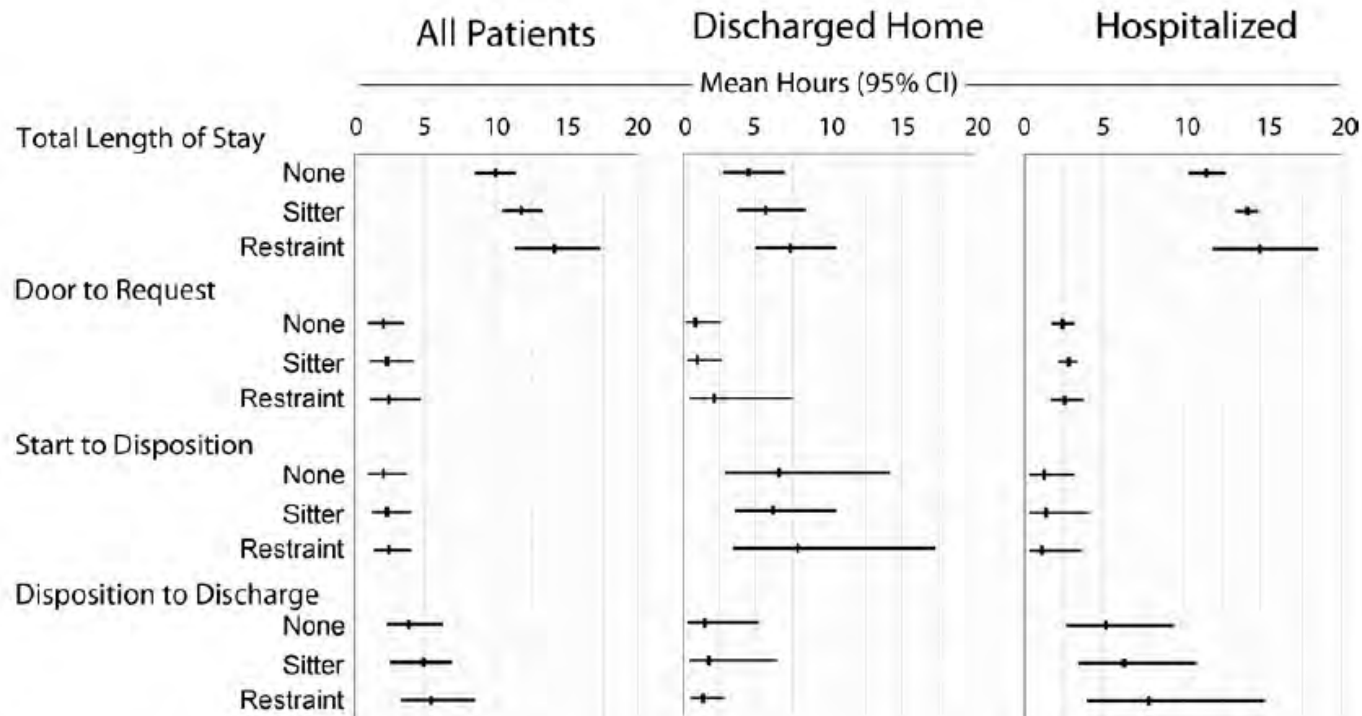
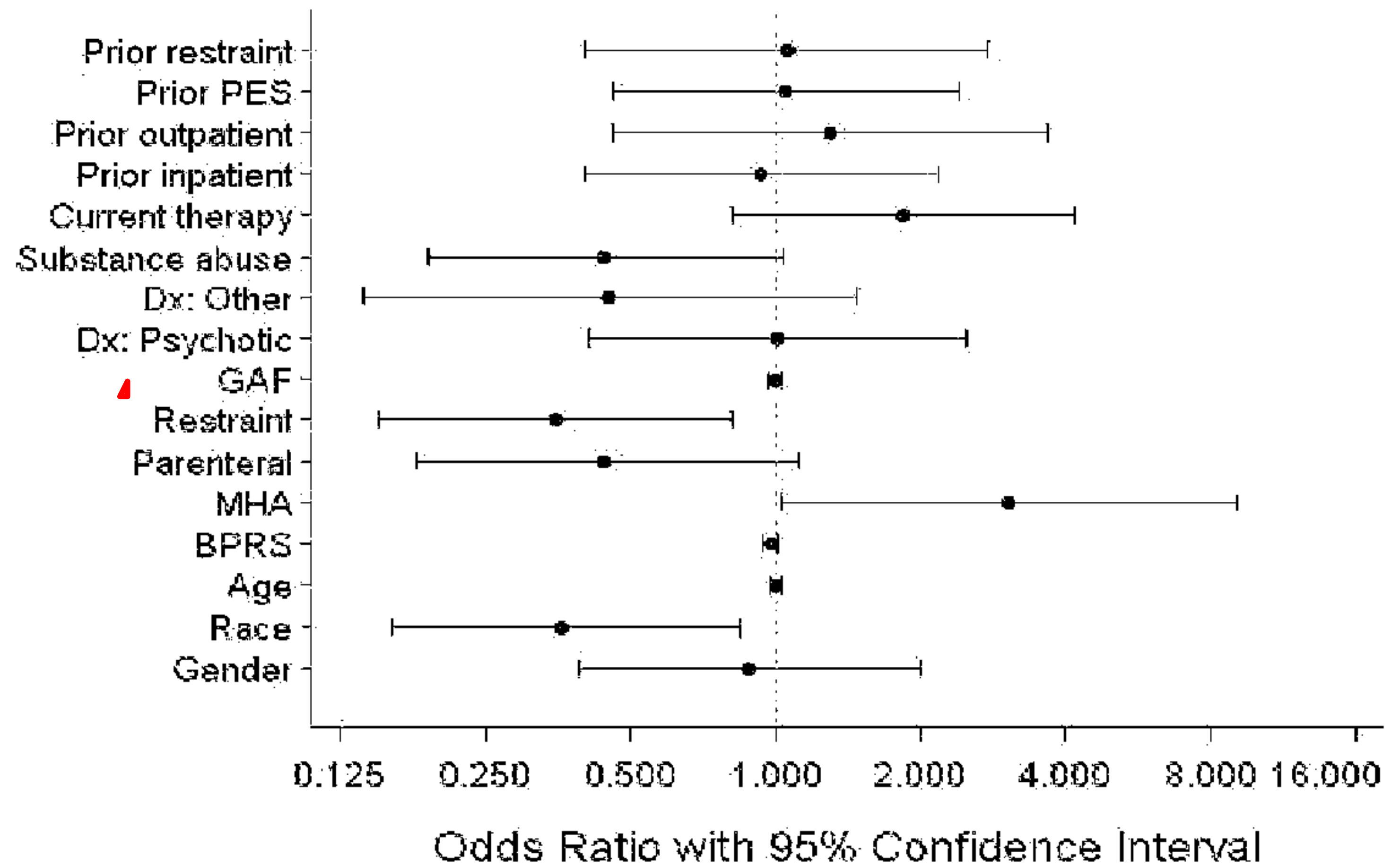


Figure 3. Effect of restraint and sitter use on ED length of stay and components. Bars represent the mean time in hours (±95% CI) of the total ED length of stay and the 3 main subcomponents, broken out by the use of restraints and sitters (1:1 observers). Results are presented separately for the entire sample and then the subgroups of patients discharged to home and patients hospitalized (including those transferred for hospitalization elsewhere).

Weiss AP, et al. Patient and practice-related determinants of emergency department Length of stay for patients with psychiatric illness. Ann Emerg Med. 2012; 60(2):162-171.



Currier GW, et al. Physical restraints and attendance at subsequent outpatient psychiatric treatment. J Psychiatr Pract. 2011; 17(6):387-393.

Selected Guidelines

- Use verbal de-escalation
- Staff should be appropriate for the job
- Oral medications instead of IM
- Reduce seclusion & restraint

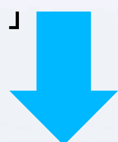
Does BETA work?

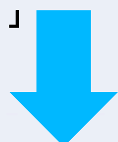
A California psychiatric ER
using BETA recommendations:

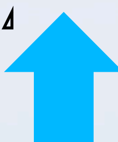
6 months 1/2010 to 6/2010 compared to
6 months 7/2011 to 12/2011

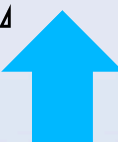
Seclusion/Restraint	⬇	**43%**
Assaults	⬇	**58%**

Decrease in assaults, injuries, insurance costs; Increase in patient/staff satisfaction at John George Psychiatric Hospital


35% further **reduction in assaults**, with or without injury, over this continued time period


Workman's Compensation Insurance Costs by **90%**


Patient Satisfaction Scores >**90th percentile** for the USA, **99th percentile** two of the past three months


Employee **Satisfaction** and Retention

Similar Improvements in Hospitals Worldwide

- BETA guidelines in use in multiple locations around the world with good results

- Honolulu, HI Queen's Medical Center Trauma Center/ED – after implementing BETA recommendations, decreased from 20 restraints/month to ZERO restraints/month

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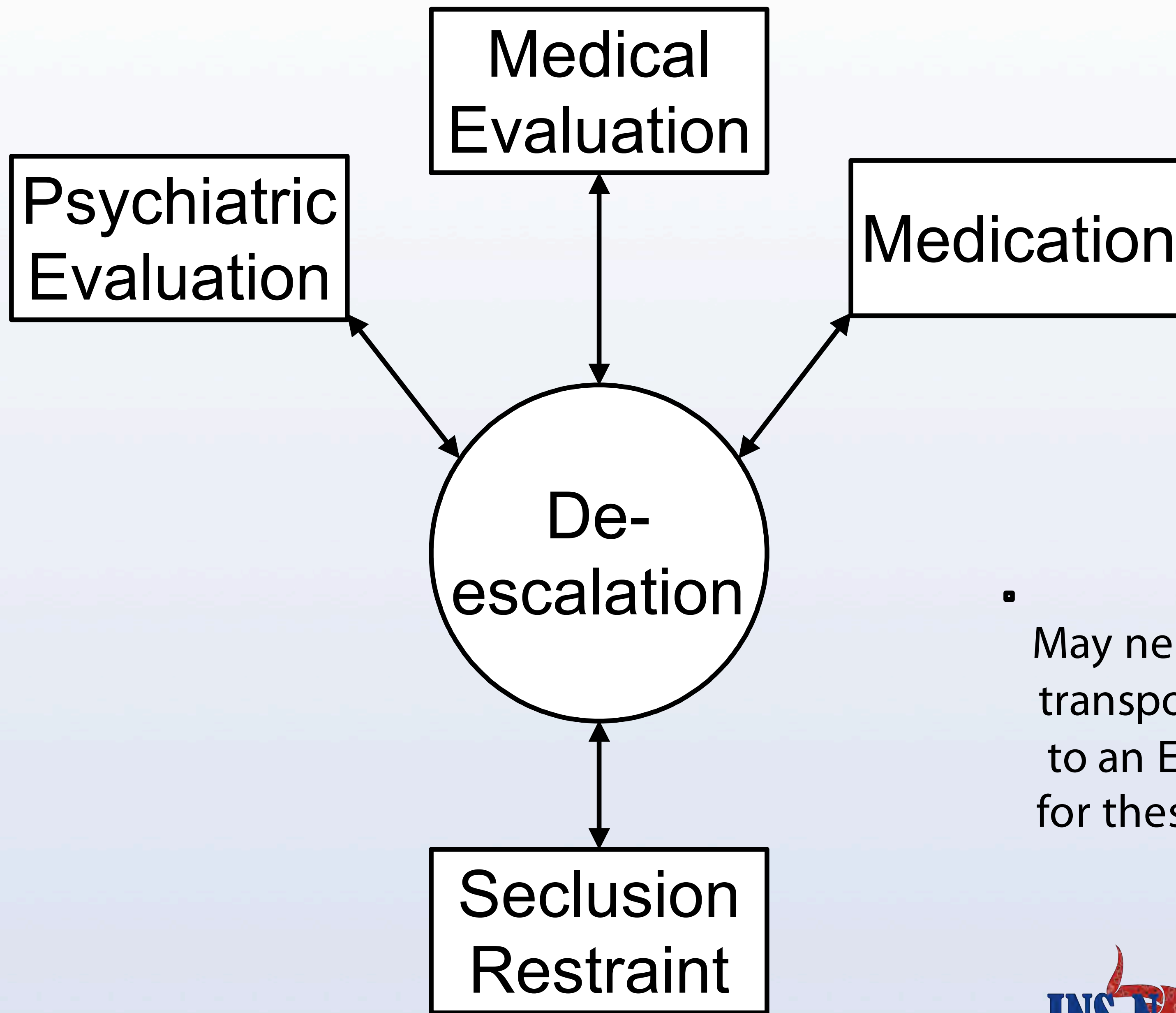
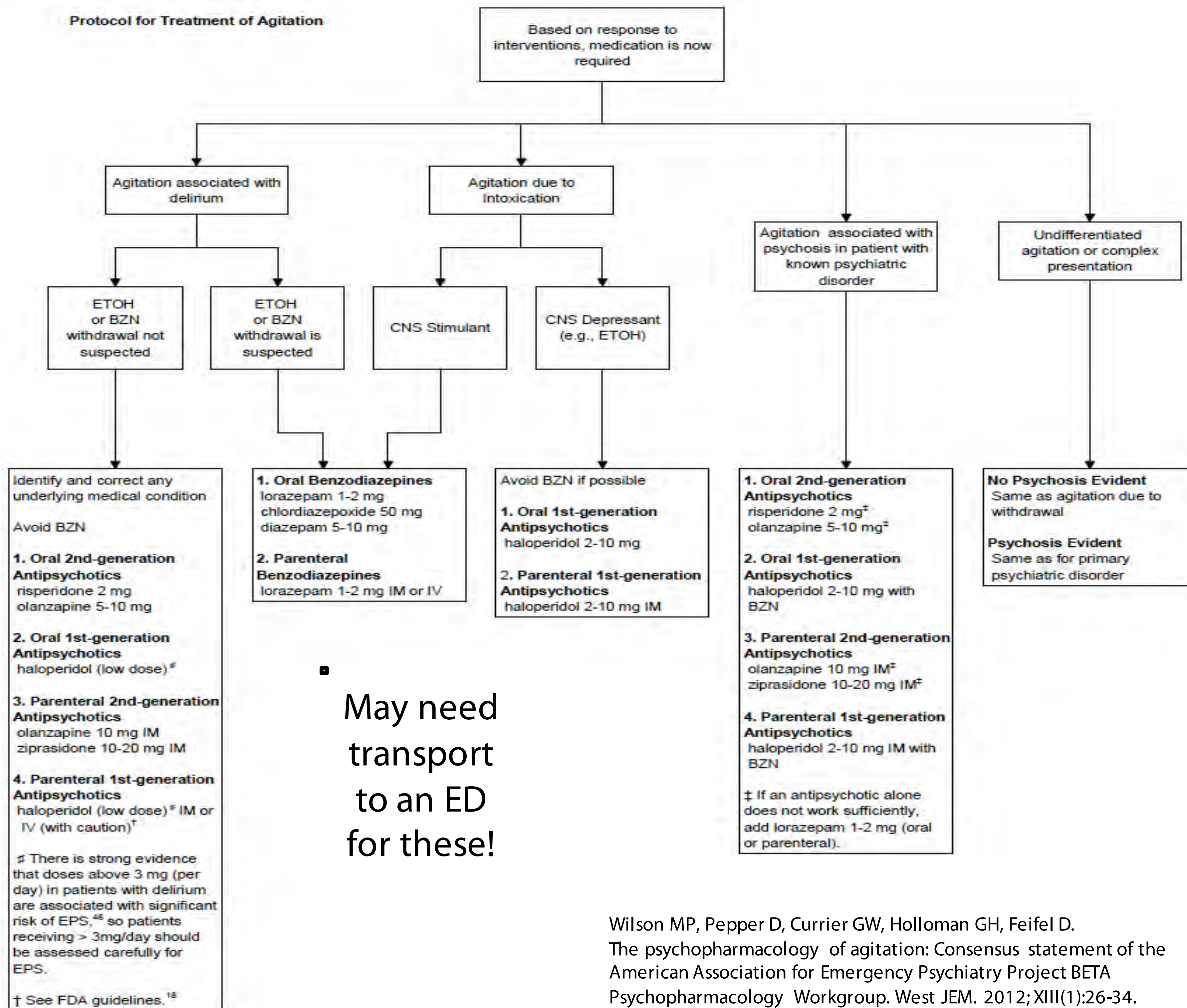
Cole R. Reducing restraint use in a trauma center emergency room. Nurs Clin N Am. 2014;49:371-381.

Summary:
How do I approach an agitated patient?

Courtesy of Scott Zeller, MD



- May need transport to an ED for these!


Protocol for Treatment of Agitation
Based on response to interventions, medication is now required
Agitation associated with delirium
Agitation due to Intoxication
Agitation associated with psychosis in patient with known psychiatric disorder
Undifferentiated agitation or complex presentation
ETOH or BZN withdrawal not suspected
ETOH or BZN withdrawal is suspected
CNS Stimulant
CNS Depressant (e.g., ETOH)
Identify and correct any underlying medical condition
Avoid BZN
1. Oral 2nd-generation Antipsychotics
risperidone 2 mg
olanzapine 5-10 mg
2. Oral 1st-generation Antipsychotics
haloperidol (low dose)♯
3. Parenteral 2nd-generation Antipsychotics
olanzapine 10 mg IM
ziprasidone 10-20 mg IM
4. Parenteral 1st-generation Antipsychotics
haloperidol (low dose)♯ IM or IV (with caution)†
♯ There is strong evidence that doses above 3 mg (per day) in patients with delirium are associated with significant risk of EPS,[46] so patients receiving > 3mg/day should be assessed carefully for EPS.
† See FDA guidelines.[18]
1. Oral Benzodiazepines
lorazepam 1-2 mg
chlordiazepoxide 50 mg
diazepam 5-10 mg
2. Parenteral Benzodiazepines
lorazepam 1-2 mg IM or IV
Avoid BZN if possible
1. Oral 1st-generation Antipsychotics
haloperidol 2-10 mg
2. Parenteral 1st-generation Antipsychotics
haloperidol 2-10 mg IM
1. Oral 2nd-generation Antipsychotics
risperidone 2 mg‡
olanzapine 5-10 mg‡
2. Oral 1st-generation Antipsychotics
haloperidol 2-10 mg with BZN
3. Parenteral 2nd-generation Antipsychotics
olanzapine 10 mg IM‡
ziprasidone 10-20 mg IM‡
4. Parenteral 1st-generation Antipsychotics
haloperidol 2-10 mg IM with BZN
‡ If an antipsychotic alone does not work sufficiently, add lorazepam 1-2 mg (oral or parenteral).
No Psychosis Evident
Same as agitation due to withdrawal
Psychosis Evident
Same as for primary psychiatric disorder
May need transport to an ED for these!
Wilson MP, Pepper D, Currier GW, Holloman GH, Feifel D.
The psychopharmacology of agitation: Consensus statement of the American Association for Emergency Psychiatry Project BETA Psychopharmacology Workgroup. West JEM. 2012; XIII(1):26-34.

Project BETA

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Department of Emergency Medicine
Behavioral Emergencies Research

Sinai Health System

December 2-4
Flamingo LAS VEGAS

Rosalind Franklin University of Medicine and Science

6th Annual National Update on Behavioral Emergencies

Topics (Tentative)
Thursday December 3 (Day 1)

- Introduction/AAEP
- Medical Clearance
- UDS
- Ketamine and EMS
- Disorders that Can Kill
- Treatment of Agitation
- Informed consent and Involuntary medication
- Applying BETA Guidelines
- Interviewing techniques
- Starting a PES/Psych Ed
- Research Forum

Topics (Tentative)
Friday December 4 (Day 2)

- Improving Efficiency
- Synthetic Cannabinoids
- High Utilizer Case Management
- HEADS ED
- Excited Delirium
- Violence in the ED/PES
- Neurobehavioral Manifestations of Non-Convulsive Status
- Fellowship
- AMA and other risk issues
- Psych collaborative
- Will I Get Sued
- Psych Boarders
- Working with law enforcement,

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Pre-Conference Course Dec 2th
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$400 In Advance $500 at the door.
See www.IBHI.Net for Details

Invited Speakers

Michael Wilson, Karen Murrell, Kingwai Lui, Jagoda Pasic, Clare Gray, Terry Kowalenko, Silvna Riggio, Stephen Hargarten, Laura Vearrier, Michael Geraldi, Jack Rozel, Kim Nordstrom, Nidal Moukaddam, Aaron Doral-Laskey, Doug Rund, Michael Wilson, Laura Vearrier, Scott Zeller, Jon Berlin, David Hnatow, Kurt Isenburger

Course Director
Leslie Zun, MD, MBA
Endorsements
Sinai Health System
The Chicago Medical School
American Association for Emergency Psychiatry

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For further information contact Les Zun, MD at zunl@sinai.org
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Questions?

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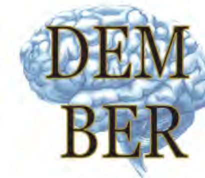

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