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

INS NT 2015
National Academy of Infusion Therapy
Dallas, TX November 6-8
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 Best practices for the Evaluation and Treatment of Agitation.
Project BETA

Available for free reading/download:

Through PubMedCentral or Bing “Agitation BETA”
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
De-escalation

Psychiatric Evaluation

Medical Evaluation

Medication

Seclusion Restraint

May need transport to an ED for these!
Guideline: verbal de-escalation
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

### BETA recommendations: Verbal de-escalation

<table>
<thead>
<tr>
<th>IV You shall be concise:</th>
<th>VIII You shall agree or agree to disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>• use short phrases or sentences</td>
<td></td>
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<tr>
<td>• repeat yourself, repeat yourself</td>
<td></td>
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<tr>
<td>• Get the patient’s attention..don’t confuse</td>
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<table>
<thead>
<tr>
<th>V You shall identify their wants and feelings</th>
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<table>
<thead>
<tr>
<th>VI You shall lay down the law:</th>
<th>IX You shall have a moderate show of force and be prepared to use it</th>
</tr>
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<tbody>
<tr>
<td>• set limits</td>
<td></td>
</tr>
<tr>
<td>• offer choices; propose alternatives</td>
<td></td>
</tr>
<tr>
<td>• establish consequences</td>
<td></td>
</tr>
<tr>
<td>• use positive reinforcements</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>VII You shall listen:</th>
<th>X You shall debrief with patients and staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Don’t argue</td>
<td></td>
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<tr>
<td>• Don’t up the ante</td>
<td></td>
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<tr>
<td>• Listen and agree</td>
<td></td>
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<td>• Check understanding</td>
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Courtesy of Scott Zeller, MD
Do verbal techniques work for all patients?
Do verbal techniques work?

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

<table>
<thead>
<tr>
<th>Rating</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Difficult or unable to rouse</td>
</tr>
<tr>
<td>2</td>
<td>Asleep but responds normally to verbal or physical contact</td>
</tr>
<tr>
<td>3</td>
<td>Drowsy, appears sedated</td>
</tr>
<tr>
<td>4</td>
<td>Quiet and awake (normal level of activity)</td>
</tr>
<tr>
<td>5</td>
<td>Signs of overt (physical or verbal) activity, calms down with instructions</td>
</tr>
<tr>
<td>6</td>
<td>Extremely or continuously active, not requiring restraint</td>
</tr>
<tr>
<td>7</td>
<td>Violent, requires restraint</td>
</tr>
</tbody>
</table>

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

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.
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

Oral meds work just as quickly

<table>
<thead>
<tr>
<th>Author</th>
<th>Trial design</th>
</tr>
</thead>
<tbody>
<tr>
<td>Currier, et al. (2001)</td>
<td>Prospective, nonrandomized, rater-blinded, double -arm. Informed consent not required, but willing to accept oral meds.</td>
</tr>
<tr>
<td>Hatta et al. (2008)</td>
<td>Pseudorandomized, open-label, flexible dose, Multicenter. Informed consent after treatment, but willing to accept oral meds.</td>
</tr>
<tr>
<td>Hsu et al. (2010)</td>
<td>Prospective, randomized, rater-blinded.</td>
</tr>
<tr>
<td>Lejeune et al. (2004)</td>
<td>Open-label, active controlled, Multicenter. Patients allowed to choose their own group.</td>
</tr>
<tr>
<td>Lim et al. (2010)</td>
<td>Prospective, randomized, open-label, rater-blinded.</td>
</tr>
<tr>
<td>Normann et al. (2006)</td>
<td>Prospective, open-label study. Since observational only, no informed consent required.</td>
</tr>
<tr>
<td>Pascual et al. (2007)</td>
<td>Naturalistic, prospective, open-label. Informed consent after treatment, but willing to accept oral meds.</td>
</tr>
<tr>
<td>Veser et al. (2006)</td>
<td>Prospective, randomized, placebo-controlled, doubleblind.</td>
</tr>
</tbody>
</table>

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.
\( \dagger p < .001 \) vs. IM treatment.

**INS NTIT 2015**
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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


Original Contributions

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

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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

PII: S0735-6757(15)00827-X
DOI: doi: 10.1016/j.ajem.2015.09.044
Reference: YAJEM 55308


Received date: 14 August 2015
Revised date: 10 September 2015
Accepted date: 26 September 2015
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


Oral meds have fewer side effects with EtOH

Wilson MP, Pepper D, Currier GW, Holloman GH, Feifel D. 
Guideline:
reduce restraints
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
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).

Figure 1. Univariate odds ratios for baseline variables with respect to attendance at psychiatric outpatient appointment

**Figure 1**

- Prior restraint
- Prior PES
- Prior outpatient
- Prior inpatient
- Current therapy
- Substance abuse
- Dx: Other
- Dx: Psychotic
- GAF
- Restraint
- Parenteral
- MHA
- BPRS
- Age
- Race
- Gender

**Odds Ratio with 95% Confidence Interval**

**PES:** Psychiatric emergency service

**GAF:** Global Assessment of Functioning Scale

**MHA:** mental health arrest

**BPRS:** Brief Psychiatric Rating Scale

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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  \downarrow  43%

Assaults  \downarrow  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

Summary:
How do I approach an agitated patient?
De-escalation

Psychiatric Evaluation

Medical Evaluation

Medication

Seclusion Restraint

May need transport to an ED for these!

May need transport to an ED for these!
Project BETA

Available for free reading or download at the Western Journal of Emergency Medicine website

Or through Bing/Google
Educational resources

Department of Emergency Medicine
Behavioral Emergencies Research

December 2-4
Flamingo
LAS VEGAS

6th Annual
National Update on Behavioral Emergencies

Topics (Tentative)
Thursday December 3 (Day 1)
- Introduction/AAEP
- Medical Clearance
- ODS
- Ketamine and EMS
- Disorders that Can Kill
- Treatment of Agitation
- Informed consent and Involuntary medication
- Applying BETA Guidelines
- Interviewing techniques
- Starting a PES/Paych 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 1 Get Stabbed
- Psych Boarders
- Working with law enforcement,

Every Registrant Receives a Copy

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

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For further information contact Les Zun, MD at zieal@sinai.org
773.257.6937
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mpwilso1@outlook.com