“Diagnosis, Management, and Treatment of Agitation”

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- Organizational:
  - Milwaukee Chapter President for the Wisconsin Psychiatric Association (WPA)
  - President Elect for the American Association for Emergency Psychiatry (AAEP)
- Consulting Relationships:
  - **Active member of the National Health Service Corps
  - **MCW faculty in Dept. of Psychiatry

Acknowledgements (Organizational)

- American Association of Emergency Psychiatry (AAEP)
  - Dr. Scott Zeller, Dr. Zun, Dr. Rozel, Dr. Nordstrom, et al

- [https://www.emergencypsychiatry.org](https://www.emergencypsychiatry.org)

- Advocacy and research on Project BETA and others
“Well, that’s just your opinion man…..”

Rationale for my role as a speaker today……

- Very busy Psychiatric Emergency Room
  - Psychiatric Crisis Service (PCS)
- National point of view pertaining to process improvement and standard of care
- Previous experience in the emergent/high acuity milieu in other states:
  - Psychiatric ER in St. Louis and forensic state setting
With all that out of the way….

Goals for the next 50-55 minutes

1) Process why the treatment of agitation is important in all venues of care
2) Discuss why the appropriate treatment of agitation is a right for all of our patients suffering as such!
3) Examine the evidence based recommendations (Project BETA)
4) Consider any residual questions or cases
What is agitation?

- It is a behavioral and medical emergency!
- 1.7 million medical ER visits per year in US involve agitated patients (Sachs, GS, J Clin Psych, 2006)
- “Excessive verbal and/or motor behavior” when the pt displays:
  - Psychomotor activation - Aggression
  - Mood Lability - Potential to harm self/property/etc..
  - Verbal Abuse
- Citrome, L. Post grad Med, 2002

Why is this an issue?

- JCAHO reviews restraint related incidents as a main marker of functionality
- Most patient-to-staff assaults lead to missed days of work, not to mention the psychological sequelae (Allen, Currier, Hughes et al, Postgraduate Medicine, 2001)
- Almost 2/3 of these assaults occur during containment procedures (Carmel, Hunter, Hospital and Community Psychiatry, 1989)
Issues continued

- **Most physical interactions are AVOIDABLE**
- Problems noted in systems:
  - “That’s someone else’s job”
  - “Psych will handle it”
  - “They don’t have the ability to make decisions”
  - “Why are they here………….”
  - “We just need to medically clear and get them out of here………….”

Most often heard……..

- “We aren’t used to handling *those types* of patients”

This is:
- Unethical
- Uninformed
- Improper
- **Liable**
- UNACCEPTABLE!
ETHICAL Issues

- Patients have a **right to not be agitated**
- This should be treated as a symptom like any other medical symptom……...

- **Physicians treat:**
  1) Pain
  2) Fever
  3) Insomnia
  4) WHY NOT AGITATION?

UT-SW: Journal of Emergency Psychiatry (Sept. 2016)

- “Characteristics of Violent Behavior in County Hospital Emergency Departments”
- Violence in ED continues to be present with assaults not uncommon

- **Noted interventions of “successful” programs:**
  - Recognizing high risk
  - Improving security
  - Designating rooms for patients with agitation
  - Shortening the time for de-escalation processes
  - Shortening the time for either chemical or physical restraints
  - Training ED staff on agitation protocols
Does all this work……YES

- Psychiatric Crisis Service (PCS) as an example!
- **Selection Bias for:**
  - High acuity
  - The most treatment resistant and affected
  - Highest law enforcement complications
  - Largest degree of involuntary patients
  - Those who have been turned away and marginalized by others……….Yet………lower restraint numbers than other milieus nationally…………and remarkably low incidence of aggressive acts to staff

How does this work in our Psychiatric Emergency Room?

- Immediate RN assessment for medical, legal, or social complications for agitation
- Option of immediate MD assistance at the door for all de-escalation options
- Intense training of all our staff in de-escalation techniques
  - Verbal
  - Social
  - Physical plant
  - Communication between disciplines
What causes agitation?

- Medical issues………delirium
- Involuntary detainment
- Paranoia
- Fear of legal repercussions
- Mania/irritable depression
- AODA
- Past experiences
- Feeling scared
- History of trauma (Trauma Informed Care)
- Feeling like “things are out of control”
  - NOT ALWAYS PATHOLOGICAL
Take a step back…..

➢ Please note that on that list………..

➢ Agitation can happen to any patient for a myriad of issues

➢ While agitation can go hand in hand with a treatable mental illness, it can also occur in the absence of any such diagnosis

How do I know if they’re agitated?

➢ Broset Violence Checklist (BVC)
  ➢ A) Confusion
  ➢ B) Irritability
  ➢ C) Boisterousness
  ➢ D) Physically Threatening
  ➢ E) Verbally Threatening
  ➢ F) Attacking Objects
  ➢ 1-2, consider moderate risk with meds indicated
Another option…..BARS

- **Behavioral Activity Rating Scale (BARS)**
  - Single item scale
  - Meant to solely rate agitation
  - Range of 1-7
    - 1 being unarousable, 7 being violent with need for restraint

  - "Using BARS as a Vital Sign", Denver Medical Center, Dr. Nordstrom et al

- Increased feelings of staff safety
- Increased feelings of staff skill set

Staff Safety (cont.)

- **Having the whole team understand the process assists in morale**
  - Decreases helplessness
  - Increases feelings of knowledge/skill
  - **Assists the patient in feeling SAFE**
    - When we are anxious/agitated……it has clear affect on our patients
    - Something to consider when patient is arriving agitated at your door for reasons tied to WHO BROUGHT THEM IN………….
You’ve diagnosed agitation, now what??

- 1) Ruling out life threatening causes
- 2) Verbal options / de-escalation by staff
- 3) Pharmacological Options
- 4) Physical plant Options
  - Seclusion
  - Restraint
Project BETA

- “Best Practices in Evaluation and Treatment of Agitation”
- W. Journal of Emergency Medicine (2/12)
- Six related articles
  - Most downloaded in the history of the journal
  - Can be obtained for free reading or download at the WJEM website:
    - [http://escholarship.org/uc/uciem_westjem?volume=13;issue=1](http://escholarship.org/uc/uciem_westjem?volume=13;issue=1)

The six Project BETA articles are the most downloaded and most cited 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.
Project BETA Articles (6)

- 1) Overview of the Project
- 2) Medical Evaluation and Triage
- 3) Psychiatric Evaluation of the Agitated Patient
- 4) Verbal De-escalation of the Agitated Patient
- 5) Psychopharmacology of Agitation
- 6) Use and Avoidance of Seclusion and Restraint

Overview

- Notation that emergency departments nationally are becoming more frequented by the crises of those with mental illness
- This is tied to national deinstitutionalization with minimal change in outpatient services
- Hence, patient boarding is being seen everywhere
  - Info on handling these situations were needed…….
Next steps?

- 1) Adding back inpatient capacity?
- 2) Making sure the current capacity is USED CORRECTLY?
- 3) Increasing outpatient services?
- 4) Increasing ACCESS/PARITY to outpatient services? (TIED to BILLING)
- 5) ***Helping to construct/train emergency departments on the best way to treat said patients?
Pitfalls of Delirium in Psychiatric Patients

- **Psychiatric patients:**
  - Have more chronic medical issues
  - On more meds with less compliance
  - Often have symptoms that make exam hard!
  - Psychotropic often carrying their own medical burden (side effects)

- “It’s just their mental illness……”
- “This is too much to be drugs…..”
- “This is too crazy to be medical……”

To clarify……..

- Those with chronic mental illness have:
  - Greater risk of delirium
  - Greater risk of delirium being overlooked
  - Greater risk of chronic health conditions
  - Shorter life span due to a myriad of issues, including the above

- **To not heed this is to further stigmatize the mentally ill**
"Verbal" De-escalation

Why is de-escalation hard in an ER?

1) **Limited space, time, and staff**

2) Shorter hospital stays now, leading to higher outpatient acuity

3) **Distrust and fear of authority figures**

4) Inheriting the patient after they have already been with outside law enforcement

5) **Brain issues: frontal lobe damage, AODA, inherent illnesses**
Further challenges

- 6) Active psychiatric symptoms
  - Thought disorder, paranoia, mania, lability

- 7) **Stigma by non-behavioral health providers**

- 8) Refusal of health systems to provide psychiatric care
  - Yet provide other specialty care (neuro, OB, ortho, etc….)

- 9) Assumption *that all issues must be psychiatric*

- 10) ***Focus on “getting them out of here!”
  - Both to outpatient and to other systems……..

Hints for De-escalation

- 1) “I feel”………not “you should”
- 2) Watch posture
- 3) Keep proper space
- 4) Be aware of your position in the ER
- 5) Avoid “circling the wagon”
- 6) Have one voice at a time
- 7) Speak low and slow
- 8) **IF YOU ARE UNEASY THE PATIENT LIKELY WILL BE TOO……so pick your words accordingly**
“Seek First to Understand…….”
-Stephen Covey

Can we talk?
- safety, distance, security

What do you want?
- find positive items….be honest about
  what you can and cannot help with

I want to help you get that!
-this does not rule out therapeutic
LIMIT SETTING

“….then to be Understood”
-Stephen Covey

- Identify automatic feelings:
  - Fight or Flight..........even “freezing”
  - “What can I do”..........hopelessness
  - “Not my job”..........often systemic in nature

- Psychological First Aid (PFA):
  - Seek to meet the patient where they are…
  - It’s about what they need........not what I want!

- Trauma Informed Care (TIC)
  - Recognize how past history affects not only our
    patients but also our STAFF
Take Home Point #1

- Most providers drastically **overemphasize the risks of psychiatric medication**

- AND

- Most providers immensely **underemphasize the risks of untreated mental illness**!
Take Home Point #2

- Most providers do not intervene EARLY enough
- Treating agitation is an ONGOING issue
  - Not “one PRN” and then stop monitoring…..
- **Physicians have a duty to lead this charge**: however, they are often not involved at the beginning
  - Some of this is due to the physical structure
  - Some of this is due to institutional ignorance

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Take Home Point #3

- While restraints may be clinically necessary, it is **ethically inappropriate to**:
  - 1) Place patients in restraints without any psychotropic intervention
  - 2) Leave patients in restraints **waiting** for a resolution of agitation
  - 3) Using untreated restraint episodes as punitive behaviors to be held against the patient
  - 4) Assuming, systemically, **that all restraints should / must be avoided**
Pharmacological Options in an ED

- It depends on several factors:
  - Routine vs. emergent
  - **Target Symptom**
    - Large disconnect on this topic
    - *Must aim to treat what is actually affecting them!*
  - Route of Administration
  - Allergies and past exposures
  - Co-morbid medical issues
    - Namely, hypotension and QTc issues
Pharmacological Options (cont.)

- In emergencies, always try to clarify ALLERGIES
- “What helps to calm you down?”

- “What has worked for you in the past?”

- The order of requests (escalating in persuasion)
  - “Would you like something?”
  - “I need you to take something.”
  - “Would you prefer an oral med or an injection?”

Other Pharmacological general comments

- Remember that not all usage of medication must result in complete sedation

- The skilled provider will know to tailor their choice in med to fit the need of the patient
  - Sedation - Facilitating an interview
  - Calming - Establishing rapport/trust!
  - Alleviating psychosis
Project BETA recommendations

- **Reviewed:**
  - First Generation Antipsychotics
  - Second Generation Antipsychotic
  - Benzodiazepines

- **Lead Editor:**
  - Dr. Zun, Chicago Sinai, Current AAEP President

- **Delirium:**
  - Given special attention to ensure that the CAUSE is being sought prior to medication

Project BETA recs (cont.)

- **Intoxication:**
  - BZDs first line……..SGAs added if needed
  - Alcohol depending on w/d vs. intoxication
  - Haloperidol somewhat preferred in EtOH situations due to lack of studies with SGAs

- **Psychiatric Illness:**
  - Antipsychotics first line (SGAs preferred)
  - Risperidone has most evidence, OLZ “some” (low n)
  - Adding BZDs is second line

- **Delirium:**
  - SGAs or low dosage haloperidol
What about KETAMINE?

- This has become VERY popular amongst EMS and Emergency Departments
- Quick onset……often longer degrees of sedation

- ***The issue is that it has good data for NON-psychiatric agitation……not for those with mental illnesses (having agitation)
  - In the moment..........how does one know?
- Additionally, more concerns on respiratory insufficiency and stability

Ketamine, part two

- Good data on Ketamine being used for “excited delirium”, but not first line for psychiatric agitation
- **ACEP position paper Feb 2017:**
  - “In the adult patient presenting to the ED with acute agitation, can ketamine be used safely and effectively?” (ONLY a LEVEL C rec)
  - Just sedating……not treating the underlying symptoms (as with other Project BETA recs)
What about ADASUVE?

- **Adasuve (inhaled loxapine powder):**
  - Quick onset
  - Ability to have the patient self administer
  - Lessened concerns on compliance and/or diversion/cheeking……..

- **FDA warnings:**
  - Risk of bronchospasm with ADASUVE™ (loxapine) inhalation powder
  - ADASUVE™ available only in enrolled healthcare facilities, under an
  - FDA‐required REMS Program

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Common Medications Utilized (in our PCS)

- **Quick dissolve antipsychotic tabs**
  - Risperdal M-tabs, Zyprexa Zydis, etc….
  - Avoid the stigma of the IM while still having faster onset
  - Difficult to cheek or not fully absorb

- **Benzodiazepines**
  - They do not always deserve the reputation they have
  - Very useful in one time situations in the ED

- **Antihistamines**
  - Diphenhydramine, hydroxyzine, doxasozin etc…
  - Sedating, but wary of anticholingergic issues
Common Medications (IM variety)

- **IM Antipsychotics**
  - Haloperidol, fluphenazine, ziprasidone, aripiprazole, chlorpromazine, and olanzapine
  - Co-administer with anticholinergics and/or BZDs?
  - QTc concerns? EPS concerns?

  - “Special Topic – Depot medication”

  - So many to choose from?
    - Prolin-D Invega Sustenna
    - Haldol-D Zyprexa Relprevv
    - Risperdal Consta Abilify Maintenna

  - Do we administer in ERs? What role do outside agencies play in this?
What about children and adolescents?

- “Best Practices for Evaluation and Treatment of Agitated Children and Adolescents (BETA) in the ED: Consensus Statement of the AAEP”
  - Western Journal of Emergency Medicine
  - February 2019
  - Acknowledges that these cases are:
    - Multimodal, needing ETIOLOGY to drive treatment
    - Non-pharm options should precede…..but not replace pharmacological options

“Baby BETA” (cont.)

- Noted 5 main areas in which agitation normally emerges in this sub-population:
  - 1) Delirium
    - Similar to adults
  - 2) Substance intoxication or withdrawal
  - 3) IDD / Autism spectrum
    - Try extensive non pharm first….then consider home medications at higher dosing
  - 4) Primary psychiatric
    - Diphenhydramine, lorazepam, Zyprexa, Risperdal, QTP, chlorpromazine, or Haldol/ativan
  - 5) Unknown etiology
Restraints

- Never a preferred option, but can be clinically indicated
  - Violence, self harm, intrusive psychosis, agitation
  - Removes from milieu, briefly
- Medical risk factors?

- *Key is to minimize amount of time
- **Hence, why it is so important to medicate!
- ***And even more important to follow up........

Organizational Costs of Restraints

- Single episode of restraints costs an institution $302-$352\textsuperscript{1}
- One study reports a 1-hour restraint involves 25 different activities and claims nearly 12 hours of staff time to manage and process the event from beginning to end\textsuperscript{1}
- High staff turnover (expensive to re-staff), high liability costs and high legal costs associated with restraints use\textsuperscript{2}
- Insurance companies even look at an organization’s restraint and seclusion numbers when underwriting\textsuperscript{2}

1. Lebel & Goldstein 2005  
2. SAMHSA, 2011
Improving Throughput

- Restraint use leads to a length of stay of psychiatric patients in EDs averaging 4.2 hours longer than that of patients not requiring restraints\(^1\)

\(^1\) Weiss AP et al, Annals of Emergency Medicine 2012
Conclusions

Dealing with agitation is a complex procedure that requires the following:

- Ruling out medical causes
- Verbal de-escalation
- Involving pharmacological options
- Supporting your team and utilizing debriefing skills

- It is important to not underutilize psychiatric medication
- It is equally important to not underemphasize untreated psychiatric illness
  - This is applicable in ALL settings........

Conclusions (cont.)

1) Recognize agitation at an EARLY stage
2) It is a patient’s right to have this agitation treated to alleviate their suffering
3) The most dangerous thing is to do nothing, give minimal effort, or just restrain
4) Excellent evidence base in Project BETA
5) All interactions with patients can be therapeutic
Some “Systems” Thoughts

- The care of the mentally ill is a medical issue that requires all stakeholders to be involved.
- Treating this as “someone else’s issue” is not only not ethical……it is not realistic for the future state of our area!
- The mentally ill have the right to be treated in all venues……not segregated to certain areas.
References - Conferences

- National Update on Behavioral Emergencies
- Annually offered in December
- Collaboration of Chicago Medical School, Mt. Sinai Hospital, AAEP, and FAAEM
- [www.behavioralemergencies.com](http://www.behavioralemergencies.com)
- Multidisciplinary effort

References - Organizations

- AAEP
- American Association for Emergency Psychiatry

- Good resources for both ER docs and psychiatrists

- Evidence based, forward thinking
  - i.e. Project Beta
References - Texts

- “Emergency Psychiatry: Principles and Practice”
  - Glick, Berlin, Fishkind, and Zeller
  - 2008

- “Behavioral Emergencies for Emergency Physicians”
  - Zun et al
  - Cambridge Press, May 2013

“History, despite its wrenching pain, cannot be unlived, but if faced with courage does not need to be lived again!”

- Maya Angelou