"Diagnosis, Management, and Treatment of Agitation"

- WACEP Spring Symposium
- Thursday April 4, 2019
- 1430-1530

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Disclosures

- Source of Research Support – NONE
- Stock Equity (>$10,000) / Speaker's Bureau – NONE
- QA/QI involvement – Precedence and Greeley
- 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
- 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 -Aggresssion
  - 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)

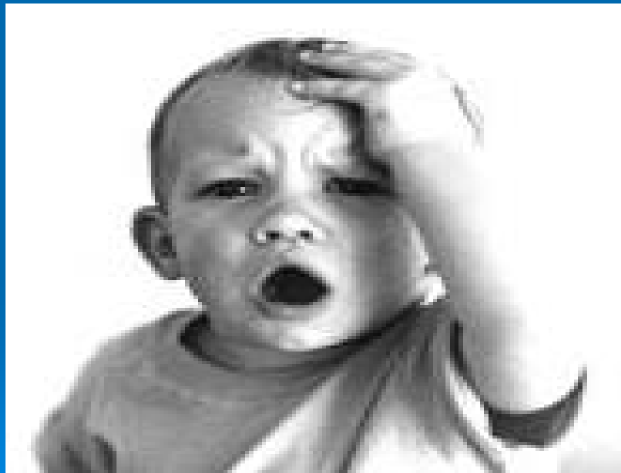
- "Characteristics of Violent Behavior in County Hospital Emergency Departments"
- Violence in ED continues to be present with assaults not uncommon
- Noted interventions of "successful" programs:
  - **Recognizing high risk**
  - Improving security
  - Designating rooms for patients with agitation
  - ***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

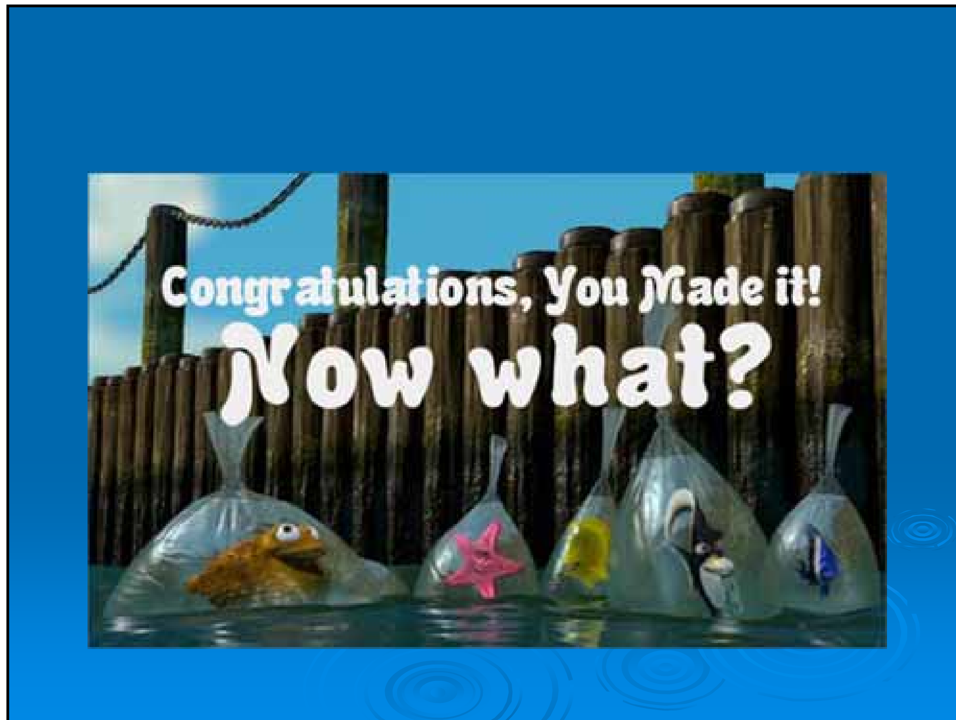
- Behavioral Activity Rating Scale (BARS)
  - Single item scale
  - Meant to solely rate agitation
  - Range of 1-7
    - 1 being unarousable, 7 being violent with need for restraint
      - *"Using BARS as a Vital Sign", Denver Medical Center, Dr. Nordstrom et al*

***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

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

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*

OK……….moving on………

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 <u>has good data for NON-psychiatric agitation</u>…….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 **<u>not first line</u>** for psychiatric agitation
- **<u>ACEP position paper Feb 2017:</u>**
  - "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**

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, fluphenzaine, 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?
  - Prolixin-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[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[1]
- High staff turnover (expensive to re-staff), high liability costs and high legal costs associated with restraints use[2]
- Insurance companies even look at an organization's restraint and seclusion numbers when underwriting[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
- Multidisciplinary effort

References - Organizations

- AAEP
- American Association for Emergency Psychiatry
- www.EmergencyPsychiatry.org
- 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