Agitation/De-Escalation Pre-Reading

Agitation: A state of excessive psychomotor activity accompanied by increased tension and irritability.

Framework to approaching the agitated patient:

Verbal De-Escalation

- Assess Situation & Establish Leadership
- Approach with Empathy
- Accommodate & Ensure Safety
- Set Boundaries & Give Options
- Send for Backup
- Keep Safe Distance & Use Open Body Language
- Know What Your End Goal Is

IF FAILS…

Offer Medication

- Offer PO before IM
- Use minimum effective dose
- Choose medication based on patient profile and agitation etiology

IF FAILS AND VIOLENCE IMMINENT…

Restraints as a Last Resort

- **Restraint = any procedure or device employed to limit a person's mobility**
- Tell patients why they are being restrained and criteria for release
- Restrain for **shortest time** with the **least amount of restriction** and should be **continuously reassessed**
- Document a restraint note
- Debrief afterward; discuss ways to avoid future use of restraints
- Review your hospitals' restraint policy

Helpful **video demonstrating verbal de-escalation** from CU/Denver Health**:** Uses a different framework than AAASSKK however principals are the same

Medical treatment of agitation

For **undifferentiated agitation:** If there is no psychosis event would treat the same as substance intoxication/withdrawal. If there is a psychosis event, treat the same as primary psychiatric disorder.

Medical Illness/ Delirium

Examples: infection, uremia, metabolic and electrolyte disturbances, medications/poly-pharmacy, ANY critical illness

- Identify and address underlying medical conditions
- Optimize non-pharmacologic management!
- Choose small doses of less anticholinergic antipsychotics (in order of preference depending on clinical situation and side effect profile):
  - PO olanzapine, PO risperidone
  - Low dose PO haloperidol
  - IM olanzapine or IM ziprasidone
  - IM Haldol (preferred over IV)
- Avoid benzos

Neurologic and Neurocognitive

Examples: dementia, brain tumors, focal seizures, Wilson's

- Choose small doses of less anticholinergic antipsychotics as in medical illness/delirium
- Risk of EPS significantly higher for patients with parkinsonism as well as lewy body dementia. would avoid Haldol in these circumstances. Prefer quetiapine
- Optimize non-pharmacologic management!

Substance intoxication & withdrawal

Examples: suspect alcohol or benzodiazepine intoxication or withdrawal, or CNS stimulant use

- **For ETOH withdrawal and CNS Stimulant use:** Use benzodiazepines (PO, IM, or IV depending on circumstances) for ETOH withdrawal and stimulant intoxication
- **For CNS depressants** (e.g. ETOH intoxication): haloperidol is often effective

Primary psychiatric disorder

Examples: schizophrenia, bipolar, MDD, anxiety, personality disorders

- Try to anticipate PRN needs in advance
- Consider psychiatry consultation
- Order of preference depending on clinical situation and side effect profile:
  - PO olanzapine,PO risperidone
  - PO haloperidol **plus benzodiazepine**
  - IM olanzapine or IM ziprasidone
  - IM Haldol (preferred over IV) **plus benzodiazepine**

Modified from the following: Wilson, M., Pepper, D., Currier, G., Holloman, G., Feifel, D., 2012. The Psychopharmacology of Agitation: Consensus Statement of the American Association for Emergency Psychiatry Project BETA Psychopharmacology Workgroup. Western Journal of Emergency Medicine 13, 26–34.. doi:10.5811/westjem.2011.9.6866

Medication	Dosing Considerations	Notes
Olanzapine (Zyprexa) PO 2.5-10mg (tablets, disintegrating tablets) IM 10mg MAX 30mg /day	Can be used in hepatic or renal failure, but use lower doses (5 mg/day initially)	**Lowest risk of QTc prolongation amongst antipsychotic meds (~6 msec)** Slight inc risk hypotension Do NOT use IM olanzapine with IM/IV benzodiazepines (can cause resp. depression)
Ziprasidone (Geodon) IM: 10mg Q2hrs or 2mg Q4hrs (max 40mg/day)	No renal dose adjustment in renal insufficiency. Cautious with hepatic impairment as drug is extensively metabolized by the liver.	**High risk QTc prolongation - Dose-dependent**
Risperidone (Risperdal) PO 0.5-2mg (tablets, disintegrating tablets, liquid) Not available IM/IV MAX 4mg/day	Do not exceed 0.5 mg BID in pts with moderate/severe renal disease (given clearance reduced by 60%)	Elevated risk of EPS compared with other SGA Moderate risk of hypotension **Minimal anticholinergic side effects** **First line agent in pregnant patients (no known teratogenic effects)** **Prolongs QTc (~10 msec)**
Quetiapine (Seroquel) PO 12.5-100mg BID PRN (tablets, liquid) Not available IM/IV MAX 200mg/day	Use reduced doses in liver disease or renal impairment	**Minimal anticholinergic side effects** **Lowest risk of EPS – good choice for elderly patients, though not generally considered 1st line for agitation** Prolongs QTc (~15 msec)
Haloperidol (Haldol) 1-5 mg PO or IM TID PRN MAX 30mg/day Caution with IV -increased risk arrhythmias	Good choice in pts w/ severe liver disease; use lower doses in renal failure	Elevated risk of EPS (especially in delirious/medically ill patients) Risk of QTc prolongation, especially with IV formulation Bonus: May help with nausea Can give with diphenhydramine OR benzodiazepine to reduce risk of acute dystonia. Typically don't give both at once as this is not likely to give additional benefit and risks more complications *(Ref: Jeffers et al, J Emerg Med, 2022)* **Second-line agent in pregnant patients**
Lorazepam (Ativan) 1-2mg PO, IM, IV **Midazolam (Versed)** 2.5-5mg PO, IM, IV		Benzodiazepine. Paradoxically worsens delirium (except if DTs/ ETOH) Inc risk resp depression, sedation, and confusion. Do not give concomitantly with opioids or IM olanzapine due to higher risk of respiratory depression. **Does not prolong QTc or cause EPS**
Ketamine IM 4-6 mg/kg, IV 1-2mg/kg	Avoid doses lower than 1mg/kg as this may cause dissociative effects without sedation	Used more in Emergency Dept. setting Highly sedating. Can cause respiratory depression and laryngospasm. Emergence reactions (psychotic symptoms as medication wears off) can occur - sometimes given with benzo for this reason **Does not prolong QTc**

References used to help inform table creation:

- Wilson MP, Pepper D, Currier GW, et al: The psychopharmacology of agitation: consensus statement of the American Association for Emergency Psychiatry Project BETA Psychopharmacology Workgroup. West J Emerg Med 2012; 13:26–34
- Garriga M, Pacchiarotti I, Kasper S, et al: Assessment and management of agitation in psychiatry: expert consensus. World J Biol Psychiatry 2016; 17:86–128
- Jeffers, T., Darling, B., Edwards, C., Vadiei, N., 2022. Efficacy of Combination Haloperidol, Lorazepam, and Diphenhydramine vs. Combination Haloperidol and Lorazepam in the Treatment of Acute Agitation: A Multicenter Retrospective Cohort Study. The Journal of Emergency Medicine 62, 516–523.. doi:10.1016/j.jemermed.2022.01.009

Important info about RESTRAINTS:

MUST read your institutional guidelines about restraint use. You must assess the patient face-to-face and document a restraint note.

Restraints can be used for non-violent indications(e.g. patient is interfering with devices necessary to provide critical care, patient is interfering with surgical healing) or **violent, self-destructive indications** (e.g. immediate harm to self or others)

What qualifies as a restraint?

- All 4 bed side rails up against a patient's will
- Any "hold" including to give medication (e.g. IM) counts as a restraint
- Mitts
- Soft wrist restraint
- Vest restraint
- Locked limb restraints (must be applied by security)
- Seclusion (more common in ED, Psychiatric units)

Restraint or seclusion is considered a last resort. If seclusion is available as an alternative, it should be utilized. The Joint Commission advises that restraint or seclusion episodes must be:
• Performed by trained staff,
• Implemented only after less restrictive options have failed,
• Initiated for safety and not as a means to punish or retaliate,
• Monitored continuously with a goal to discontinue as soon as possible, and
• Clearly documented (including reason, monitoring practices, patient response, and indications to discontinue).

Useful resources on Restraints:

- *Knox DK, Holloman GH, Jr.: Use and avoidance of seclusion and restraint: consensus statement of the American Association for Emergency Psychiatry Project BETA Seclusion and Restraint Workgroup. West J Emerg Med 2012; 13:35–40*
- *Joint Commission Standards on Restraint and Seclusion/Nonviolent Crisis Intervention Training Program. Milwaukee, Crisis Prevention Institute, 2010. https://www.crisisprevention.com/CPI/media/Media/Resources/alignments/Joint-Commission-Restraint-Seclusion-Alignment-2011.pdf*