Project BETA

Best Practices for Evaluation and Treatment of Agitated Patients

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Agitation is a Behavioral Emergency

- Agitation can be described as “excessive verbal and/or motor behavior\(^1\),” when a patient displays:
  - Psychomotor activation
  - Mood lability
  - Verbal abuse
  - Aggression
  - Potential to harm self, others or property

- **7 million** medical emergency room visits in USA per year may involve agitated patients\(^2\)

- Agitation can present in a wide spectrum, from restlessness to combativeness; best to intervene early as possible before symptoms progress

2. Sachs GS. *Journal Clinical Psych*. 2006
Costs of Agitation

- eight patient-to-staff assaults per facility annually, with some centers reporting more than 25 assaults per year\(^1\)

- Most of these assaults resulted in staff injury severe enough to miss work\(^1\)

- one-third of assaults random, but two-thirds occur during containment procedures\(^2\)

2. Carmel, Hunter. *Hospital and Community Psychiatry* 1989
A Call for Change

- Regulatory agencies and advocacy groups have called for a reduction in physical restraint and less coercion in the treatment of the mentally ill.
- Some facilities have made innovative changes to address these concerns.
- However, far too many facilities continue to treat agitation using “restrain and sedate.”
- Clearly, more discussion has been needed on effective, alternative management of agitation.
Institute of Medicine, 2003

“The status quo is not acceptable and cannot be tolerated any longer. Despite the cost pressures, liability constraints, resistance to change and other seemingly insurmountable barriers, it is simply not acceptable for patients to be harmed by the same healthcare system that is supposed to offer healing and comfort.”
Project BETA Workgroups

- Medical Evaluation and Triage
- Psychiatric Evaluation
- Verbal De-escalation
- Psychopharmacology of Agitation
- Use and Avoidance of Seclusion and Restraint
‘Zeller’s Six Goals’
of Emergency Psychiatric Care

- Exclude medical etiologies of symptoms
- Rapidly stabilize the acute crisis
- Avoid coercion
- Treat in the least restrictive setting
- Form a therapeutic alliance
- Formulate an appropriate disposition and aftercare plan

from Zeller, *Primary Psychiatry*, 2010
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.
Agitation is an Acute Behavioral Emergency

- Agitation is an acute behavioral emergency requiring immediate intervention.
- The preferred intervention for calming the agitated patient is verbal de-escalation.
- Medication can help, and offering medication is part of verbal de-escalation.
- Unless signs and symptoms dictate emergent medical intervention, de-escalation must take precedence in an effort to calm the patient.
Verbal De-escalation

• The goal is to help the patient regain control so that he can participate in his evaluation and treatment.

• While engaging the patient in verbal de-escalation, the clinician’s observations and medical judgment must drive decisions regarding management of the patient.

• Successful de-escalation of the patient is the key to avoiding seclusion and restraint.
Benefits of Mastering Skills

- Verbal de-escalation usually takes less time than the process of restraint and involuntary medication.
- Avoiding “containment” procedures will result in less injuries to both staff members and patients.
- Patients are more trustful when not restrained or forcibly medicated.
- Receiving facilities may be more willing to accept a patient who has not been restrained, improving throughput.
One patient’s experience

“Being restrained costs a lot!

I was abused before I was in psychiatric care. Being restrained made me feel the same way – except staff are supposed to help you, right?

It made me worse and took away my self-esteem. How is that supposed to make me feel better?

I don’t get it.

Wouldn’t it be cheaper if staff just listened?”
The Ten De-Escalation Commandments

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

from Fishkind, Current Psychiatry, 2002
The Ten De-Escalation Commandments

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

from Fishkind, Current Psychiatry, 2002
Goals of Treating Agitation

– Reduce dangerous behaviors, distress, anguish
– Minimize side effects
– **Calm to tranquility, not unconsciousness**
– Minimize need for physical restraints
– Treat while creating therapeutic alliance
– Help decrease future episodes of acute agitation
General medication recommendations

- Medications are not chemical restraints, but appropriate agents chosen to treat symptoms
- Non-pharmacologic approaches first
- Medication is used to calm, not induce sleep
- Patients should be involved in the process of selecting medication
  - Oral medications are preferred over IM
Complications of Oversedation

- Prevents ability to do full medical/psychiatric evaluation, and can mask medical comorbidities
- Patients unable to answer questions
- Patients unable to keep self hydrated, other self care
- Psychiatric consultant will typically not come to evaluate until patient is awake
- Receiving hospitals/programs unwilling to consider patient transfers until alert, leading to boarding, dispositional delays
- Unconscious patient not receiving treatment but taking up vital space in ED – thus not helping patient while preventing other ED patients from treatment
Does it work?

A California psychiatric ER using BETA recommendations:

6 month period prior to implementation compared to 6 month period 120 days after implementation

Seclusion/Restraint ↓ 43%
Assaults ↓ 58%
And continued to improve....
And assaults dropped, too

35% reduction in assaults, with or without injury, over this time period
And continued to improve…

- As of 2015, the Psychiatric Emergency Service, averaging 1500-1800 involuntary, danger-to-others and danger-to-self patients per month is now averaging only:

  One (2) uses of restraints per 1000 patients

  (0.002 of patients seen in ER go into restraints)
Decrease in assaults, injuries, insurance costs; Increase in patient/staff satisfaction

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 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
Psych ED Seclusion Rate Dallas

Seclusion Events per Patient Encounter

Prior to Jul 2011:
Physical holds not logged
Mechanical restraints ranged 0-2 events per month

Rates for Full CY 2013
Seclusion: 0.66%  Hold 2.75%  Mech: 0.21%

Achieved a **96% reduction** in the **rate** of seclusions* that has been sustained over time.

* Episodes per patient encounter. Jan-Jun 15.2% vs Jul-Dec 3.3%*)
Things that did NOT change in Dallas

No significant change in...

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<thead>
<tr>
<th></th>
<th>Pre</th>
<th>Post</th>
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</thead>
<tbody>
<tr>
<td># Encounters</td>
<td>879</td>
<td>859</td>
</tr>
<tr>
<td>% Male</td>
<td>58.6%</td>
<td>58.8%</td>
</tr>
<tr>
<td>% Involuntary</td>
<td>58.2%</td>
<td>56.3%</td>
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<tr>
<td>Positive Tox/BAL</td>
<td>45.0%</td>
<td>43.6%</td>
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<tr>
<td>% Requiring Admit/Transfer to higher level</td>
<td>35.2%</td>
<td>37.5%</td>
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<tr>
<td>% Restrained in Main ED</td>
<td>1.4%</td>
<td>2%</td>
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Assaults analysis confounded by a massive effort to increase reporting of all safety events resulting in a 158% increase in events reported to the safety tracking system. That said, the increase is still not statistically significant (p=0.13) and as a percentage of all events reported, assaults accounted for 7.3% and 11.3%, again not significant.

PED Seclusions vs Volume

Volume actually went UP during the month with biggest decrease in the seclusion rate.

So... we cannot explain away the results as a change in our patient population. **WE changed, not our patients.**
Major Culture Change in Dallas

- Less forced IM meds
- More voluntary PO meds
- A shift towards less restrictive interventions EVEN BEFORE the rates decreased.

This suggests **we got better at engagement.**
Having a goal of zero coercion is very worthy and should be a target for all mental health clinicians and caregivers.

Until we can reach that goal, we must do all we can to minimize coercion, and in those cases where it is necessary, we must work collaboratively with consumers to engage and quickly move willingly into voluntary care.

Better approaches today will mean less need for coercion in the future.
Project BETA

Available for free reading, download, sharing at the Western Journal of Emergency Medicine Website:
http://escholarship.org/uc/uciem_westjem?volume=13;issue=1

Or through PubMedCentral

Or Google “BETA agitation”
(it will come up at top of your search)