

Managing Suicidal and Aggressive Patients in the ED

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Prediction is hard, especially when you're talking about the future.

Yogi Berra

The Problem of Overprediction

- Prediction of a rare event is an inherently difficult task. The prevalence of suicide is 13 per 100,000, prevalence of aggressive behavior in the general population has been estimated at 200 persons per 100,000, or .2 percent – a rare event indeed
- The second bias toward over prediction stems from the relative costs of mistaken prediction. Incorrectly labeling someone safe who later commits suicide or a violent act may expose the predictor to public outcry or liability. Since the cost of false negatives are high, therapists are biased to over-predict in self-defense.
- False positives range from 40 – 100 percent

FORSEEABILITY

- The question retrospectively addressed is: was there sufficient evidence to suggest to a reasonable clinician, making a reasonable assessment, that the patient's suicide (or nonfatal attempt) could have been anticipated
- The question prospectively addressed is: Might this patient sitting with me here and now be about to attempt to take his or her own life?

TJC Recommendations

- Review each patient's personal and family hx for suicide risk factors.
- Screen all pts for suicide ideation using a brief, standardized, evidence-based screening too – PHQ, ED-Safe patient safety screener, SBQ-R, Columbia Screening
- Review screening questionnaires before pt leaves the appt or discharge – determine next steps (Safe-T pocket card)
- Take action using assessment results
 - Keep patients in acute suicidal crisis in a safe environment
 - Lower risk of suicide make linkages for follow-up care

TJC Recommendations

- National suicide prevention lifeline number 1-800-273-Talk
 - Suicide Prevention Resource Center
<http://www.suicidepreventionlifeline.org/>
 - **National Suicide Prevention Life Line**
<http://www.suicidepreventionlifeline.org/GetHelp/>
 - Conduct safety planning
 - Restrict access to lethal means
-
- Establish collaborative, ongoing, systematic process with other providers, family and friends as appropriate
 - To improve outcomes use evidence based approaches for tx and discharge plans
 - Educate all staff in patient care settings to identify and respond to suicidal ideation
 - Document decisions regarding the care and referral of pts with suicide risk

Identification & Precautions

- Risk Factors can help us identify patients at risk for suicide.
- Screening tools
- Communicating with patients can reduce suicide risk.
- Precautions can help prevent suicide attempts or acts.

Suicide: General Statistics

- **An American dies by suicide every 12.95 minutes, 40,000 per yr with 1M attempts annually**
- **Suicide accounts for 13 deaths/100,000 people in US/yr and rising**
 - **Rate varies with sex, age, ethnicity**
 - **Women, teens, and vets are a big reason for the rising rates**
 - **2nd leading cause of death for 10-24**
 - **5th leading cause of death for 45-59**

Risk Factors

- “A measureable characteristic, variable, or hazard that increases the likelihood of development of an adverse outcome”

Jacobs, 1999

Education on Suicide:

General Epidemiologic Risk Factors

- Male:Female 4:1 suicide rate
- Women 3x as attempters
- White > Native American > African American > Asian
- Age
 - Men: Incidence peaks in teens/20's and elderly (>85)
 - Women: Incidence peaks in midlife
- Men: comparative incidence / 100,000 population
 - Widowed: 78
 - Divorced: 69
 - Single: 33
 - Married 18

Age as a risk factor

- Men age 75 and older have the highest rate of suicide – 35.7 per 100,000
- The highest incidence of reported attempts occurs in 18-24 year age group
- Suicide is the third leading cause of death among 15-24 year olds

Attempted Suicides

- Of the adults who attempt suicide, 62.3 percent received medical attention for their suicide attempt and 46 percent stayed overnight or longer in a hospital for their suicide attempt
- 20-40% of patients who suicide made prior attempts but 90% of attempters do not later complete suicide
- 50% saw their PCP a month before suicide

Completed Suicide

- Most common:
 - Firearms – 57% of suicides (62% men, 39% women)
 - 71% suicides in 65+ y/o
 - 79% all firearm suicides by white men
- Second most common for women:
 - Self poisoning (overall 16.7%)
- Second most common for men (overall) 24.8%:
 - Suffocation (including hanging)

Suicide: General Risk Factors

- 90% of suicides have diagnosable psychiatric disorder at the time of death: Depression, Bipolar Disorder, Schizophrenia, Alcoholism, Drug Addiction, Personality Disorder
- History: h/o Suicide Attempts, h/o abuse or trauma, family history of suicide
- Personal Features: Impulsivity
- Emotional Symptoms: Hopelessness, Helplessness, Despair, anhedonia, anxiety
- Social Situation: Grief, Divorce, Estrangement, job loss, financial stress
- Profession: Veterans (23%) Doctors, Lawyers
- Medical Illness
- Timing: anniversaries, annual events

World Mental Health Surveys (WHO)

- Mental disorders increase odds of experiencing Si
- After controlling for psychiatric comorbidity – disorders characterized by anxiety & poor impulse control predict transition to suicidal behavior
- Depression predicts suicidal ideation, not plans or attempts, in ideators
- Disorders with severe anxiety/agitation or impulse dyscontrol predict ideators that proceed to both impulsive & planned attempts
- Depression + agitation = suicidal behavior
- Similar in developed and undeveloped countries

Nock et al. PLOS Medicine, 2009

Suicide Outpatient vs Inpatient

- Patients who commit suicide as outpatient differ from patients who commit suicide as inpatient\
- TJC: National Patient Safety Goal 15.01.01 requires behavioral health care organizations, psych hospitals, and general hospitals to identify individuals at high risk for suicide
 - Risk assessment
 - Immediate safety needs
 - On discharge provide suicide prevention information

Patients who commit suicide outpatient differ from patients who commit suicide inpatient

	<u>Outpt</u>	<u>Inpt</u>
• Psych Hx	+	-
• Suicide Att Hx	+	-
• Depression	+	+
• Dement/Delirium	-	+
• Medical Illness	-	+
• Pain	-	+
• Poor Prognosis	-	+

Suicide:

Risk Factor of Medical Illness

- Medical illness is present in 25-75% of people who commit suicide
- Medically ill Patients who commit suicide tend to have:
 - Illnesses that are chronic or terminal or painful or debilitating
CAD, CHF, Cancer, ESRD, Epilepsy, MS, TBI, Parkinson's, Huntington's, Dementia, AIDS, Cushing's, Klinefelter's, Porphyria, BPH
 - Illnesses that are associated with depression & alcoholism
 - Surgeries that are disfiguring, including ostomies
 - Stigmatized Illnesses, e.g. AIDS
 - Bad Prognosis or Treatment Failure

Inpatient Suicides

- 51% no history of prior suicide attempts (SA)
- 47% died during 1st hospitalization
- 25% admitted s/p SA; 39% SI alone
- 78% denied SI last contact pre-death
- 79% severe/extreme agitation within 7 days

Two Types :

- Patients identified as suicidal on admission
 - Admitted for medical complications and clearance of suicide attempt
 - Brought in for suicidal ideation or attempt, and other medical findings prompt medical hospitalization
- Patients who become suicidal during course of medical hospitalization
 - Patients who express suicidal ideation
 - Patients who silently contemplate or plan suicide

Busch, Fawcett, & Jacobs, 2003

Suicide Risk Assessment Question Series

- Are you discouraged about your medical condition?
- Are there times when your situation makes you feel tearful?
- When you feel that way, what sorts of thoughts go through your mind?
- Have you felt that if your life were to go on like this, it would not be worth living?
- Have you gotten to the point at which you've actually thought of a specific plan to end your life?
- You say you've thought of shooting yourself. Do you have access to a gun?

Suicide Completion in Inpatients

- Status
 - One study: 1/3 absconding, 1/3 on pass, 1/3 in place
 - One study: 71% in hospital, 29% absconding or on pass or after eloping
- Methods:
 - Hanging in a bathroom, bedroom, or closet
 - 75 % in 1998 Joint Commission study of 65 cases
 - Jumping from window or roof
 - 20% in recent Joint Commission study of 65 cases
 - Majority of 12 cases in British Study 1980-1992
 - In 19/22 & 10/12 cases in older studies (before window securing)
 - Jumping in front of trains, streetcars, cars
 - Drowning in nearby bodies of water
 - Throwing self down open stairwells or chutes

Screening

- PHQ 9 – Especially item 9 with scores of 2 and 3
- Columbia Screener – 6 item with triage protocols
- SAD PERSONS
- SAFE T

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: _____

DATE: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?

(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3

add columns

_____ + _____ + _____

(Healthcare professional: For interpretation of TOTAL, TOTAL: _____
please refer to accompanying scoring card).

10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all _____
Somewhat difficult _____
Very difficult _____
Extremely difficult _____

PHQ-9 Patient Depression Questionnaire

For initial diagnosis:

1. Patient completes PHQ-9 Quick Depression Assessment.
2. If there are at least 4 ✓'s in the shaded section (including Questions #1 and #2), consider a depressive disorder. Add score to determine severity.

Consider Major Depressive Disorder

- if there are at least 5 ✓'s in the shaded section (one of which corresponds to Question #1 or #2)

Consider Other Depressive Disorder

- if there are 2-4 ✓'s in the shaded section (one of which corresponds to Question #1 or #2)

Note: Since the questionnaire relies on patient self-report, all responses should be verified by the clinician, and a definitive diagnosis is made on clinical grounds taking into account how well the patient understood the questionnaire, as well as other relevant information from the patient.

Diagnoses of Major Depressive Disorder or Other Depressive Disorder also require impairment of social, occupational, or other important areas of functioning (Question #10) and ruling out normal bereavement, a history of a Manic Episode (Bipolar Disorder), and a physical disorder, medication, or other drug as the biological cause of the depressive symptoms.

To monitor severity over time for newly diagnosed patients or patients in current treatment for depression:

1. Patients may complete questionnaires at baseline and at regular intervals (eg, every 2 weeks) at home and bring them in at their next appointment for scoring or they may complete the questionnaire during each scheduled appointment.
2. Add up ✓'s by column. For every ✓: Several days = 1 More than half the days = 2 Nearly every day = 3
3. Add together column scores to get a TOTAL score.
4. Refer to the accompanying PHQ-9 Scoring Box to interpret the TOTAL score.
5. Results may be included in patient files to assist you in setting up a treatment goal, determining degree of response, as well as guiding treatment intervention.

Scoring: add up all checked boxes on PHQ-9

For every ✓ Not at all = 0; Several days = 1;
More than half the days = 2; Nearly every day = 3

Interpretation of Total Score

Total Score	Depression Severity
1-4	Minimal depression
5-9	Mild depression
10-14	Moderate depression
15-19	Modestly severe depression
20-27	Severe depression

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SUICIDE IDEATION DEFINITIONS AND HISTORY		month
Ask questions that are bolded and <u>underlined</u> .	YES	NO
Ask Questions 1 and 2		
1) Wish to be Dead: Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up. <u><i>Have you wished you were dead or wished you could go to sleep and not wake up?</i></u>		
2) Suicidal Thoughts: General non-specific thoughts of wanting to end one's life/commit suicide, "I've thought about killing myself" without general thoughts of ways to kill oneself/associated methods, intent, or plan. <u><i>Have you actually had any thoughts of killing yourself?</i></u>		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3) Suicidal Thoughts with Method (without Specific Plan or Intent to Act): Person endorses thoughts of suicide and has thought of a least one method during the assessment period. This is different than a specific plan with time, place or method details worked out. "I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it....and I would never go through with it." <u><i>Have you been thinking about how you might kill yourself?</i></u>		
4) Suicidal Intent (without Specific Plan): Active suicidal thoughts of killing oneself and patient reports having <u>some intent to act on such thoughts</u> , as opposed to "I have the thoughts but I definitely will not do anything about them." <u><i>Have you had these thoughts and had some intention of acting on them?</i></u>		
5) Suicide Intent with Specific Plan: Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out. <u><i>Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?</i></u>		
6) Suicide Behavior Question: <u><i>Have you ever done anything, started to do anything, or prepared to do anything to end your life?</i></u> Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc. If YES, ask: <u><i>How long ago did you do any of these?</i></u> • Over a year ago? • Between three months and a year ago? • Within the last three months?		

Suicide Risk Screening Tool
SAD PERSONS Risk Factors for Harm

	Risk Factor	Points
S	Sex (male)	1
A	Age (<19 or >45)	1
D	Depression or hopelessness	2
P	Previous suicide attempts or psychiatric care	2
E	Excessive alcohol or drug use	1
R	Rational thinking loss	2
S	Separated, divorced or widowed	1
O	Organized or serious attempt or stated future intent	2
N	No social supports	1
S	Sickness (chronic debilitating disease)/School Problems (children and adolescents)	2
	TOTAL Points	
	High Risk Score: greater than 6 Low Risk Score: 6 or less	

SAFE-T

Suicide Assessment Five-step Evaluation and Triage

- Identify Risk Factors: Note those that can be modified to reduce risk
- Identify Protective Factors: Note those that can be enhanced
- Conduct Suicide Inquiry: Suicidal thoughts, plans, behavior and intent
- Determine Risk Level/Intervention: Determine risk, choose appropriate intervention to address and reduce risk
- Document: Assessment of risk, rationale, intervention and follow-up

Suicide Assessment & Warning Signs

SAFE-T Suicide Assessment Five-Step Evaluation and Triage (download www.sprc.org)	American Association of Suicidology Mnemonic: IS PATH WARM (www.suicidology.org)
Identify Risk	Ideation Substance Abuse
Identify Protective Factors	Purposelessness Anxiety Trapped Hopelessness
Conduct Suicide Inquiry – thoughts, plans, behavior, and intent	Withdrawal Anger Recklessness
Determine risk level/intervention	Mood Change
Document – risk, rationale, intervention and follow-up	

Signs of Acute Suicide Risk

- Talking about suicide or thoughts of suicide
- Seeking lethal means to kill oneself
- Purposeless – no reason for living
- Anxiety or agitation
- Insomnia
- Substance abuse – excessive or increased
- Hopelessness – Beck and Ari Kiev
- Social withdrawal
- Anger – uncontrolled rage/seeking revenge/partner violence
- Recklessness – risky acts/unthinking
- Mood changes – often dramatic
- Delusions & hallucinations
- Past suicide attempts; multiple prior attempts dramatically increase risk
- Triggering events leading to humiliation, shame, or despair elevate risk. These may include loss of relationship, financial or health status – real or anticipated
- Firearms accessible to a person in acute risk magnifies that risk. Inquire and act to reduce access

Protective Factors

Even if present, may not counteract significant acute risk

Internal

- Ability to cope with stress
- Religious beliefs
- Frustration tolerance

External

- Responsibility to children or pets
- Positive therapeutic relationships
- Social supports

Suicide Inquiry

Use a non-judgmental, non-condescending, matter-of-fact approach

- Have you ever thought about death or dying?
- Have you ever thought that life was not worth living?
- Have you ever thought about ending your life?
- Have you ever attempted suicide?
- Are you currently thinking about ending your life?
- What are your reasons for wanting to die and reasons for wanting to live

When suicidal ideation is present we should ask about:

- Frequency, intensity, and duration of thoughts;
- The existence of a plan and whether preparatory steps have been taken; and
- Intent – e.g., “How much do you really want to die?” and “How likely are you to carry out your thoughts/plans?”)

High Risk Patients

Risks

- Made a serious or nearly lethal attempt
- Persistent suicide ideation or intermittent ideation with intent and/or plan
- Psychosis, including command hallucinations
- Recent onset of major psych syndromes esp. depression
- Recent discharge from inpatient

Interventions

- One to one staff observation and/or security
- Prevent elopement
- prevent sharp objects from being available
- Inpatient psych admission
- Admin psychotropic meds or physical restraints if needed
- Use suicide precautions on inpatient, ED, or office
- Contact significant others in an emergency you do not need patients agreement

Moderate risk patients

Risks

- Suicide ideation with some level of suicide intent, but who have taken no action on the plan
- No other acute risk factors
- A confirmed, current, and active therapeutic alliance

Interventions

- Evaluate soon/when sober
- Use family or friend to monitor
- Develop a crisis/safety plan
- Make sure the patient has follow-up appt.

Low risk patients

Risks

- Some mild or passive suicide ideation with no intent or plan – usually a passive wish to die
- Usually bring themselves to the ED or with family/friend
- No history of suicide attempts
- Available social support

Intervention

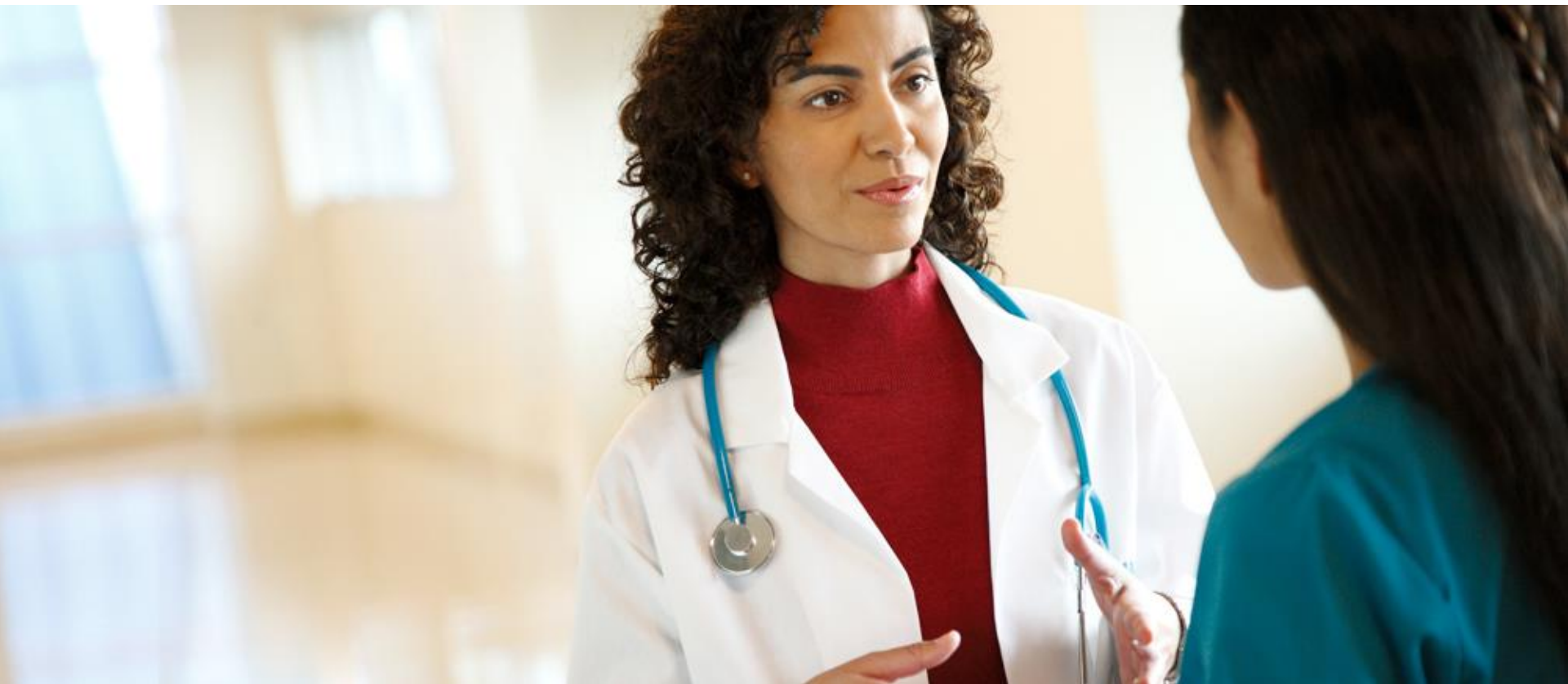
- Outpatient referral
- If accompanied by family or friend let them monitor while waiting
- Focus on symptom reduction (sleep and anxiety)
- Give crisis numbers and make sure we follow-up with phone call

Discharge planning

Transitions of care are particularly concerning e.g., inpt to o/p

- Secure firearms and lethal medications
- A supportive person is available and if possible is made aware of follow-up observations and communication about risks
- Follow up appt. is arranged
- Give phone number for clinic and after hours call center
- Document
 - Observations
 - Mental status
 - Level of risk
 - Rationale for all judgments and decisions to hospitalize or discharge
 - Interventions based on levels of risk
 - Informed consent and patient's compliance with recommended intervention
 - Attempts to contact/sign others and current caregivers

Managing Agitated Patients



Goals For Managing Aggressive and difficult Clients

- Beginning early intervention reduces aggressive behavior of psychiatric presentations
 - More rapidly reduce patient (and family) distress
 - Increase likelihood of discharging patient to outpatient treatment
 - Decrease inpatient LOS if admission still needed
 - Decrease injuries to staff
- EDs that begin treatment on arrival, while simultaneously beginning medical clearance will reduce LOS in the ED

Basic approach

- Focus on presenting symptoms: presence or absence of agitation
- Details of medical clearance and agreements with psych facilities
- Use consultants, nonpharmacologic interventions, and medications if needed to reduce symptoms in ED sufficiently to permit discharge to outpatient treatment as appropriate
- Use expert resources as needed: nonMD psychiatry consultation, on call psychiatrist, and/or ED medical social worker
- Arrival of a patient on involuntary hold, and/or presence of suicidal/homicidal ideation, does not = psychiatric hospitalization. Think TREATMENT, not PLACEMENT, even before psych consultant arrives
- If EDMD removes involuntary, write note in ED chart stating that hold is removed and justifying this decision
- Make sure to refer if pt discharged – f/u phone call next business day

Note to remove an Involuntary Hold

Feel free to improvise, covering key points. Example

The patient has been observed in the Emergency Department for approximately *** hours and is no longer intoxicated, based on ***. She***He does not, in my opinion, meet criteria for involuntary hold.

The patient, now sober, denies suicidal ideation or intent and attributes prior suicidality to ***, now resolved.

The patient denies access to firearms or other means of violence *** *(if pt does have access, edit and explain why discharge is safe)*

The patient denies a suicidal plan.

Behavior in the ED: ***

The patient agrees to *** for followup within ***.

Followup: We have made a for followup referral and have given the patient contact information for mental health services.

When non-MD psych consultation may not be helpful

- Patient is catatonic and not eating, drinking, walking, whether for psychiatric or medical reasons
- Patient is not medically clear, including if currently impaired by intoxication or withdrawal from EtOH or other drugs
- Patient is significantly demented. (Patients with *early* dementia and suicidality may still benefit from consultation to identify whether psychiatric illness is present)
- Patient is too agitated to communicate

If not a case for nonMD consultant, complete medical clearance and consider medications, and, if consultation needed, discuss with ED medical SW/PCC +/- Psychiatrist +/- HBS

Psychiatrist on call or by video Conference

- Advises re medication management while in ED to quickly reduce symptoms and to increase likelihood of discharge to outpatient treatment (or reducing inpatient LOS)
- Advises re specific medication, either for acute ED care or for outpatient/residential treatment
- Advises re management of patients, especially:
 - with complex medical history
 - taking multiple psychiatric medications
 - concurrently using or withdrawing from multiple other substances

Medical clearance

- Medical clearance needed for all patients before consultation by nonMD psychiatry consultant, for placement or for discharge
- If consultation is anticipated, replace clothing with gown or scrubs, remove shoes
- Includes near-normalization of VS and medically stable for discharge
- Should virtually always include ethanol (blood or breathalyzer) level and drug screen. Urine Drug Screen is useful for outpatient followup even if not useful in ED
- Customized to age, comorbidities, past medical/psychiatric/substance abuse history, presentation. If any doubt, do all “routine” labs (CBC, chem 7, Upreg)
- If patient is not medically clear and admitted to medical hospital, order sitter and security presence may still be indicated
- Awaiting clearance should not delay ED assessment and treatment, and need not delay psychiatry (MD) consultation if indicated

Focus

- Rapid patient assessment, medical clearance, and initiation of treatment by ED staff
- Clarifying ED choice of consultant if available: with increased use of psychiatrist/behavioral health consultation early in ED stay
- All staff trained in management of assaultive behavior
- Developing shared approach **and language/vocabulary** across all ED staff, consultants, transfer facilities

Agitation Basics

- Excessive verbal and/or motor behavior
- Escalation phase signs include:
 - Pacing frequent change of body positions
 - Verbal outbursts – loud aggressive speech
 - Irritability, anger
 - Affective lability (tearful one moment, angry the next)
 - Threatening or destructive behavior (pounding walls or the gurney)
 - Tense posturing - Clenching fists or jaws
 - Slamming or banging objects
- Fear, intimidation, confusion
- Interventions include – move patient to a quiet area, reduce stimulation, remove objects that can be used as weapons, verbal de-escalation, medication, restraints
DO NOT WAIT TO BEGIN TREATMENT

De-escalation

- Respect Personal Space
- Do Not be Provocative
- Establish Verbal Contact
- Identify Wants and Feelings
- Listen Closely to What the Person Is Saying
- Agree or Agree to Disagree
- Lay Down the Law and Set Clear Limits
- Offer Choices and Optimism
- Debrief the Person and the Staff Afterward

From De-escalation of the Aggressive Patient and Avoiding Coercion Fishkind, Averim, MD in Emergency Psychiatry Principles and Practice, Glick, Berlin, Fishkind and Zeller, Eds. Lippincott Philadelphia 2008

Medicating Agitation

- Use BETA best practice medicating agitation (see handout)
- Three classes of medications used
 - Benzodiazepines – such as Lorazepam - preferred when sedating a patient with violence from unknown causes. Rapid onset, short half-life can be given IM or IV
 - Typical Antipsychotics – Haldol orally or IM 2-10mg onset within 30-60 min. Caution b/c of EPS (cogentin, benadryl), youths, elderly. Benzo plus typicals to achieve rapid sedation.
 - Atypical Antipsychotics – Olanzapine (Zyprexa), Risperidone (Resperidol), Aripiprazole (Abilify)
- Considerations – Safety
 - Hypotension, respiratory depression, NMS, dystonic rx, akathesia

Initial ED Management

Based on initial presentation

Acutely agitated	Somewhat agitated	Not agitated
<ul style="list-style-type: none">■ Is the patient so agitated that s/he is at immediate risk of physically injuring self or others, or is profoundly disruptive of ED operations, and thus requires rapid tranquilization?	<ul style="list-style-type: none">■ Is the patient somewhat agitated but not in need of rapid tranquilization?	<ul style="list-style-type: none">■ Is the patient not agitated?

Acute severe agitation/agitated delirium – general

For patients at immediate physical risk of danger to themselves or staff and in need of immediate tranquilization

- Assure safety of patient and staff – locate in a less stimulating quiet space. Alert MAB team and security as back up
- For rapid tranquilization (which will likely delay further psychiatric assessment), usual starting ED cocktail is Haldol 5mg plus Ativan 1mg, +/- Benadryl 25mg, all given IM
- Stay tuned for use of ketamine or dextromethorphan
- May repeat above in 30-60 minutes if needed. Note that overly sedated patient will not be assessable for psychiatric disposition

Moderate to Low Agitation: not needing rapid tranquilization

Consider probable cause:

- Anxiety with or without depression
- Suspect alcohol/drug intoxication/withdrawal
- Psychoactive medications, including steroids
- Mania
- Psychosis (delusional, auditory hallucinations, paranoid, etc)
- Dementia
- Delirium (medical)
- Combination of above



ED-Psych Medication Summary Guidelines

Agitation:

- with delirium, crisis: Haldol 5/Ativan 1 IM or other emergency cocktail
- with delirium (not from stimulants or withdrawal): Haldol 1 po or Zyprexa 5-10 po
- with delirium from stimulants/withdrawal: benzodiazepines
- with mania (not stimulants): Zyprexa 5-10 po (2.5 in elderly)
- with psychosis (not stimulants or withdrawal): zyprexa 5-10 po. Add Ativan 0.5 po as needed and/or Haldol 1 po for prominent psychosis
- with dementia: Seroquel 25 po or Zyprexa 2.5 mg IM

Depression with sleep deprivation: Ativan 0.5-1 po and sleep in ED

Dementia with psychosis or aggressive behavior: Seroquel 25 po or Zyprexa 2.5 IM

Call Psychiatrist any time for psychopharmacology advice

Appendix

Medication Suggestions for Other Conditions

Acute severe agitation/ agitated delirium – nuances

- If stimulant use suspected, **OMIT HALDOL** and increase Ativan or other benzodiazepine as needed
- Consider lower doses of Haldol in demented and frail patients (IM is twice as bioavailable as po)
- If “allergic” to Haldol, consider substituting olanzapine (Zyprexa) 10 mg IM. May add Ativan 1 mg OR Benadryl 25 mg IM
- If elderly and/or demented, avoid ativan as possible because of risk of disinhibition
- Once agitation resolved, if etiology appears to be psychiatric (ie, not delirium) will likely need acute consult with therapist and/or psychiatrist. If discharged, eConsult Psych

Agitation with anxiety/depression

- Goal: reduce symptoms in ED to a level that would allow discharge to outpatient treatment
- Offer non-pharmacologic treatment
- If using meds, use ORAL ONLY, lowest dose possible, explain that this is only to take the edge off sx today in order to refer for more definitive relaxation and mindfulness approaches
 - Ativan 1 mg po
 - If Ativan is insufficient or if patient is “seeking” benzodiazepines use Seroquel (12.5 mg po in elderly/frail, 25 mg po in others)—unless in benzodiazepine or alcohol withdrawal, which requires benzodiazepine
- Consult psychiatrist for further med guidance, if needed
- Consult therapist AFTER medical clearance, if needed
- Ensure safe discharge plan

Agitation with mania

- Goal: reduce symptoms in ED to a level that would allow discharge to outpatient treatment
- Consider stimulant intoxication and sedative/alcohol withdrawal and if found, treat with benzodiazepines
- If not stimulant-induced, Zyprexa 5-10 mg ORALLY or Zydis ODT (same dose). In elderly/frail, begin with 2.5 mg. Treat as early as possible in ED stay
- Consult psychiatrist if needed for further medication guidance. May need therapist evaluation for advice re appropriateness of 5150 after med clearance

Agitation with psychosis

- Delusional, auditory hallucinations
- Goal: reduce symptoms in ED to a level that would allow discharge to outpatient treatment
- **If etiology is stimulant intoxication or sedative/alcohol withdrawal, treat with benzodiazepines**
- If symptoms represent acute exacerbation of chronic psychiatric disease in noncompliant patient, restart meds immediately. If compliant, consider increasing usual meds
- For first episode or if compliant with chronic meds:
 - Zyprexa 5-10mg po immediately
 - Add Ativan 0.5 mg po if Zyprexa inadequate, **OR**
 - Add Haldol 1 mg po for prominent psychotic sx (hallucinations, paranoia)
- Therapist or psychiatrist consult if needed, ensure f/u appt

Agitation with dementia

- Goal: reduce symptoms in ED to a level that would allow discharge to outpatient or nonhospital residential treatment
- Need medical clearance. Consider and rule out delirium prior to attributing to psychiatric disorder
- Compare current agitation status to baseline
- Seroquel 25mg po or ODT if needed for symptom management
- If patient is followed by neurology primarily, they may be best first contact

Agitation with delirium

- Assume this is a medical problem, requires extensive medical evaluation and disposition. Mortality is 8% in acute delirium
- Haldol or Zyprexa for management of agitated symptoms
- Consider psychiatry consultation for patients on multiple psychiatric medications

Agitation with Depression/Suicidal Ideation

- Place or accept civil commitment if indicated **and medically clear**
 - Generally, this refers to patients who have made a serious attempt, or who clearly state their suicidal intent and plan, and are not intoxicated
 - Refer to receiving facility: Psychiatric Call Center (members with inpatient coverage), Public system(others)
- **Intoxicated patients:** ED must reevaluate for suicidality once sober. If patient denies suicidality, consider removing (or not requesting) the hold and refer to Chemical Dependency for next business day contact. Consider therapist consult if unsure ED must reevaluate once sober. Generally this means BAL < 80 (0.08), even if clinically not intoxicated. If patient then denies suicidality, consider removing (or not requesting) 5150 and send eConsult to Chem Dep for next business day contact. Consider nonMD consultation if unsure

Dementia with Psychosis

- Seroquel 25 mg po OR Zyprexa 2.5 mg IM
- Repeat in 2 hours if sx not improved
- If patient has prior history psychiatric disease or prior use of these medications, may require higher doses
- Medical clearance
- Contact psychiatrist if needed
- ED medical SW/PCC for help with family and placement, if needed

Dementia with Aggressive Behavior

- Seroquel 25 mg po OR Zyprexa 2.5 mg IM if aggressive in ED
- Repeat in 2 hours if behavior not improved
- If cooperative in ED, may not need medication while in ED
- ED medical SW/PCC for help with family and placement, if needed
- Contact psychiatry as needed for help in ED and for outpatient medication plan