

Do Not Disturb

A REVIEW OF MANAGEMENT STRATEGIES FOR
ACUTE AGITATION AND AGGRESSION

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Disclosures

Dr. Steckler does not have any actual or potential conflicts of interest to disclose.

Off-label use of medication will be discussed throughout.

This presentation includes information about legal issues. Such materials are for informational purposes only and are not intended, and should not be taken, as legal advice on any particular set of facts or circumstances. You should contact an attorney for advice on specific legal problems.

Learning Objectives for Pharmacists

- Apply at least 3 domains of de-escalation when addressing agitated patients
- Understand the difficulty in creating trials to evaluate management strategies
- Recognize the importance of patient selection in medications for agitation
- Given a patient case, formulate an appropriate treatment plan for acute management of agitation
- Recall the legal considerations when restraining an agitated patient

Learning Objectives for Technicians

- Apply at least 3 domains of de-escalation when addressing agitated patients
- Discuss the importance of targeting agitation treatment towards the underlying cause
- Recognize the antipsychotics, benzodiazepines, and anesthetics commonly used in the management of agitation
- Recall the legal considerations when restraining an agitated patient

Definitions

- **Agitation:** a state of excessive psychomotor activity accompanied by increased tension and irritability
- **Aggression:** hostile, injurious, or destructive behavior or outlook especially when caused by frustration
- **Delirium:** a mental disturbance characterized by confusion, disordered speech, and hallucinations
- **Sundowning:** a state of increased agitation, confusion, disorientation, and anxiety that typically occurs in the late afternoon or evening in some individuals affected with dementia

Meriam-Webster, inc. 2018.
Journal of Psychiatric Practice. 2005;11 [Suppl 1]:3-108.
Lancet. 2014; 383(9920): 911-922.

Agitation

- Behavioral emergency
- Requires immediate intervention to mitigate harm to the patient and surrounding individuals
- Agitation is relatively common in the healthcare setting
 - Patient illness
 - Prolonged waiting times
 - Confusion and frustration about patient health
 - Availability of medications

Epidemiology



- Of healthcare providers are the victim of violence in their career
- 50% Of emergency department nurses are verbally or physically threatened weekly
- Of hospitalized seniors develop delirium

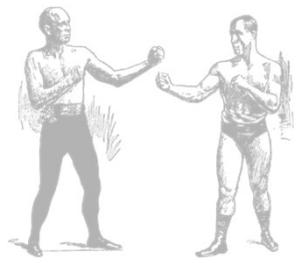
- 1.7 million ED visits per year in the US involving agitated patients
- 4-8% of patients who present to psychiatric emergency departments are armed

Eur J Emerg Med. 1999;6(4):301-4.
West J Emerg Med. 2012;13(1):26-34.
Lancet. 2014; 383(9907): 918-922.
Clin Ther. 2010;32(3):403-25.

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Risk Factors

- History of violence or aggression
- Impulsiveness or hostility
- Prolonged hospitalization
- Non-voluntary admission
- Aggressor and victim same gender
- Alcohol or drug misuse
- Younger age
- Suicidal risk



Psychiatry Res. 2012;189(1):20-20.

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Presentation & Diagnosis

- Agitation exists on a continuum
- Non-verbal cues of agitation
 - Repetitive, non-goal-directed movements
 - Labile or threatening behaviors
 - Clenching jaw
- Symptoms of agitation may suggest different causes depending on patient, provider, and pharmacist background



Clin Ther. 2010;32(3):403-25.
West J Emerg Med. 2012;13(1):26-34.

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Agitation Assessment

- No standard tool for assessment
- Most validated in psychiatric or correctional settings
- Varying level of predictive ability
- Most clinicians don't need or use a tool
- May be used to identify patients for early intervention (i.e. de-escalation)

Available Tools for Assessment of Agitation
Aggressive Behavior Scale
Agitated Behavior Scale
Brief Psychiatric Rating Scale
Breset Violence Checklist
Clinical Global Impression
Cohen-Mansfield Agitation Inventory
Historical, Clinical, and Risk Management-20 Violence Risk Assessment Scheme
McNiel-Binder Violence Screening Checklist
Neurobehavioral Rating Scale-Revised
Overt Aggression Scale
Overt Agitation Severity Scale
Positive and Negative Syndrome Scale-Excited Component
Ryden Aggression Scale
Thomas Combativeness Scale

Clin Ther. 2010;32(3):403-25.

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Preparation and Prevention

- Staff training
 - Annual behavioral emergency training for highest-risk staff
 - Self-reflection on recognizing one's emotions, nonverbal behavior, and limits in dealing with agitated patients
 - Creation of a de-escalation team, where possible (i.e. code green team)
- Physical environment
 - Movable furniture = flexible and equal access to exits for both patients and staff
 - Avoid extremes in sound, wall color, and temperature
 - Limit access to objects that may be thrown or used as a weapon
 - Be capable of creating a quiet room with low lighting

West J Emerg Med. 2012;13(1):17-25.
West J Emerg Med. 2012;13(1):26-34.

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Management Outline

- Goal:** calm the patient to facilitate assessment and safety
 - Verbal de-escalation
 - Pharmaceutical management
 - Physical restraint
- Historically, management has involved seclusion or restraints
- Current emphasis on non-coercive approaches, if possible
 - Enhances relationship with patient
 - Shorten hospital length of stay
 - Avoid unintended consequences (e.g. adverse drug reactions, legal ramifications)

West J Emerg Med. 2012;13(1):26-34.
AHRO Publication No. 16-EHC02EF.
West J Emerg Med. 2012;13(1):17-25.

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Verbal De-Escalation

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Throughout, West J Emerg Med. 2012;17(1):17-25

Verbal De-Escalation Principles

- Reasons to start with non-coercive approach
 - Physical force reinforces idea that violence is necessary to resolve conflict
 - Physically restrained patients are more likely to be admitted and have longer length of stay
 - Patients and staff are less likely to be injured
 - TJC and CMS consider low restraint rates a key quality indicator
- Main objectives of de-escalation
 - Ensure safety of patient, staff, and others nearby
 - Help the patient to manage emotions and control behavior
 - Avoid coercive actions that may escalate agitation
 - Avoid use of restraint

TJC = The Joint Commission
CMS = Centers for Medicare and Medicaid Services

Verbal De-Escalation Principles

- **Three-step approach**
 1. Verbally engage the patient
 2. Create a collaborative relationship
 3. Verbally de-escalate the patient out of the agitated state
- Typically involves a verbal communication loop
 - May have to repeat several times until your message is heard
 - Young, inexperienced clinicians often give up too early
- Taking time to de-escalate appropriately is less time consuming because restrained patients will require closer monitoring (i.e. more nursing involvement)

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            graph TD
            A[Listen to Patient] --> B[State How They Should Act]
            B --> C[Validate Their Position]
            C --> A
            
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10 Domains of De-Escalation

1. Respect personal space
2. Do not be provocative
3. Establish verbal contact
4. Be concise
5. Identify wants and feelings
6. Listen closely to what the patient is saying
7. Agree or agree to disagree
8. Lay down the law and set clear limits
9. Offer choices and optimism
10. Debrief the patient and staff

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10 Domains of De-Escalation

<p style="text-align: center;">1. Respect Personal Space</p> <ul style="list-style-type: none"> • Maintain ≥2 arm's length distance from the patient • Allow clear paths of exit for yourself and patient • Especially important for patients with history of trauma 	<p style="text-align: center;">2. Do Not Be Provocative</p> <ul style="list-style-type: none"> • Body language should convey no harm to the patient, listening attitude, and desire for safety • Keep hands open • Avoid directly facing the patient, excessive eye contact • Maintain open body language
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10 Domains of De-Escalation

<p style="text-align: center;">3. Establish Verbal Contact</p> <ul style="list-style-type: none"> • The first person to encounter the patient should attempt de-escalation • Introduce yourself and orient the patient 	<p style="text-align: center;">4. Be Concise and Keep It Simple</p> <ul style="list-style-type: none"> • Use short sentences and simple vocabulary • Wait for understanding and repeat as needed to ensure the patient hears what you are saying
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10 Domains of De-Escalation

5. Identify Wants and Feelings

- Ask the patient for their request, whether or not it can be granted
- Use "free information" from the patient's nonverbal cues, past encounters, and seemingly trivial statements

6. Listen Closely to the Patient

- Use active listening to repeat and summarize
- Use Miller's Law
 - Assume they are speaking the truth
 - Try to understand how it could be true to them

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10 Domains of De-Escalation

7. Agree or Agree to Disagree

- Use fogging to find something about the patient's position to agree about
 - Agree with the truth
 - Agree in principle
 - Agree with the odds
 - Agree to disagree

8. Lay Down the Law; Set Limits

- Explain what behaviors are acceptable and injury to anyone is not acceptable
- Teach the patient how to stay in control

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10 Domains of De-Escalation

9. Offer Choices and Optimism

- Patients may feel their only options are fight or flight, so giving choices can empower
- May offer trivial things perceived as acts of kindness (e.g. food, blankets, phone access)
- Broach the subject of medications

10. Debrief the Patient and Staff

- Explain to the patient why further intervention was necessary
- Teach how to more appropriately respond next time
- Huddle with staff to identify successes and areas for improvement

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Case #1

ARG is a 37 year old male who presents to your pharmacy to pick up a medication. After briefly talking to you, it is discovered that insurance denied the claim for his expensive medication. He becomes visibly upset and starts pacing and wringing his hands, what would be the most appropriate action?

- Go block his path and let him know aggression will not be tolerated
- Call over the other two technicians for assistance
- Keep talking with him and ask what he would like you to do
- Grab the secret vial of haloperidol from your lab coat and give 5 mg IM STAT

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Pharmaceutical Management of Agitation

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Evidence Base

- Most studies are small, from single-sites, and in patients with pre-existing psychiatric diagnoses
- Lack of high-quality studies on management of agitation
 - Practical difficulties
 - Challenging to obtain consent in an agitated patient
 - Unable to predict when agitation will occur (i.e. cannot pre-enroll patients)
 - Ethical difficulties
 - Delaying treatment to obtain consent places patient and others at risk of harm
 - If consent obtained, was patient competent enough to understand its meaning
- Body of evidence continues to grow

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Journal of Psychiatric Practice, 2005;11 (Suppl 1): 1-108

When to Use Pharmacotherapy

- Failure of verbal de-escalation
- Immediate threat to patient, staff, or others
- Patient cannot be evaluated
- Goals:
 - Calm the patient without over-sedating
 - Enhance safety
 - Facilitate timely diagnosis and treatment
 - Target the underlying cause of the agitation
- NOT used for punishment or staff convenience



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Pathophysiology of Agitation

Underlying Disorder	Pathophysiology
Depression	↓ GABA, ↑ serotonin
Panic or anxiety disorder	↓ GABA, ↑ norepinephrine
Dementia	↓ GABA
Mania	↑ dopamine
Psychosis	↑ dopamine
Acute intoxication	↑ dopamine
Delirium	multifactorial



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J Clin Psychiatry. 2000;61 Suppl 14:5-10.

The Ideal Medication

- Targeted towards underlying cause
- Easy preparation and administration
- No associated pain or need for restraint
- Rapid onset
- Minimal PK or PD variability between patients
- Sufficient duration of action to enable triage and assessment
- Minimally sedating
- Low risk of adverse drug reactions or drug-drug interactions

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Clin Ther. 2010;32(3):403-25.

Oral vs. Parenteral Therapy

- Oral
 - Patients may refuse or cheek tablets
 - Longer onset of action
- Parenteral
 - Higher risk of adverse events
 - More involved preparation for administration (e.g. IV line, syringe/needle prep)
 - Compromises relationship with the patient
 - Risk of needle-stick injuries



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Clin Ther. 2010;32(3):403-25.

First Generation Antipsychotics (FGA)

- **Mechanism:** dopamine (D₂) antagonist → reduction in underlying psychotic symptoms
- **Adverse Drug Reactions (ADRs):** anticholinergic effects, extrapyramidal reactions, sedation, and prolonged QTc
- Phenothiazines (e.g. chlorpromazine) are not preferred due to more frequent ADRs: hypotension, anticholinergic effects, lowered seizure threshold
- Butyrophenones (e.g. haloperidol, droperidol) are more often used due to higher potency and D₂-selectivity, fewer drug interactions, and lower risk of ADRs

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West J Emerg Med. 2012;13(1):26-34.

Haloperidol and Droperidol

- QTc prolongation, Torsades de Pointes
 - Highest risk with higher doses and IV administration
 - Haloperidol not approved for IV administration and typically requires EKG monitoring while administering
- Acute extrapyramidal side effects
 - Lower risk of EPS when co-administered with lorazepam or promethazine
 - Often done in practice to limit doses of both agents
 - Increases risk of drug interactions
 - Droperidol is less frequently used due to cardiovascular risk and no PO availability
 - Only approved for post-operative nausea and vomiting

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West J Emerg Med. 2012;13(1):26-34.
Ann Emerg Med. 2006;47(1):79-99.

Second Generation Antipsychotics (SGA)

- **Mechanism:** dopamine (D₂) and serotonin (5-HT_{2a}) antagonists with actions at other receptors
- **ADRs:** metabolic effects, hypotension, sedation, anticholinergic effects, and extrapyramidal effects
- Route of administration does not impact efficacy, only onset of action
 - IM or PO: olanzapine, ziprasidone
 - PO only: risperidone, quetiapine, aripiprazole
- Systematic reviews suggest most SGAs are equally effective, with a few exceptions
 - Aripiprazole appears slightly less effective
 - Quetiapine has a higher risk of orthostatic hypotension

FGA vs. SGA

- Numerous studies and reviews support SGAs as being as effective as haloperidol
- The American Association of Emergency Psychiatry (AAEP) recommends use of SGAs over FGAs in most situations where an antipsychotic is indicated
 - Highly efficacious
 - Lower EPS risk
 - Subjectively preferred by patients
- Haloperidol is still preferred in alcohol intoxication

Study: SGA vs. FGA

Population	Patients admitted to psychiatry emergency service with agitation and acute psychosis and requiring medications (n=101)
Treatments	<ul style="list-style-type: none"> o Oral haloperidol, risperidone, olanzapine, or quetiapine for 72 hours o Randomized, doses determined by treating physician; multiple doses (over 72 hours)
Assessment Tools	<ul style="list-style-type: none"> o Brief Psychiatric Rating Scale o Modified Overt Aggression Scale o Clinical Global Impression-Severity Scale
Findings	<p>Efficacy: There was no difference in baseline characteristics or medication efficacy at 72 hours (using any scale).</p> <p>Safety: Haloperidol caused significantly more extrapyramidal symptoms (21.4% vs 0-7.4%; p=0.012). There was no difference in other adverse events.</p>
Conclusions	<ul style="list-style-type: none"> o All three SGAs were as effective as haloperidol and better tolerated o No differences in efficacy or safety between the SGAs

Case #2

GR is a 54 year old female who is admitted to your inpatient psychiatry unit for acute worsening of her schizophrenia. She is becoming more agitated and the treating physician fears for the safety of the other patients. Which of the following would be the best medication to reduce her agitation?

- A. Haloperidol, PO
- B. Haloperidol, IM
- C. Risperidone, PO
- D. Aripiprazole, PO



Benzodiazepines

- **Mechanism:** Activates benzodiazepine receptors on GABA-A receptors → enhanced inhibitory effects of GABA
- **ADRs:** sedation, respiratory depression, hypotension
- Lorazepam and midazolam are best studied
- ACEP guidelines state benzodiazepines are as effective as haloperidol



Study: Benzodiazepine vs. FGA

Population	Patients presenting to one emergency department who required emergency sedation for the control of violent behavior or severe agitation (n=111)
Treatments	<ul style="list-style-type: none"> o Midazolam 5 mg IM, haloperidol 5 mg IM, or a lorazepam 2 mg IM o Randomized, double blind; single dose
Assessment Tool	Modified Thomas Combativeness Scale (assess time to adequate sedation and arousal)
Findings	<p>Efficacy: Midazolam produced more rapid sedation than haloperidol and lorazepam (18.3 min vs 28.3 min vs 32.2 min). Arousal occurred quickest for midazolam, then haloperidol, then lorazepam (81.9 min vs 126.5 min vs 217.2 min).</p> <p>Safety: Haloperidol caused one episode each of hypotension and apnea.</p>
Conclusion	Midazolam is superior to lorazepam and haloperidol at producing timely sedation and arousal

Study: Benzodiazepine vs. FGA

Population	Patients presenting to one of five emergency departments with psychosis and behavioral dyscontrol requiring pharmacologic intervention (n=98)
Treatments	<ul style="list-style-type: none"> Lorazepam 2 mg IM, haloperidol 5 mg IM, or a combination Randomized, double blind; multiple doses (up to 6 over 12 hours)
Assessment Tools	<ul style="list-style-type: none"> Brief Psychiatric Rating Scale (BPRS) Agitated Behavior Scale (ABS) Clinical Global Impression Scale (CGIS)
Findings	<p>Efficacy: Patients who received combination therapy had more improved ABS and BPRS scores at 1 and 2 hours versus monotherapy. There was no significant difference between monotherapy groups.</p> <p>Safety: Patients who received haloperidol spent less time asleep versus the lorazepam or combination group. EPS were more common in the haloperidol group.</p>
Conclusions	<ul style="list-style-type: none"> Repeated doses of lorazepam and haloperidol are equally effective Combination of lorazepam and haloperidol is more effective than either alone

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Am J Emerg Med. 1997;15:335-340.

Study: Combo Therapy vs. FGA vs. SGA

Study Population	Patients presenting to one of two emergency departments requiring IV medication sedation for acute agitation (n=349)
Treatments	<ul style="list-style-type: none"> Droperidol, olanzapine, or combination midazolam-droperidol Randomized, double blind; multiple doses
Assessment Tool	Six-point sedation scale (used to monitor changes in agitation in ED patients)
Findings	<p>Efficacy: At 10 minutes, more patients in the combination group were adequately sedated, versus either monotherapy group and fewer required additional doses of medication.</p> <p>Safety: There was no difference between groups and most ADRs were related to respiratory depression.</p>
Conclusion	Combination of midazolam-droperidol works more rapidly and effectively than the other two monotherapies in sedating acutely agitated patients

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Ann Emerg Med. 2017;69:328-326

Combo Therapy

- Combination of an antipsychotic and benzodiazepine may be more effective than either alone
 - Reduced doses of either agent = less risk of ADRs
 - Using multiple agents = higher risk of drug interactions
- B52 is a commonly used IM example
 - Benadryl (diphenhydramine; often 50 mg)
 - Haloperidol 5 mg
 - Lorazepam 2 mg
- Avoid use of IM olanzapine with a IM/IV benzodiazepine

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Ketamine

- Mechanism:** glutamergic NMDA receptor antagonist → dissociated state with analgesia and amnesia
- ADRs:** emergence reactions, tachycardia, and hypertension
 - Avoid in elderly or those with heart disease or risk for heart disease
 - Avoid in schizophrenia as it can worsen symptoms
- Emerging therapy; not widely used
- May be used as a second-line option, especially in patients with excited delirium secondary to drug abuse

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Ann Emerg Med. 2017;69(4):480-485

Study: Ketamine vs. FGA vs. Benzodiazepine

Population	Acutely agitated patients presenting to one emergency department who required chemical sedation for acute agitation (n=98)
Treatments	<ul style="list-style-type: none"> Ketamine, haloperidol, midazolam, lorazepam, or benzodiazepine + haloperidol Observational study; single dose
Assessment Tool	Six-point sedation scale (used to monitor changes in agitation in ED patients)
Findings	<p>Efficacy: At 5, 10, and 15 minutes more patients who received ketamine were no longer agitated compared to all other medication groups.</p> <p>Safety: inadequately powered to assess</p>
Conclusion	Ketamine is faster at controlling agitation than FGAs or benzodiazepines

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Am J Emerg Med. 2017;14(7):1000-1004

		Initial Dose (mg)	Tmax (min.)	Repeat Interval (hr.)	Max. daily dose (mg)
PO	Risperidone	2	60	2	6
	Olanzapine	5-10	360	2	20
	Haloperidol	2.5-5	30-60	0.25	20
	Lorazepam	2	20-30	2	12
IM	Ziprasidone	10-20	15	2-4	40
	Olanzapine	10	15-45	0.5	30
	Haloperidol	5	30-60	0.25	20
	Lorazepam	2	20-30	2	12
	Ketamine	4-5 (per kg)	15	-	-
	Droperidol	5-10	30	0.25-0.5	-
IV	Midazolam	2.5-5	30-60	-	-
	Haloperidol	2-5	15	4	10
	Ketamine	1 (per kg)	1-5	0.25	-
	Droperidol	2.5-10	15	0.1	20
	Midazolam	2.5-5	3-5	-	-

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Adapted from: West J Emerg Med. 2012;13(1):26-34
<https://doi.org/10.1016/j.wjem.2012.01.004>

AAEP Guidelines

43 Throughout, West J Emerg Med. 2012;13(1):26-34.

Agitation Due to Intoxication

- Alcohol
 - First line: Avoid medications, if possible
 - Second line: Haloperidol (best studied), SGAs
- Other recreational drugs
 - First line: Benzodiazepines (for most)
 - Second line: SGA (especially in amphetamine users with psychotic symptoms)

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Agitation Due to Psychiatric Illness

- First line: SGAs
 - Antipsychotics address the underlying disorder
 - Oral risperidone has best data
 - If IM is required, ziprasidone or olanzapine are preferred
- Second line: Combination of SGA and benzodiazepine

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Agitation Due to Delirium

Cause of Delirium	Withdrawal (alcohol or benzodiazepine):	Benzodiazepine Clonidine
	Withdrawal (other medication):	Replace the medication
	Acute ingestion (drug or medication):	Avoid any medications
	Lab or vital abnormality:	Correct the underlying cause
	Unknown cause:	SGA Haloperidol (second line)

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Agitation Due to Unknown or Complex Etiology

- No psychotic features: Benzodiazepine
- Psychotic features: SGAs
- ACEP recommendations
 - Voluntary administration: Benzodiazepine + SGA
 - Involuntary administration: Benzodiazepine or FGA

47 Ann Emerg Med. 2005;42(1):79-90

48 West J Emerg Med. 2012;13(1):26-34.

Case #3

PO'd is a 23 year old male who presents to your emergency department and after 5 minutes in the waiting area he starts screaming "I NEED TO SEE A DOCTOR!" and knocking chairs over. There are no ED beds to provide him a room and no indication of what is causing this reaction. After failed attempts at de-escalation, which IM medication would you recommend to assist in calming him and facilitating a diagnosis?

- A. Midazolam 10 mg
- B. Lorazepam 2 mg
- C. Haloperidol 5 mg
- D. Olanzapine 10 mg



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Case #4

One hour after receiving two doses of the medication you suggested, PO'd remains agitated and has begun directly threatening the nursing staff. Which of the following is the best option for management of his agitation?

- A. Administer a combination of haloperidol and lorazepam
- B. Give another dose of the same medication
- C. Calmly ask for his demands and his cooperation
- D. Lunge towards him and attempt to subdue him with a half-nelson

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Alternative Recommendations

- "A written survey of 61 questions was mailed to 50 experts in the field... the survey sought to define..."
 - Level of agitation where emergency intervention is appropriate
 - Guiding principles for selecting interventions
 - Appropriate physical and medication strategies for a variety of provisional diagnoses and complicating conditions
- All experts have extensive clinical or research experience in agitation
- 48 of 50 experts responded
- Survey items were statements that participants would rate on appropriateness from 1 to 9

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Journal of Psychiatric Practice, 2005;11 (Suppl 1):1-108

Alternative Recommendations (cont.)

- Panel reached consensus on 78% of the items
- Unknown/multifactorial cause: benzodiazepines
- Intoxication: benzodiazepines
- Schizophrenia/mania: olanzapine, risperidone (IM: ziprasidone), or haloperidol + benzodiazepine
- Not a gold standard of evidence
 - Results provide evidence of how agitation is managed in practice
 - An interesting approach given the paucity of evidence

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Journal of Psychiatric Practice, 2005;11 (Suppl 1):1-108

Use of Physical Restraint

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Rationale and Methods of Restraint

- Like pharmacologic restraint, reserved for use in facilitating diagnosis and treatment or preventing injury to self or others
- Considered a procedure, where each member of the restraint team plays a specific role and the team enters room as one single unit
- Once patient is restrained, announcing "the crisis is over" is calming
- Close monitoring needed to ensure patient safety and provision of basic human needs
- Remove restraints as soon as possible

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Ethical & Legal Considerations

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Competence & Consent

- **Competence:** the ability of a person to act on his/her own behalf
- **Consent:** a voluntary agreement by a competent person to do something proposed by another
- Considerations in agitation
 - Best to obtain consent if possible, even if from next of kin
 - Have another medical professional document agreement with the decision
 - Document considerations when deeming someone incompetent
 - Courts have supported physician actions without consent when needed to preserve life or health

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Duty to Protect

- Use of restraints takes away a patient's freedom
 - Gives the provider a fiduciary responsibility for all health and welfare of the patient
 - Physically restrained patients require frequent monitoring
- **Example: Estate of Doe v. ABC Ambulance**
32-year old patient with schizophrenia threatened to kill his psychologist and was taken to the ED... when informed of his involuntary admission, he became violent... he was physically restrained, chemically sedated, with a towel placed over his face to prevent spitting... it was later noticed that one of his hands was turning blue and was found to have experienced cardiac arrest... his estate was awarded \$2 million.

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Battery & False Imprisonment

- **Battery:** intentional infliction of a harmful or offensive bodily contact
- **False Imprisonment:** intentional confinement and deprivation of personal liberty, without consent
- Considerations in agitation
 - Battery and false imprisonment are applicable if a patient is restrained for convenience, not medical necessity
 - Must follow appropriate protocol and document rationale when using restraint

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Duty to Warn

- Providers must warn a third party of imminent danger, regardless of obligation to patient confidentiality
- Dictated on a state-by-state basis (Iowa: permitted, not required)
- **Example: Dorothy McGrath et al. v. Barnes Hospital et al.**
Patient with paranoid schizophrenia treated as an inpatient repeatedly told hospital workers of thoughts of stabbing his mother with a kitchen knife... the night he was released he stabbed both his parents, killing his father and severely injuring his mother... plaintiff was awarded \$2 million despite his parents' knowledge of his risk of violence

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Key Points

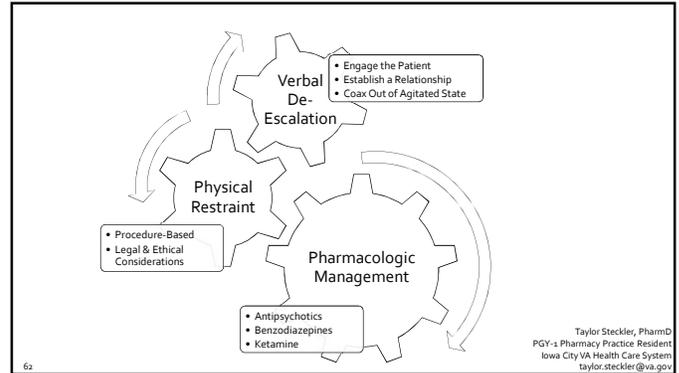
- Agitation is a behavioral emergency and exists on a continuum from anxiety to aggression
- Management of agitation should always start with attempts at de-escalation, if safe to do so
- Verbal de-escalation aims to engage the patient, establish a relationship, and coax him or her out of the agitated state
- Use of physical or chemical restraint should be done only if needed to enable further diagnostic workup or ensure safety of the patient and others

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Key Points

- Antipsychotics are generally preferred in patients intoxicated with alcohol, those with pre-existing psychiatric illness, or if patient is exhibiting psychotic symptoms regardless of etiology
- Benzodiazepines are generally preferred in patients using illicit drugs, withdrawing from alcohol, or with idiopathic or multifactorial agitation with no psychotic symptoms
- Combination therapy with an antipsychotic plus a benzodiazepine may be more safe and effective than monotherapy with either agent
- Ketamine is an emerging treatment option for agitation and evidence for its use continues to accumulate
- Use of restraint can open up healthcare providers to legal action if protocols are not followed and documented

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