

In Dealing with Agitation, Use De-Escalation Rather Than Coercion

Summarized by Thomas T. Thomas

Our September presenter was **Scott Zeller, MD**, Chief of Psychiatric Emergency Services at John George Psychiatric Hospital and past President of the American Association of Emergency Psychiatry. Described by one NAMI official as the “Johnny Appleseed of Crisis Stabilization,” Dr. Zeller has practiced emergency psychiatry for 28 years, authored numerous articles, written and co-edited several books, and received distinguished honors for his work with crisis treatment of agitation in individuals with mental illness. He has become an expert on reducing the use of restraints, seclusion, and forced injection in the emergency hospital setting.¹

We also had **Beverly Bergman**, Family Caregiver Advocacy Specialist at John George, and **Francesca Tenenbaum**, Patients’ Rights Director for Alameda and San Mateo counties, join the discussion to share their comments and impressions.

“It’s frustrating working with medical professionals,” Dr. Zeller said, “and getting them to understand that people in the emergency room are not their enemy. That the easiest but most coercive treatment is probably not the best.” Many doctors, he said, are most concerned about the safety of their staff. So their solution to an agitated patient is to tackle him with security guards, restrain him, and inject him with strong medications—and if he sleeps for a couple of days, at least the staff is safe. But two-thirds of staff injuries are usually sustained while restraining the patient instead of trying less coercive methods.

Patients experiencing agitation are often in anguish and distress, with racing thoughts, paranoia, and the fear they are in jeopardy. They are often engaged in basic “fight or flight” decisions. Dr. Zeller tells colleagues that such agitation is the equivalent of experiencing “the worst headache in the world.” Imagine you had that headache, and people were telling you to sit down, be quiet, and wait for treatment. “Understanding and treating agitation with compassion can be the basis for an overall approach to involuntary crisis care,” he said.



SCOTT ZELLER, MD

¹ For YouTube videos of Dr. Zeller’s techniques, click on:
www.youtube.com/playlist?list=PLkEyLB5TkXVI2gWLVxByNm3N2MR0niu-2.

In 2010, the American Association for Emergency Psychiatry started work on Project BETA, which stands for **B**est practices for **E**valuation and **T**reatment of **A**gitation in an emergency setting. More than 40 emergency psychiatrists, emergency room physicians and nurses, mental health clinicians, and patient advocates participated in the project. In 2012, the findings of Project BETA were published in six articles in the *Western Journal of Emergency Medicine* and have since become that journal's most downloaded and frequently cited.² These practices apply not just to mental illness, because agitation can occur in people getting out of surgery or suffering a stroke or head injury.

So, what is agitation? Dr. Zeller defined it as “excessive verbal and/or motor behavior”—people talking a bit too loudly or moving around too much. Agitation is a spectrum, he said, from a patient who is irritable and frustrated to the Incredible Hulk smashing cars—but that's the rare end point. But many emergency room staff just think about the agitated patient becoming the Hulk and react in kind.

To deal with agitation, Dr. Zeller formulated the “Six Goals of Emergency Psychiatric Care.”

1. Exclude medical etiology of symptoms. Observe the patient and his or her vital signs. Agitation may result from head injury of brain bleeding, a thyroid problem, infection and fever, high or low blood sugar, or some kind of intense pain. Look for signs such as sweating, different sized pupils in the eyes—caused by brain trauma—or low blood oxygen.

2. Rapidly stabilize the acute crisis. Don't waste time, and don't put the patient off until you have time to see him. De-escalate the patient in verbal and nonverbal ways (see below).

3. Avoid coercion. Commands and force only make the patient more scared, hostile, and agitated.

4. Treat in the least restrictive setting. Don't use restraints or a locked room. Make the patient feel relaxed. Avoiding bright lights and confusion is best. John George has created unlocked “comfort rooms,” where patients can sit and talk with a clinician.

5. Form a therapeutic alliance. The goal is not a doctor-patient confrontation but “we're going to do this together.” Often the patient *can't* regain control by him- or herself, so the clinician needs to provide ways—sometimes by offering options and choices—for the patient to take control of the situation.

6. Formulate an appropriate disposition and after-care plan. The goal is for the patient not to end up in this situation again. This goal is actually to put the emergency psychiatrist out of a job.

By following the Project BETA practices and the Six Goals, Parkland Hospital in Dallas, TX, dropped its use of seclusion and restraints by 96% and its use of forcible injection by 94%. Queen's Medical Center in Honolulu, HI, decreased from 20 restraints per month to zero.

John George, which takes patients from all 11 emergency rooms in Alameda County, has developed what Dr. Zeller called the “Alameda Model.” Elsewhere,

² To read the six journal articles, click on:

http://escholarship.org/uc/uciem_westjem?volume=13;issue=1 or Google “Agitation BETA.”

when police are called on a 5150,³ they may move aggressively and often put the person in handcuffs to take him or her to the emergency room. In Alameda County, because the federal government defines a psychiatric emergency the same as a medical emergency, police will do the initial intervention but then call for an ambulance and paramedics to take the patient. (Crisis Intervention Training [CIT] is being provided to Alameda County law enforcement staff.) About a third of such patients go to the emergency room and then, when medically stable, are taken to John George. They are usually admitted immediately and seen by a clinician in less than two hours. In Sacramento County, the patient may wait an average of 26 hours; in Georgia, it's 34 hours.

The Psychiatric Emergency Service at John George tries to provide one staff member for each six patients, and depending on the time of day, may achieve one for three. They are moving toward zero restraints and have reached 68 days without putting a patient in restraint; they now average two restraints per 1,000 patients. Interestingly, Dr. Zeller said, when the number of restraints went down, the number of forcible injections did not go up. Their treatment emphasizes collaboration and offering the patient what medications have worked for him or her in the past. He noted that oral medications such as the anxiolytic Ativan (Lorazepam) work just about as fast as a forced injection.

“People get hurt when you try to force them,” he said. So fewer restraints equal fewer assaults and staff injuries.

Scott Zeller demonstrated for the audience what he calls verbal and nonverbal de-escalation. “It’s a bit counter-intuitive, but when someone is agitated, you don’t want to be agitated back. You want to be the calm one.” Some of his techniques include:

- Stay open, with knees bent and arms at sides. Don’t get defensive or ready to fight. Much of the de-escalation technique is based on the patient’s perception of your intentions.
- Speak in a calm, soft voice, getting softer each time. Use simple, short phrases and ask positive questions: What do you need? How can I help you? Are you hungry or cold? John George provides a comfort station where patients can get a blanket or something to eat or drink.
- Offer the patient a means of escape. He will be in fight or flight mode, so don’t back him into a corner. Make sure he can see a way out.
- Never challenge the patient on what he says. They believe what they’re thinking; but you can agree to disagree.
- Give the patient choices and alternatives, which give him or her a sense of control in the situation.

Dr. Zeller pointed out that these techniques work best in a clinical setting but may not always work at home in a family setting, where there may be more of a history. He also noted that these techniques are for short-term de-escalation of an agitated patient; they are not intended as a long-term solution. (In discussion afterwards, some audience members feared that de-escalating the patient might

³ This is the section of the California Welfare & Institutions Code which authorizes a qualified officer or clinician to involuntarily confine a person suspected of a mental disorder that makes him or her a danger to self or others or gravely disabled.

mean they no longer met the criteria of “danger to self or others” and so might not get treatment.)

The Alameda Model is now being tested and applied in seven other places in California, in Portland, OR, and in New Jersey, North Carolina, Connecticut, Arizona, and Illinois.