CENTRE NEUCHÂTELOIS DE PSYCHIATRIE CNP

Agitation in liaison psychiatry

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Symposium SSCLPP, Congrès SSPP
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UNIL | Université de Lausanne

SSCLPP
Swiss Society of Consultation-Liaison Psychiatry and Psychosomatics

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Agitation: what meaning?

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- ✓Major and severe psychiatric emergency
- ✓Very varied etiologies
- ✓Breaking the communication channel that is speech and exchange
- ✓It is not tolerable: giving limits
- ✓Giving meaning: giving back speech where it has disappeared...

⇒ But one can only make sense **after dealing with the agitation**!

Stigmatized patient?

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- ✓Non-collaborating patient
- ✓Disruptive patient
- ✓Patient "taking the place of real emergencies"
- ✓…

Unwanted patient?

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The agited patient represents a dilemma, because:

- It requires **time**
- It is necessary to **ensure the flow** (particulary in emergency dpt)
- It must be **sedated quickly** but not too much...
- It must be able to be **evaluated quickly**
- He has to leave the emergency dpt
- It endangers the cohesion of the unit (e.g. hospital)

What does it matter?

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✓Agitation would represent between 4-10% of consultations in psychiatric emergencies.

Sachs 2006, Pascual 2006, Huf 2005

✓Between 20-50% of patients consulting psychiatric emergencies are at risk of agitation.

Allen & Currier 2004, Marco & Vaughan 2005

✓ About 6% of hospitals have a specific protocol.

Currier 2000

Why is it complicated?

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- ✓Agitation rarely considered as a medical problem
- ✓Until recently, lack of recognition of the degree of urgency of agitation
- ✓Lack of staff training
- ✓Counter-attitudes and defensive reactions of somatic and psychiatric teams

'Official' recognition

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Agitation/aggressiveness = degree 1 or 2 EST

EST = échelle suisse de tri

SEST = swiss emergency triage scale

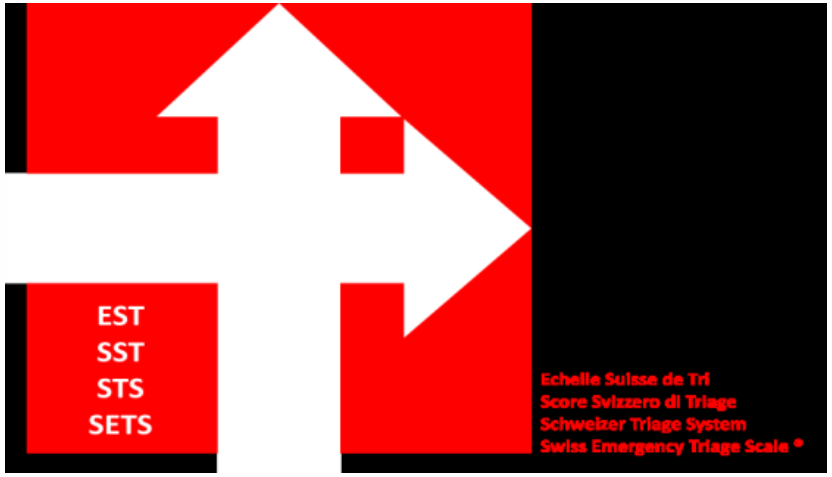

Table 2. Medical and psychiatric conditions that may cause agitation.

Agitation from general medical condition
- Head trauma
- Encephalitis, meningitis or other infection
- Encephalopathy (particularly from liver or renal failure)
- Exposure to environmental toxins
- Metabolic derangement (e.g., hyponatrer
  hypoglycaemia)
- Hypoxia
- Thyroid disease
- Seizure (postictal)
- Toxic levels of medication (e.g., psychiatr

Agitation from intoxication/withdrawal
- Alcohol
- Other drugs (cocaine, ecstasy, ketamine, bath salts, inhalants, methamphetamines)

Agitation from psychiatric disorder
- Psychotic disorder
- Manic and mixed states
- Agitated depression
- Anxiety disorder
- Personality disorder
- Reactive or situational agitation (adaptive disorder)
- Autism spectrum disorder

Undifferentiated Agitation (presumed to be from a general medical condition until proven otherwise)

Adapted from Nordstrom et al. (2012).

Agitation of unknown origin, must be considered as being of somatic cause until proven otherwise!

Importance of hetero-anamnesis for the search for the cause of agitation!

Garriga M, Pacchiarotti I, Kasper S et al. *Assessment and management of agitation in psychiatry: Expert consensus*. World J Biol Psychiatry 2016;17(2):86-128.

Psychiatric or somatic??

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✓Emergency physicians:

"To psychiatry to take care of it, he has a psychic problem."

✓Psychiatrists:

"For emergency physicians to take care of it, you can't talk to the patient."

Optimal/ideal management?

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Calm the patient by avoiding excessive sedation
Collaboration with the patient
Good flow management: speed, efficiency
Optimal patient assessment
Non-pharmacological approaches in 1st intention
2nd line drug approaches
Avoid physical restraint
Enable rapid management of the etiology of agitation

Garriga 2016, Baker 2012, , Lukens 2006, Allen 2005, Currier 2005, Carpenter 2005, De Fruyt 2004

Gradation in the intervention

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Non-pharmacological measures
(de-escalation techniques)

Non-pharmacological measures
+ pharmacotherapy per os

Non-pharmacological measures
+ injectable drug therapy *(IM)*

Benefits of no sedation?

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1. Assessment, discussion and development of a care plan jointly with the patient
2. Contribute to the smooth running of the flow in an emergency department
3. Promote the proper functioning of a hospital care team

First: talk to patient

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Before any physical and/or medicinal intervention, speech is preferred.

De-escalation techniques are very useful in these situations and can prevent sedation.

Transparency

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“Say what you do and do what you say.”

“Do not promise what we will not be able to keep.”

- Promote simple/understandable messages
- Stay in the here and now, avoid any interpretation or psychotherapeutic movement. Now is not the time!

Support Tools

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1. Environmental management
2. De-escalation techniques
3. Coercive & isolation measures
4. Pharmacological approach

Garriga 2016, Petit 2005

What scientific evidence?

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- Few studies of non-pharmacological interventions
- Expert recommendations, consensus

Before any "coercive" intervention:
- Managing the environment
- De-escalation techniques

=> Trying to get the restless patient to cooperate

Garriga 2016, The project BETA 2012, NICE Guidelines 2005

Managing the environment

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- ✓Quiet room
- ✓Visual hypostimulation
- ✓Sound hypostimulation
- ✓Calm and reassuring atmosphere
- ✓Sheltering potentially dangerous objects

Patient and staff safe

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- ✓never intervene alone
- ✓leave an exit exit
- ✓do not turn your back on the patient
- ✓keep physical distance
- ✓no direct physical restraint

Schleifer 2011

De-escalation techniques: facing oneself

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- ✓Calm and calm tone of voice
- ✓Appropriate and respectful language
- ✓Lack of judgment
- ✓Attentive to his own experience & his counter-attitudes
- ✓Giving up your place if emotional overflow

Richmond 2012, Schleifer 2011, Marder 2006, Petit 2005,
Fishkind 2002, Stevenson & Otto 1998

De-escalation techniques: facing the patient

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- ✓1 single interlocutor with the patient
- ✓Talk & inform continuously
- ✓Be attentive to the patient's emotional experience
- ✓Be clear and concise
- ✓No sudden or sudden movements
- ✓Possible threatening experience on the part of the patient:
  - prolonged or insistent eye contact
  - body language

Richmond 2012, Schleifer 2011, Marder 2006, Petit 2005, Fishkind 2002, Stevenson & Otto 1998

Coercion and isolation

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Conditions:

- *Danger to the patient and staff*
- *Principle of proportionality*
- *Shortest possible duration; lift as soon as possible*
- *Not for staff comfort*
- *Not punitive*
- *If decision made = > effectiveness and absence of hesitation*

Knox & Holloman 2012 (project BETA), Marder 2006, Petit 2005
art. 3, 10 & 36 CF

Pharmacological approach

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- Always propose per os; better adherence to care! Villari 2008
- Great importance especially in patients suffering from a psychotic disorder!
- IM, avoid IV because:
  - Often unavailable route
  - Risk of injury to the patient & staff
  - More major side effects if IV
- Effectiveness of the medication: p.o. = parenteral,
- slightly faster start of action in IM

Currier & Simpson 2001, Villari 2008

Choice of medication

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Types	molécules
Schizophrenia, psychosis, manic decompensation	olanzapine IM aripiprazole IM
Alcohol intoxication	halopéridol
Intoxication of psychoactive substances	BZD
Unknown or complex etiology	BZD ± halopéridol
Delirium	halopéridol ou NLA

NLA: atypical neuroleptics; BZD: benzodiazepines

Garriga 2016, Bauer 2016, Kittipeerachon 2016, Wilson 2012, McDonald 2012, Rund 2006, Allen 2005

Basic principles of somatic-psychiatry collaboration

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- *Anticipate in order to avoid finding yourself in difficulty*
- *Avoiding the somato-psychiatric dichotomy*
- *Treatment of agitation, regardless of the cause*

Benefits of a common protocol

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- ✓Destigmatization of agitation situations
- ✓Identical practice between somatic and psychiatric emergency physician
- ✓Speed
- ✓Safety of treatment & medication
- ✓Staff safety
- ✓Support in a somatic box!
- ✓Australian experience in the field: "Black Code" (Downes et al. 2009)

What is happening in French-speaking Switzerland?

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ORIGINAL ARTICLE

A mixed somatic-psychiatric protocol for managing psychomotor agitation in the ED

The Code White protocol

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SWISS ARCHIVES OF NEUROLOGY, PSYCHIATRY AND PSYCHOTHERAPY 2018;169(4):121–126

Contenir l'agitation psychomotrice dans les unités somatiques: mise en place d'un protocole aux HUG

Dr VASILEIOS CHYTAS[a], Dre LAMYAE BENZAKOUR[a], LAURENCE VIGNA[a], SABRINA DELEAN[a], Dre ALESSANDRA COSTANZA[b], Dre JULIA AMBROSETTI[c] et Dr PACO PRADA[a]

Rev Med Suisse 2022; 18: 282-6 | DOI : 10.53738/REVMED.2022.18.769.282

«Code blanc»: modèle de collaboration interprofessionnelle aux urgences

Dre CÉLINE GUGGISBERG[a,*], Dr FABIEN FILLIETTAZ[b,*], Dr CHRISTOPHE BIANCHI[a], Dr STÉPHANE SAILLANT[c], NOÉ JAQUET[c], Dr VINCENT DELLA SANTA[b] et Dr NICOLAS BEYSARD[a]

Rev Med Suisse 2022; 18: 1492-6 | DOI : 10.53738/REVMED.2022.18.791.1492

Two types of collaboration within the hospital (réseau hospitalier neuchâtelois, RHNE)

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1. Agitation management in **emergency departement**
2. Agitation management for **inpatients**

White code in emergency department

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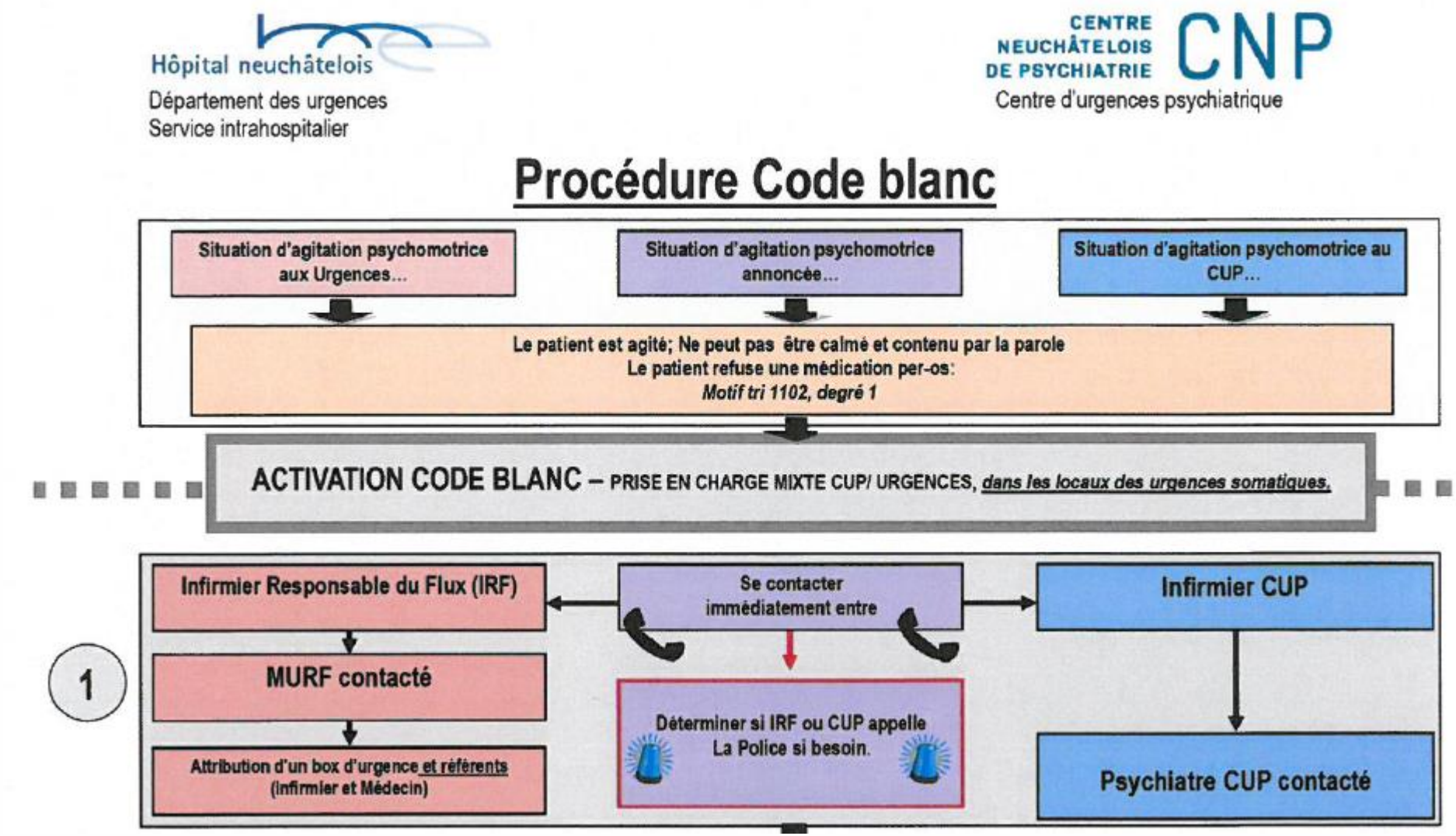

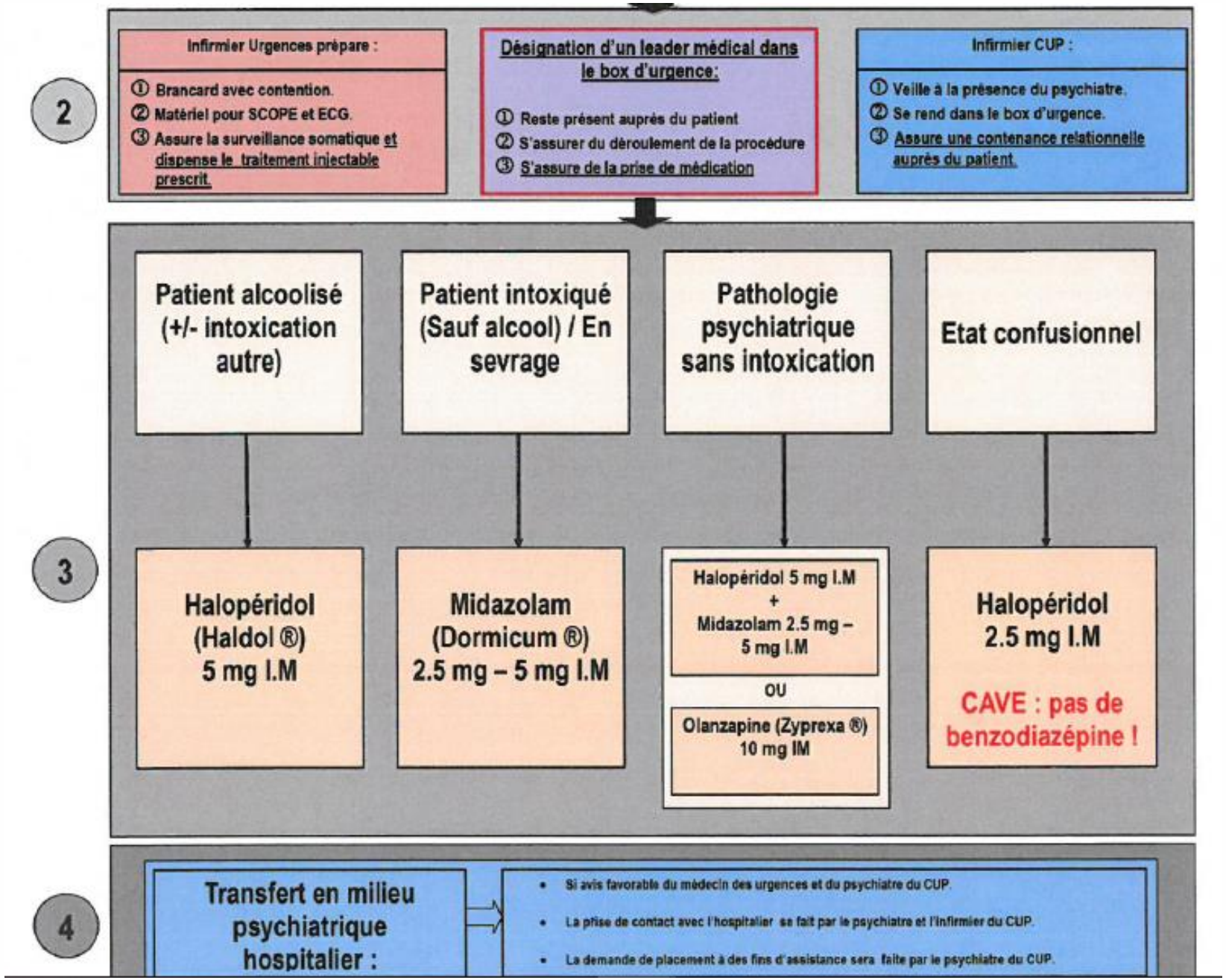
2
Infirmier Urgences prépare :
① Brancard avec contention.
② Matériel pour SCOPE et ECG.
③ Assure la surveillance somatique et dispense le traitement injectable prescrit.
Désignation d'un leader médical dans le box d'urgence:
① Reste présent auprès du patient
② S'assurer du déroulement de la procédure
③ S'assure de la prise de médication
Infirmier CUP :
① Veille à la présence du psychiatre.
② Se rend dans le box d'urgence.
③ Assure une contenance relationnelle auprès du patient.
3
Patient alcoolisé (+/- intoxication autre)
Patient intoxiqué (Sauf alcool) / En sevrage
Pathologie psychiatrique sans intoxication
Etat confusionnel
Halopéridol (Haldol ®) 5 mg I.M
Midazolam (Dormicum ®) 2.5 mg – 5 mg I.M
Halopéridol 5 mg I.M + Midazolam 2.5 mg – 5 mg I.M
OU
Olanzapine (Zyprexa ®) 10 mg IM
Halopéridol 2.5 mg I.M
CAVE : pas de benzodiazépine !
4
Transfert en milieu psychiatrique hospitalier :
• Si avis favorable du médecin des urgences et du psychiatre du CUP.
• La prise de contact avec l'hospitalier se fait par le psychiatre et l'infirmier du CUP.
• La demande de placement à des fins d'assistance sera faite par le psychiatre du CUP.

White code in emergency department

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Mixed somatic and psychiatric responsibility as soon as the patient arrives
Support in a somatic shock box
Immediate release of the shock box
Standardization of medication (via protocol) in pre-hospital and intra-hospital
Roles defined and assigned between somaticians and the psychiatric team
Minimum monitored monitoring of 30 min. post-injection in the emergency room before any transfer

Saillant & al. 2018

Benefits of a common protocol in the emergency department

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- ✓Average duration before initiation ttt: 7 min
- ✓Average pick-up time: 120 min
- ✓Patients hospitalized next (%): 50.7%
- ✓Avoidance of unnecessary hospitalizations under duress
- ✓Reassured and confident staff => effect on staff and patient safety

Saillant & al. 2018

RHNe Réseau Hospitalier Neuchâtelois

Titre

Gestion de l'agitation psychomotrice en médecine

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Soins
Médecine

Document Public

Symptomatologie :	Cause somatique : (CAM©, *Confusion Assessment Method*)	Cause psychiatrique :	Cause toxique : (CIWA©, *Clinical Institute Withdrawal Assessment*)
– Tension interne – Instabilité psychomotrice – Agressivité, menaces auto/-hétéro-agressives	– Causes : métabolique[1], neurologique[2], infectieuse[3], cardiorespiratoire[4] – Globe vésical, fécalome – Douleur	– Trouble anxieux, trouble psychotique, trouble de l'humeur, trouble de la personnalité – Démence	– Effets indésirables médicaments[5] – Intoxication[6] – Sevrage[7]

3 AXES SIMULTANES DE PRISE EN CHARGE MEDICO-SOIGNANTE

1 Bilan somatique (selon contexte clinique)

Traitement étiologique des facteurs précipitants réversibles

- **Anamnèse + status clinique complet** (inclus neurologique), paramètres vitaux
- **Examens paracliniques** : laboratoire (FSC, CRP, électrolytes (Na, Ca), glycémie, fonction rénale et hépatique, stix urinaire, TSH, vit. B12, gazométrie), ECG, US vessie, radiographie thorax, éventuellement CT/ IRM céréb., EEG, PL

Évaluation du niveau d'agitation

- BVC©, *Brøset Violence Checklist* (coter 1 pt par item) : confusion – irritabilité – remuant – menaces verbales – menaces physiques – attaques d'objets

Si le comportement est habituel pour un patient (ex : confusion ou irritabilité), seule une majoration du comportement donne un score de 1.

2 Conduite à tenir selon niveau d'agitation

(et dans le respect du principe de proportionnalité)

3 Traitement pharmacologique (cf détails page 2)

	Somatique	Psychiatrique	Toxique
Comportement calme, alliance possible, communication fluide (score BVC = 0) *Accompagner dans le processus thérapeutique en recherchant la coopération et l'engagement du patient*	*Penser à donner un traitement en réserve si nécessaire, avec l'accord du patient :* Quétiapine (Seroquel®)	1. Quétiapine (Seroquel®) 2. Lorazépam (Temesta®)	Oxaxépam (Anxiolit®)
Comportement avec tension/irritabilité – Angoisse modérée (score BVC = 1) *Désescalade verbale : hypostimulation sonore et verbale, tout en gardant le contact, diminuer l'asymétrie, s'affirmer avec le "Je", être attentif à sa posture* → Infirmière contacte le médecin assistant (MA) → MA/infirmière contacte le CUP (51 515) pour une pré-évaluation → Sécuriser l'environnement : pièce calme, fenêtres fermées, rassurer le voisin, …	*Négocier une médication, introduire un traitement en systématique (et en réserve) po, avec l'accord du patient :* – Si ECG ok et absence de syndrome extrapyramidal : Halopéridol (Haldol®) – Si syndrome extrapyramidal : Quétiapine (Seroquel®) – Si QTc > 500ms : Clométhiazole (Distraneurin®)		Oxaxépam (Anxiolit®)
Comportement avec agitation psychomotrice – Angoisse élevée (score BVC = 1-2) *Désescalade verbale : hypostimulation sonore et verbale, donner de l'espace, proposer des alternatives, répondre aux besoins immédiats, déterminer un leader* → Se protéger soi-même (garder sa distance, se laisser une issue de secours) → MA/infirmière contacte le CUP (51 515) et le médecin superviseur de médecine (CDC ou cadre) → Anticiper l'étape suivante : infirmière prépare les injectables et prépare la contention mécanique, infirmière contacte les agents de sécurité (33 333) → Sécuriser l'environnement : chambre individuelle, fenêtres fermées, éloigner les objets dangereux (table de nuit, potence, sonnette, …)	*Donner le traitement systématique et les réserves (cf étape précédente), avec l'accord du patient :* – Si refus du traitement par le patient (y compris réserve) : informer rapidement le MA		
Comportement agressif et menaces verbales – Angoisse extrême – Risque d'agression (score BVC > 2) *Absence d'alternative, le patient ne peut plus être contenu par la parole* → Infirmière contacte les agents de sécurité (33 333) → Si mise en danger de l'équipe ou du patient: contacter la police (117) → Médecin superviseur de médecine contacte le médecin cadre des SI (si PRT) ou SC (si CDF); réévaluation dans un délai de 30 minutes → Avertir les p…	*Médication forcée PO ou injectable (IM/SC) :* Halopéridol (Haldol®)	Halopéridol (Haldol®) + Midazolam (Dormicum®)	Midazolam (Dormicum®) (si intoxication OH : Halopéridol (Haldol®))

! Le personnel du CUP ne prescrit, ne prépare et n'injecte pas mais est disponible pour conseiller l'équipe médico-soignante et accompagner le patient !

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Take home

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- ✓The agitated patient is part of the psychiatric physician's casuistry;
- ✓This type of patient must be considered as truly urgent by somatic physicians;
- ✓**The management of agitated patients should be mixed, structured and protocolized**;
- ✓Restraint measures should be avoided and applied only when necessary
- ✓Training in the management of agitation must be improved

Thank you for your attention!

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