Managing Behavioral Health Crises: Tackling Agitation Management and the Opioid Epidemic in the Emergency Setting

December 11, 2019

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Disclosures

Sources of research support: Funding for Opioid ACT pilot project from ADAMH, Columbus Foundation and OhioHealth Foundation

Consulting relationships: None

Stock equity (>10,000): None

Speaker's bureau(s): None

Objectives

- Value a team-based approach to agitation management
- Recognize the role of appropriate agitation management in optimizing safety & throughput for psychiatric patients in crisis
- Understand both pharmacologic and non-pharmacologic methods of agitation management
- Appreciate the impact of community collaboration in the management of patients with opioid use disorders who present with behavioral health crises

PART ONE: AGITATION MANAGEMENT

Background: Violence in Healthcare Settings

- Safe and effective management of agitated patients poses multiple challenges for health care professionals
- Lack of standardized, team-based education limits consistency and continuity of care among healthcare workers.
- A majority of healthcare providers, particularly ED staff, report having been assaulted in the past year.
- Patients who are placed in restraints as a result of agitated behavior are at higher risk for complications, including death.

Team-based De-escalation Simulation Training Pilot

PROBLEM: Education silos prevent hospital staff from being on the same page in regards to de-escalation & agitation management.

SOLUTION: Team-based simulation training teaches staff to work together to de-escalate agitated patients.

Methods

- ED nurses, technicians, and protective services officers assigned to interdisciplinary groups
- 90 minute educational intervention:
  1) 30 minute lecture
  2) 15 minute simulation
  3) 45 minute structured debriefing
- Data collected:
  1) Standardized return-on-learning (ROL) assessment tool used to determine participants' reactions to and application of the intervention
  2) Data was extracted from the medical record to track the number of restraints applied and number of ED visits during the six months before & after the education

Results

- A pilot group of 30 ED staff members completed the training
- Following the intervention, the rate of manual restraint use decreased by 29.6%
- ROL data showed significant improvement in staff members' appreciation for value of the use of de-escalation techniques and early use of PRN medication for agitation
- 86% of participants felt more confident in their ability to manage agitated patients after receiving the training

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Discussion

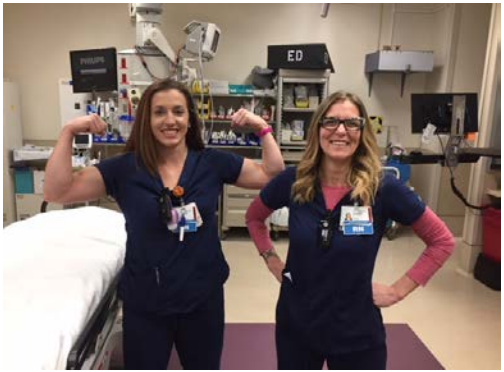
- Education silos can limit optimal de-escalation of patients by ED staff
- Early use of verbal de-escalation techniques and PRN medication for agitation can prevent the need for manual restraints in some cases
- Improvement in the confidence of staff members in the management of violent patients is a win for everyone

Conclusions

A **multi-disciplinary simulation-enhanced educational intervention** was successful in:

1. Reducing the use of manual restraints in the emergency department

2. Improving staff attitudes regarding the value of de-escalation techniques and early use of medication for agitation



Causes of Agitation in the Emergency Setting

- Delirium (acute brain injury secondary to a medical condition e.g. infection)
- Bipolar mania
- Anxiety (panic disorder, OCD, PTSD, GAD)
- Psychosis in schizophrenia (e.g. paranoid delusions)
- Substance abuse-intoxication or withdrawal
- Trauma
- Personality disorder (e.g. antisocial, borderline)
- Pain
- Frustration

Agitation Management

The goal in optimal management of an agitated patient:

- Ensures patient & staff safety
- Ensures appropriate treatment of the patient

Agitation Management

Non-pharmacologic methods of behavioral control

- Verbal intervention
- De-escalation
- Nicotine replacement therapy

Pharmacologic management

- First-generation antipsychotics
- Second-generation antipsychotics
- benzodiazepines

ATTITUDE:

Tips for optimal agitation management

- Use a non-judgmental approach
- **Separate the patient from his/her behavior**
- Manage triggers to promote a response (vs. a reaction)
- While managing a crisis, it is critical for each person involved to consider the perspective of others
- Be tuned into “baseline”…trust your intuition
- It is critical to sense the needs & emotional experience of those in our care to de-escalate

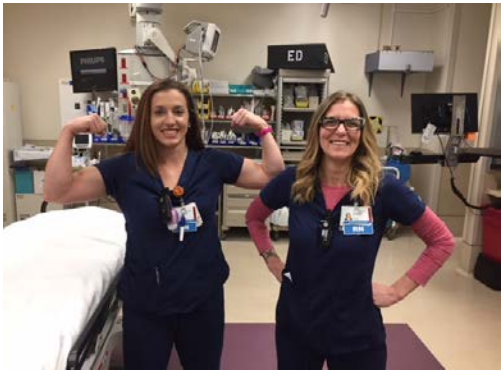
APPROACH:

Tips for optimal agitation management

- ***Staff members' verbal & nonverbal presentation must be consistent to optimally de-escalate***
- Crisis de-escalation is all about effective communication
- Meet the patient where he/she is to establish rapport

TEAMWORK:

Tips for optimal agitation management



1. Use Rapport
2. Project confidence
3. Provide consistency among team with boundaries & limit setting

Crowd Control

- When possible, particularly in early stages of de-escalation, minimize number of staff in patient's room
- Keep backup staff quiet and in hallway out of patient's view when possible, to avoid further agitating the patient

Role of Medication

- **Have a low threshold for using medication early on in the de-escalation process**
- **Use an evidence-based agitation management algorithm based on etiology to treat agitation**

Goals of pharmacologic agitation management

- Calm patient for more accurate clinical assessment
- Endpoint: calm patient without inducing sleep*
- Manage agitation prior to stabilization of underlying etiology e.g. delirium

Pharmacologic management of agitation: Haloperidol

PROS

-minimal effects on vital signs

-negligible anticholinergic activity

-minimal drug interactions

CONS

Higher doses and IV administration associated with higher risk of QT prolongation and torsades

Pharmacologic management of agitation: Second Generation Anti-psychotics (SGAs)

- Developed in 1990's
- D2 antagonists & 5-HT2A antagonists
- Anti-histaminic effects: olanzapine, quetiapine
- Reduced risk of EPS vs. FGAs
- Available in IM formulation: ziprasidone, olanzapine

Pharmacologic management of agitation: benzodiazepines

- Act on GABA receptor
- Effective in managing agitation secondary to
  - Stimulant intoxication
  - Alcohol withdrawal
  - Etiology of agitation unclear (NO DELIRIUM)
  - Lorazepam, midazolam

*In agitation with psychosis, benzodiazepines sedate the patient but DO NOT treat underlying psychosis

*Potential for oversedation, respiratory depression, & hypotension (esp. in patients with respiratory conditions or when used in combination with alcohol)

Etiology-based Agitation Management

***Treat an agitated patient according to the condition which is driving the agitation** (e.g. delirium, substance intoxication/withdrawal, or psychiatric illness, such as schizophrenia)

Best Practice: An agitation management protocol was established by AAEP Beta workgroup to provide a standardized evidence-based etiology-driven algorithm

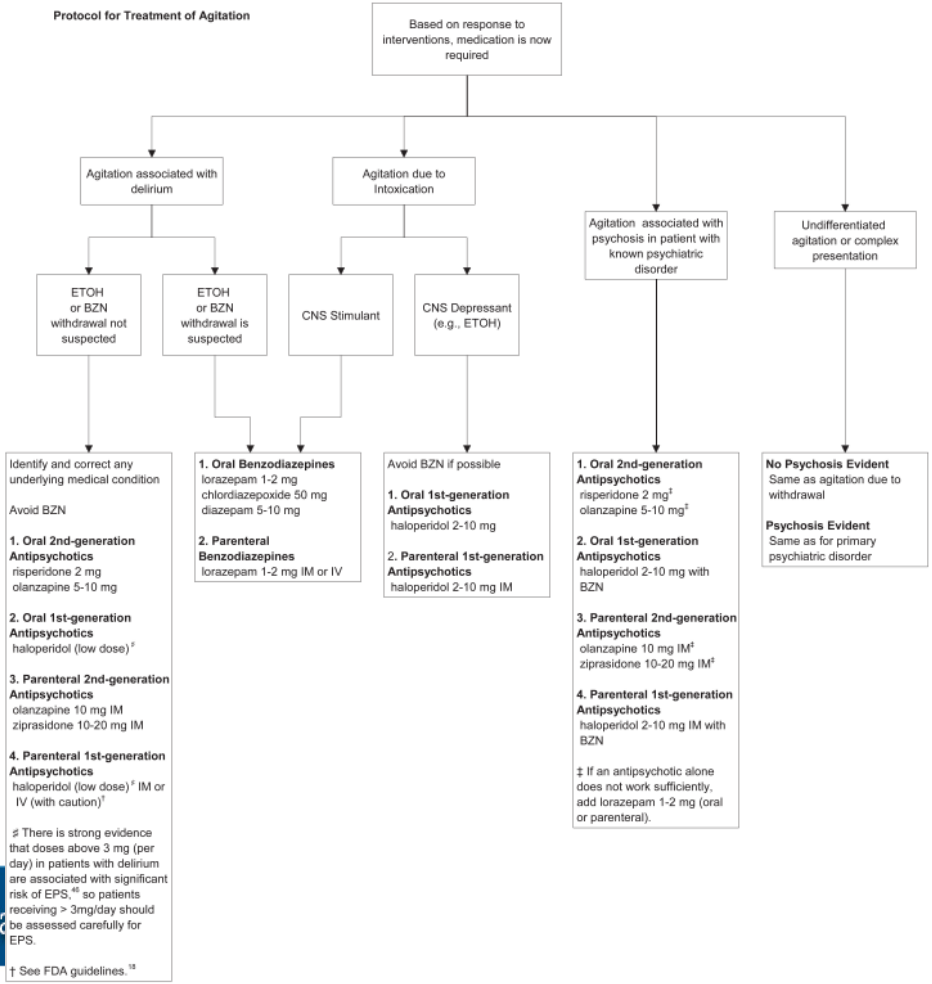


Figure. Protocol for treatment of agitation. *BZN*, benzodiazepine; *EPS*, extrapyramidal side effects; *ETOH*, alcohol; *IM*, intramuscular.

PART TWO:

MANAGING THE OPIOID EPIDEMIC IN THE EMERGENCY SETTING

Opioids vs. Opiates: What's the difference?

OPIOIDS

1) group of endogenous neural polypeptides (such as an endorphin or enkephalin) that bind especially to opiate receptors and mimic some of the pharmacological properties of opiates
2) a synthetic drug possessing narcotic properties similar to opiates but *not derived from opium*

   e.g. oxycodone, fentanyl, hydrocodone

*any substance, natural or synthetic, which binds the brain's opioid receptors

OPIATES

drugs derived from, or containing, opium, which tend to induce sleep and alleviate pain

e.g. heroin, morphine, & codeine

All opiates are opioids but not all opioids are opiates

Late Breaking News…

- 2018 CDC report: 2017 U.S. life expectancy down to 78.6 years (down a tenth of a year from 2016)
- Increased rates of drug overdose and suicide determined to be contributing factors in this decrease in life expectancy

Opioid Deaths: The Numbers

- In 2017, there were 70,237 drug overdose deaths in the U.S., up almost 10% from 2016
- The age-adjusted rate of drug overdose deaths in 2017 (21.7 per 100,000) was 9.6% higher than the rate in 2016 (19.8)
- Adults aged 25-54 had highest rates of drug overdose deaths in 2017.
- West Virginia (57.8 per 100,000), Ohio (46.3), Pennsylvania (44.3), and the District of Columbia (44.0) had the highest age-adjusted drug overdose death rates in 2017
- The age-adjusted rate of drug overdose deaths involving synthetic opioids other than methadone (drugs such as fentanyl, fentanyl analogs, and tramadol) increased by 45% between 2016 and 2017, from 6.2 to 9.0 per 100,000

Different Presentations of Opioid Addiction in the Emergency Setting

- Pain
- Altered mental status (intoxication)
- “Found down” (overdose: intentional vs. unintentional)
- Anxiety (withdrawal)
- Suicidal thoughts/intent/plan/attempt
- Suicidal comments (malingering as means of obtaining detox)
- Nausea/vomiting (withdrawal)

Why does addiction happen?

Addiction (substance use disorder): a chronic relapsing brain disease characterized by compulsive drug seeking and use, despite harmful consequences (NIDA, 2014)

Risk Factors for addiction

- Genetic disposition
- Prenatal alcohol and/or drug exposure
- Parents who use drugs and/or alcohol or who suffer from mental illness
- Child abuse and maltreatment
- Inadequate supervision
- Neighborhood poverty and violence
- Norms and laws favorable to substance use
- Adverse Childhood Experiences

What Can You Do To Help Solve the Opioid Crisis?

1. **Stop it before it starts**.
   - Start the conversation with your children
   - Be aware of what your kids are doing (including on social media!)

2. **If someone you know is experiencing opioid addiction, get them help**.
   - Be aware of the warning signs
   - If someone talks about suicide/wanting to die, take it seriously
   - Casey's law (involuntary drug treatment)

3. **Advocate for government support for research and treatment**.

4. **Take advantage of opportunities in grant funding to increase access to treatment for your patients**.

Opioid ACT Pilot

PROBLEM: Minimal resources for addiction treatment for Medicaid & self-pay ED patients with opioid use disorders limits potential for linkage and negatively impacts throughput

SOLUTION: A grant-funded collaboration between OhioHealth, Southeast Inc., and CompDrug, to increase access to treatment for patients with opoid use disorders who present to the ED with mental health complaints

- Southeast substance abuse counselor works on the ground in OhioHealth EDs to meet with patients and link them with substance abuse treatment in the community
- Project coordinator
- Informatics specialist

Opioid ACT Pilot Timeline

- **December 2017**: Pilot design and grant writing efforts initiated by Debbie Catri, System Director of Philanthropy for OhioHealth Foundation, and Dr. Schabbing, in collaboration with Southeast Inc. & CompDrug
- **January 2018**: Grant application for Opioid ACT Pilot submitted to Cardinal Health
- **March 2018**: Cardinal Health grant not awarded to OhioHealth
- **August 2018**: Grant funding obtained from OhioHealth Foundation, ADAMH, and Columbus Foundation
- **June 2019**: Opioid ACT Pilot goes live

Current State: Southeast Addiction Specialist Working in Ohiohealth EDs

Home in Ohio Grant Report
Opioid Addiction and Crisis Team (ACT)

By utilizing the Home in Ohio funds, the Opioid ACT Team was able to meet 125 patients with opioid addiction who presented to an OhioHealth Emergency Department with a mental health complaint since June 2019. In only three months of operation, the Opioid ACT Team has had the following success in increasing access to treatment for our patients:

- 56 Fifty six patients were discharged with direct access to addiction treatment
- 20 Twenty patients with opioid addiction were placed into inpatient treatment at the Maryhaven Acute Stabilization Center
- 9 Nine patients with opioid addiction were linked with outpatient Medication Assisted Treatment through CompDrug and other community providers
- 27 Additionally, twenty-seven patients with non-opioid addictions were also linked to addiction treatment

Success Stories

One of the patients touched by the Opioid ACT Team had been seeking treatment for opioid addiction for years without success. He was encouraged by a friend to go to the Riverside Emergency Department in yet another attempt to get help. Homeless and hopeless, with nowhere else to go, he met with Adrian Furman, Southeast addiction specialist, who managed to get the patient transferred directly to MASC (Maryhaven Addiction Stabilization Center) for inpatient treatment. Both the patient and his friend expressed their appreciation to Adrian, as he was finally going to get the help he needed.

A woman new to Columbus presented to the Grant Emergency Department in severe opioid withdrawal, having lost her Suboxone, without an outpatient provider. Adrian not only linked her with Comp Drug, but drove her to her appointment to pick up her Suboxone prescription, since she had no car and could not afford bus fare.

A young man with alcohol and opioid addiction presented to the Riverside Emergency Department with depression and suicidal thoughts, voicing hopelessness over his ongoing struggles with addiction. Though he had failed to get into addiction treatment despite numerous visits to various emergency departments over the past few years, with Adrian's help, he was able to get into Talbot Hall that day for detox from both alcohol and opioids.

SUMMARY

A **multi-disciplinary simulation-enhanced educational intervention** was successful in:

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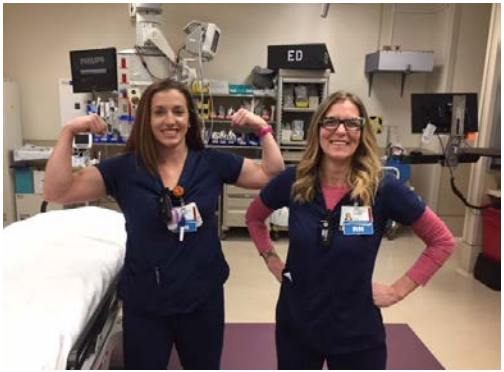

SUMMARY

- Patients with opioid use disorders who present to the ED with behavioral health crises can pose a challenge given the lack of treatment resources.

- Collaborating with community partners can increase access to treatment for patients with opioid use disorders who present to the ED in mental health crisis.

Thank you

PSS Social Workers
Riverside ED staff
Lorri Charnas, LISW
Kristen Boudreau LISW
Evelyn Cano, BSN, RN
Eric Rebraca, BSN, RN
Warren Yamarick, MD
OhioHealth Protective Services
CME-I staff
Dallas Erdmann, MD

Adrian Furman
Sandy Stephenson
Bill Lee
Dustin Metz
Southeast Inc.
CompDrug
Brad Gable, MD

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