AGITATION & DE-ESCALATION

5 Fundamentals of Non-coercion

Jon S. Berlin, MD

Milwaukee County Behavioral Health Division
Medical College of Wisconsin

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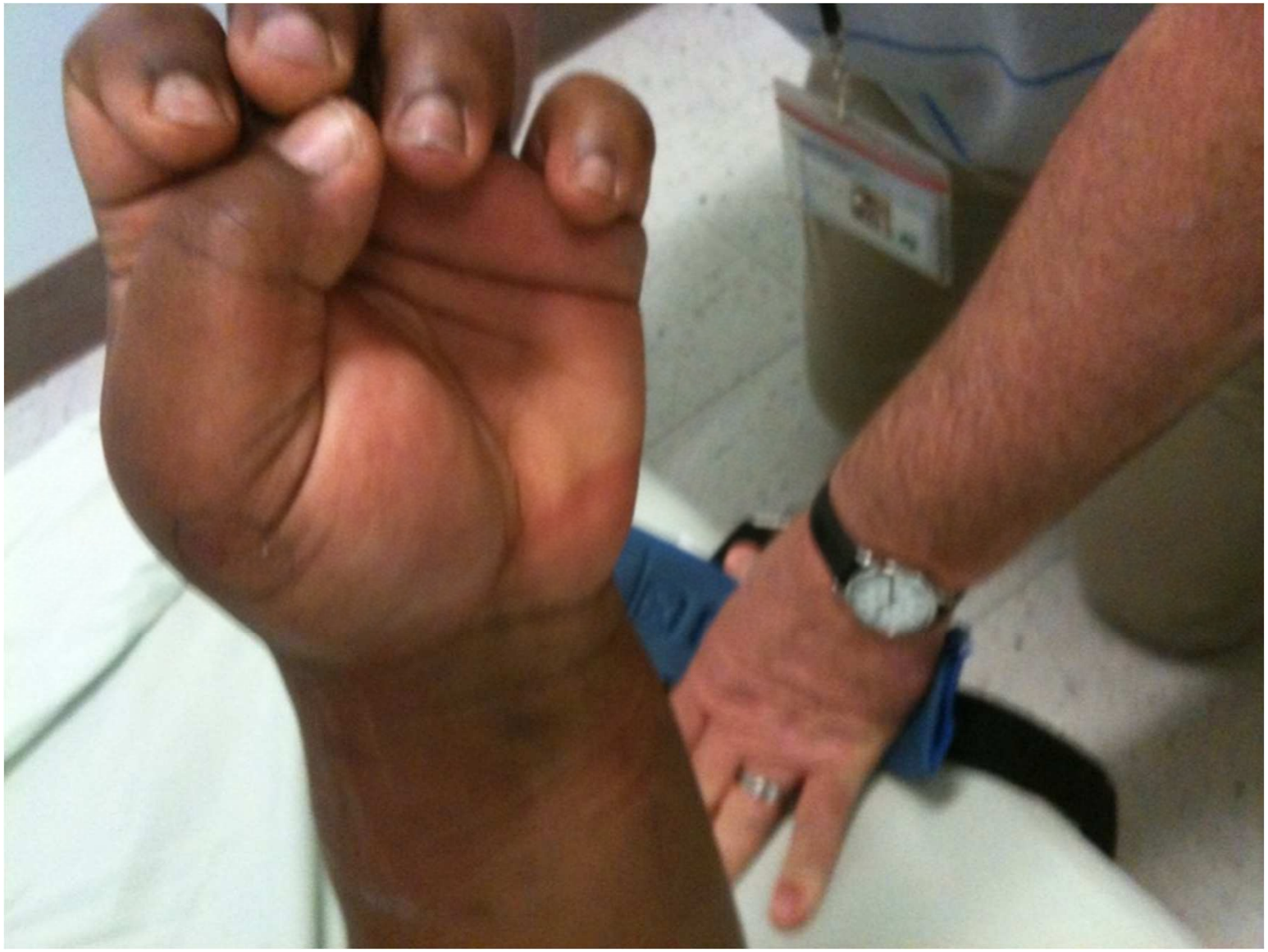
Disclosure & Background

- No pharma ties
- 140,000 PES visits (~ 5% agitation)
- 1974 1st case: glass of milk

Pushing envelope on non-coercion

- Without injury
- Being realistic



Traditional goals

- Calm patient
- Prevent harm
- Triage and diagnose
- Reduce psychosis
- Shorten time in restraint

Limitations

1. Limited space & staff

2. Limited treatment resources & higher outpatient acuity

3. Limited brain: delirium, substances, underdeveloped, damaged

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V. Avoid iatrogenic escalation

Why the emphasis on engagement?

The 3 characteristics of patients on mental health hold:

- Resisting help
- Illness
- High acuity

Scenario

28 yo man brought in by 2 squad cars for running around and screaming in his sister's apt building. Not making sense and scaring people. He was just returning from an escapade of stealing and losing his brother's car. Appeared paranoid and delusional. According to family, he had just moved to town and was off his meds. 5'11", 230 lbs, long dreadlocks, had played football in high school.

Upon arrival in the ED, he sat down briefly. Vital signs stable, no medical history. Refused UDS. Told the triage nurse he was previously on a Haldol injection, but said, "I love weed," then stood up abruptly and walked away, saying, "I know you're trying to kill me."

What is your emotional reaction to this? What do you think? What do you do?

I. PREPARE FOR ENGAGEMENT

Clear sense of purpose

1. ↑ Safety
2. Restraint rate is a quality indicator
3. ↓ Recidivism via experiential learning

Temper crisis affects

Identify reflexive reactions:

1) “Fight or flight” or freeze

2) “What can I do?” (Hopeless/helpless)

3) “Not my job”

Calm oneself

Apply psychological first aid

Psychological First Aid (PFA)

Fear		
Overstimulation		
Separation		
Helplessness		
Hopelessness		

PREPARE FOR ENGAGEMENT

- Clear sense of purpose
- Master personal reaction to crisis affect
- Be ready to act with intermediate diagnosis

INTERMEDIATE DIAGNOSIS

- Repeating cycles of data, assessment, intervention.

- Most common error: failure to include the behavior before arrival that necessitated the referral to the hospital or crisis center

Modern goals of management

A. Successfully resolve a crisis without violence

B. Initiate, repair or strengthen therapeutic alliance

C. Make medication a good experience

D. Help pt stabilize in order to address the acute precipitant

E. Turn an emergency patient into an outpatient

II: ENGAGE RAPIDLY, SAFELY

- Psychological first aid for patient

Psychological First Aid (PFA)

Fear	Safety, information	
Overstimulation	Calming, active listening	
Separation	Connectedness	
Helplessness	↑ personal efficacy	
Hopelessness	↑ hope	

ENGAGE SAFELY, RAPIDLY

- Psychological first aid
- Seek first to understand:

Have a seat, talk, I'll listen.

“Seek first to understand…” S. Covey

- *Can we talk?* Safe distance, security
- *What do you want to have happen?* Find the positive.
- *I want to help you get that.* Join with positive.

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…THEN TO BE UNDERSTOOD

Scenario: part 1

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What are crisis feelings? Handle them how?

Scenario: part 2

Paces back and forth waiting to see the doctor. Five minutes after the triage interview he stands in the middle of a busy waiting room, puts his head back and roars like an lion.

What do you do? What does team do? Who leads team?

III: AUTHORITATIVENESS

Various stances

- Authoritarian
- Laissez-faire
- Authoritative

Elements of authoritativeness

- Expertise

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- Ability to explain rationale

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Elements of authoritativeness

- Expertise
- Ability to explain the rationale
- Power to influence or persuade
- Knowing your limits, willingness to be influenced
- Setting limits

Balanced position

- Collaborate without abdicating expertise
- Recommend without claiming infallibility

“…then to be understood”

- **Safety**: “Keep you safe and this place safe”
- **Hope**: “People can handle problems without force”
- **Care**: “We are here to help”
- **Mission**: “We are deeply committed to non-violence”
- **Desired outcome**: “You must be safe to go”

Scenario: continued

Paces back and forth waiting to see the doctor. Five minutes after the triage interview he stands in the middle of a busy waiting room, puts his head back and roars like an lion.

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Scenario: part 3

Returns to triage booth and sits down.

Labile in interview: angry, friendly, fearful.

Has flight of ideas. People are trying to kill him.

Says, “I’m Bipolar.”

Asks for weed. Works better than anything to control his temper. Only problem is that he’s out of money to buy it.

Insists it’s July 1st and his check should have come today.

You gently attempt some reality testing: today is really June 30th. All conversation proves useless.

You describe your view of the problem and invite his ideas, but everything you say escalates him. He stands up.

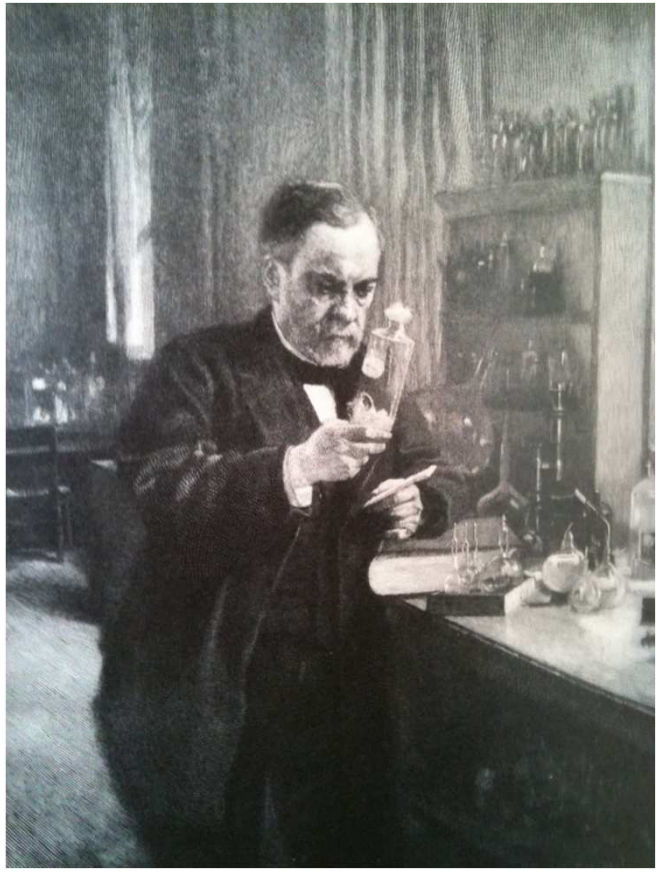
What do you think and do? Any options?

When words fail

- Defenses mechanisms failing. Talking about life problems can make things worse
- Crisis state, overpowering illness
- Other calming maneuvers are failings

IV: TIMELY MEDICATION

- Don’t rush
- Don’t delay



Escalating persuasion

1. *What helps you at times likes this?* Listen, engage

Escalating persuasion

1. *What helps you at times likes this?* Invite patient's ideas.

2. *I think you would benefit from medication.* Express opinion.

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2. *I think you would benefit from medication.* Stating belief.

3. *I really think you need a little medicine.* Persuading.

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1. *What helps you at times likes this?* Invite pt's ideas.

2. *I think you would benefit from medication.* Stating a fact.

3. *I really think you need a little medicine.* Persuading.

4. *You're having a psychiatric emergency. I'm going to get you some emergency medication. It works well and it's safe.* Inducing

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5. *I'm going to have to insist.* Coercing. Last resort.

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What do you think? What do you do? Would it be all right to revert back to the traditional goals of management?

V. LIMIT IATROGENIC ESCALATION

TRAUMA-INFORMED CARE

- High percentage of patients with trauma history

- Mishandling in the ED can be traumatizing:

  Longer waits than other pts, lack of information, forced disrobing, minimization of medical concerns, restraints

Emergency Department Treatment of the Psychiatric Patient. Policy Issues and Legal Requirements. Susan Stefan, Oxford University Press, 2006.

All interaction is treatment

- All interaction is treatment from the start

- Pt's view of treatment includes how he or she was treated.

A Manual for Psychiatric Case Study, 2nd edition. Menninger, Mayman, Pruyser. Grune & Stratton, New York. 1962

Stabilize before probing

- Necessary to deal with the underlying problem
- But if talking about it came easily, the individual wouldn’t have resorted to such extreme coping skills.
- Defer digging till the explosiveness is defused.

Symptoms before arrival count

- "…running around and screaming in his sister's apt building"

Case example

26 yo male left detox center, went home, drank, came to PES voluntarily same day. Said to triage nurse, “I’m only here for anger management.” Breathalyzer .021.

Nurse told him that in order to really get help, he needs to be sober.

He said, “Don’t talk to me ever again about my addictions…You will not be able to help me at all because I already choked my girlfriend…I’m afraid I’ll f--- someone else up.” He then stood up from his chair and cocked his fists. Security came over.

On prior visit 7 days ago, same initial presentation, had just battered girlfriend, .064, he took Zydis Zyprexa 5 mg and Librium 75 mg. Accepted involuntary commitment to detox. Never escalated.

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III. Be authoritative and clear on desired outcome

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V. Limit iatrogenic escalation