Overview of Project BETA: Best practices in Evaluation and Treatment of Agitation

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Supervising Section Editor: Leslie Zun, MD
Submission history: Submitted July 29, 2011; Revision received August 29, 2011; Accepted September 22, 2011
Reprints available through open access at http://escholarship.org/uc/uciem_westjem
DOI: 10.5811/westjem.2011.9.6865
[West J Emerg Med. 2012;13(1):1–2.]

Agitation in emergency settings is a major concern, with a staggering 1.7 million episodes annually in the United States alone.[1] Agitated individuals are at risk of becoming aggressive and violent, and of causing harm to themselves, others, and property. Agitation is a leading cause of hospital staff injuries and can cause untold physical and psychological suffering for patients and all those nearby.[2–4]

Yet, despite the pervasiveness of agitation, there is surprising inconsistency in treatment approaches, which can vary widely by region and institution. Many facilities now use techniques such as intervention teams, which are paged instantly when there is an agitated patient, or "management of assaultive behavior" protocols that seek to engage patients into voluntarily accepting treatment. However, far too many agencies still treat all episodes of agitation in a fashion that might best be described as "restrain and sedate."

Although regulatory agencies and advocacy groups have called for a reduction in the use of restraint and less coercion in psychiatric treatment, there has been inadequate discussion regarding effective, alternative management of the agitated patient. Clearly, a void has existed in quality guidelines for the treatment of agitation.

To help address this need, the American Association for Emergency Psychiatry (AAEP), in October 2010, embarked on Project BETA (Best practices in Evaluation and Treatment of Agitation). Recruiting dozens of emergency psychiatrists, emergency medicine physicians, and others associated with acute care of the mentally ill, Project BETA has intended to provide guidelines that are not only effective and safety minded but also in the best interests of the patient.

Creating quality guidelines for agitation is no easy task. Unlike most disease states, the research database on agitation is quite limited. Much of this can be ascribed to the difficulty in obtaining the informed consent necessary for most clinical studies. How does one get informed consent from a combative, threatening individual? Further, in those studies that do involve informed consent, questions might arise as to the severity of subjects' levels of agitation, if indeed they were even able to comply with the consent process.

Given these obstacles, the Project BETA team determined that the best guidelines would be ascertained through a synthesis of the best available research with the expert consensus of seasoned clinicians.

Until now, existent guidelines for agitation have focused solely on medication strategies. Yet, agitation can result from myriad origins, and its treatment is multifaceted, with pharmacology only playing 1 part. The Project BETA members recognized that to truly address the agitation spectrum, for the first time, guidelines should be developed that would direct clinicians in all interventional aspects, including triage, diagnosis, and verbal de-escalation, as well as medicine choices.

Thus, 5 study workgroups were developed by using the basic approaches of emergency psychiatry as a foundation. The treatment goals of emergency psychiatry are as follows: (1) exclude medical etiologies for symptoms; (2) rapid stabilization of the acute crisis; (3) avoid coercion; (4) treat in the least restrictive setting; (5) form a therapeutic alliance; and (6) appropriate disposition and after-care plan.[5] The 5 workgroups, projected in the order of following a patient through an intervention, were established to address the following topics:

- Medical evaluation and triage of the agitated patient
- Psychiatric evaluation of the agitated patient
- Verbal de-escalation of the agitated patient
- Psychopharmacologic approaches to agitation
- Use and avoidance of seclusion and restraint

Each group then created a written article and guidelines derived from evidence-based research and consensus outcome, which follow in this issue of *Western Journal of Emergency Medicine*. Although each article is able to stand on its own, the

entire group is intended to be read and used collectively, as the articles are intertwined, referring to and leading into each other.

Working with an agitated patient can be challenging, and, as in managing other medical emergencies, it requires both knowledge and skills. As in advanced cardiovascular life support training, the former can be learned in the classroom, but the latter requires practice.

An important first step is learning to balance how to evaluate and manage the patient simultaneously. Medical assessment is essential to rule out life-threatening causes of agitation; yet, the patient who is agitated may not be cooperative with the evaluation. Thus, one's observation of the patient and medical judgment must drive decisions while engaging the patient in verbal de-escalation to obtain cooperation.

Some patients with agitation can be de-escalated to calmness by verbal de-escalation alone. However, others will require medication, and the preferred medication should be one that targets the underlying etiology.[6] Therefore, there is a need to establish a working diagnosis before instituting appropriate pharmacologic intervention.

Mastering verbal de-escalation will result in many positive rewards for the clinician. Although some might believe that in their busy clinic there is no time to attempt de-escalation and restraining a patient is the speediest solution, it can indeed be just the opposite. Verbal de-escalation can typically be quite effective in a relatively brief period, while placing a patient in restraints can require significant staff involvement—from the time needed to "take down" and restrain the patient to the obligation for one-to-one observation. Throughput can be even more affected from a disposition standpoint, as many receiving facilities will not consider accepting a patient who has been recently restrained or a patient who is oversedated from injudicious use of medication.

Avoiding the restraint process altogether can have safety and long-term implications. Perhaps as many as two thirds of staff injuries involving psychiatric patients occur during "containment" procedures for restraint.[7] Furthermore, patients who have not been restrained and forcibly medicated during an emergency department visit will be less likely to mistrust and fear medical personnel and, thus, may feel more comfortable seeking assistance in the future, hopefully before reaching a highly agitated state.

The authors of Project BETA understand that not all of the guidelines can be followed in every situation and have endeavored to make accommodations for that. The algorithms included in the articles provide guidance for noncoercive evaluation and management of the agitated patient, but allow for direct implementation of more restrictive interventions for those unfortunate patients who are so combative or delirious that other options would not be practical. Still, it is hoped that these guidelines will assist clinicians in recognizing that agitated individuals need not necessarily go straight into restraints but instead can be treated in a more benign, collaborative fashion, which will lead to less injuries, better therapeutic alliance, improved throughput and superior long-term outcomes.

ACKNOWLEDGMENTS

We thank all members of Project BETA for their commitment and countless hours of hard work needed to make this effort a success. Also, we thank the AAEP board members and office staff for their support and for facilitating this project, and we deeply appreciate Toni Nouri for her editing of all articles, tables, and diagrams.

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Conflicts of Interest: By the *West*JEM article submission agreement, all authors are required to disclose all affiliations, funding, sources, and financial or management relationships that could be perceived as potential sources of bias. The authors disclosed none.

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