Management of acute behavioral disturbance in the Emergency Department: An Italian position paper from AcEMC, CNI-SPDC, SIP-Lo, SITOX

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Abstract

The phenomenon of acute behavioral disturbance is an underrecognized and potentially life-threatening syndrome, and sometimes an emergency in psychiatric settings. Patients presenting to the Italian Emergency Departments (EDs) with acute behavioral disturbances account for approximately 3.2% of all ED visits. The spectrum of behaviors and of the signs overlaps with many clinical diseases. In addition to patients with behavioral problems related to mental disorders or substance abuse and toxicity, there is also a large group whose behavioral emergencies result from a medical illness. The complexity of these patients, as well as the interdisciplinary nature of their care, requires a clear and consensual framework for the appropriate medical management. A network of Italian scientific societies developed ten recommendations for good clinical practice. The main purpose is to draw up a document that presents a standardized method for the organization of the care of patients with acute behavioral disorders in EDs.

Introduction

The phenomenon of acute behavioral disturbance is an underrecognized and potentially life-threatening syndrome, and sometimes an emergency in psychiatric settings. The spectrum of behaviors and of the signs overlaps with many clinical disease. In addition to patients with behavioral problems related to mental disorders or substance abuse and toxicity, there is also a large group whose behavioral emergencies result from a medical illness. In fact, various medical conditions can masquerade as psychiatric disorders: electrolyte and metabolic imbalance, infection, hypoxia, myocardial infarction, or cerebrovascular disease. Studies of psy-

chiatric inpatients have demonstrated that approximately 50% of these have serious comorbid medical conditions.[1]

The Emergency Department (ED) is a gateway to care for patients with behavioral disorders. Patients presenting to the Italian EDs with acute behavioral disturbances account for approximately 3.2% of all ED visits. In elderly, the statistics are more significant: the 24% of the ED patients older than 70 is diagnosed as having delirium, and the 40% have an alteration of the mental status.[2]

There is a strong association between primary mental disorders and substance abuse. The number of youths admitted to EDs for acute behavioral disturbances related to drug abuse has increased of 40% in the last five years.[3]

Excited delirium can be associated with many psychiatric conditions, including schizophrenia, bipolar disorder, personality disorders (mainly antisocial and borderline personality disorders), general anxiety disorder, panic disorder, and major depression. The assessment of an agitated patient is complicated by several difficulties. The uncooperativeness and/or the inability to give a relevant history often force clinicians to make decisions based on very limited information. Usually, a complete psychiatric assessment cannot be completed until the patient is calm enough to participate in a psychiatric interview.

A 2016 poll carried out by the Academy of Emergency Medicine and Care among doctors and nurses working in EDs highlighted a serious difficulty in knowing how to recognize a patient suffering from acute behavioral disorders and even more in knowing how to identify patients at risk of a dangerous agitation. Furthermore, about 70% of the doctors and nurses interviewed worked without a local health policy program.

Moreover, the experience and content of the visits to the emergency room can have significant consequences on the continuity of care for the psychiatric patients. Therefore, it is important to issue recommendations for good clinical practices in the management of patients with an altered mental clinical presentation in the ED.

Materials and Methods

A network of Italian scientific societies (AcEMC, CNI-SPDC, SIP-Lo, SITOX) developed the present consensus. Taskforce members were identified by the boards of each scientific society. Published guidelines of national and international scientific societies were reviewed.[4-8]

A writing group has produced a first draft of the document. To obtain a widespread consensus, the draft was distributed to the scientific societies for local evaluation and revision by as many experts as possible. The ensuing final draft was finally approved by all the involved scientific societies. The main purpose of the present work is to draw up a document as multidisciplinary consensus aimed to establish a standardized method for the management of acute behavioral disorders in ED.

Endorsed items

The group focused on ten items for the care of these patients: i) Clinical parity in the emergency setting for acute behavioral disorders; ii) Organization; iii) Management of the agitated and violent patient; iv) Initial medical assessment; v) Psychiatric evaluation; vi) Voluntary drug poisoning/adverse drug reaction; vii) Teamwork; viii) Boarding reduction; ix) Safety care; x) Construction of a shared interdisciplinary approach.

Clinical parity in emergency for acute behavioral disorders

In the EDs, every subject with an acute behavioral disorder is entitled to timely access and to receive appropriate care. The behavioral emergencies must receive high-quality, multidisciplinary, evidence-based, and structured treatment regardless of the underlying cause (organic, psychiatric, toxicological) on par with other clinical/medical emergencies**.**

Organization

The emergency department must be prepared to receive behavioral emergencies by setting up adequate and equipped spaces, training staff, and promoting the taking charge by ED physicians and nurses. Early integration with psychiatrists and toxicologists (Poison Control Center) is essential, as well as with other consultants to be involved as needed, as well as with social services, law enforcement, and security personnel. Organization of work by teams based on the needs is desirable.

Management of the agitated and violent patient

The agitated and violent patient, or the patient at risk of committing violence, is a critical high-risk patient due to the complexity of clinical and environmental management. As such, he or she should be provided with all appropriate care and assistance. Relational de-escalation interventions, pharmacological treatment (tranquilization) and, if necessary, restraint measures must be implemented early, respecting the dignity of the patient and following specific procedures that each hospital should prepare.

Initial medical assessment

The medical screening (clearance) is a clinical assessment carried out by the Emergency Physician that aims to exclude that the acute behavioral disorder may be caused or exacerbated by an organic cause, drugs, psychoactive substances, or withdrawal conditions.

Psychiatric evaluation

The patient admitted to the emergency department for an acute psychiatric disorder is a complex patient at high risk for an unfavorable outcome. The psychiatrist, called to work within the team, takes charge of the interventions within his competence, promoting the coordinated, effective, and safe procedures.

Voluntary drug poisoning/Adverse drug reactions

The patient with suspected intoxication/adverse drugs-psychoactive substances effect/abstinence must receive appropriate diagnosis and treatment with the help of the specialist advice of the Poison Control Center of reference, with the availability of diagnostic tests to identify the most frequent and dangerous causative agents.

Teamwork

Given their complexity, the patients with acute behavioral disorders should be taken care of by a team of professionals consisting of the emergency physician, the emergency department nurse, the psychiatrist, and, possibly, the clinical toxicologist. When necessary, the emergency physician, based on clinical suspicion and after medical and toxicological clearance, makes use of the expertise of the other team members. This may happen also during the stabilization phase, with the aim to share therapeutic choices, dispositions, and pathways.

Boarding reduction

The phenomenon of boarding is unacceptable for these patients because it worsens the outcome. Once stabilized, and after the need for hospitalization is shared, patients should be sent early to

their chosen destination, reducing the time spent in the ED to the minimum.

Safety of care

It is a priority to ensure adequate protection of the patient, other users, operators, and the facility through collaboration with law enforcement and security personnel.

Construction of a shared interdisciplinary approach

It is responsibility of Health and Hospital Management to ensure shared training, procedures, structural adjustment, and organization.

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