Acknowledgements:
Keith R Stowell, MD, Associate Medical Director, Psychiatric Emergency & Intake Services; Western Psychiatric Institute & Clinic, 3811 O'Hara Street, Pittsburgh, PA 15213; stowellkr@upmc.edu

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Abstract:
It is difficult to fully assess an agitated patient, and the complete psychiatric evaluation usually cannot be completed until the patient is calm enough to participate in a psychiatric interview. Nonetheless, emergency clinicians must perform an initial mental status screening to begin this process as soon as the agitated patient presents to an emergency service. For this reason, the psychiatric evaluation of the agitated patient can be thought of as a two-step process. First a brief evaluation must be aimed at determining the most likely cause of agitation, so as to guide preliminary interventions to calm the patient. Once the patient is calmed, more

extensive psychiatric assessment can be completed. The goal of the emergency assessment of the psychiatric patient is not necessarily to obtain a definitive diagnosis. Rather, ascertaining a differential diagnosis, determining safety, and developing an appropriate treatment and disposition plan are the goals of the assessment. This article will summarize what components of the psychiatric assessment can and should be done at the time the agitated patient presents. The complete psychiatric evaluation of the patient whose agitation has been treated successfully is beyond the scope of this paper and Project BETA, but will be outlined briefly to give the reader an understanding of what a full psychiatric assessment would entail. Other issues related to the assessment of the agitated patient in the emergency setting will also be discussed. [West J Emerg Med. 2012;13(1):11–16.]

Psychiatric Evaluation of the Agitated Patient: Consensus Statement of the American Association for Emergency Psychiatry Project BETA Psychiatric Evaluation Workgroup

Keith R. Stowell, MD, MSPH* * University of Pittsburgh School of Medicine, Department of Psychiatry, Pittsburgh, Pennsylvania
Peter Florence, MD† † Dalhousie University, Department of Psychiatry, Halifax, Nova Scotia
Herbert J. Harman, MD‡ ‡ Carolinas Medical System, Department of Psychiatry, Charlotte, North Carolina
Rachel L. Glick, MD§ § University of Michigan School of Medicine, Department of Psychiatry, Ann Arbor, Michigan

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It is difficult to fully assess an agitated patient, and the complete psychiatric evaluation usually cannot be completed until the patient is calm enough to participate in a psychiatric interview. Nonetheless, emergency clinicians must perform an initial mental status screening to begin this process as soon as the agitated patient presents to an emergency setting. For this reason, the psychiatric evaluation of the agitated patient can be thought of as a 2-step process. First, a brief evaluation must be aimed at determining the most likely cause of agitation, so as to guide preliminary interventions to calm the patient. Once the patient is calmed, more extensive psychiatric assessment can be completed. The goal of the emergency assessment of the psychiatric patient is not necessarily to obtain a definitive diagnosis. Rather, ascertaining a differential diagnosis, determining safety, and developing an appropriate treatment and disposition plan are the goals of the assessment. This article will summarize what components of the psychiatric assessment can and should be done at the time the agitated patient presents to the emergency setting. The complete psychiatric evaluation of the patient whose agitation has been treated successfully is beyond the scope of this article and Project BETA (Best practices in Evaluation and Treatment of Agitation), but will be outlined briefly to give the reader an understanding of what a full psychiatric assessment would entail. Other issues related to the assessment of the agitated patient in the emergency setting will also be discussed. [West J Emerg Med. 2012;13(1):11–16.]

INTRODUCTION

Often, agitated patients are uncooperative or unable to give a relevant history, leaving clinicians to make decisions based on limited information. Fortunately, definitive diagnosis is not considered a primary goal of the initial emergency assessment of the agitated patient. However, a major decision to be made early in the assessment is whether or not the patient has an underlying medical problem that should be addressed in the medical setting. This is discussed in detail in a Project BETA (Best practices in Evaluation and Treatment of Agitation) companion article.[1,2] Project BETA represents recommendations for best practices in the evaluation and treatment of agitated patients by workgroups of the American Association for Emergency Psychiatry. In this article, we discuss the initial assessment of the agitated patient, including developing a working differential diagnosis based on the patient's mental status examination, to guide the appropriate course of care, whether it be a full psychiatric evaluation or ongoing medical investigation or both.

When a patient arrives in a state of agitation, triage, initial assessment, and de-escalation must occur at the same time the initial assessment is done. When evaluating the patient for a

psychiatric illness, being able to determine a broad category that defines the patient's presenting problem is very important. Knowing the patient's problem in these terms is useful when choosing a medication to help calm the patient. De-escalation, pharmacologic management, and issues related to seclusion and restraint are discussed in detail in Project BETA companion articles.[3–5] The discussion below will focus on broad identification of the agitated patient's problem during the initial interaction.

PSYCHIATRIC EVALUATION AND MANAGEMENT OF THE AGITATED PATIENT

Psychiatric evaluation of the agitated patient includes visual observation of the patient before direct patient interview and paying careful attention to the patient's verbal and nonverbal interaction with the examiner during de-escalation. Collateral information can be very helpful. While de-escalation is in process, another team member can obtain verbal reports from family, paramedics, or police officers or review written material that may accompany the patient. Medical records are also an important source of information, and electronic records, if available, can be readily accessed to determine previous diagnoses and medications. These sources of information can be invaluable in determining the cause of agitation. Once it is determined that the patient does not have an acute medical problem, there are several important questions, the answers to which will guide the next step in management of the patient. These are illustrated by the algorithm shown in the Figure.

The first question is whether the patient has a delirium. It is not uncommon for a patient to go through initial screening and have a diagnosis of delirium overlooked. The patient may be mistakenly diagnosed as being psychotic, or the signs and symptoms of delirium may be subtle and easily overlooked. In delirium, the patient has an altered level of awareness and problems directing, focusing, sustaining, or shifting attention.[6] The examiner must pay close attention to how the patient interacts during the encounter to even recognize these often subtle signs. Does the patient seem confused and unable to focus? Are there perseverative behaviors? Does the patient appear to be responding to visual hallucinations? Are there signs of language impairment, problems naming, or other cognitive deficits? If agitation is associated with any of these findings, especially in the setting of drug or medication use or medical illness, the presumptive diagnosis is delirium.

Next, the examiner must consider whether the patient has chronic cognitive impairment that is contributing to the current state of agitation. The patient with a history of brain injury, developmental disability, or dementia can be easily upset in unfamiliar settings, and might respond to the hospital visit with agitation. Although the examiner may notice cognitive deficits in these patients at presentation, history from family members, friends, or other caregivers may be all that is available, since the agitated patient may not be able to participate in a formal examination. Brief cognitive screening, using tools such as the Folstein Mini Mental State Examination[7] or the Brief Mental Status Examination, based on the Orientation-Memory-Concentration Test[8] and described by Kaufman and Zun,[9] can be attempted. However, these instruments may have to wait until the patient is calmer and able to participate. If defects in cognition are found, collateral history is needed to determine if these are old or new.

The next question is whether the patient is intoxicated or in withdrawal. History of recent drug use is important, as is consultation of the *Diagnostic and Statistical Manual of Mental Disorders*,[10] which describes specific criteria for intoxication and withdrawal syndromes caused by common drugs. The emergency clinician should be familiar with these diagnostic criteria, many of which can be picked up by observation. This is illustrated by the following examples: (1) cocaine intoxication criteria include pupillary dilation, perspiration, vomiting, confusion, dyskinesias, dystonias, and seizures; (2) the patient intoxicated with opiates has pupillary constriction and may have slurred speech; (3) alcohol withdrawal is associated with sweating; hand tremor; vomiting; transient visual, tactile, or auditory hallucinations; and anxiety. All of these signs are readily observable.

The next question is whether the patient is agitated owing to psychosis caused by a known psychiatric disorder. Family or friends who have brought the patient to the emergency department may know of an existing psychotic disorder. If the patient is alone, someone may try to call to get collateral information from family, friends, outpatient care providers, or any other individuals who might know about the patient's history. While there may be confidentiality concerns, a patient's state of agitation must be considered a medical emergency, and obtaining information from others is necessary to provide appropriate care in this setting.

Finally, there are those patients who do not fall into the above categories. If the patient is not psychotic but exhibiting signs and symptoms of mania, the treatment is the same as for the patient with psychosis.[11] For agitation due to nonpsychotic depression or an anxiety disorder, treating the underlying anxiety is appropriate.[12] If the patient is simply angry or out of control (often in the setting of a personality disorder), verbal de-escalation techniques may work, even with the aggressive patient.[3]

When the patient is calm enough to undergo an interview, formal psychiatric assessment can be completed. There is no established standard assessment; however, the evaluation of an agitated patient should be as in depth and as complete as possible. Assessment should include not only discussion with the patient, but also collection of collateral history and review of available records, both of which are invaluable if the patient is unable to engage in an interview. Chief complaint, history of present illness, past psychiatric history, past medical history, substance use history, social history, family history, and the

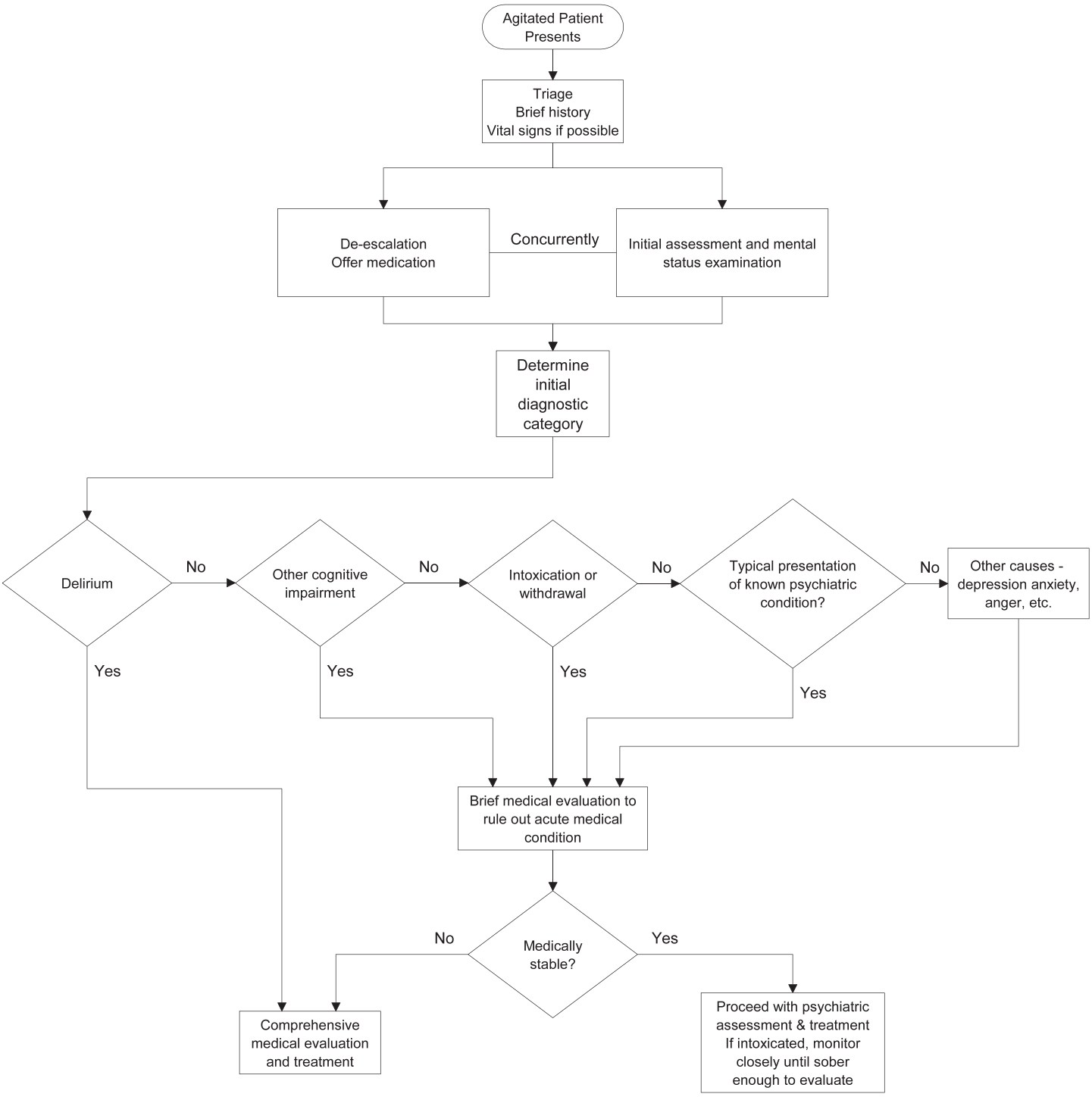

Figure. Algorithm for psychiatric assessment of the agitated patient.

mental status examination should be covered. These are summarized briefly in the upcoming text.

Chief Complaint

The patient may give a different reason for being brought to an emergency setting than that given by family members, police officers, or others who may accompany the patient. Both reasons should be noted and considered. A skilled interviewer can use this part of the assessment to tease out the stated chief complaint from what is really the issue that has brought on the crisis. For example, the patient may give a chief complaint of "feeling down," but a family member may report that he has been obsessed with his ex-girlfriend since a recent breakup and has been going to her house. The ex-girlfriend has had to call the police on 2 occasions. In this

case, the family member provided additional detail to the patient's more general complaint.

History of Present Illness

The patient's story should be heard. Invaluable information can be obtained just by listening to the patient. The patient's history should guide an exploration of diagnostic criteria to help arrive at a definitive diagnosis. The time frame during which symptoms developed should be determined. Stresses identified by the patient should be explored and the patient's support system or lack thereof should be reviewed. It is also important to identify issues related to safety of the patient and others. Suicide risk and risk of violence toward others should be discussed with the patient.

Past Psychiatric History

Psychiatric history should include past contacts with psychiatric care, past diagnoses, medication trials, hospitalizations, suicide attempts, history of violence, and the patient's current care providers. When possible, this history should be corroborated with current providers.

Past Medical History

All current and past medical illnesses and previous surgeries should be documented. Special attention should be paid to head injuries. Also, deceleration injuries that do not involve direct head trauma can result in brain injury.[13] Thus, a history of a motor vehicle collision in which the patient did not have a direct blow to the head but broke both femurs is significant. Determine all medications currently taken and why, including a review of any over-the-counter or herbal/alternative remedies that are being taken or recently have been taken. Allergies to medications should also be noted.

Substance Use History

A review of alcohol and street drug use, including the effect these have had on the patient's life, and any past treatment, should be obtained. This should be supplemented with questions about nicotine, caffeine, and other psychoactive substance use.

Social History

The social history provides a better understanding of who the patient is. Were there developmental problems? What is the patient's level of education? Has the patient had previous arrests? If the patient was in the military, does he have an honorable discharge? Does the patient have a consistent work history? Has the patient had a stable marriage or has he been married multiple times? Does he pay child support? Does the patient have spiritual concerns? While knowledge of past physical or sexual abuse can be important and can explain why the patient has responded in certain ways to behavioral management (such as restraint or seclusion), delving into abuse history is rarely appropriate in the emergency setting.

Family History

A complete family history should be obtained to include medical illness, mental illness, and substance use. Be sure to ask about family suicides or suicide attempts, as both are known risk factors for suicide.

Mental Status Examination

All components of the mental status examination should be included. Particular attention should be paid to the patient's appearance and behavior; affective state and stability; thought process; suicidal and homicidal ideation; the presence of psychotic symptoms; level of awareness; attention and concentration; judgment/insight; executive functions and reasoning; and reliability. If not already done, a screening cognitive examination, such as the Folstein Mini Mental State Examination[7] or the Brief Mental Status Examination[9] can be a helpful tool for assessing basic cognitive abilities and deficits.

OTHER ASPECTS OF EMERGENCY EVALUATION AND MANAGEMENT

Assessment for Risk of Suicide and Other Violence

An important part of the assessment of the agitated patient in the emergency setting is addressing the potential of harm to self or others. This will be a key focus in developing an appropriate disposition plan, but an exhaustive review of the evidence to use in suicide/violence risk assessment is beyond the scope of Project BETA. Therefore, in this article we will summarize the important points all clinicians should keep in mind.

Patients often arrive at an emergency department indicating they have thoughts, intent, or plan to harm themselves or others, or behaving in a way that suggests they may be dangerous. The emergency provider must quickly establish a treatment plan that will mitigate the risk of self-harm or violence toward others. Unfortunately, there is no specific tool that can be used to assess all such suicidal or potentially violent patients. While several scales are available, their utility in a busy emergency department setting is often rather limited. Further, while many such scales often have some utility in research settings, they do not have demonstrated predictive validity for clinical practice.[14] As such, a thorough understanding of the many static and dynamic risk factors for suicidal or violent behavior is needed. Relying solely on the patient's report that he or she is not suicidal or homicidal has been found to be inadequate.[15,16] Instead, a thorough mental status examination, a reasonable effort at obtaining collateral information, and a review of the patient's past behaviors, with a focus on suicidal or violent behaviors, are indicated.

In early stages of evaluation, careful attention should be given to collateral informants such as police or family members who may have vital information regarding recent acts of self-harm, aggression, threats made, and possible drug and alcohol intoxication. Often, the licensed provider responsible for treatment planning is not part of the triage process, and efforts

should be made to educate and train other clinical staff to gather pertinent clinical data, while it is easily obtainable, at the time when the patient presents to the emergency setting with others, whether family, emergency medical technicians, or police. In the evaluation of suicidality and homicidality, it is important to determine the nature of suicidal or violent thoughts in detail, including how often they occur, how long they last, and how the patient copes with such thoughts. Clinicians should ask specific questions to ascertain the urgency of these thoughts, with the understanding that they occur on a continuum. The assessment should include a risk factor review, including those that are modifiable. One especially important factor to assess in the emergency setting is access to guns, since this is a potentially modifiable risk factor with major impact. Other important areas of risk to assess include history of prior suicide attempts or acts of violence, substance use, limited support, and poor engagement or nonadherence with treatment. Protective factors should also be reviewed. These include strong spiritual beliefs, feeling that suicide or violence is immoral, custodial children or other family members under the patient's care, ability to identify reasons for living, and engagement in school or work. This will ultimately allow for a broader classification of risk and help in the determination of disposition. To be sure, this process does not allow for the prediction of suicide or violence, but rather, is a clinical judgment based on the available information to help estimate the likelihood of suicide or violence.[14,17]

Collateral History, Confidentiality, and Family Involvement

As discussed, collateral information should ideally be obtained from multiple sources including police and emergency personnel, physicians, nursing and other clinical staff in the emergency setting, and from family and friends who accompany the patient. Relevant historical information can be shared among those with a duty of care to the patient. However, ethical and legal issues of patient confidentiality arise with third parties. It is generally considered ethical and legally defensible practice to reveal what is medically necessary to third parties in an emergency, without the patient's consent. In addition, the duty to maintain confidentiality does not prevent the clinician from receiving information from third parties.[18] This is an important consideration when such information is necessary for thorough emergency assessment and management of the agitated patient.

Family and friends are often a good source of historical information and important collaborators in disposition planning in the emergency setting.[19] Additionally, recovery-based models consider family and peers to be an important part of the recovery process of mental illness. Clinical experience suggests that the presence of family or friends with an agitated patient can be both beneficial and detrimental, often during the same visit.[20] Often, the presence of family members can have a calming effect on patients initially, but may exacerbate agitation when there are apparent differences of opinion about management among the patient, family members, and clinical staff. One such situation is when a decision is made to restrain or involuntarily hospitalize the patient. Family members may need to be removed from view during procedures such as restraint or administration of parenteral medication to avoid escalation of the patient's agitation. Input from patients, their families, and peers about the emergency management of agitation should be an important part of practice when evaluating patients in the emergency setting.

Other Legal Issues

Medical-legal issues are often at the forefront of the assessment of the agitated patient. These include involuntary hospitalization and treatment, statutory reporting requirements (eg, child abuse) and "duty to warn" obligations (eg, Tarasoff requirements).[21,22] Laws that define when a clinician can place a patient on involuntary status vary among jurisdictions but generally include risk to the safety of self or others, significant impairment in self-care or grave disability and the need for treatment, or risk of deterioration in the presence of a mental disorder. The clinician should be familiar with legal requirements in the jurisdiction in which he or she practices, as statutes and case law may vary widely.[18]

Documentation

Documentation of sources of information for the patient's history should be included in the medical record. Collateral information obtained in addition to attempts to elicit or review relevant information, even if not available, should be included. The patient's consent for discussion with collateral sources should be noted. If the patient refuses to give permission, reasons for contacting others should be clearly documented. The relevant decision-making process related to disposition and statutory reporting obligations should form part of the patient's medical record.[23]

Ultimately, the results of the psychiatric assessment of the agitated patient should be documented in an organized manner in the medical record. In addition to a relevant patient history and mental status examination, a clinical impression should summarize the case and describe *who* the patient is and *why* he is presenting with agitation at this point in time. A summary of the risk assessment, including a discussion of risk factors for suicide or other violence, as well as protective factors, should be included. In addition, steps that have been taken to mitigate risk or strengthen protective factors, or steps that may still need to be taken to do so, should also be discussed. The rationale for the preferred disposition and overall management plan should be included as part of the clinical impression.[24]

CONCLUDING REMARKS

Initial psychiatric assessment of the agitated patient can often be quite challenging. As outlined in the related articles within this issue, de-escalation and other strategies may need to be used before or at the same time psychiatric assessment is

started. The possibility of medical etiologies must be considered first and foremost. Particular attention should be paid to the patient's appearance and behavior, level of awareness, attentional deficits, and cognitive abilities to rule out delirium/medical causes for the agitation. Affective state, thought process, suicidal and homicidal ideation, the presence of psychotic symptoms, judgment/insight, executive functions, and reasoning and reliability must ultimately also be assessed. The clinician may need to gather a significant amount of information from collateral sources. The focus of the evaluation is on developing a reasonable differential diagnosis, ascertaining safety and self-care concerns, and deciding how to manage the agitation. Developing the most appropriate treatment and disposition plan with the information gathered is more important than making a definitive diagnosis.

Address for Correspondence: Keith R. Stowell, MD, MSPH, Western Psychiatric Institute and Clinic, 3811 O'Hara St, Pittsburgh, PA 15213-2593. E-mail: stowellkr@upmc.edu.

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REFERENCES

1. Holloman GH Jr, Zeller SL. Overview of Project BETA: best practices in evaluation and treatment of agitation. *West J Emerg Med*. 2011;13:1–2.
2. Nordstrom K, Zun LS, Wilson MP, et al. Medical evaluation and triage of the agitated patient: consensus statement of the American Association for Emergency Psychiatry Project BETA Medical Evaluation Workgroup. *West J Emerg Med*. 2011;13:3–10.
3. Richmond JS, Berlin JS, Fishkind AB, et al. Verbal de-escalation of the agitated patient: consensus statement of the American Association for Emergency Psychiatry Project BETA De-escalation Workgroup. *West J Emerg Med*. 2011;13:17–26.
4. Wilson MP, Pepper D, Currier GW, et al. The psychopharmacology of agitation: consensus statement of the American Association for Emergency Psychiatry Project BETA Psychopharmacology Workgroup. *West J Emerg Med*. 2011;13:27–35.
5. Knox DK, Holloman GH Jr. Use and avoidance of seclusion and restraint: consensus statement of the American Association for Emergency Psychiatry Project BETA Seclusion and Restraint Workgroup. *West J Emerg Med*. 2011;13:36–41.
6. American Psychiatric Association. DSM-5 development: delirium. Available at: http://www.dsm5.org/ProposedRevision/Pages/proposedrevision.aspx?rid=32. Accessed September 11, 2011.
7. Folstein MF, Folstein SE, McHugh PR. "Mini-mental state": a practical method for grading the cognitive state of patients for the clinician. *J Psychiatr Res*. 1975;12:189–198.
8. Katzman R, Brown T, Fuld P, et al. Validation of a short Orientation-Memory-Concentration Test of cognitive impairment. *Am J Psychiatry*. 1983;140:734–739.
9. Kaufman DM, Zun L. A quantifiable, Brief Mental Status Examination for emergency patients. *J Emerg Med*. 1995;13:449–456.
10. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders* [text revision (DSM-IV-TR)]. 4th ed. Arlington, VA: American Psychiatric Association; 2000.
11. Cipriani A, Barbui C, Salanti G, et al. Comparative efficacy and acceptability of antimanic drugs in acute mania: a multiple-treatments meta-analysis [published online ahead of print August 16, 2011]. *Lancet*.
12. Rynn MA, Brawman-Mintzer O. Generalized anxiety disorder: acute and chronic treatment. *CNS Spectr*. 2004;9:716–723.
13. Meythaler JM, Peduzzi JD, Elefheriou E, et al. Current concepts: diffuse axonal injury-associated traumatic brain injury. *Arch Phys Med Rehabil*. 2001;82:1461–1471.
14. Jacobs D, Baldessarini R, Yeates C, et al. American Psychiatric Association practice guidelines: assessment and treatment of patients with suicidal behaviors. American Psychiatric Association Web site. Available at: http://www.psychiatryonline.com/pracGuide/pracGuideTopic_14.aspx. Accessed July 11, 2011.
15. Ennis BJ, Litwack TR. Psychiatry and the presumption of expertise: flipping coins in the courtroom. *Cal L Rev*. 1974;62:693–752.
16. Lidz CW, Mulvey EP, Gardner W. Accuracy of predictions of violence to others. *JAMA*. 1993;269:1007–1011.
17. Howard J, Cavanaugh J. Violence risk assessment: part II. *Psychopharm Rev*. 2010;45:83–90.
18. Saldanha CE. Legal issues in emergency psychiatry. In: Glick RL, Berlin JS, Fishkind AB, et al, eds. *Emergency Psychiatry: Principles and Practice*. Philadelphia, PA: Lippincott Williams & Wilkins; 2008:371–380.
19. Heru A, Combrinck-Graham L. The family in psychiatric emergencies. In: Glick RL, Berlin JS, Fishkind AB, et al, eds. *Emergency Psychiatry: Principles and Practice*. Philadelphia, PA: Lippincott Williams & Wilkins; 2008:107–116.
20. Lindenmayer JP, Crowner M, Cosgrove V. Emergency treatment of agitation and aggression. In: Allen MH, ed. *Emergency Psychiatry*. Washington, DC: American Psychiatric Publishing; 2002:115–125.
21. Fortunati FG, Zonana HV. Legal considerations in the child psychiatric emergency department. *Child Adolesc Psychiatric Clin N Am*. 2003;12:745–761.
22. *Tarasoff v Regents of the University of California*, 17 Cal 3d 425, 551 P.2d 334, 131 Cal Rptr 14 (Cal. 1976).
23. Canadian Medical Protective Association. Medico-legal principles and duties. Available at: http://www.cmpa-acpm.ca/cmpapd04/index.cfm?index=1. Accessed July 11, 2011.
24. Lofchy J. Emergency assessment. In: Goldbloom DS, ed. *Psychiatric Clinical Skills*. Philadelphia, PA: Mosby; 2006:199–214.