



Evaluation and Management of Children and Adolescents With Acute Mental Health or Behavioral Problems. Part I: Common Clinical Challenges of Patients With Mental Health and/or Behavioral Emergencies

Thomas H. Chun, MD, MPH, FAAP, Sharon E. Mace, MD, FAAP, FACEP, Emily R. Katz, MD, FAAP,
AMERICAN ACADEMY OF PEDIATRICS, COMMITTEE ON PEDIATRIC EMERGENCY MEDICINE, AND AMERICAN
COLLEGE OF EMERGENCY PHYSICIANS, PEDIATRIC EMERGENCY MEDICINE COMMITTEE

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INTRODUCTION

Mental health problems are among the leading contributors to the global burden of disease.¹ Unfortunately, pediatric populations are not spared of mental health problems. In the United States, 21% to 23% of children and adolescents have a diagnosable mental health or substance use disorder.^{2,3} Among patients of emergency departments (EDs), 70% screen positive for at least 1 mental health disorder,⁴ 23% meet criteria for 2 or more mental health concerns,⁵ 45% have a mental health problem resulting in impaired psychosocial functioning,⁵ and 10% of adolescents endorse significant levels of psychiatric distress at the time of their ED visit.⁶ In pediatric primary care settings, the reported prevalence of mental health and behavioral disorders is between 12% to 22% of children and adolescents.⁷

Although the American Academy of Pediatrics (AAP) has published a policy statement on mental health competencies and a Mental Health Toolkit for pediatric primary care providers, no such guidelines or resources exist for clinicians who care for pediatric mental health emergencies.^{8,9} This clinical report supports the 2006 joint policy statement of the AAP and American College of Emergency Physicians (ACEP) on pediatric mental health emergencies, with the goal of addressing the knowledge gaps in this area.^{10,11} The report is written primarily from the perspective of ED clinicians, but it is intended for all clinicians who care for children and adolescents with acute mental health and behavioral problems.

Recent epidemiologic studies of mental health visits have revealed a rapid burgeoning of both ED and primary care visits.^{12–20} An especially problematic trend is the increase in “boarding” of psychiatric patients in

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the ED and inpatient pediatric beds (ie, extended stays lasting days or even weeks). Although investigation of boarding practices is still in its infancy, the ACEP²¹ and the American Medical Association²² have both expressed concern about it, because it significantly taxes the functioning and efficiency of both the ED and hospital, and mental health services may not be available in the ED.²³⁻²⁶

In addition, compared with other pediatric care settings, ED patients are known to be at higher risk of mental health disorders, including depression,^{27,28} anxiety,²⁹ posttraumatic stress disorder,³⁰ and substance abuse.³¹ These mental health conditions may be unrecognized not only by treating clinicians but also by the child/adolescent and his or her parents.³²⁻³⁶ A similar phenomenon has been described with suicidal patients. Individuals who have committed suicide frequently visited a health care provider in the months preceding their death.^{37,38} Although a minority of suicidal patients present with some form of self-harm, many have vague somatic complaints (eg, headache, gastrointestinal tract distress, back pain, concern for a sexually transmitted infection) masking their underlying mental health condition.³⁴⁻³⁶

Despite studies demonstrating moderate agreement between emergency physicians and psychiatrists in the assessment and management of patients with mental health problems,^{39,40} ED clinicians frequently cite lack of training and confidence in their abilities as barriers to caring for patients with mental health emergencies.⁴¹⁻⁴⁴

Another study of emergency medicine and pediatric emergency medicine training programs found that formal training in psychiatric problems is not required nor offered by most programs.⁴⁵ Pediatric primary care providers report similar

barriers to caring for their patients with mental health problems.^{46,47}

Part I of this clinical report focuses on the issues relevant to patients presenting to the ED with a mental health chief complaint and covers the following topics:

- Medical clearance of pediatric psychiatric patients
- Suicidal ideation and suicide attempts
- Involuntary hospitalization
- Restraint of the agitated patient
 - o Verbal restraint
 - o Chemical restraint
 - o Physical restraint
- Coordination with the medical home

Part II discusses challenging patients with primarily medical or indeterminate presentations, in which the contribution of an underlying mental health condition may be unclear or a complicating factor, including:

- Somatic symptom and related disorders
- Adverse effects to psychiatric medications
 - o Antipsychotic adverse effects
 - o Neuroleptic malignant syndrome
 - o Serotonin syndrome
- Children with special needs in the ED (autism spectrum and developmental disorders)
- Mental health screening in the ED

An executive summary of this clinical report can be found at www.pediatrics.org/cgi/doi/10.1542/peds.2016-1571.

MEDICAL CLEARANCE OF PEDIATRIC PSYCHIATRIC PATIENTS

Background

Medical clearance can be defined as the process of excluding acute

medical illnesses or injuries in patients presenting with psychiatric complaints. Concern that medical illness may be the underlying cause of a psychiatric problem has led some to suggest “that emergency patients with psychiatric complaints receive a full medical evaluation.”⁴⁸ Medical clearance originates from the perspective that an ED evaluation of a psychiatric patient may be the only opportunity to diagnose underlying illnesses or injuries that could result in morbidity or mortality because resources for diagnosing and treating medical conditions may not be readily available in some psychiatric facilities. In addition, many psychiatric complaints and disorders can be exacerbated or precipitated by medical illness,⁴⁹ and some psychiatric patients may have unmet medical needs.⁵⁰⁻⁵²

Medical Diseases in ED Psychiatric Patients

Previous studies of medical conditions in ED psychiatric patients have been almost exclusively conducted with adults and have had highly variable findings. Past reports have found underlying medical problems in 19% to 63% of ED psychiatric patients.⁵³⁻⁵⁵ Studies of adults admitted to psychiatric units after an ED medical evaluation have had similarly disparate results. Some have reported missed medical conditions in up to half of patients,^{53,56} including diabetes, uremic and hepatic encephalopathy, pneumonia, urinary tract infections, and sepsis,⁵⁷ but another found that only 4% (12 of 298) needed treatment of a medical condition within 24 hours of admission to the psychiatric unit.⁵⁸ To address these concerns, some have suggested a standardized evaluation and documentation of the ED medical evaluation.⁵⁹ Major limitations of these studies are that they are from older literature, and they did not include children. More recent adult and pediatric studies, discussed later, suggest that

significant rates of medical morbidity in psychiatric patients may be less likely.

Some authors argue that it is not possible to rule out all potential medical etiologies for psychiatric symptoms and believe that the role of the ED evaluation is to determine whether the patient is “medically stable” rather than “medically cleared.”⁶⁰ Although the concept of “medical stability,” which can be defined as the lack of medical conditions requiring acute evaluation and/or treatment, is gaining traction, for the purposes of this discussion, the term “medical clearance” will be used. A growing body of adult and pediatric studies suggest that an ED patient’s history, physical examination, and vital signs provide important data for determining the appropriate medical evaluation for a psychiatric patient. These findings support the 2006 ACEP policy statement, which recommends “focused medical assessment” for ED psychiatric patients, in which laboratory testing is obtained on the basis of history and physical examination rather than a predetermined battery of tests for all patients with psychiatric complaints.⁶¹ When ED resource utilization and the cost of medical screening evaluations for pediatric psychiatric patients are considered, additional questions are raised about such evaluations and whether the ED is the optimal site for them.^{62,63}

The Goals of Medical Clearance

Medical clearance of psychiatric patients focuses on determining whether the patient’s behavioral or psychiatric signs and symptoms are caused or exacerbated by an underlying medical condition and whether there are medical conditions that would benefit from acute treatment in the ED. Given the vast number of medical illnesses that can masquerade as a behavioral problem or psychiatric disorder,

a comprehensive list of such conditions is beyond the scope of this article. Table 1 focuses on medical conditions that can be evaluated within the context and time frame of an ED visit. Examples of medical conditions requiring ED treatment includes suturing, wound or injury care, and treatment of an overdose. In addition, some psychiatric patients may have comorbidities that are not contributing to their behavioral or psychiatric complaints but would benefit from ED care, such as asthma or diabetes.⁵⁸

Key elements for detecting underlying medical condition(s) include careful assessment of abnormal vital signs, a complete history and physical examination, with particular attention to the neurologic, cardiac, and respiratory systems.⁶⁴ Various screening tools have been developed to assist in the medical clearance of psychiatric patients in the ED,^{60,65} although these authors also stress the importance of an adequate history and physical examination and do not mandate laboratory or other investigations.⁶⁵ After medical clearance has been performed, the AAP and ACEP support the development of transport protocols to definitive psychiatric treatment facilities for EDs that transfer patients with mental health care needs.^{10,11}

Diagnostic Laboratory Testing and Medical Clearance

In 1 study of emergency physicians, “routine testing” was performed in 35% of respondents, with 16% of the testing performed because it was ED protocol and 84% of the testing performed at request of the mental health service. Of those with protocol testing, the most frequently ordered tests were urine toxicology screen (86%), serum alcohol (85%), complete blood cell count (56%), electrolytes (56%), blood urea nitrogen (45%), creatinine (40%), serum toxicology screen (31%), and

electrocardiogram (18%).⁶⁶ Other commonly obtained laboratory evaluations for medical clearance include testing for pregnancy and sexually transmitted infections.

Recently, the utility of routine medical screening tests has been questioned. In contrast to the older literature, more contemporary studies are finding much lower rates of unsuspected, clinically emergent, or urgent laboratory abnormalities. Two studies of adult ED patients with psychiatric complaints found low rates of clinically significant abnormalities on routine laboratory testing,^{55,67} the majority (94%) of which were clinically suspected on the basis of the patient’s history and physical examination.⁵⁵ Similar results have been reported in admitted adult psychiatric patients after an ED evaluation. One study of 250 psychiatric inpatients found a mean of 27.7 tests were ordered per patient, with only 4% (11 of 250) having “important” medical problems discovered and less than 1 test in 50 resulting in any clinically useful information.¹⁰ Another study identified only 1 patient of 519 (0.2%) with an abnormal laboratory test result that would have changed ED management or patient disposition.⁶⁸

Similar results have emerged for ED pediatric psychiatric patients. Several studies have found little to no utility for routine urine drug testing. Shihabuddin et al evaluated such testing in 547 patients presenting with a psychiatric complaint. A positive result was found in 20.8% of patients, half of which were suspected on the basis of the patients’ reported substance use history. Urine drug testing resulted in no changes in patient management, and all were medically cleared.⁶⁹ Fortu et al examined 652 (385 routine and 267 medically indicated) urine toxicology screens.⁷⁰ For the routine toxicology screens, only 5% were positive, and there were no changes

TABLE 1 Medical Disorders That Can Present as a Psychiatric Disorder or Behavioral Problem^a

| |
|---|
| Neurologic (CNS) Diseases |
| Stroke/transient ischemic attacks |
| Hemorrhage: intracerebral, subdural, subarachnoid, epidural |
| CNS vascular: aneurysms, venous thrombosis, ischemia, vertebrobasilar insufficiency |
| CNS malignancy/tumors |
| CNS trauma: primary injury, secondary injury or sequelae of head trauma |
| CNS infections: meningitis, encephalitis, abscess (brain, epidural, spinal), HIV, syphilis |
| Congenital malformations |
| Hydrocephalus |
| Seizures |
| Headaches including migraines |
| Neurodegenerative disorders: multiple sclerosis, Huntington chorea |
| Tuberous sclerosis |
| Delirium (“ICU psychosis”) |
| Metabolic, Endocrine, and Electrolyte Disturbances |
| Hyponatremia |
| Hypocalcemia |
| Hypoglycemia |
| Hyperglycemia |
| Ketoacidosis |
| Uremia |
| Hyperammonemia |
| Inborn errors of metabolism: lipid storage diseases, Gaucher disease, Niemann-Pick disease |
| Thyroid disease: hyperthyroidism, thyroid storm, hypothyroidism |
| Adrenal disease: Addison disease, Cushing disease |
| Pituitary: hypopituitarism |
| Parathyroid disease: hypoparathyroidism, hyperparathyroidism |
| Pheochromocytoma |
| Respiratory |
| Hypoxia |
| Hypercarbia/hypercapnia |
| Respiratory failure |
| Medications |
| Drug withdrawal: alcohol, amphetamines, barbiturates, benzodiazepines, cocaine, psychiatric medications |
| Drug overdose: |
| Drugs of abuse: phencyclidine, heroin, cocaine, marijuana, MDMA (3,4-methylenedioxy-methamphetamine), LSD (lysergic acid diethylamide), alcohol, amphetamines, “bath salts” |
| Prescription drugs: steroids, birth control, antihypertensives, statins, anticonvulsants, barbiturates, benzodiazepines, opioids, anticholinergics, antibiotics, antifungal agents, antiviral agents, asthmatic medications, muscle relaxants, gastrointestinal tract drugs, anesthetics, anticholinergics, cardiac medications (such as digoxin), decongestants, antiarrhythmics, immunosuppressives |
| Drugs for psychiatric patients: antidepressants, antipsychotics, lithium |
| Hematologic/Oncologic |
| Malignancies |
| Tumors |
| Paraneoplastic syndromes |
| Inflammatory/Rheumatologic |
| Sarcoidosis |
| Systemic lupus erythematosus |
| Toxins |
| Carbon monoxide |
| Lead poisoning |
| Organophosphates |
| Volatile substances |
| Other |
| Fever |
| Child maltreatment |

^a This is not an exhaustive inclusive list but one that provides examples of the many diseases/conditions and drugs/medications that can masquerade as a psychiatric/behavioral disorder.

in management and no significant differences in disposition between those with positive and negative toxicology screens. Tenenbein reviewed 3 retrospective case studies of urine drug testing in children and concluded, “The emergency drug screen is unlikely to impact significantly upon the management of the patient in the emergency department.”⁷¹

Santiago et al prospectively studied 208 children and adolescents presenting to the ED with psychiatric conditions.⁶² Half of the patients underwent medical testing, 26% (55 patients) were medically indicated (ie, because of clinical suspicions based on the elicited history and physical examination), and 24% (54 patients) were obtained at the request of the mental health consultant. Only 3 patients had laboratory abnormalities that required further medical intervention, all of which were suspected on the basis of patient’s presenting history and physical examination. Among patients for whom “routine testing” was performed, 9% (5 patients) had unsuspected abnormalities, none of which altered ED patient management.

Two recent studies of ED pediatric psychiatric patients have raised similar questions about the utility of routine medical testing and of “medical clearance” evaluations. Donofrio et al investigated the utility of extensive laboratory testing of these patients.⁷² Of 1082 eligible patients, more than 68% had multiple laboratory testing, including urine toxicology, urinalysis, and blood tests for complete blood cell count, electrolytes, hepatic transferases, thyroid stimulating hormone, and syphilis. Of these tested patients, only 7 had a laboratory abnormality that resulted in a disposition change. Not only was the number of disposition changing laboratory abnormalities low, only 1 of these abnormalities

was not suspected from the patient's history and physical examination. Santillanes et al studied all patients referred to their ED for medical screening clearance by a mobile psychiatric crisis team.⁶³ All patients had been placed on an involuntary psychiatric hold. Among 789 patients, 9.1% met criteria for a medical screening examination (ie, altered mental status, ingestion, hanging, traumatic injury, sexual assault, or medical complaints), and only 1.2% (9 patients) were admitted for medical reasons. Of these 9 patients, only 2 did not meet criteria for a medical screening evaluation, although both patients' conditions (possible disorientation and urinary tract infection in an HIV-positive patient) were suspected on the basis of a basic history and physical examination.

Diagnostic Radiology Testing and Medical Clearance

All studies of radiographic evaluation of psychiatric patients have been conducted with adults. Although central nervous system (CNS) abnormalities such as oligodendroglioma, glioblastoma, meningioma, intracerebral cysts, and hydrocephalus can present with primarily psychiatric symptoms,⁷³ other studies have found low rates of clinically significant findings on computed tomography (CT) scan. In 1 study of 127 young military recruits with new-onset psychosis, none had clinically significant findings on brain CT scans.⁷⁴ In another analysis of new-onset acute psychosis in patients admitted to a psychiatric unit, only 1.2% had clinically significant findings.⁷⁵ A larger study of 397 patients with a psychiatric presentation and no focal neurologic findings detected specific abnormalities in 5%, all of which had no relevance to the patient's condition. The pretest probability of a space occupying lesion or any relevant abnormality was no greater than finding one

in the general population.⁷⁶ These findings have led some authors to question the utility of routine brain CT scans.⁶⁴ Given the concerns about the long-term effects of radiation exposure on pediatric patients,⁷⁷⁻⁷⁹ the utility of routine brain CT in children and adolescents is, at best, unclear.

Summary

The current body of literature supports focused medical assessments for ED psychiatric patients, in which laboratory and radiographic testing is obtained on the basis of a patient's history and physical examination. Routine diagnostic testing generally is low yield, costly, and unlikely to be of value or affect the disposition or management of ED psychiatric patients. When patients are clinically stable (ie, alert, cooperative, normal vital signs, with noncontributory history and physical examination and psychiatric symptoms), the ACEP states that routine laboratory testing need not be performed as part of the ED assessment.⁶¹ If a discrepancy occurs between the ED and psychiatry clinicians regarding the appropriate ED medical evaluation of a psychiatric patient, direct communication between the ED and psychiatry attending physicians may be helpful. For patients with concerning findings on history and/or physical examination (eg, altered mental status or unexplained vital signs abnormalities) or with new-onset or acute changes in psychiatric symptoms, a careful evaluation for possible underlying medical conditions may be important.

SUICIDAL IDEATION AND SUICIDE ATTEMPTS

For an extended discussion on the assessment and management of suicidal adolescents, please refer to the AAP clinical report on suicide.⁸⁰

Epidemiology and Risk Factors

Suicide is the third leading cause of death among people 10 to 24 years of age, accounting for more than 4000 deaths per year.⁸¹ Although only a small percentage of suicide attempts lead to medical attention,⁸² they nonetheless account for a significant number of ED visits.⁸³ Suicidal ideation in the absence of a suicide attempt is also a common chief complaint in pediatric EDs.

Approximately 16% of teenagers report having seriously considered suicide in the past year, 12.8% report having planned a suicide attempt, and 7.8% report having attempted suicide in the past year. Females are more likely to consider and attempt suicide, but males are more than 5 times more likely to die by suicide. The higher fatality rate among males is primarily accounted for by their use of more lethal means: males are more likely to attempt suicide via firearms and hanging, whereas females are more likely to attempt via overdose.⁸²

American Indian/Alaska Native males have the highest suicide rates among ethnic groups. Non-Hispanic white males are also at increased risk.⁸¹ Adolescents who have previous suicide attempts,⁸⁴ impulsivity, a mood or disruptive behavior disorder,⁸⁵ recent psychiatric hospitalization,^{86,87} substance abuse,⁸⁸ a family history of suicide,⁸⁹ or a history of sexual or physical abuse⁹⁰; are homeless/runaway⁹¹; or who identify as lesbian, gay, bisexual, or transgender⁹² are also at higher risk for attempting and/or completing suicide. Suicide and suicide attempts are often precipitated by significant psychosocial stressors. These can include family conflict, the breakup of a romantic relationship, bullying, academic difficulties, or disciplinary actions/legal troubles. Younger patients tend to be triggered more often by family conflict, whereas older adolescents are more likely to cite peer or romantic conflicts as a precipitant.⁹³

Evaluation

For patients reporting current or recent suicidal ideation and those who present after clear or suspected intentional self-injury, best practices include an evaluation by a clinician experienced in evaluating pediatric mental health conditions. Whenever concern for suicidal ideation or attempt is present, having the patient undergo a personal and belongings search, change into hospital attire, and be placed in as safe a setting as possible (eg, a room without easy access to medical equipment) with close staff supervision may be important.

Interviewing patients and caregivers both together and separately may be beneficial. Obtaining collateral information from caregivers or other individuals who may have knowledge about the patient's state of mind or the details of the event in question often has significant clinical utility, as patients frequently minimize the severity of their symptoms or the intention behind their acts. When interviewing adolescents alone, a discussion about the limits of patient confidentiality may facilitate an open and honest conversation. If there are significant concerns that the patient may be at high risk of harm to himself or herself or others (see "Determination of Level of Care"), the physician may decide to break doctor-patient confidentiality.

A thorough medical examination with careful evaluation for signs of self-injury or toxidromes and a mental status examination may be helpful. The mental status examination typically includes assessment of the patient's appearance, behavior, thought process, thought content (including presence or absence of hallucinations or delusions), mood and affect, and insight and judgment. An evaluation for delirium may also be indicated. When suspicion of delirium is high, a number of screening tools (eg, the Folstein

Mini-Mental Status Examination)⁹⁴ may be useful.

Determination of Level of Care

No validated criteria exist for assessing level of risk for subsequent suicide or determining level of care. However, most experts agree that patients who continue to endorse a desire to die, remain agitated or severely hopeless, cannot engage in a discussion around safety planning, do not have an adequate support system, cannot be adequately monitored or receive follow-up care, or had a high-lethality suicide attempt or an attempt with clear expectation of death may be at high risk of suicide, and consideration should be given to admission to an inpatient psychiatric facility once medically cleared.⁸⁰ Additional risk factors, such as gender, comorbid substance abuse, and high levels of anger or impulsivity, may also be considered.

Patients who do not meet criteria for inpatient psychiatric hospitalization may be candidates for outpatient mental health treatment and intervention. Where available, partial hospital programs, intensive outpatient services, or in-home treatment/crisis stabilization interventions may be considered, especially when ED clinicians believe that a patient may benefit from more intensive or urgent treatment. Experts suggest that even patients who are deemed to be at relatively low risk of future suicidal or self-injurious acts benefit from outpatient follow-up. Whenever possible, a follow-up appointment with the medical home provider and an outpatient mental health clinician may be helpful. When outpatient mental health services are not readily accessible or wait times for intake appointments are considerable, the medical home providers can play an important bridging role. These providers may also

continue to work with patients and families to promote engagement in and adherence to mental health treatment. Consensus expert opinion suggests direct contact with these outpatient providers, either by the mental health consultant or the ED clinician, documentation of this contact, and documentation of the discharge treatment plan.^{95,96}

Discharge Planning

Some patients evaluated in the ED for suicidal ideation or a suicide attempt struggle to obtain follow-up care.^{97,98} The ED visit may, therefore, be a valuable link in obtaining care for these patients. ED physicians may stress the importance of follow-up to both the patient and the family and attempt to identify and address barriers to subsequent treatment. Counseling and educating families about suicide risk and treatment may be beneficial. The greatest risk of reattempting suicide is in the months after an initial attempt. In addition, given that counseling takes time to work, emphasizing the importance of consistent follow-up may help patients and families.⁹⁹⁻¹⁰¹

Although having a patient sign a no-suicide contract has not been shown to prevent subsequent suicides,⁹⁵ a safety-planning discussion is still an important element of ED care. A safety plan typically includes steps such as identification of (1) warning signs and potential triggers for recurrence of suicidal ideation; (2) coping strategies the patient may use if suicidal ideation returns; (3) healthy activities that could provide distraction or suppression of suicidal thoughts; (4) responsible social supports to which the patient could turn if suicidal urges recur; (5) contact information for professional supports, including instructions on how and when to reaccess emergency services; and (6) means restriction.¹⁰²

Studies suggest that means restriction counseling may be a key component of discharge planning discussions. A large percentage of suicide attempts are impulsive. One study of patients 13 to 34 years of age who had near-lethal suicide attempts found that 24% of patients went from deciding to attempt suicide to implementing their plan within 0 to 5 minutes, 24% took 5 to 19 minutes, and 23% took 20 minutes to 1 hour.¹⁰³ Several studies have demonstrated that patients usually misjudge the lethality of their suicide attempts.^{104–106} There is also a wide variation in the case-fatality rates of common methods of suicide attempt, ranging from 85% for gunshot wounds to 2% for ingestions and 1% for cutting.¹⁰⁷ It follows that interventions that decrease access to more lethal means and/or increase the amount of time and effort it takes for someone to carry out their suicidal plan and, as a result, increase the amount of time they have to reconsider or for someone to intervene may have a positive effect.

It may be helpful to ask and counsel patients and families about restricting access to potentially lethal means, including access to such means in the homes of friends or family. Means restriction counseling includes suggestions for securing knives, locking up medicines, and removing firearms. It is important to note that parents often underestimate their children's abilities to locate and access firearms and that simply having a gun in the home has been shown to double the risk of youth suicide.^{108, 109} Families who are reluctant to permanently remove firearms from the home may be open to temporarily relocating them (eg, for safe keeping with a relative, friend, or local law enforcement) until the child is in a better emotional state. If families insist on keeping firearms in the home, counseling them on how to store them as safely as possible (eg,

by locking all firearms unloaded in a specialized or tamper-proof safe, separately locking or temporarily removing ammunition, and restricting access to keys or lock combinations) may be helpful. Given the high rates of drug and alcohol intoxication among individuals who attempt and complete suicide, physicians may also want to suggest alcohol access restriction and, where indicated, referral for substance abuse counseling and treatment.

INVOLUNTARY HOSPITALIZATION

Under certain circumstances, physicians may insist on admission to a psychiatric inpatient unit over the objections of patients and/or their guardians. This type of admission is often referred to as a “psychiatric hold.” Every state has laws governing involuntary admission for inpatient psychiatric hospitalization. Specific details of such laws vary from state to state, as do laws regarding confidentiality and an adolescent's right to seek mental health or substance abuse treatment without parental consent. As such, ED clinicians may benefit from familiarizing themselves with the relevant laws, statutes, and involuntary commitment procedures in the states in which they practice. In general, physicians are able to admit a patient against his or her will for a brief period of time, typically up to 72 hours, but ranging from 1 to 30 days. After that initial period, the psychiatric facility works to obtain a court order for civil commitment for ongoing treatment, if the patient and/or his or her guardian still object to the hospitalization. Criteria for involuntary hospitalization typically include the patient having a mental disorder and being at immediate risk of harm to self or others. Some states also allow for involuntary hospitalization if the patient is “gravely disabled.” The criteria for being gravely disabled may include

the inability to meet basic physical needs including nourishment, shelter, safety, and/or basic medical care.¹¹⁰ State laws differ over whether and, if so, at what age, assent for psychiatric admission must be obtained from minors. For more information on related state laws, contact the AAP Division of State Government Affairs at stgov@aap.org.

RESTRAINT OF THE AGITATED PATIENT

Restraint typically refers to methods of restricting an individual's freedom of movement, physical activity, or normal access to his or her body because of concerns about the person harming himself or herself or others. Some experts believe that interventions to help control a person's activity and behavior span a wide gamut, including verbal and behavioral strategies and favor the term “de-escalation interventions.” Restraints may be used for either “medical” or “psychiatric” patients¹¹¹ and have been subdivided into verbal, chemical, and physical restraints. Chemical restraint, sometimes called “rapid tranquilization,” is the use of pharmacologic means for the acute management of an agitated patient.¹¹²

Four guiding principles for working with agitated patients are as follows: (1) maximizing the safety of the patient and treating staff; (2) assisting the patient in managing his or her emotions and maintaining or regaining control of his or her behavior; (3) using the least restrictive, age-appropriate methods of restraint possible; and (4) minimizing coercive interventions that may exacerbate agitation.¹¹³

Verbal Restraint

The general principles of verbal restraint can be found across a wide variety of disciplines,

including various psychotherapeutic approaches (eg, anger management, stress reduction), linguistic science, law enforcement, martial arts, and nursing.^{113–116} Although consensus is that verbal restraint is preferable to chemical or physical restraint,¹¹⁷ reviews of the literature find primarily case studies, with a paucity of rigorous studies of verbal restraint, and little on specific strategies or efficacy.^{113,118} For example, although a study by Jonikas et al found a decrease in restraint use, it was not clear whether the decrease was attributable to staff training in de-escalation techniques or to crisis intervention training, which occurred at the same time.¹¹⁹ Other protocols emphasize the importance of prevention in behavior management protocols.^{115,120}

Detailed in Table 2 are Fishkind's "Ten Commandments of De-escalation," which incorporate practical, commonly used verbal restraint strategies.^{112–114,121–123} Other strategies that may improve the chances of successful de-escalation include a calming physical environment with decreased sensory stimulation, rooms that have been "safety-proofed" (ie, removal or securing of objects that could be used as weapons) or close monitoring if this is not possible,¹¹³ modifying or eliminating triggers of agitation (eg, an argumentative acquaintance, friend, or family or staff member, a long ED wait time),^{117,124,125} and staff training in behavioral emergencies.^{126,127} A child life specialist may also be an excellent resource to help calm an agitated child. To minimize risk to themselves, health care providers may take precautions, such as removing neck ties, stethoscopes, or securing long hair.

Chemical Restraint

All controlled trials of medications for acute agitation in the ED or inpatient psychiatric setting have

been conducted with adults. In the literature, different terms have been used to describe the use of medications to treat agitation, violent or aggressive behavior, or excessive psychomotor activity (eg, psychosis or mania), including pharmacologic or chemical restraint¹²⁸ and rapid tranquilization.¹¹² The 3 most commonly used classes of drugs for this purpose are the typical antipsychotics, atypical antipsychotics, and benzodiazepines.^{124,125,129}

Antipsychotics

Antipsychotics exert their effect primarily as CNS dopamine receptor antagonists.^{130,131} "Low-potency" agents (eg, chlorpromazine and thioridazine) are more sedating, with fewer extrapyramidal symptoms than "high-potency" agents (eg, haloperidol and droperidol), which are less sedating but more likely to cause extrapyramidal symptoms.¹³² The second-generation "atypical" antipsychotics are both serotonin-dopamine receptor antagonists.¹³⁰ Some consider aripiprazole the first "third-generation" antipsychotic, because it has partial dopamine receptor agonist activity, distinguishing it from other antipsychotics.^{130,132,133} Antipsychotics also have varying ability to block other CNS neurotransmitters, which, combined with their disparate affinity for the postsynaptic D₂ receptors, account for the side effect profiles of each medication, which are discussed in greater detail below and in part II of this clinical report.^{130,132}

Benzodiazepines

Benzodiazepines exert their CNS depressant effect by binding to presynaptic γ -aminobutyric acid (GABA) receptors. GABA, the primary CNS inhibitory neurotransmitter, decreases neuronal excitability. Benzodiazepines that have been commonly used to treat agitation

are lorazepam, midazolam, and diazepam. Some experts prefer lorazepam for the management of acute agitation because it has fast onset of action, rapid and complete absorption, and no active metabolites. Midazolam may have a more rapid onset of action, but it also has a shorter duration of action. Diazepam has a longer half-life and erratic absorption when given intramuscularly (IM).^{134,135}

Less Commonly Used Drugs

Other drugs also used for management of the agitated patient include the antihistamines diphenhydramine, and hydroxyzine and the α -adrenergic agent clonidine.^{117,134,136,137} Diphenhydramine and hydroxyzine have sedative effects and are commonly used as nighttime sleep aids for insomnia. Clonidine is a presynaptic α_2 -agonist, often used off-label for attention-deficit/hyperactivity disorder and opiate withdrawal. Doses are typically given at night because a significant effect of the medication is somnolence. Although there have been some controlled trials of diphenhydramine as a sedative,^{138,139} clonidine has been less well studied.¹⁴⁰

Drug Selection for Chemical Restraint

Drug selection for chemical restraint will depend largely on the specific details of the clinical scenario (Table 3) and collaboration among ED, psychiatric, and pharmacy colleagues. The combination of a benzodiazepine and an antipsychotic is a regimen frequently suggested by experts for acutely agitated patients, including children and adolescents^{124,134,141–147} (Table 4). The route of administration, orally or IM, will depend on the patient's condition. The choice of medication(s) also depend(s) on the patient's current medications. If a patient is already on an antipsychotic, an additional or increased dose of that medication may be preferred.^{61,145,147}

TABLE 2 Verbal Restraint Strategies

| | Guiding Principle | Strategies, Suggestions, and Examples |
|--|--|--|
| 1. Respect personal space | <ul style="list-style-type: none"> Physical environment can make a patient feel threatened and/or vulnerable | <ul style="list-style-type: none"> Two arms' length distance from patient Unobstructed path out of room for both patient and ED staff |
| 2. Minimize provocative behavior | <ul style="list-style-type: none"> Posture and behavior can make a patient feel threatened and/or vulnerable Concealed hands might imply a hidden weapon | <ul style="list-style-type: none"> Calm demeanor and facial expressions Visible, unclenched hands Minimize defensive and/or confrontational body language, eg, hands on hips, arms crossed, aggressive posture, directly facing patient (instead, stand at an angle to the patient) |
| 3. Establish verbal contact | <ul style="list-style-type: none"> Multiple messages and "messengers" may confuse and agitate the patient | <ul style="list-style-type: none"> Ideally, designate 1 or limited staff members to interact with the patient Introduce self and staff to patient Orient patient to ED and what to expect Reassure patient that you will help him or her |
| 4. Be concise | <ul style="list-style-type: none"> Agitated patients may be impaired in verbally processing information Repeating the message may be helpful | <ul style="list-style-type: none"> Simple language, concise sentences May be helpful to frequently repeat/reinforce message Allow the patient adequate time to process information and respond |
| 5. Identify patient's goals and expectations | <ul style="list-style-type: none"> Use body language and verbal acknowledgment to convey | <ul style="list-style-type: none"> "I'd like to know what you hoped or expected would happen here." "What helps you at times like this?" "Even if I can't provide it, I'd like to know so we can work on it." |
| 6. Use active listening | <ul style="list-style-type: none"> Convey to the patient that what he or she said is heard, understood, and valued | <ul style="list-style-type: none"> "Tell me if I have this right ..." "What I heard is that ..." |
| 7. Agree OR agree to disagree | <ul style="list-style-type: none"> Builds empathy for patient's situation Minimize arguing | <ul style="list-style-type: none"> (Agree) "What you're (specific example) going through/ experiencing is difficult." (Agree) "I think everyone would want (the same as you)." (Agree) "That (what patient is complaining about) would upset other people too." (Agree to disagree) "People have a lot of different views on (the focus of disagreement)." |
| 8. Clear limits and expectations | <ul style="list-style-type: none"> Reasonable and respectful limit setting Set expectations of mutual respect and dignity, as well as consequences of unacceptable behaviors Minimize "bargaining" | <ul style="list-style-type: none"> "We're here to help, but it's also important that we're safe with each other and respect each other." "Safety comes first. If you're having a hard time staying safe or controlling your behavior, we will ... (clear, nonpunitive consequence)." "It'll help me if you (sit, calm yourself, etc). I can better understand you if you calmly tell me your concerns." |
| 9. Offer choices and optimism | <ul style="list-style-type: none"> Coach patient on how to maintain control Realistic choice helps empower the patient, regain control of himself/herself, and feel like a partner in the process Link patient's goals to his or her action Minimize deception and/or bargaining | <ul style="list-style-type: none"> "Instead of (violence/agitation), what else could you do? Would (offer choice) help?" Acts of kindness (eg, food, blanket, magazine, access to a phone or family member) may help "You'd like (desired outcome). How can we work together to accomplish (their goal)?" |
| 10. Debrief patient and staff | <ul style="list-style-type: none"> If an involuntary intervention is indicated, debriefing may help restore working relationship with the patient and help staff plan for possible future interventions | <ul style="list-style-type: none"> Explain why the intervention was necessary Ask patient to explain his or her perspective Review options/alternative strategies if the situation arises again |

In situations in which the cause of agitation is unclear, many clinicians prefer a stepwise rather than combination approach, administering either a benzodiazepine or first-generation antipsychotic. When treating an agitated patient with a known psychiatric disorder, either a first- or second-generation antipsychotic is generally preferred.

TABLE 3 Acute Agitation Medication Considerations

| Suspected Etiology of Agitation | Symptom Severity | |
|---------------------------------|---|---|
| | Mild/Moderate | Severe |
| Medical/intoxication | Benzodiazepine | Benzodiazepine first, consider adding antipsychotic |
| Psychiatric | Benzodiazepine or antipsychotic | Antipsychotic |
| Unknown | Dose of benzodiazepine or antipsychotic; consider a dose of the other medication if the first dose is not effective | |

TABLE 4 Medications for the Acutely Agitated Pediatric Patient^a

| Drug: How Supplied | Dose: Route of Administration | Time: Course/Onset Peak/ Duration | Side Effects | Advantages | Comments |
|---|---|--|--|---|---|
| Benzodiazepines | See individual drugs | See individual drugs | • Sedation | • No EPS | • Contraindicated for intoxication due to other GABAergic drugs (eg, barbiturates, benzodiazepine abuse) • Use with caution in patients with respiratory compromise • Pregnancy class D |
| Lorazepam PO, IM, IV | 0.05–0.1 mg/kg PO/IM/IV | Onset: 5–10 min IV 15 min IM 20–30 min PO Peak: 30 min IV 1 h IM 2 h PO Duration: 2 h IV 6–8 h PO/IM | • Respiratory depression • Hypotension • Paradoxical disinhibition (especially younger children and those with developmental disabilities) | • Preferred agent for many intoxications (eg, cocaine can cause seizures), withdrawal (eg, alcohol) | • Most commonly used drug for acute pediatric agitation |
| Midazolam PO, IM, IV | 0.1 mg/kg PO/IM/IV Usual dose: Adult: 2 mg PO/IM May repeat every 30–60 min | Onset: 5–10 min IV 10–15 min IM 20 min PO Peak: 5–15 min IV 15–30 min IM 1 h PO Duration: 3–4 h | | | |
| Antipsychotics First-generation, “typical antipsychotics” ^b | | | • Prolonged QT _c , • Torsades de pointes • Dysrhythmias • Hypotension • Dystonia/EPSe • NMS | | • Pregnancy class C |
| Haloperidol PO, IM | 0.025–0.075 mg/kg IM/PO | Onset: | | • Most commonly used drug in adults for acute agitation | • Lowers seizure threshold in animals |

TABLE 4 Continued

| Drug: How Supplied | Dose: Route of Administration | Time: Course/Onset Peak/ Duration | Side Effects | Advantages | Comments |
|---|---|---|---|---|---|
| | Usual dose: Child: 0.5–2 mg Adolescent: 2–5 mg Adult: 5–10 mg May repeat IM every 20–30 min, PO every 60 min Usual total dose for tranquilization: 10–20 mg (adults) | 20–30 min IM 45–60 min PO Peak: 60 min IM 3 h PO Duration: 4–8 h | | <ul style="list-style-type: none"> • Second most commonly used drug in pediatric patients • Low addiction potential • High therapeutic index • Lack of tolerance | |
| Second-generation, “atypical antipsychotics” | | | <ul style="list-style-type: none"> • Same as first-generation drugs • Hyperglycemia • Hyperprolactinemia | <ul style="list-style-type: none"> • May be better tolerated and may cause fewer EPS than first-generation drugs • May have higher risk of dystonia, especially with higher doses and in male and/or young patients | <ul style="list-style-type: none"> • Pregnancy class C |
| Risperidone PO (liquid, tablet, ODT), IM | 0.025–0.050 mg/kg PO/IM Usual dose: Child: 0.25–0.50 mg Adolescent: 0.5–1 mg May repeat PO every 60 min | Onset: 30–60 min PO Peak: 1–2 h PO | | | |
| Olanzapine PO (tablet, ODT) IM | 0.1 mg/kg PO/IM | Onset: | <ul style="list-style-type: none"> • Postinjection delirium/sedation | | <ul style="list-style-type: none"> • FDA investigating 2 unexplained deaths 3–4 d after appropriate IM dose • Consider monitoring for at least 3 h after IM injection |
| Ziprasidone PO, IM | Usual dose: Child: 2.5 mg Adolescent: 5–10 mg Adult: 10 mg Maximum: 30 mg daily May repeat IM every 20–30 min, PO every 30–45 min Usual dose: Younger adolescent (12–16 y): 10 mg Older adolescent (>16 y): 10–20 mg Maximum: 40 mg daily May repeat every 2 h | 10–20 min IM 20–30 min PO Peak: 15–45 min IM 6 h PO Duration: 24 h Onset: 60 min IM 4–5 h PO Peak: IM ≤60 min PO 6–8 h PO | | | |
| Combinations ^d Antipsychotic (typical) + benzodiazepine | Haloperidol + lorazepam or midazolam | | | | |

TABLE 4 Continued

| Drug; How Supplied | Dose; Route of Administration | Time; Course/Onset Peak/ Duration | Side Effects | Advantages | Comments |
|---|--------------------------------------|--------------------------------------|--------------|------------|----------|
| Antipsychotic (typical) + antihistamine | Haloperidol + diphenhydramine | | | | |
| Antipsychotic (atypical) + benzodiazepine | Risperidone + lorazepam or midazolam | | | | |
| Antipsychotic (atypical) + antihistamine | Risperidone + diphenhydramine | | | | |

Side effects for all drugs in the class are given in the row for the drug class. Side effects for a specific drug in the class are given in the row for the drug class. Pregnancy class is based on limited data, but according to Lexicomp (<http://www.wolterskluwer.com/lexicomp-online/community-pharmacy/>), the benzodiazepines are class D and the first- and second-generation antipsychotics listed in the table are class C (last accessed December 2, 2013). EPS, extrapyramidal symptom; FDA, US Food and Drug Administration; IV, intravenous; NMS, neuroleptic malignant syndrome; ODT, oral disintegrating tablet; PO, oral administration.

^a This table provides suggestions for some of the most commonly used drugs for management of the agitated pediatric patient. Child (prepubertal) ages 6–12 y; adolescent 13 y or older. Adult doses have been used in adolescents with high BMI.^{125, 129, 135, 143, 148, 149}

^b Chlorpromazine, a phenothiazine that can be used to treat nausea/vomiting and intractable hiccups, has also been used with agitated patients^{118, 126, 150} but has many of the same adverse effects as the other drugs (extrapyramidal/dystonic symptoms, neuroleptic malignant syndrome) as well as anticholinergic side effects and a decrease in the seizure threshold, without having any major advantages over the other drugs.

^c EPSs include dystonia and akathisia, which may be treated with diphenhydramine (1.0 mg/kg/dose IV or PO, maximum 50 mg, usual dose in adults is 25 mg or 50 mg) and/or benztropine (1–2 mg in adults).

^d Studies of the coadministration of these drugs have been reported. There may be research with other combinations studied in the future. Combinations of a butyrophenone (eg, haloperidol) and a benzodiazepine (eg, lorazepam) may be given together for an additive effect and may be administered in the same syringe. Data in some adult studies suggest that coadministration of a butyrophenone with a benzodiazepine may be more effective than either medication alone.

In other clinical situations, benzodiazepines alone may be the drug of choice. A common scenario is when the agitation is attributable to drug withdrawal or drug intoxication, especially drugs that decrease seizure threshold (eg, cocaine).^{117, 123, 143, 145, 151} Because of their anticholinergic properties, antipsychotics may worsen the condition of patients who present with intoxication from drugs with anticholinergic properties (eg, hallucinogens) or with an anticholinergic delirium.^{123, 124, 143}

Adverse Effects of and Clinical Monitoring During Chemical Restraint

Monitoring of patients who have received chemical restraint is similar to patients under physical restraint, which are discussed in detail in the subsequent section on physical restraint.^{152–154} Medications used for chemical restraint may result in myriad adverse effects that benefit from close medical monitoring, including respiratory depression; hypotension; paradoxical behavioral disinhibition from benzodiazepines, especially in younger children and those with developmental disabilities^{134, 148, 155}; dystonic reactions; orthostatic hypotension; sinus tachycardia; and other dysrhythmias attributable to antipsychotics.^{61, 130, 132–134, 149} Given these concerns, monitoring patients who receive antipsychotics may include close clinical observation, cardiorespiratory monitoring, pulse oximetry,¹⁵⁶ and/or an electrocardiogram, when and if the patient will tolerate them.

The most feared cardiac adverse effect of antipsychotics is a quinidine-like QT_c prolongation, resulting in dysrhythmias such as torsades de pointes. QT_c prolongation has been noted to occur with therapeutic dosing of antipsychotics and is possible with any antipsychotic medication. Potential risk factors for QT_c prolongation and dysrhythmia include coadministration with

TABLE 5 QT-Interval-Prolonging Medications in Pediatrics

| | | |
|---------------------------------|-------------------|--|
| Antiemetics | Cardiac | Antidepressants |
| • Ondansetron | • Adenosine | • Fluoxetine |
| • Dolasetron | • Dopamine | • Sertraline |
| Macrolides | • Epinephrine | • Paroxetine |
| • Azithromycin | • Dobutamine | • Venlafaxine |
| • Clarithromycin | • Quinidine | • Amitriptyline |
| • Erythromycin | • Procainamide | • Desipramine |
| Fluoroquinolones | • Flecainide | • Imipramine |
| • Ciprofloxacin | • Amiodarone | Mood-stabilizing agents |
| • Levofloxacin | • Bretylium | • Lithium |
| • Moxifloxacin | • Nicardipine | Antipsychotics |
| Other Antibiotics | • Sotalol | • Please see Table 4 at www.pediatrics.org/cgi/doi/10.1542/peds.2016-1573 |
| • Amantadine | Antihistamines | Other medications |
| • Trimethoprim-sulfamethoxazole | • Diphenhydramine | • Cisapride |
| Antimalarials | • Hydroxyzine | • Octreotide |
| • Quinine | • Loratadine | • Pentamidine |
| • Chloroquine | • Astemizole | • Tacrolimus |
| Neurologic | • Terfenadine | • Vasopressin |
| • fos-Phenytoin | Respiratory tract | |
| • Sumatriptan | • Albuterol | |
| • Zolmitriptan | • Terbutaline | |
| • Chloral hydrate | • Phenylephrine | |
| | • Pseudoephedrine | |

This is an incomplete list of QT-interval-prolonging medications, limited to those that are commonly used in pediatrics. For a more comprehensive list, please refer to the cited references Haddad et al, Olsen et al, and Yap et al.^{159–161}

other drugs that prolong the QT_c; administration of high doses of haloperidol^{157,158}; and underlying medical illness (eg, electrolyte abnormalities, hepatic or renal impairment, heart failure, elderly, congenital long QT syndromes). Among the typical and atypical antipsychotics, thioridazine and ziprasidone, respectively, are associated with the greatest degrees of QT_c prolongation.^{130,134,145,159} Many other commonly used pediatric medications may prolong the QT_c, including antiemetics (eg, ondansetron), antibiotics such as macrolides, fluoroquinolones, and antifungal agents (eg, ketoconazole), antiarrhythmics, and other psychiatric medications (Table 5).^{160–162} US Food and Drug Administration “black box” warnings have been issued for both droperidol and thioridazine because of this risk, although the actual clinical risk of and dangers from antipsychotic-induced cardiac dysrhythmias is unclear and is being vigorously debated.^{61,134,149,163–168} However, since the black box

warning, the use of droperidol has declined exponentially.^{114,117,125,157}

Acute dystonia usually presents as involuntary motor tics or spasms usually involving the face, neck, back, and limb muscles and may occur after antipsychotic administration. Oculogyric crisis is a specific form of acute dystonia, characterized by continuous rotatory eye movements. A rare, life-threatening form of dystonia is laryngeal dystonia, which presents as a choking sensation, difficulty breathing, or stridor. Acute dystonia is commonly treated with diphenhydramine or benztropine administered intravenously or IM. Additional doses of these medications may be indicated, given that their half-life is shorter than antipsychotics.

Among the less commonly used chemical restraint medications, antihistamines, such as diphenhydramine and hydroxyzine, can cause anticholinergic adverse effects including dry mouth, dry skin, urinary retention, constipation, flushing, dizziness,

mydriasis, delirium, and conduction abnormalities. Clonidine can result in hypotension and sedation.^{136,137}

Physical Restraint

Physical restraint involves the use of mechanical restrictive devices to limit physical activity. Some differentiate physical restraint from “therapeutic holding,” a method in which health care providers or caregivers hold the individual to contain the agitated behavior. Therapeutic holding is most often used in patients of younger ages as a method to help patients regain control of their behavior.¹⁶⁹ In 1 study, restraint was achieved with a mean of 3.5 people per patient, with patients held for an average of 21 minutes.¹⁷⁰ Another technique is seclusion, which refers to the placement of an individual in isolation in an enclosed space.¹⁷¹

The prevalence of the use of physical restraints among ED adult psychiatric patients varies widely, ranging from 8% to 59%.^{172–177} There are much fewer data on the use of restraint among pediatric patients.^{62,144}

Complications of Physical Restraints

Over the past 2 decades, there has been increasing concern regarding adverse events, including deaths, associated with the use of physical restraints in psychiatric facilities.¹¹¹ The New York State Commission on Quality of Care in 1994 reported 111 deaths over a 10-year period in New York facilities that were linked to the use of physical restraints.¹⁷⁸ Four years later, the *Hartford Courant* detailed 142 mortalities nationwide attributed to physical restraint use, with children disproportionately represented among the deaths.¹⁷⁹ Among child and adolescent psychiatric facilities, between 1993 and 2003, 45 deaths were ascribed to the use of restraints.¹⁸⁰

There is also significant morbidity associated with the use of physical

restraints. The most common complication is skin breakdown at the site of the restraint, with the possibility of neurovascular damage also occurring.¹²³ Rhabdomyolysis may occur, especially in patients who continue to struggle, which can lead to kidney failure. Other reported complications include accidental strangulation from vest restraints, brachial plexus injuries, electrolyte abnormalities, hyperthermia, deep vein thrombosis, pulmonary injury/diseases, and asphyxia.¹⁷¹

Physical Restraint Policies and Regulations

Because of increasing awareness of the potential complications and dangers of physical restraint, federal agencies and hospital accreditation organizations have developed formal regulations regarding physical restraint. In 2006, the Centers for Medicare and Medicaid Services published its most recent guidelines on patients' rights regarding the use of restraints and seclusion.¹⁵² The US General Accounting Office and The Joint Commission (formerly, The Joint Commission for the Accreditation of Health Care Organizations) have published similar policies and regulations.^{153,181} Medical professional organizations, including the AAP,¹⁸² the ACEP,¹⁸³ the American Academy of Child and Adolescent Psychiatry,¹¹⁵ and the American Medical Association,¹⁸⁴ all have policies supporting these regulations, the principles of the humane and least restrictive possible use of restraint, and the need for further research in this area.

The use of restraints remains controversial. Although restraints can be a component of patient treatment in certain situations,^{61,182,185} the use of restraints and seclusion has been questioned by some. According to the National Association of State Mental Health Program Directors, "Seclusion and restraint should be considered a security measure, not a form of

'medical treatment' that should only be used as 'last resort measure.'¹⁸⁶ Adding to the complexity of this issue, it is important to keep in mind the potential liability for failure to restrain a patient who loses control and injures someone and/or destroys property, which may be greater than the liability for appropriately restraining an aggressive/violent patient.¹¹⁴

Indications for the Use of Physical Restraints

There are specific indications for the use of restraints: when the patient is an acute danger to harm himself/herself or others,^{111,123,124,176,187} to prevent significant disruption of the treatment plan including considerable disruption of property, and when other less restrictive measures have failed or are not possible options.^{61,129,182,185} It is unethical to use restraints for convenience or punishment and when prohibited by law or regulation or by untrained personnel.¹⁸⁵

Techniques for Application of Physical Restraints

If other less restrictive measures have failed, nursing staff may initiate restraint use in extenuating circumstances, with a physician or other licensed independent practitioner performing a face-to-face evaluation and reviewing and approving the order within 1 hour.¹²³ Sometimes, the mere show of force by a cohort of trained professionals may induce the agitated/violent individual to deescalate, rendering restraint unnecessary. When possible, 5 or more individuals may be included in the application of physical restraints. One person supports the head, and 4 other individuals secure each limb. Experts suggest applying restraints securely to each extremity, then to the bed frame rather than the side rails. Maximizing patient safety includes allowing the patient's head to rotate freely, elevating the head of the bed, if possible, to decrease the risk of

aspiration. If a female patient is being restrained, having at least 1 female on the restraint team may be helpful. In some cases, a "sandwiching" technique between 2 mattresses has been used, with careful monitoring for risk for asphyxia.¹²²

Although definitive studies evaluating the best and safest restraint practices are lacking, experts suggest the use of age-appropriate or leather restraints. Restraints made of softer, makeshift, or other materials may be less effective and more likely to result in patient injury. After their review of deaths of patients who were being physically restrained, The Joint Commission made the following suggestions¹⁸⁸:

- Proper staff training on alternatives to and proper application of physical restraints
- Continuous monitoring of restrained patients
- Supine positioning, with
 - the head of the bed elevated, and
 - free cervical range of motion, to decrease aspiration risk
- Prone positioning may be used if other measures have failed or are not possible. Deaths have been associated with its use. If used, helpful strategies include the following:
 - monitoring for airway obstruction,
 - minimizing or eliminating pressure on the neck and back, and
 - discontinuing as soon as possible
- Minimize covering of the patient's face or head
- Minimize the use of high vests, waist restraints, and beds with unprotected, split side rails
- Remove smoking materials from the patient
- Minimize restraint of medically compromised or unstable patients
- In cases of agitation because of suspected illicit stimulant

use, chemical restraint may be preferable, as a rapid increase in serum potassium secondary to rhabdomyolysis may result in cardiac arrest.

The Joint Commission guidelines also include a schedule for the evaluation of the need for and ordering of restraints, as well as patient monitoring and assistance, by a licensed independent practitioner (licensed independent practitioner; eg, physician, nurse practitioner, physician assistant) and the staff members who apply or monitor the restrained patient (Table 6).¹⁵³

Techniques for Removal of Restraints

Before removal of restraints, it may be helpful to inform the patient of what behavior is expected to minimize the chance that restraints will be reapplied. The same number of staff members that was used to apply the restraints may be present when the restraints are removed. A common strategy is removing 1 restraint at a time, usually starting with 1 lower extremity, next the other leg, then 1 of the upper extremities, and then the other arm, to monitor the patient's response. If the patient becomes violent or disruptive, then the limb restraint(s) may be reapplied; if the patient is cooperative, the restraint removal process may continue.

COORDINATION WITH THE MEDICAL HOME

Experts strongly endorse the benefits of a "medical home"—patient-centered care that is coordinated and integrated by the patient's personal physician, especially for high-risk and/or high-utilization patients.^{189,190} The AAP also supports the integration of mental health treatment within the medical home so that youth can "benefit from the strength and skills of the primary care clinician in establishing rapport with the child and family, using the primary care clinicians' unique

TABLE 6 The Joint Commission Requirements for Evaluating and Ordering Restraint

| | Age | | |
|---|--|---------------------------------------|---------------------------------------|
| | <9 y | 9–17 y | >18 y |
| LIP in-person evaluation to order restraint | Within 1 h of placement of restraints | Within 1 h of placement of restraints | Within 1 h of placement of restraints |
| Renew restraint order by qualified staff | Every 1 h | Every 2 h | Every 4 h |
| LIP in-person evaluation to renew restraint order | Every 4 h | Every 4 h | Every 8 h |
| Assessments every 15 min (all ages) | <ul style="list-style-type: none"> • Vital signs • Signs of injury due to restraint or seclusion • Nutrition/hydration • Extremities circulation and range of motion • Hygiene and elimination (bowel/bladder) • Physical and psychological status/comfort • Readiness to discontinue restraint | | |

LIP, licensed independent practitioner.

opportunities to engage children and families in mental health care without stigma."¹⁹¹ Unfortunately, nearly half of adolescents lack a medical home, with those with mental health problems being even less likely to have the benefit of a medical home.¹⁹² Whenever possible, best practices include consulting primary care pediatricians regarding level-of-care determination, follow-up planning, and referrals. When referral to an outpatient mental health specialist is indicated, providers who are either colocated within or have established collaborations with the medical home may be strongly considered. The medical home provider can follow up with the family to help facilitate and encourage adequate aftercare. In circumstances when a referral to a mental health specialist or higher level of psychiatric care is either not indicated or unavailable, encouraging patients to seek follow-up treatment through their medical home may be beneficial.

There are likely additional health benefits to involving a child's medical home in the aftercare plan. Although data in children are limited, there is a body of data demonstrating that access to primary care may be problematic and morbidity and

mortality are increased in adults with psychiatric illness. In fact, studies suggest that the life expectancy of adults with severe psychiatric illness is between 13 and 35 years lower than their peers without psychiatric illness.¹⁹³ Pediatric studies have demonstrated increased rates of obesity and worse self-reported health in adolescents with mental illness.¹⁹⁴ Youth with attention-deficit/hyperactivity disorder and developmental disabilities, such as autism spectrum disorders, have been found to have elevated rates of medical conditions including asthma, frequent ear infections, severe headaches or migraines, and seizures. They also have increased utilization of specialists and higher unmet health needs, including delays in care and inability to afford prescriptions.¹⁵⁰ Therefore, emergency physicians may have a significant effect on children presenting with mental health concerns by referring and encouraging them to participate in coordinated care through a suitable medical home.

LEAD AUTHORS

Thomas H. Chun, MD, MPH, FAAP
 Sharon E. Mace, MD, FAAP, FACEP
 Emily R. Katz, MD, FAAP

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Paul Sirbaugh, DO, MBA, FAAP - *National Association of Emergency Medical Technicians*
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Dale Woolridge, MD, PhD, FACEP

FORMER COMMITTEE MEMBERS

Carrie DeMoor, MD
James M. Dy, MD
Sean Fox, MD
Robert J. Hoffman, MD, FACEP
Mark Hostetler, MD, FACEP
David Markenson, MD, MBA, FACEP
Annalise Sorrentino, MD, FACEP
Michael Witt, MD, MPH, FACEP

STAFF

Dan Sullivan
Stephanie Wauson

ABBREVIATIONS

AAP: American Academy of Pediatrics
ACEP: American College of Emergency Physicians
CNS: central nervous system
CT: computed tomography
ED: emergency department
GABA: γ -aminobutyric acid
IM: intramuscularly

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