Maryland Behavioral Health Integration in Pediatric Primary Care (MD BHIPP)

Managing Pediatric Agitation and Aggression in the Emergency Department

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Maryland Behavioral Health Integration in Pediatric Primary Care

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www.mdbhipp.org

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Goals and Objectives

Objectives:

- Identify pharmacological and non-pharmacological approaches to managing pediatric agitation and aggression
- Strategies to address family escalation during crisis situations
- Learn ways to create a safe and supportive environment to prevent agitation and aggression

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Outline

- Setting the Stage
- Current Evidence
- Assessing Agitation
- Non-pharmacology: Environment, Psychological, Behavioral
- Pharmacologic Measures Focusing on Etiology
- Summary

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Why are we here?

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Many Children Lack Access to Mental Health Care

Nearly **1** in **5** U.S. children are diagnosed with a mental disorder. **20%** of those with a mental disorder receive care from a specialized care provider for mental health.

Barriers to pediatric mental health specialty care

- Parents may be reluctant to seek professional help
- Cost
- Not enough mental health providers to meet demand
- Lack of access to specialized providers
- Long waiting lists
- Lack of insurance coverage

CDC Infographic

Current State of Children's Mental Health

- This year, the nation's leading experts in pediatrics and psychiatry declared a state of emergency in children's mental health, citing increased rates of depression, anxiety, trauma, loneliness and suicidality.

- A staggering total of at least 167,000 children in the United States have lost a parent or caregiver during the pandemic.

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What Does This Mean For You?

More pediatric patients coming to the ER for behavioral health issues!!

More patients with aggressive or agitated behaviors.

Of youth presenting to ED, 6-10% require restraint

Gerson et al, BETA guidelines 2019

Case Vignette

- Destiny is 15 yo and is currently living with her mother and 2 younger siblings.
- Destiny's mother called the police after she had a violent outburst after her mother refused to allow her to meet friends on a school night. She went into a rage, started screaming obscenities, locked herself in the bathroom, and said she wished she had never been born.
- When the police arrived, Destiny seemed to be withdrawn, did not make eye contact, and was generally nonresponsive; she was taken to the emergency department at a local hospital.
- She has no history of medication or mental health treatment; nor is there a history of suicidal ideation or behavior.
- Although initially calm, loud yelling erupts between Destiny and her mother, Destiny starts kicking her, swinging her arms at security, knocks over medical equipment, and she tries to elope only to have security take her back and hold her so staff can give her IM medication.

Agitation

- Agitation is an acute behavioral emergency

- The DSM-5 (APA 2013) defines agitation as “an excessive activity associated with a feeling of inner tension. The activity is usually non-productive and repetitious and consists of behaviors such as pacing, fidgeting, wringing of the hands, pulling of clothes, and inability to sit still.”

  - Psychomotor activation
  - Mood lability
  - Verbal abuse
  - Aggression
  - Potential to harm self, others or property

- **1.7 million** medical emergency room visits in USA per year may involve agitated patients

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Assessment and Management of Agitation in Psychiatry: Expert consensus, 2016 Biological Psychiatry

What is the Evidence?

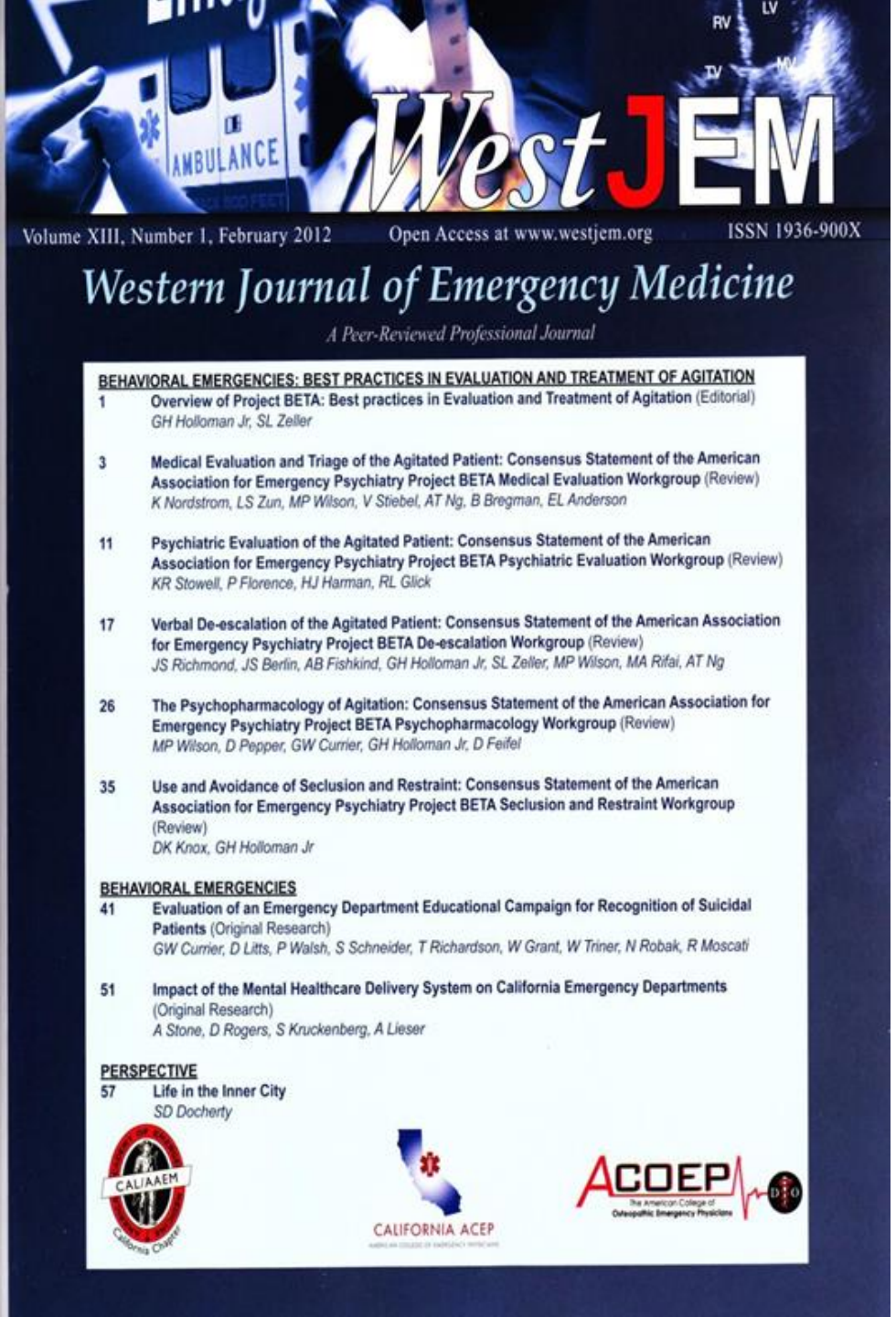
- No RCTS in pediatric ED
- Most review articles inspired by consensus guidelines for adults with agitation
- Small number of studies examine use of STAT/PRN meds for acute agitation in psych hospitalized youth
- 1 RCT of stat found no difference between diphenhydramine vs placebo. IM more effective by than PO (including PO)
- Retro study of STAT/PRN olanzapine was more likely than lorazepam or chlorpromazine to produce “settling effect” with 30 min or less

Vitiello, et al, J Clin Psychiatry, 1987
Swart et al., J Child Adolesce Psychopharmacol 2011

FDA approved drugs for agitation/aggression

Medication	Age (years)	FDA Indication
Haloperidol (Haldol)	3-12	Hyperactive behavior
Chlorpromazine (Thorazine)	0.5-12	Severe behavior disorders
Risperidone (Risperdal)	5-16	Irritability in ASD
Aripiprazole (Abilify)	6-17	Irritability in ASD

- PRN vs. Chemical restraint
- PRN aims to "calm" child so that he/she can attend to therapeutic activities.



The American Association of Emergency Psychiatry Best Practices – BETA Guidelines

- Not specially for children
- Many guidelines applicable to children
- Verbal de-escalation, medications, environmental changes decrease need for restraints

- West J Emerg Med. 2012;13(1):17–25

Child Guidelines and Consensus

ORIGINAL RESEARCH

Best Practices for Evaluation and Treatment of Agitated Children and Adolescents (BETA) in the Emergency Department: Consensus Statement of the American Association for Emergency Psychiatry

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Gerson et al, The western journal of emergency medicine, 2019, *20*(2) 409–418

4 Main Objectives of Consensus Guidelines

(1) Ensure the safety of the patient, staff, and others i… the area

…atient manage …ions and distress … maintain or regain control of his behavior

…straint …ie

(4) Avoid coercive interventions that escalate agitation

•Patient, Family and Staff safety are top priority (this includes you!)

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Multimodal Approach

- Successful management of agitation is a team effort
- Proactive problem-solving
- Management needs to be collaborative and individualized

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Importance of History

Effective history taking combined with practical measures can be extremely effective in stopping aggressive behavior before they start.

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Ask Caregivers

How does your child communicate?	Verbal, nonverbal Communication board Sign language/baby sign
Are there any triggers that may upset or aggravate your child?	Too many people in the room at one time Loud noises, etc.
Are there any interventions that help when your child becomes upset or aggravated?	Light up toys Sounds Being alone, etc.
What are your child's favorite things?	
Does your child have a daily routine schedule?	How can we incorporate that into the ED setting?
How is the best way to prepare your child for upcoming tests/procedures/transitions?	Story boards, pictures Lots of information/little information Before it happens/while it's happening
Is there anything else that would be helpful for us to know?	

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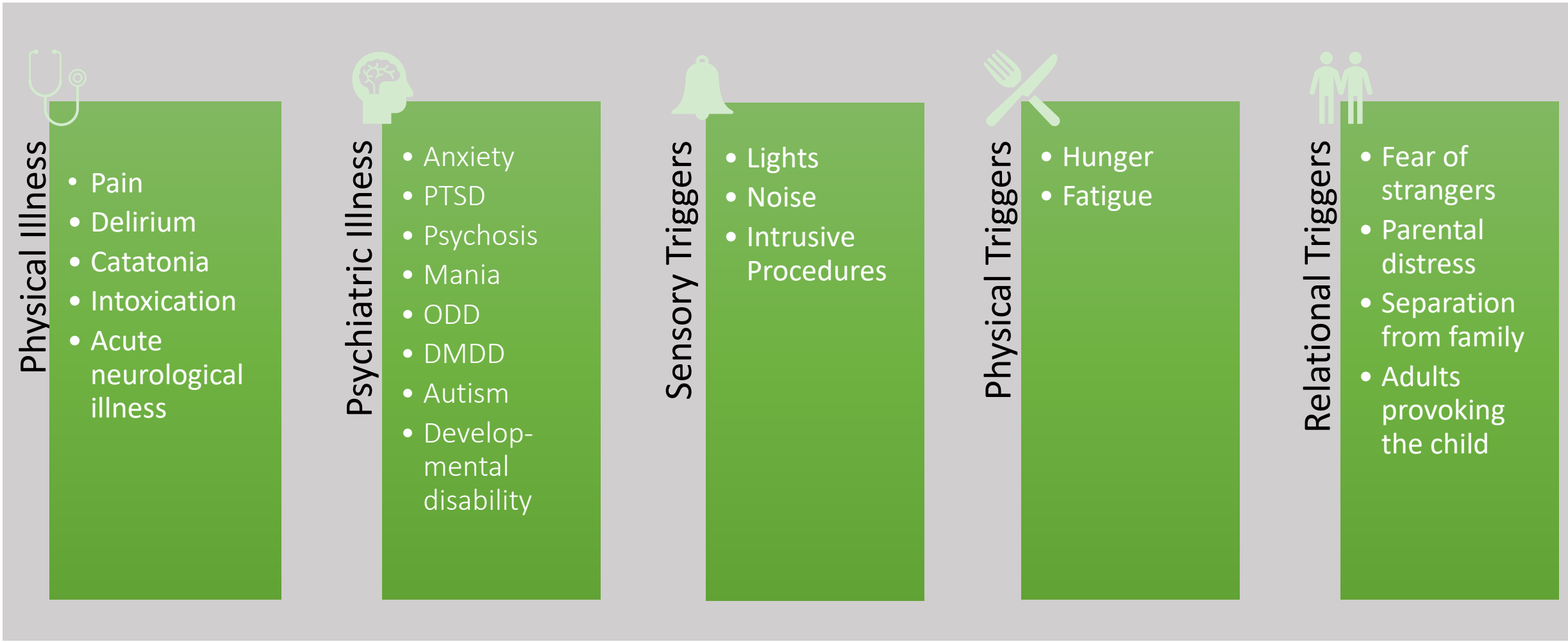
Assessing the Etiology of Agitation

- Observation
- Collateral
- Chart Review
- Why now? Why here?
- Response to interventions
- Physical exam/labs
  Ongoing reassessment
- Identify immediate trigger

Differential Diagnosis for Agitation in the ED



General Considerations for Management

- Use environmental, behavioral techniques
- Emphasize effective communication and behavioral strategies for managing behaviors
- *Always treat underlying cause of agitation first whenever possible…*

Before medication!

PRN usage if those avenues are not successful

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BETA 3-step Paradigm Approach

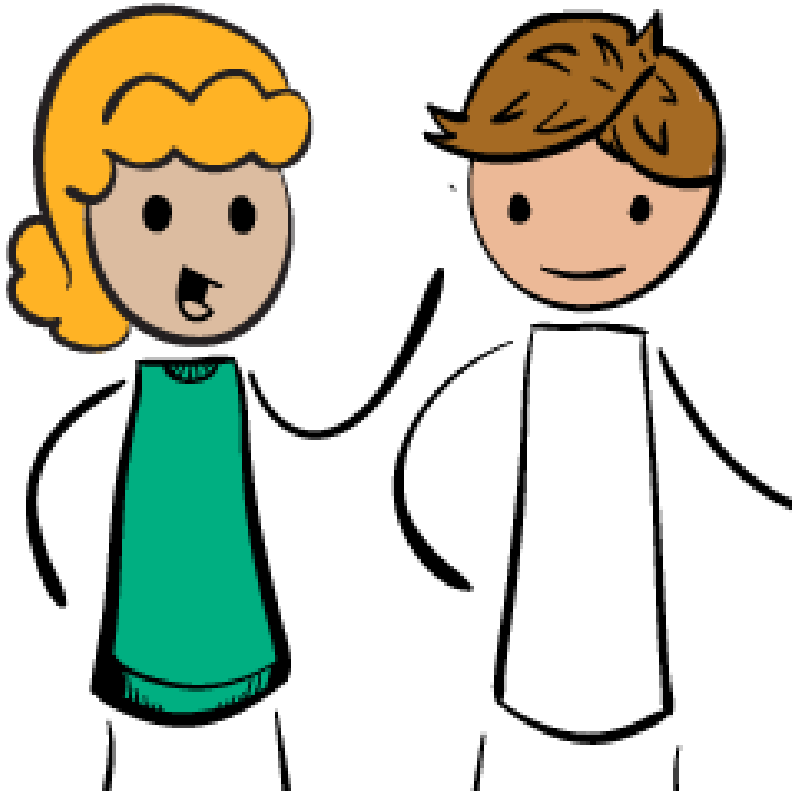
1. The patient is verbally engaged
2. Then a collaborative relationship is established
3. The patient is verbally deescalated out of the agitated state

Verbal de-escalation is usually the key to engaging the patient and helping him become an active partner in his evaluation and treatment.

West J Emerg Med. 2012;13(1):17–25

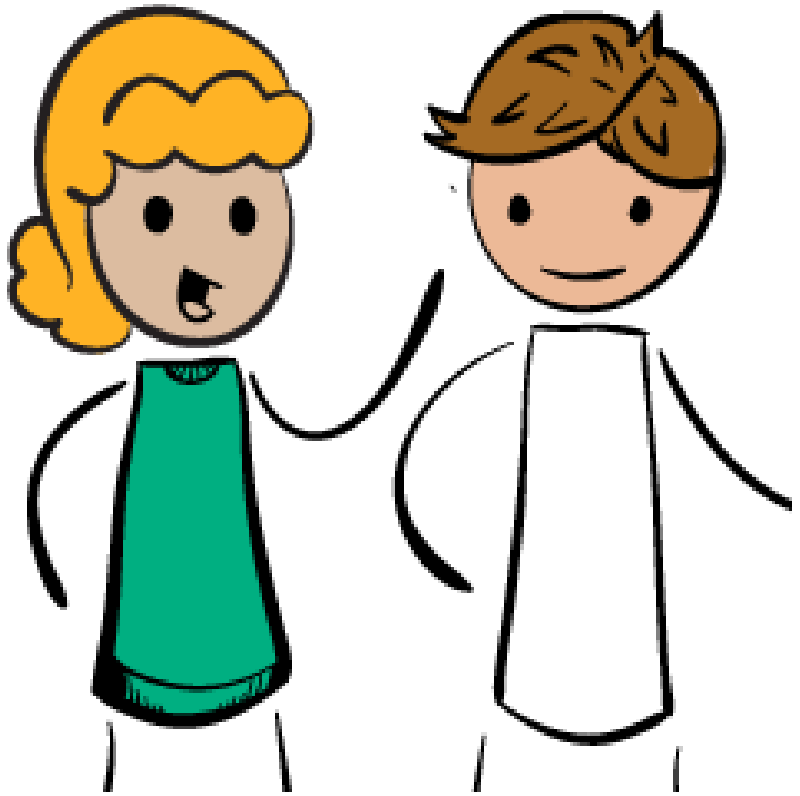
10 Principles of Verbal De-escalation

1. Respect the personal space of the individual; do not get uncomfortably close or block exits.
2. Do not be provocative or respond in anger, be in control and measured.
3. Establish verbal contact calmly with the individual.
4. Be concise and speak in short, easy to understand sentences or phrases. Repeat yourself often.
5. Listen closely to what the person is saying.



10 Principles of Verbal De-escalation

6. Identify the individual's wants and feelings and try to accommodate reasonable requests.
7. Agree or agree to disagree with the person's concerns, while avoiding negative statements.
8. Set clear limits with expected outcomes, but do not make demands or order specific behavior.
9. Offer choices and optimism.
10. Afterwards, review the event and look for areas of improvement.



Do they want…

- Something to eat or drink?
- A quiet place to go?
- A chance to talk?

Concrete Language and One-Step Instructions

Say This	Not This
Do this (demonstrate)	Hold your arms out nice and straight
Check breathing	Now I need you to take a deep breath so I can…
Sit here	Why don't you hop onto this table….
Open mouth	Open up nice and wide
Show me (body part)	Where is your ____? Give me your _____?

Anik Jhonsa, CHOP

Choices

- Working with staff on giving patient (the right) choices
- Increase sense of structure and control

Command	Choice
Hold out your arm	Do you want to hold out this arm or this arm?
It's time to eat	Which first: carrots or applesauce?
Time to go to sleep	Which bedtime story: this one or that one?
Time to go to therapy	Pick socks for therapy: orange or black?
Time for (therapy, an x-ray)	Do you want to walk or ride the wheelchair?

Anik Jhonsa, CHOP

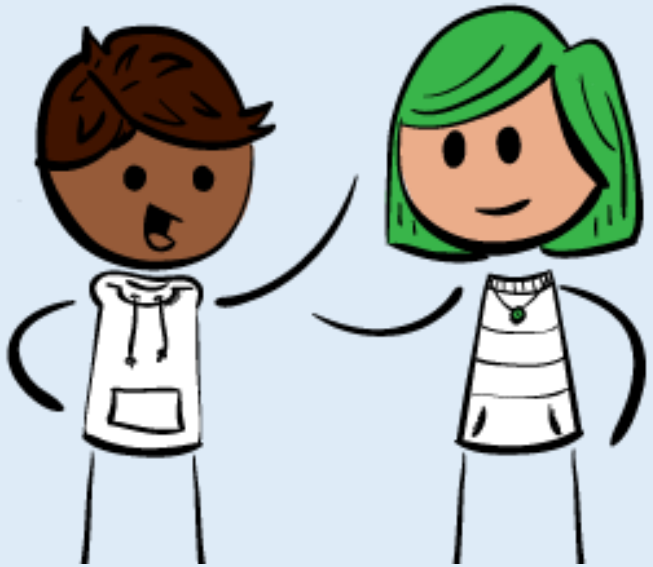
Best PRNs

SHORTBREAD COOKIES
LORNA DOONE
NET WT 1 OZ (29g)
4 COOKIES
140 CALORIES PER PACK

t PRNs

You Might Say…

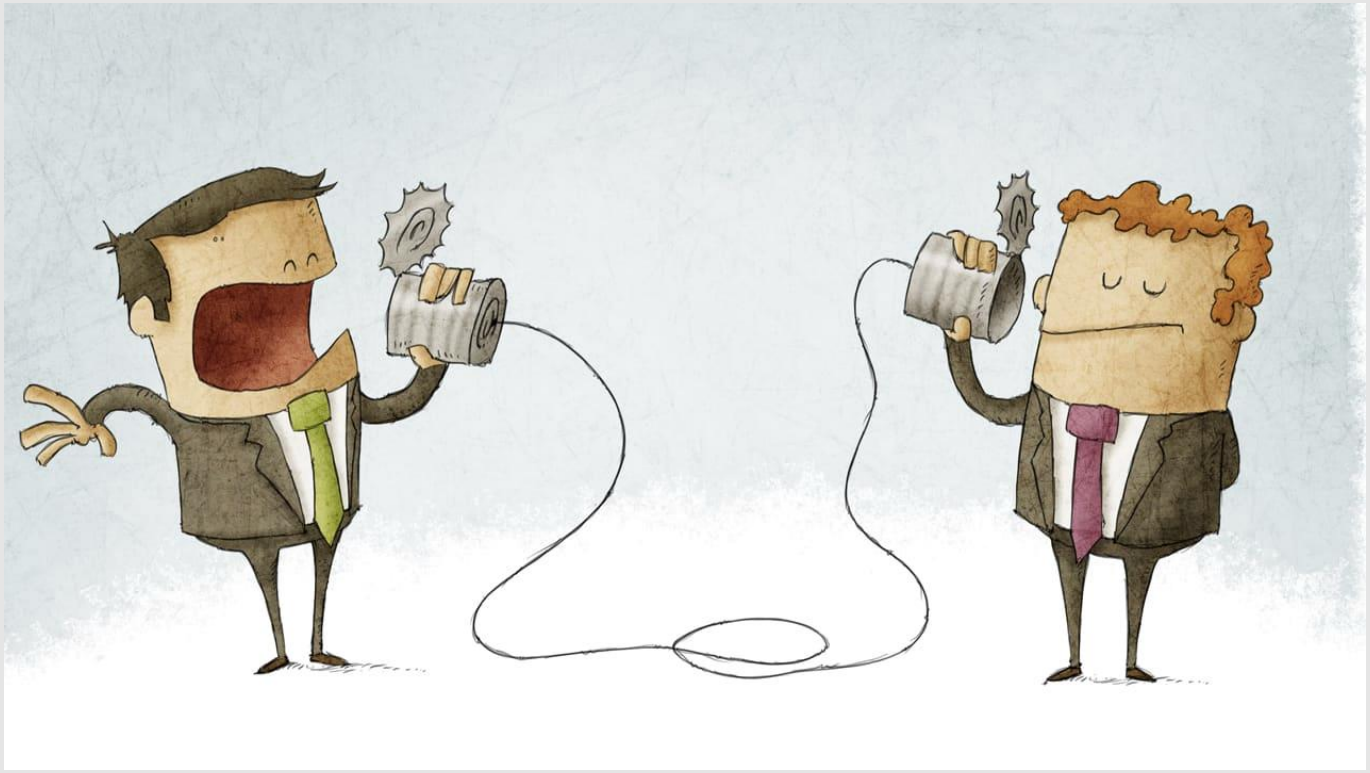
- "I am here to help, not to hurt."
- "This is a safe place."
- "No harm will come to you."
- "I will help you regain control."



Changes in Strategies

- Early explanation of process to patient and family
- Team based history taking
- Physical exams performed together
- Ensure ordering of patient’s home medications
- Frequent updates

Communication

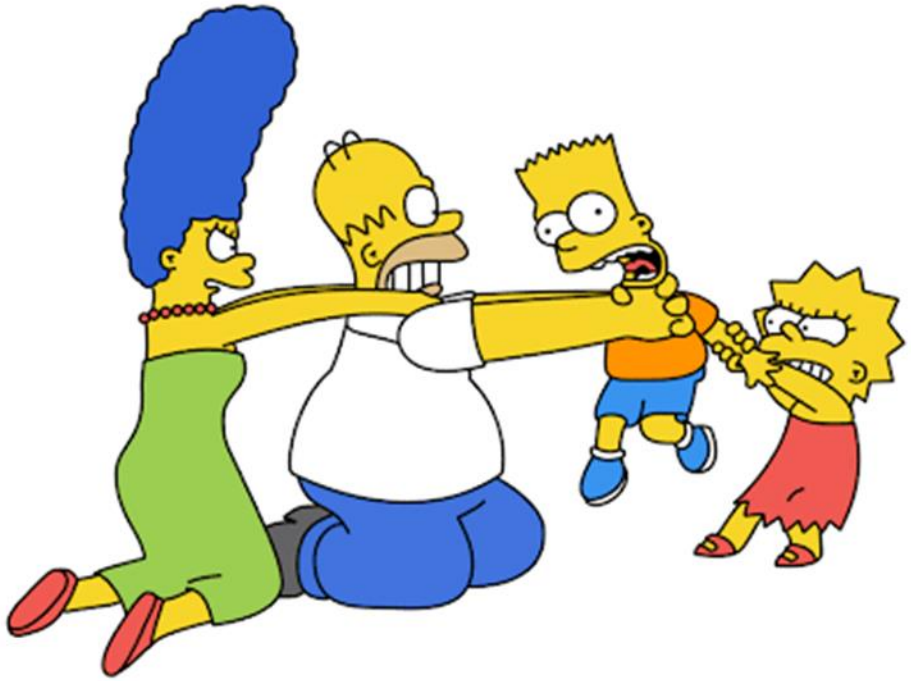


- Communication between staff members regarding a patient's specific needs
- Example: Family tells the doctor that their child does better when given a warning before anyone approaches them

Environmental Controls

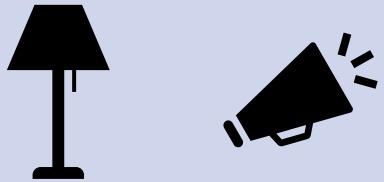
- Dim lights
- Play low music
- A favorite TV show
- Minimize noise and unnecessary activity, people in the room

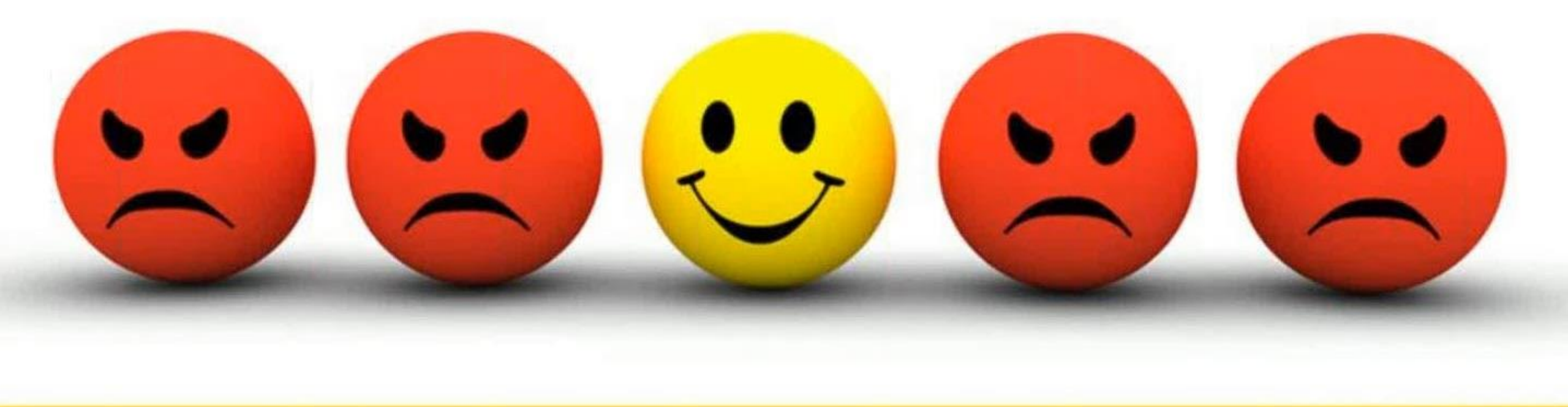
Family Escalation - tips



Review: Non-Pharmacological Interventions

Environmental Controls	Dim lights Play low music A favorite TV show Minimize noise and unnecessary activity, people in the room Remove any potential object/equipment that could cause injury
Psychological Interventions	Provide one-to-one verbal support Involve or limit family visitation as appropriate Implement a Safety Observation Level Ask eliciting questions and make uninterrupted time to listen to the patient Remain neutral and calm
Behavioral Interventions	Child Life interventions Use simple age-appropriate directions and explanations Try verbal redirection Consider distraction techniques Set reasonable limits Explain consequences of behavior in simple concrete terms





Benefits

- Verbal de-escalation usually takes less time than the process of restraint and involuntary medication.
- Avoiding “containment” procedures will result in

  less injuries to both staff members and patients.
- Patients are more trustful when not restrained or forcibly medicated.
- Receiving facilities may be more willing to accept a patient who has not been restrained

But what if that non-pharmacology fails and you need Meds?

Etiology

?

Etiology of agitation should drive medication choice

Treat the cause of agitation

It should be therapeutic Restraint ≠ Chemical

Guidelines for Medication Use

- Medication use in concert with non-pharmacologic de-escalation techniques
- Medication choice should be based on youth's history (diagnosis, comorbidities, prior medication use) and current medications
- PO always preferred over IM, IV over IM if access
- Choice of medication depends on your setting and institution
- Medications should be calming not excessively sedating!

Considerations for Medications

Medication Factors

- Formulations/ What is available?
- Onset/Durations of Action
- Interactions with other medications
- Potential Side Effects

Patient Factors

- Etiology of Agitation
- Age, Size, Hepatic/Renal Status
- Prior Response to Medications
- Severity of agitation/Aggression

System Factors

- Training and experience with Different Medications
- Training and experience with non-[pharmacological de-escalation
- Availability of Staff
- Availability of monitoring for Adverse Events (EKGs, etc.)

types of medication used for agitation

Medication	Dose	Peak Effect	Max Daily Dose	Notes/Monitoring
Clonidine (alpha2 agonist)	PO: 0.05mg-0.1mg	PO: 30-60 minutes	27-40.5kg: 0.2mg/day 40.5-45kg: 0.3mg/day >45 kg: 0.4mg/day	-Monitor for hypotension and bradycardia. -Avoid giving with BZD or atypicals due to hypotension risk.
Diphenhydramine (antihistamine)	PO/IM: 12.5-50mg 1mg/kg/dose	PO: 2 hours	Child: 50-100mg Adolescent: 100-200mg	-Avoid in delirium. -Can be combined with haloperidol or chlorpromazine if concern for EPS. -Can cause disinhibition or delirium in younger or DD youth.
Lorazepam (benzodiazepine)	PO/IM/IV/NGT: 0.5mg-2mg 0.05mg-0.1mg/kg/dose	IV: 10 minutes PO/IM: 1-2 hours	Child: 4mg Adolescent: 6-8mg Depending on weight/prior med exposure	-Can cause disinhibition or delirium in younger or DD youth. -Can be given with haloperidol, chlorpromazine or risperidone. -Do not give with olanzapine (especially IM) due to risk of respiratory suppression.
Chlorpromazine (antipsychotic)	PO/IM: 12.5-60mg (IM should be half PO dose) 0.55mg/kg/dose	PO: 30 minutes IM: 15 minutes	Child <5 yo: 40mg/day Child >5 yo: 75mg/day	- Monitor for hypotension.
Haloperidol (antipsychotic)	PO/IM: 0.5mg-5mg (IM is half dose of PO) 0.05-0.1mg/kg/dose	PO: 30 minutes IM: 15 minutes	15-40kg: 6mg >40kg: 15mg Depending on prior antipsychotic exposure	-Monitor for hypotension. -Consider EKG or cardiac monitoring for QT prolongation, **especially for IV dosing** -Note EPS risk with MDD>3mg/day, with **IM and PO dosing having higher EPS risk** -Consider AIMS testing
Olanzapine (antipsychotic)	PO/ODT or IM: 2.5-10mg	PO: 4.7 +/- 3.7 hours IM: 15-45 minutes	10-20 mg Depending on prior antipsychotic exposure	-Do not give with or within 1h of any BZD given risk for resp. suppression
Risperidone	PO/ODT: 0.25-1mg	PO: <1 hour	Child: 1-2mg	- Can cause akathisia (restlessness/agitation) in higher doses

Monitoring Potential Side Effects

- Benzos: Respiratory Depression
- Anti-Psychotics:
  - QT Prolongation
  - EPS
  - NMS
  - Orthostatic Hypotension
  - lower seizure threshold

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Is it delirium?

acute onset/fluctuating course *plus*
inattention *plus*
disorganized thinking or altered level of consciousness

Medical workup

- address underlying medical etiology
- assess pain
- avoid benzodiazepines and anticholinergics which may worsen delirium

Still severely agitated / needs medication

PO: quetiapine or risperidone or clonidine
IM: olanzapine ☢ or chlorpromazine
IV: haloperidol
or Lorazepam (PO/IM/IV/NGT) if there are seizure concerns or catatonia

Is it substance intoxication or withdrawal?

history, Utox, physical exam

Unknown substance
Lorazepam (PO/IM/IV), with haloperidol if severely agitated or hallucinating

EtOH/Bzd Withdrawal or Stimulant Intoxication
Lorazepam (PO/IM/IV/NGT), add haloperidol if severely agitated or hallucinating

Opiate withdrawal
Clonidine and/or opiate replacement (methadone, suboxone) per hospital protocol
Add symptomatic meds (ibuprofen, maalox, loperamide, ondansetron, dicyclomine) as needed

PCP Intoxication
Lorazepam (PO/IM/IV/NGT)

EtOH Intoxication
Haloperidol (IV/IM/PO)
or chlorpromazine (PO/IM)

Utox Negative?
Suspect **Synthetic Cannabinoids or cathinones**
Lorazepam+/- haloperidol (PO/IM/IV) or chlorpromazine (PO/IM)

Is the patient developmentally delayed or autistic?

note ASD/DD its are at higher risk for delirium and medical or psych symptoms

Yes

- Attempt behavioral interventions
- Assess pain, hunger, other physical needs
- Consider visual communication tools
- Utilize sensory tools
- Ask what usually soothes child
- Ask about prior medication responses (positive or negative), especially to benzodiazepines and diphenhydramine

Still severely agitated / needs medication

Consider extra dose of pt's regular standing medication
Avoid benzodiazepines due to risk of disinhibition
Avoid IM route

Clonidine (PO)
or diphenhydramine (PO/IM)
Or antipsychotic (risperidone PO, chlorpromazine PO/IM or olanzapine (PO/IM/ODT) ☢

Does patient have a clear psychiatric diagnosis?

obtain collateral to clarify diagnosis and reason for agitation,
use behavioral deescalation strategies

Yes

agitated catatonia
Lorazepam (PO/IM/IV/NGT)

ADHD*
Clonidine (PO) or diphenhydramine (PO/IM) or risperidone (PO) if concerned about hypotension

Mania or Psychosis*
note: extremely rare under age 12
If on standing antipsychotic, give extra dose

PO: Risperidone or quetiapine
IM: Chlorpromazine
or haloperdiol +/- lorazepam (add diphenhydramine for EPS concern), or olanzapine ☢

anxiety, trauma, or PTSD
Lorazepam (PO/IM/IV)
or clonidine (PO) if <12yo or concerned about disinhibition

ODD or CD*
Chlorpromazine (PO/IM) or lorazepam (PO/IM) or olanzapine (PO/IM) ☢
or risperidone (PO)

unknown etiology for agitation?

obtain collateral, continue behavioral deescalation strategies, continually reevaluate for above and other causes of agitation

Yes

Unknown etiology, mild agitation
eg. verbal aggression

utilize behavioral and environmental strategies to deescalate

Unknown etiology, moderate agitation
eg. aggression against objects or property destruction*

Diphenhydramine (PO/IM)
or lorazepam (PO/IM)
or olanzapine (PO/IM) ☢

Unknown etiology, severe agitation
eg. aggression to self or others*

Chlorpromazine (PO/IM) or haloperidol+lorazepam (PO/IM)
or olanzapine (PO/IM/ODT) ☢

Medical Considerations

Delirium: acute brain dysfunction

Behavioral syndrome caused by medical illness or by treatment of medical illness

acute, fluctuating, inattention, disorganized thinking

- Medical Work-up
- Treat pain
- Treat underlying cause

PO	IM	IV
• Quetiapine • risperidone	• *olanzapine • chlorpromazine	• Haloperidol • chlorpromazine

Substance Intoxication

Medical Work-up:

- Urine toxicology
- Physical exam
- Collateral

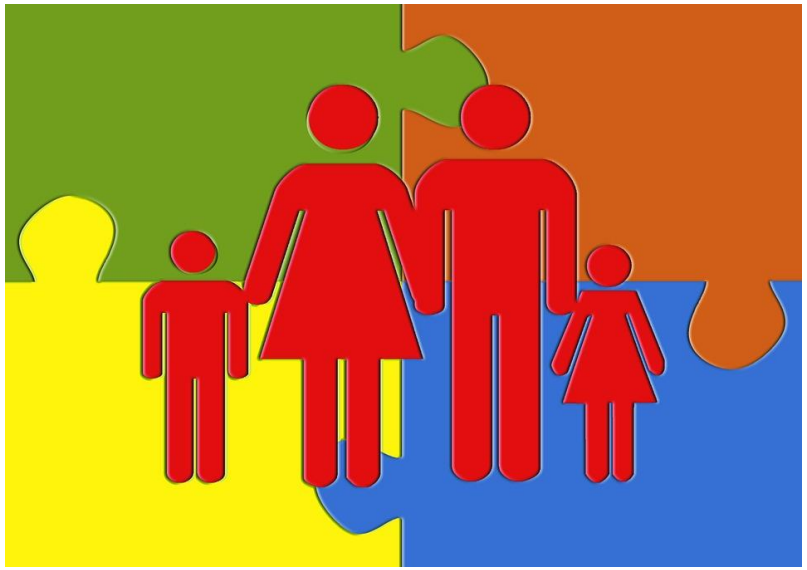
Intoxications

Stimulant /PCP Intoxication	ETOH Intoxication	Synthetic Cannabinoids
• Lorazepam	• haloperidol or chlorpromazine	• Lorazepam + haloperidol or chlorpromazine

Withdrawal

ETOH/BENZO Withdrawal	Opiate Withdrawal
• Lorazepam	• Symptom tx • Clonidine • replacement

Autism & Intellectual Disability



Consider Developmental Level

- Medical Work-up
- Collateral! What helps child
- Communication tools
- Reduce Stimulation
- Avoid IM
- Avoid Benzos

PO	IM	IV
• Clonidine • Diphenhydramine • Chlorpromazine • Risperidone • Olanzapine*	• Try to Avoid	• Diphenhydramine

Autism & Intellectual Disability

Once Agitated:

Stop Talking!!!!!

Move Back!!!!!

Catatonia

Not only in Psychosis!

Agitated Catatonia

IV
• Lorazepam

Anxiety/Trauma/ PTSD

- Medical Work-up

- Lorazepam (PO/IM/IV)
- Clonidine (PO) if under 12 years and worried about disinhibition.

Conduct / ODD

- Set clear limits
- Multidisciplinary collaboration for consistency
- Effective communication

PO	IM
• Chlorpromazine • lorazepam • Risperidone	• Chlorpromazine or • Haloperidol +/- Lorazepam/Diphenhydramine • Olanzapine

Mania / Psychosis

- Medical Work-up
- Extremely rare <12 years

PO	IM
• Risperidone • Quetiapine	• Chlorpromazine or • Haloperidol +/- Lorazepam/Diphenhydramine • Olanzapine

Unknown Etiology??

- mild agitation
  - behavioral strategies
- moderate agitation
- aggression against objects or property destruction
  - diphenhydramine
  - lorazepam
  - olanzapine*
- severe agitation
- aggression to self or others
  - chlorpromazine
  - haloperidol+lorazepam
  - olanzapine*

Take Home Points…

- Importance of TEAM!!!
- Importance of Non-Pharmacological Interventions
- Keep trying to determine etiology – it will drive medications
- Observe response to interventions
- Continually reevaluate

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Join the 2022 Children's Mental Health Matters! Campaign

We have the opportunity to change the trajectory of children's lives across Maryland. Consider joining the 2022 Children's Mental Health Matters! Campaign.

BECOME A CHAMPION

- Each year CMHM invites organizations to join the Campaign as a Champion for Children's Mental Health, focusing on participation during their annual Awareness Week.
- You are provided with a digital toolkit complete with ideas on how to increase awareness of the importance of children's mental health within their communities and encourage them to partner with others to promote their local efforts.

AWARENESS WEEK – MAY 1 – 7, 2022

- Campaign Partners and Champions across the state will elevate the importance of children's mental health on a local level. Be sure to follow the Campaign on social media platforms to see the exciting activities that take place around this time.

To Learn More about the Campaign, please visit the CMHM Campaign website

Questions? Contact Tiffany Thomas, Campaign Coordinator; tthomas@mhamd.org

Interested in becoming a Partner? Click here to Sign Up as A Community Champion

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