PEDIATRIC PSYCHIATRIC EMERGENCIES

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Why?

- Common
- High rates of admission/transfer
- Long lengths of stay
- Many ED’s unprepared
Common reason for ED visits

- A study using 1995-2001 data found that visits for mental health conditions accounted for 5% of ED visits for children.

- Children’s hospital encounters for suicidality & self-harm doubled from 2008 to 2015:
  - 0.67% in 2008 to 1.79% in 2015.
Objectives

- Review the evidence: medical evaluation of pediatric patients with psychiatric emergencies
- Discuss best practices in prevention and de-escalation of agitation in pediatric patients
- Be familiar with suicide screening tools for use in pediatric patients
A tearful 15 year old girl is brought in for medical clearance for psychiatric hospital placement after telling her school counselor that has a suicide plan.

What is the appropriate ED evaluation?
“Medical Clearance”

- Common practice?
- Cursory examination followed by a panel of lab tests
“Medical Clearance”

■ Goals
  - Ensure that the symptoms are due to psychiatric disease, not another medical disorder
“Medical Clearance”

- Goals
  - Ensure that the symptoms are due to psychiatric disease, not another medical disorder
  - Stabilize any other medical conditions
“Medical Clearance”

■ Goals
  - Ensure that the symptoms are due to psychiatric disease, not another medical disorder
  - Stabilize any other medical conditions
  - Treat any ingestions or other self-harm
“Medical Clearance”

■ Goals
  – Ensure that the symptoms are due to psychiatric disease, not another medical disorder
  – Stabilize any other medical conditions
  – Treat any ingestions or other self-harm
  – Evaluate for child maltreatment
“Medical Clearance”

- Labs not necessarily helpful
- Term “medically clear” confusing
ED Evaluation

- Medical evaluation is NOT a guarantee that patient has no underlying medical condition
- Better terminology:
  - Medically stable for psychiatric evaluation
  - Medically stable for transfer to a psychiatric hospital
What is an appropriate medical evaluation?


- “Do not routinely order laboratory testing on patients with acute psychiatric symptoms. Use medical history, previous psychiatric diagnoses, and physician examination to guide testing.”
What is an appropriate medical evaluation?

- American Academy of Pediatrics 2016
  - Current literature supports focused medical assessments
  - Routine diagnostic testing unlikely to affect disposition or management
What is the evidence in pediatric patients?

- Santiago et al (2006)
  210 patients with psychiatric complaints in ED – testing not helpful unless indicated by H&P

  Routine urine drug screens don’t change management

- Donofrio et al (2014)
  1082 PED visits for psychiatric emergencies – no urgent medical problems identified solely by screening laboratories
**SMART Medical Clearance Form**

<table>
<thead>
<tr>
<th><strong>S</strong>uspect New Onset Psychiatric Condition?</th>
<th>No*</th>
<th>Yes</th>
<th>Time Received</th>
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<table>
<thead>
<tr>
<th><strong>M</strong>edical Conditions that Require Screening?</th>
</tr>
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<tbody>
<tr>
<td>Diabetes (FBSG less than 60 or greater than 250)</td>
</tr>
<tr>
<td>Possibility of pregnancy (age 12-50)</td>
</tr>
<tr>
<td>Other complaints that require screening</td>
</tr>
<tr>
<td>-----------------------------------------------</td>
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<table>
<thead>
<tr>
<th><strong>A</strong>bnormal:</th>
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<tr>
<td>Vital Signs?</td>
</tr>
<tr>
<td>Temp: greater than 38.0°C (100.4°F)</td>
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<tr>
<td>HR: less than 50 or greater than 110</td>
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<tr>
<td>BP: less than 100 systolic or greater than 180/110 (2 consecutive readings 15 min apart)</td>
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<tr>
<td>RR: less than 8 or greater than 22</td>
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<tr>
<td>O2 Sat: less than 90% on room air</td>
</tr>
<tr>
<td>Mental Status?</td>
</tr>
<tr>
<td>Cannot answer name, month/year and location (minimum A/O x 3)</td>
</tr>
<tr>
<td>If clinically intoxicated, HIII score 4 or more? (next page)</td>
</tr>
<tr>
<td>Physical Exam (unclad)?</td>
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<tr>
<td>---------------------------------------------</td>
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<table>
<thead>
<tr>
<th><strong>R</strong>isky Presentation?</th>
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<tbody>
<tr>
<td>Age less than 12 or greater than 55</td>
</tr>
<tr>
<td>Possibility of ingestion (screen all suicidal patients)</td>
</tr>
<tr>
<td>Eating disorders</td>
</tr>
<tr>
<td>Potential for alcohol withdrawal (daily use equal to or greater than 2 weeks)</td>
</tr>
<tr>
<td>Ill-appear, significant injury, prolonged struggle or “found down”</td>
</tr>
<tr>
<td>---------------------------------------------</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>T</strong>herapeutic Levels Needed?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phenytoin</td>
</tr>
<tr>
<td>Valproic acid</td>
</tr>
<tr>
<td>Lithium</td>
</tr>
<tr>
<td>Digoxin</td>
</tr>
<tr>
<td>Warfarin (INR)</td>
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<td>---------------------------------------------</td>
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</table>

* If ALL five SMART categories are checked "NO" then the patient is considered medically cleared and no testing is indicated. If ANY category is checked "YES" then appropriate testing and/or documentation of rationale must be reflected in the medical record and time resolved must be documented above.

Date: ___________ Time: ___________ Completed by: ____________________________ Signature: ___________________ Print: ___________ MD/DO

Currently in use by Sacramento EDs
What are the goals for the 15 year old girl’s medical evaluation?

- Ensure that current symptoms are due to psychiatric disease, not another medical disorder
- Stabilize any other medical conditions
- Treat any ingestions or other self-harm
- Evaluate for child maltreatment
Medical evaluation of 15 year girl with suicidality

- History and physical to evaluate for other causes of symptoms
- Evaluate for pregnancy
- Evaluate any underlying medical problems
- Evaluate for ingestions and self-harm
- Screen for child maltreatment
A 13 year old boy brought in by police for danger to self because he was running in the street while trying to run away from the group home where he lives. He is agitated and screaming in triage saying he doesn’t need to be in the ED.
Approach to the Agitated Patient

- Acknowledge negative reactions that you may feel
- Approach the patient calmly
  - Be aware of non-verbal communication
- Approach the patient with empathy
Best Practices in Management of the Agitated Patient

■ “Fight or flight mode”

■ Patient generally doing the best they can under the circumstances
Best Practices in Management of the Agitated Patient

- Many patients have significant trauma histories
  - Emotional dysregulation
  - ED experience may be re-traumatizing
Best Practices in Management of the Agitated Patient

■ Ensure safety
■ Avoid coercive interventions that escalate agitation
■ Help the patient manage emotions and regain control of behavior
  - *Help with patient calm self rather than calming the patient*

Best Practices in Management of the Agitated Patient

- Avoid the use of restraint whenever possible
  - Patient deaths have been attributed to restraint use
  - Staff injuries occur during restraints
  - Consider as a last resort
Verbal De-escalation Strategies

1. Respect personal space
2. Do not be provocative
3. Establish verbal contact
4. Be concise
5. Identify wants and feelings
6. Listen closely to what the patient is saying
7. Agree or agree to disagree
8. Lay down the law and set clear limits
9. Offer choices and optimism
10. Debrief the patient and staff
Best Practices in Management of the Agitated Patient

- Physical environment
  - Reduce stimuli
  - Ensure safety
- Attend to patient comfort
### Non-medication interventions

#### Prevent agitation/intervene with mild agitation:

| General Principles | Increase physical safety  
|                    | Orient the child to ER and to staff  
|                    | Reduce sensory stimulation  
|                    | Reduce Crowding  
|                    | Comfort the child  
|                    | Distract the child  

| Environmental Control | Assess room and remove dangerous equipment  
|                       | Have child change into hospital clothes  
|                       | Separate older and younger children, if possible  
|                       | Limit crowding, if possible  
|                       | Dim lights  
|                       | Crack door or otherwise reduce noise  
|                       | Offer food/water  
|                       | Offer games, toys, movies  

| People | Assess sitter/patient interaction  
|        | Involve/limit family (offer phone calls if family not pres.)  
|        | Consider Child Life  

| Consults | Consider Child Psych (323-409-1818)  
|          | Consider Psychiatry (323-409-4088)  
|          | Consider Child Life (323-409-3802)  
|          | Recreational Therapy requires for >24h stay (323-409-4952 or 323-409-4088)  

LAC+USC Guideline for Management of Agitation/Aggression in Psychiatrically Ill Patients in the Pediatric ER
Medications for Agitation

- Offer early
- Oral medication if situation allows
- Use medications that have worked for patient in the past
- Don’t skip doses of home medications in the ED
Medications for Agitation

- No clear consensus on best medications
- Diphenhydramine & benzodiazepines
  - Possibility of disinhibition
- Avoid parenteral administration of olanzapine within 2 hours of benzodiazepines
  - Respiratory depression
## LAC+USC Guidelines

### Mild to Moderate Agitation

<table>
<thead>
<tr>
<th>Child Size</th>
<th>First Choice Medication</th>
<th>Second Choice Option</th>
<th>Third Choice Option</th>
</tr>
</thead>
<tbody>
<tr>
<td>15-30 kg</td>
<td>Risperidone liquid 0.25 mg PO</td>
<td>Olanzapine 2.5 mg tablet PO (crushed in syrup OK)</td>
<td></td>
</tr>
<tr>
<td>30-60 kg</td>
<td>Olanzapine 5 mg quick-dis. (Zydis) tab PO</td>
<td>Risperidone 0.5 mg quick-dis. (M-Tab) PO</td>
<td>Olanzapine 5 mg IM</td>
</tr>
<tr>
<td>60 kg +</td>
<td>Olanzapine 5 mg quick-dis. (Zydis) tab PO (10 mg if large or chronic user)</td>
<td>Risperidone &gt;60kg: 1 mg quick-dis (M-Tab) PO</td>
<td>Olanzapine 5-10 mg IM</td>
</tr>
</tbody>
</table>
Medications for Agitation

- Guanfacine 0.5 – 2 mg oral
- Chlorpromazine 12.5 - 50 mg oral (1/2 dose may be given IM)
- 1st generation antipsychotics (haloperidol)
  - Higher risk of extrapyramidal side effects in young children
Avoiding Agitation in Patients with Autism & Developmental Disorders

■ Environmental modification
  – Quietest room possible
  – Turn off some lights
Avoiding Agitation in Patients with Autism & Developmental Disorders

- Visual communication systems
  - Patient’s device
  - Simple laminated cards developed for your ED
Avoiding Agitation in Patients with Autism & Developmental Disorders

- Transition planning
  - Break down step by step what will happen
  - Anticipate upsetting events
  - Allow breaks

- Desensitization
  - Approach gradually
  - Move from periphery to central areas of body
Avoiding Agitation in Patients with Autism & Developmental Disorders

- OT/PT techniques
  - Weighted blankets (radiology lead apron)
  - Fidget devices (gauze roll to squeeze)
A 16 year old girl is brought to the ED by her parents. She needs a school note after missing multiple days for headaches. She has been in the ED previously for the same and had a work-up for her headaches in the past. You wish to screen her for suicide risk.

What tools are available?
Why screen?

- Suicide is a leading cause of death in adolescents & young adults
- 2017 Youth Risk Behavior Surveillance
  - High school students: 22.1% of females and 11.9% of males reported seriously considering suicide in the last 12 months
- ED visit may be the only contact with a health care provider
ASQ Suicide Screening Tool

- Designed for ED use in ages 10-24
- High sensitivity
- 4 questions
- 97% sensitivity, 88% specificity
ASQ Suicide Screening Tool

■ Available at the National Institutes of Mental Health

■ Toolkit includes
  ■ Patient resources
  ■ Suggested script
  ■ Assessment guide for positive screen
Ask the patient:

1. In the past few weeks, have you wished you were dead?  
   - Yes  
   - No

2. In the past few weeks, have you felt that you or your family would be better off if you were dead?  
   - Yes  
   - No

3. In the past week, have you been having thoughts about killing yourself?  
   - Yes  
   - No

4. Have you ever tried to kill yourself?  
   - Yes  
   - No

   If yes, how?  
   __________________________________________________________________________
   __________________________________________________________________________
   __________________________________________________________________________
   When?  
   __________________________________________________________________________
   __________________________________________________________________________

If the patient answers Yes to any of the above, ask the following acuity question:

5. Are you having thoughts of killing yourself right now?  
   - Yes  
   - No
Next steps:

- If patient answers “No” to all questions 1 through 4, screening is complete (not necessary to ask question #5). No intervention is necessary (*Note: Clinical judgment can always override a negative screen).

- If patient answers “Yes” to any of questions 1 through 4, or refuses to answer, they are considered a positive screen. Ask question #5 to assess acuity:
  - “Yes” to question #5 = acute positive screen (imminent risk identified)
    - Patient requires a STAT safety/full mental health evaluation.
    - Patient cannot leave until evaluated for safety.
    - Keep patient in sight. Remove all dangerous objects from room. Alert physician or clinician responsible for patient’s care.
  - “No” to question #5 = non-acute positive screen (potential risk identified)
    - Patient requires a brief suicide safety assessment to determine if a full mental health evaluation is needed. Patient cannot leave until evaluated for safety.
    - Alert physician or clinician responsible for patient’s care.

Provide resources to all patients

- 24/7 National Suicide Prevention Lifeline 1-800-273-TALK (8255) En Español: 1-888-628-9454
- 24/7 Crisis Text Line: Text “HOME” to 741-741
Columbia-Suicide Severity Rating Scale
C-SSRS

- Pediatric & adolescent/adult versions available
- cssrs.columbia.edu
<table>
<thead>
<tr>
<th>SUICIDE IDEATION DEFINITIONS AND PROMPTS</th>
<th>Past month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ask questions that are bolded and underlined.</td>
<td>YES</td>
</tr>
<tr>
<td>Ask Questions 1 and 2</td>
<td></td>
</tr>
<tr>
<td>1) <strong>Have you wished you were dead or wished you could go to sleep and not wake up?</strong></td>
<td></td>
</tr>
<tr>
<td>2) <strong>Have you actually had any thoughts of killing yourself?</strong></td>
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</tr>
<tr>
<td>If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.</td>
<td></td>
</tr>
<tr>
<td>3) <strong>Have you been thinking about how you might do this?</strong></td>
<td></td>
</tr>
<tr>
<td>E.g. “I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it....and I would never go through with it.”</td>
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<tr>
<td>4) <strong>Have you had these thoughts and had some intention of acting on them?</strong></td>
<td></td>
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<tr>
<td>As opposed to “I have the thoughts but I definitely will not do anything about them.”</td>
<td></td>
</tr>
<tr>
<td>5) <strong>Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?</strong></td>
<td></td>
</tr>
<tr>
<td>6) <strong>Have you ever done anything, started to do anything, or prepared to do anything to end your life?</strong></td>
<td>YES</td>
</tr>
<tr>
<td>Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn’t swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn’t jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.</td>
<td></td>
</tr>
<tr>
<td>If YES, ask: <strong>Was this within the past three months?</strong></td>
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- Low Risk
- Moderate Risk
- High Risk
Other Behavioral Emergencies
Resources

- https://www.calhospital.org/emergency-department-toolkit
When your child has been placed on an involuntary psychiatric hold it can be a very confusing and frightening time for you, your family, and child.

Your child may be troubled and needs help.

Your strength will help your child’s recovery.

This handout will give you some information to help you understand a very difficult situation.

Patient’s and Parent’s frequently asked questions

Q. Why is my child at LAC-USC Hospital and not in a psychiatric hospital?

A. Because your child is on a “hold” and there are no outside psychiatric beds are available or the child has no hold written and evaluation is needed.

Q. Can my child be treated without my consent or presence?

A. Yes. The inability to get consent from a minor’s parent or guardian will not prevent treatment of a child held under the Lanterman-Petris Short Act (LPS). The hospital staff will make every effort to notify the child’s parent or legal guardian as soon as possible after the child is detained.
QUESTIONS?