Complete Summary

GUIDELINE TITLE

Practice parameter for the prevention and management of aggressive behavior in child and adolescent psychiatric institutions with special reference to seclusion and restraint.

BIBLIOGRAPHIC SOURCE(S)

American Academy of Child and Adolescent Psychiatry. Practice parameter for the prevention and management of aggressive behavior in child and adolescent psychiatric institutions with special reference to seclusion and restraint. Washington (DC): American Academy of Child and Adolescent Psychiatry; 2001 May 13. 81 p. [124 references]

Practice parameter for the prevention and management of aggressive behavior in child and adolescent psychiatric institutions, with special reference to seclusion and restraint. J Am Acad Child Adolesc Psychiatry 2002 Feb;41(2 Suppl):4S-25S. [125 references]

COMPLETE SUMMARY CONTENT

SCOPE
METHODOLOGY - including Rating Scheme and Cost Analysis
RECOMMENDATIONS
EVIDENCE SUPPORTING THE RECOMMENDATIONS
BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS
QUALIFYING STATEMENTS
IMPLEMENTATION OF THE GUIDELINE
INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES
IDENTIFYING INFORMATION AND AVAILABILITY

SCOPE

DISEASE/CONDITION(S)

Aggressive behavior

GUIDELINE CATEGORY

Evaluation
Management
Prevention

CLINICAL SPECIALTY

Pediatrics
Psychiatry
Psychology

INTENDED USERS

Advanced Practice Nurses
Nurses
Physician Assistants
Physicians
Psychologists/Non-physician Behavioral Health Clinicians

GUIDELINE OBJECTIVE(S)

- To examine methods of preventing aggressive behavior in institutions before the need for seclusion or restraint is necessary
- To review the current state of literature about the safe implementation of seclusion and restraint
- To illustrate ways of using patient and staff processing of seclusion or restraint events to promote the use of alternative strategies and therefore lessen further need for these interventions
- To identify current research questions, which will help improve clinical practice with these interventions

TARGET POPULATION

Children and adolescents in psychiatric institutions with aggressive behavior

INTERVENTIONS AND PRACTICES CONSIDERED

Assessment

1. Patient history, review of aggressive behavior, including triggers, warning signs, repetitive behaviors, response to treatment, and prior seclusion and restraint events associated with aggressive acts

Treatment and Prevention

1. Individualized treatment planning, with established goals
2. Anger management, problem-solving, and psycho-educational programs
3. Providing adequate staff training
4. Non restrictive de-escalation strategies, such as negotiating with peers, processing with staff, reward programs and token economies, and using self-directed time-outs
5. Restrictive interventions, such as seclusion, physical restraints, and chemical restraints [antipsychotic agents (chlorpromazine, haloperidol, droperidol, clozapine, risperidone, olanzapine, quetiapine); antihistamines (hydroxyzine, diphenhydramine); and benzodiazepines (lorazepam)]

MAJOR OUTCOMES CONSIDERED

- Behavioral self-control and self-determination/aggressive behavior
- Harm to self and others
- Adverse effects of treatment (including death)

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

The list of references for this parameter was developed by searches of PsychLit abstracts, by reviewing the bibliographies of book chapters and review articles, and by asking colleagues for suggested source materials. The PsychLit search covered the period 1993 to 1999, using the following words: seclusion, restraint, physical holding and chemical restraint. The search yielded 353 articles.

NUMBER OF SOURCE DOCUMENTS

353 articles were identified during the collecting of evidence.

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Expert Consensus (Committee)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

METHODS USED TO ANALYZE THE EVIDENCE

Systematic Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

The validity of scientific findings was judged by design, sample selection and size, inclusion of comparison groups, generalizability, and agreement with other studies

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

Clinical consensus was determined through extensive review by the members of the Work Group on Quality Issues, child and adolescent psychiatry consultants with expertise in the content area, the entire Academy membership, and the Academy Assembly and Council.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

[MS] "Minimal Standards" are recommendations that are based on substantial empirical evidence (such as well controlled, double-blind trials) or overwhelming clinical consensus or legal and regulatory requirements. Minimal standards are expected to apply more than 95 percent of the time, i.e., in almost all cases. When the practitioner does not follow this standard in a particular case, the medical record should indicate the reason.

[CG] "Clinical Guidelines" are recommendations that are based on empirical evidence (such as open trials, case studies) and/or strong clinical consensus. Clinical guidelines apply approximately 75 percent of the time. These practices should always be considered by the clinician, but there are exceptions to their application.

[OP] "Options" are practices that are acceptable, but not required. There may be insufficient empirical evidence to support recommending these practices as minimal standards or clinical guidelines. In some cases they may be indicated, but in other cases should be avoided. If possible, the practice parameter will explain the pros and cons of these options.

[NE] "Not Endorsed" refers to practices that are known to be ineffective or contraindicated.

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

This parameter was made available to the entire American Academy of Child and Adolescent Psychiatry membership for review in September 2000 and was approved by the Academy Council on May 13, 2001.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Recommendations are identified as falling into one of four categories of endorsement. These categories, which are defined at the end of the "Major

Recommendations" field, indicate the degree of importance or certainty of each recommendation.

Prevention of Aggressive Behavior

Intake and Assessment

Collecting the history regarding aggressive behavior may begin with the intake phone call, continue through the admission process, and be part of the psychiatric, nursing and social work assessments [CG]. Intake staff, admission staff, and program staff should systematically communicate to patients and their families that patients will be encouraged and expected to make every effort to manage their own behavior [MS].

The management of aggressive behavior begins with diagnosing and treating the underlying psychiatric illness. The evaluation of a patient should include a review of aggressive behavior, including triggers, warning signs, repetitive behaviors, response to treatment, and prior seclusion and restraint events that are associated with aggressive acts [MS]. Cultural factors may influence the triggers and expression of aggression by patients and the response to aggression by staff and these factors should be considered in treatment facilities [CG]. Cognitive limitations, neurological deficits and learning disabilities should be noted during intake evaluations [MS]. A medical evaluation of the patient should identify factors that may require modification of seclusion and restraint procedures [MS].

Treatment Planning

The treatment plan should include strategies to prevent aggressive behavior, de-escalate behavior before it becomes necessary to use restrictive interventions, and initiate psychological and psycho-pharmacological treatments for treating the underlying psychopathology [MS].

Patients with a history of aggressive behavior may benefit from anger management, problem-solving and psychoeducational programs [CG].

Staff Training

Repeated training in the management of aggressive behavior is necessary to develop the high degree of competence this work requires [MS]. Good training promotes the retention of qualified staff. Training should include updated information about seclusion and restraint practices, assessment of acuity levels to allow changes in staffing on a shift by shift basis as needed for patient safety, frequent practice in using restraint equipment, training in documentation, training in seclusion and restraint audits, and annual certification in cardiopulmonary resuscitation. Facilities, staff, and physicians should update themselves at least annually on seclusion and restraint information from academic, regulatory, patient advocacy and professional resources [MS].

Crisis Management

De-escalation Strategies

Each unit should have its own de-escalation program that helps patients manage angry outbursts [CG]. Anger management and stress reduction techniques are important components of prevention in psychiatric facilities and should be a component of a psycho-education program for children and adolescents. If less restrictive options have failed or cannot be safely applied, seclusion and restraint procedures may be required.

Indications for the Use of Seclusion or Restraint

The only indications for the use of seclusion and restraint are to prevent dangerous behavior to self or others and to prevent disorganization or serious disruption of the treatment program including serious damage to property. Measures promoting the child´s self-control or less restrictive options must have failed or are impractical [MS].

Seclusion and restraint should not be used as punishment for patients, for the convenience of the program, where prohibited by state guidelines, to compensate for inadequate staffing patterns, or instituted by untrained staff [NE]. When it becomes necessary to implement seclusion and restraint the autonomy and dignity of the patient must be preserved as much as possible [MS].

Ordering and Monitoring Seclusion and Restraint

The decision on when to seclude or restrain a patient must be made by the professionally trained staff working with the patient at the time of the aggressive behavior in consultation with a physician [MS]. Seclusion, physical restraint, and chemical restraint should not be ordered on a PRN (pro re nata = as the occasion may arise) basis [NE]. All patients in seclusion or restraint must be monitored continuously. All restrained patients should have their pulse, blood pressure, and the range of motion in their extremities checked every 15 minutes [MS]. The need for nutrition, hydration, and elimination and the physical and psychological status and comfort of the patient should be monitored and responded to once these needs are identified [MS]. The patient´s family should be informed of use of seclusion or restraint [MS]. Once the child or adolescent is settled and has regained self-control, the seclusion or restraint should be terminated [CG].

Physical and mechanical restraints that cause airway obstruction must not be employed (e.g. choke holds or covering the patient´s face with a towel, bag, etc.) [NE]. With supine restraints, a patient´s head must be able to rotate freely. With prone restraints, the patient´s airway must be unobstructed at all times (i.e. not buried), and the patient´s lungs must not be restricted by excessive pressure on the patient´s back [MS].

Chemical restraint is the involuntary use of psychoactive medication in a crisis situation to help a patient contain out-of-control aggressive behavior. Chemical restraint is to be distinguished from the pharmacological management of a patient´s underlying illness. The decision to order a chemical restraint must consider the available medical and psychiatric history of the patient, including concurrent medications being used [MS]. Chemical restraints must be administered and continuously monitored by trained nursing personnel. In general, oral medication should be offered prior to the administration of

parenteral medication. In order to avoid aspiration, oral medication must always be given when the patient is sitting up or standing.

U.S. Health Care Financing Administration (HCFA)* regulations require that a licensed independent practitioner have face-to-face contact with the patient within one hour of the initial order for seclusion or restraint. Additionally the patient´s treating physician must be consulted as soon as possible if the treating physician is not the practitioner who ordered the seclusion or restraint.

Joint Commission on Accreditation of Healthcare Organizations (JCAHO) standards allow qualified, registered nurses or other qualified, trained staff to initiate the use of seclusion or restraint. An order for the seclusion or restraint must be obtained from a licensed independent practitioner as soon as possible but no longer than one hour after the initiation of the seclusion or restraint. In Medicare/Medicaid funded programs a physician or licensed independent practitioner must conduct a face-to-face evaluation of the patient within one hour of the initiation of a restraint or seclusion as required by the U.S. Health Care Financing Administration* Interim Final Rule for Patients Rights, August 1, 1999. In other facilities the initial evaluation of patients in seclusion and restraint is 2 hours for a patient age 17 and under and 4 hours for ages 18 and over. If the patient is no longer in seclusion or restraint when the original order expires the licensed independent practitioner must conduct an in-person evaluation of the patient within 24 hours of the initiation of the seclusion or restraint. Verbal and written orders are limited to one hour for children under age 9 and 2 hours for individual´s ages 9-17. The order for continuation of a restraint or seclusion can be made by a qualified registered nurse or other qualified trained individual who has been authorized by the organization to perform this function. However, a licensed independent practitioner must perform an in-person reevaluation at least every 4 hours for individuals 17 years and younger.

The Joint Commission on Accreditation of Healthcare Organizations standards for restraint and seclusion do not apply: when a staff person physically redirects or holds a child, without the child´s permission, for 30 minutes or less; when the individual is restricted for 30 minutes or less from leaving an unlocked room (time-out) or when an individual is restricted to an unlocked room or area.

The U.S. Health Care Financing Administration* regulations and the Joint Commission on Accreditation of Healthcare Organizations standards were current at the time of the publication of this parameter. However, this is an area of regulatory oversight that has been in rapid evolution and practitioners should stay informed of the new regulations and standards as they are announced. (for more information, see the organization´s Web sites: www.hcfa.gov, www.jcaho.org).

Processing Strategies

The use of seclusion and or restraint should be followed by a debriefing discussion that allows the patient to process and understand what has happened [MS]. The staff should review with the patient the events that triggered the seclusion or restraint; discuss with the patient alternate strategies to avoid similar incidents and arrange whenever possible for the patient to make amends or do restitution to those who have been injured. Every episode of seclusion and restraint must be documented in the patient´s medical record [MS]. The Joint Commission on

Accreditation of Healthcare Organizations requires that patients be allowed written comment about the experience. Staff participating in a seclusion or restraint should review the episode in a separate debriefing session and document recommendations and findings for the facility´s committee that reviews seclusion and restraint reports [MS].

Administrative Oversight

Strong clinical leadership is essential in the management of aggressive behavior in order to minimize the need for seclusion and restraint. Facilities must have a committee that provides oversight of the practice of seclusion and restraint [MS]. This may include a review of restrictive interventions; restraint equipment; staff training; staff retention; patient and parental concerns about seclusion and restraint; and peer review of the application and use of seclusion, mechanical and chemical restraint, and restraint equipment. A patient and family ombudsman should also be available to review concerns about restrictive interventions [OP].

*The U.S. Health Care Financing Administration is currently known as the U.S. Centers for Medicare and Medicaid Services (CMS).

Definitions:

[MS] "Minimal Standards" are recommendations that are based on substantial empirical evidence (such as well controlled, double-blind trials) or overwhelming clinical consensus or legal and regulatory requirements. Minimal standards are expected to apply more than 95 percent of the time, i.e., in almost all cases. When the practitioner does not follow this standard in a particular case, the medical record should indicate the reason.

[CG] "Clinical Guidelines" are recommendations that are based on empirical evidence (such as open trials, case studies) and/or strong clinical consensus. Clinical guidelines apply approximately 75 percent of the time. These practices should always be considered by the clinician, but there are exceptions to their application.

[OP] "Options" are practices that are acceptable, but not required. There may be insufficient empirical evidence to support recommending these practices as minimal standards or clinical guidelines. In some cases they may be indicated, but in other cases should be avoided. If possible, the practice parameter will explain the pros and cons of these options.

[NE] "Not Endorsed" refers to practices that are known to be ineffective or contraindicated.

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is identified and graded for selected recommendations (see "Major Recommendations").

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

- Increased behavioral self-control and self-determination
    - Seclusion has been shown in many studies to be an affective technique for helping children de-escalate from situations in which they are harmful to themselves, others, or property
    - Physical restraint has been described as beneficial in promoting control for some children and adolescents through attachments to emotionally important adults and for protection and socialization
- Decreased aggressive behavior
- Prevention of harm to self and others
- Staff training develops the necessary competence this work requires, and promotes the retention of staff

POTENTIAL HARMS

Development of Posttraumatic Stress Symptoms

- Since the report of traumatic experiences associated with seclusion, recent literature has continued to indicate that the seclusion and restraint experience can be perceived by patients as an aversive and coercive experience with the potential for the development of posttraumatic stress symptoms.
- The development of posttraumatic stress disorder or its reactivation with symptoms of flashbacks, nightmares and intrusive thoughts is a potential consequence of seclusion, physical restraint, and chemical restraint, particularly when carried out in a coercive fashion.
- The use of mechanical restraint with children has been discouraged because it may provoke fear in children.

Death

- In response to these concerns and as part of its sentinel event surveys, the Joint Commission on Accreditation of Hospital Organizations (JCAHO) Board of Commissioners reviewed twenty cases of deaths of patients, 1/3 children, 1/3 adults, 1/3 geriatric, who were physically restrained. This analysis identified the following contributory factors to the deaths: restraining patients who smoke, restraining patients with deformities which prevent proper application of the restraint, supine restraint that could predispose to aspiration, prone restraint that could predispose to suffocation, and lack of continuous observation of restrained patients.

Contraindications and Dangerous Practices

- Physical or mechanical restraints that cause airway obstruction, such as choke-holds, and also covering the patient´s face with a towel, bag, etc., during therapeutic holding. With supine restraints, a patient´s head must be

able to rotate freely, and wherever possible, the head of the bed should be elevated to prevent aspiration. With prone restraints, the patient´s airway must be unobstructed at all times (i.e., not buried) and the patient´s lungs must not be restricted by excessive pressure on the patient´s back (especially with children).

- In particular, the prone wrap-up (immobilizing a patient in a face down position) has been shown to be associated with injuries and deaths and should not be used.
- Restraint by untrained staff

Chemical Restraints

- Sleepiness may persist for hours to days, far longer than is required for the patient to regain self-control. Side effects of anti-psychotic agents include extrapyramidal symptoms, neuroleptic malignant syndrome, and dystonic reactions
- The combination of droperidol´s amnestic effect and its obligatory intramuscular administration raise concerns about its potential for inducing trauma
- With anxiolytics, and antihistamines, a risk of paradoxical increase in rage exists.

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

This parameter describes recommended clinical practice. At times, these recommendations are different from regulatory guidelines and will be noted as such. Familiarity with federal, state, and other regulatory agency and institutional regulations is necessary to ensure that treatment requirements mandated by these agencies are met. For the purpose of this parameter, "parent" is used to mean biologic, foster, and adoptive parent, as well as legal guardian.

This parameter may have applications for children and adolescents in general hospitals, detention centers, and group homes that employ aggression management programs. However, modifications may need to be made for individuals with developmental disabilities, individuals treated within emergency departments and individuals in pediatric units. For children and adolescents who have a trauma history the use of physical and mechanical restraint are discouraged; seclusion may be used preferentially.

Practice parameters are strategies for patient management, developed to assist clinicians in psychiatric decision-making. This parameter, based on evaluation of the scientific literature and relevant clinical consensus, describes generally accepted approaches to assess and treat specific disorders or to perform specific medical procedures.

This parameter is not intended to define the standard of care; nor should they be deemed inclusive of all proper methods of care or exclusive of other methods of care directed at obtaining the desired results. The ultimate judgment regarding the care of a particular patient must be made by the clinician in light of all the

circumstances presented by the patient and his or her family, the diagnostic and treatment options available, and available resources. Given inevitable changes in scientific information and technology, these parameters will be reviewed periodically and updated when appropriate.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better
Living with Illness

IOM DOMAIN

Effectiveness
Patient-centeredness
Safety

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

American Academy of Child and Adolescent Psychiatry. Practice parameter for the prevention and management of aggressive behavior in child and adolescent psychiatric institutions with special reference to seclusion and restraint. Washington (DC): American Academy of Child and Adolescent Psychiatry; 2001 May 13. 81 p. [124 references]

Practice parameter for the prevention and management of aggressive behavior in child and adolescent psychiatric institutions, with special reference to seclusion and restraint. J Am Acad Child Adolesc Psychiatry 2002 Feb;41(2 Suppl):4S-25S. [125 references]

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2001 May 13

GUIDELINE DEVELOPER(S)

American Academy of Child and Adolescent Psychiatry - Medical Specialty Society

SOURCE(S) OF FUNDING

American Academy of Child and Adolescent Psychiatry (AACAP)

GUIDELINE COMMITTEE

Work Group on Quality Issues

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

This parameter was developed by:

Kim J. Masters, M.D., and Christopher Bellonci, M.D.

Work Group on Quality Issues Members: Valerie Arnold, M.D., Joseph Beitchman, M.D., R. Scott Benson, M.D., : William Bernet, M.D., Chair, Oscar Bukstein, M.D., Joan Kinlan, M.D., Jon McClellan, M.D., and David Rue, M.D., Jon A. Shaw, M.D., and Saundra Stock, M.D.

AACAP Staff: Kristin Kroeger

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

As a matter of policy, some of the authors to these practice parameters are in active clinical practice and may have received income related to treatments discussed in these parameters. Some authors may be involved primarily in research or other academic endeavors and also may have received income related to treatments discussed in these parameters. To minimize the potential for these parameters to contain biased recommendations due to conflict of interest, the parameters were reviewed extensively by Work Group members, consultants, and Academy members; authors and reviewers were asked to base their recommendations on an objective evaluation of the available evidence; and authors and reviewers who believed that they might have a conflict of interest that would bias, or appear to bias, their work on these parameters were asked to notify the Academy.

GUIDELINE STATUS

This is the current release of the guideline.

An update is not in progress at this time.

GUIDELINE AVAILABILITY

Electronic copies: Available (to members only) from the American Academy of Adolescent and Child Psychiatry (AACAP) Web site.

Print copies: Available from AACAP, Communications Department, 315 Wisconsin Avenue, NW, Washington, DC 20016. Additional information can be obtained through the AACAP Publication Catalog for Parameters.

AVAILABILITY OF COMPANION DOCUMENTS

The following is available:

- Masters KJ, Bellonci C, Bernet W, Arnold V, Beitchman J, Benson S, Bukstein O, Kinlan J, McClellan J, Rue D, Shaw JA, Stock S, Kroeger K. Summary of the practice parameter for the prevention and management of aggressive behavior in child and adolescent psychiatric institutions with special reference to seclusion and restraint. J Am Acad Child Adolesc Psychiatry 2001 Nov;40(11):1356-8.

PATIENT RESOURCES

None available

NGC STATUS

This summary was completed by ECRI on February 12, 2002. The information was verified by the guideline developer on May 1, 2002.

COPYRIGHT STATEMENT

This NGC summary is based on the original guideline, which is subject to the guideline developer's copyright restrictions. Any reproduction, retransmission, or republication of all or part of the original guideline is expressly prohibited, unless AACAP has expressly granted its prior written consent to so reproduce, retransmit, or republish the material. All other rights reserved.

© 1998-2004 National Guideline Clearinghouse

Date Modified: 11/15/2004