Management of Agitation in Individuals with Autism Spectrum Disorders in the Emergency Department

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KEYWORDS

- Autism spectrum disorders • Emergency department • Crisis management
- Acute agitation • Emergency evaluation and treatment
- Least-restrictive treatment model • Restraint

KEY POINTS

- Medical and psychiatric causes of agitation in patients with autism spectrum disorder (ASD) in the emergency department (ED).
- Rapid assessment of acute agitation.
- Nonpharmacologic and behavioral interventions in the ED.
- Reducing agitation by adapting care and treatment around the core features of ASD.
- Use of psychiatric and psychoactive medications in EDs for treating acute agitation in patients with ASD.
- Restraint and seclusion for agitated patients with ASD in the ED.

OVERVIEW

Individuals with autism spectrum disorders (ASD) presenting with acute agitation, including dangerous behaviors to self and others, often cause families, caregivers, educators, and first responders to turn to the hospital emergency department (ED) in times of crisis. An additional challenge for medical and psychiatric hospital

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personnel in the ED setting is teasing out the core deficits of ASD (social-communication and restricted and repetitive behavior patterns and interests) from acute underlying medical and/or psychiatric conditions. This article presents a framework for improving the crisis evaluation of the tip-of-the-iceberg presenting behaviors of individuals with ASD and provides a suggested least-restrictive treatment model for adapting the ED environment to improve the care of these patients.

INTRODUCTION

Individuals with ASD can present challenging behaviors and agitation. These behaviors can be dangerous, creating stress and difficulty for families, caregivers, educators, and first responders, leading to the presentation of these individuals to the hospital ED.[1] Acute management and de-escalation of children, adolescents, and adults with ASD has had limited success and has often resulted in unwanted outcomes.[2,3] The results of a 2011 survey in Pennsylvania of 3500 children, adolescents, and adults with ASD found that 28% of the respondents who required an ED or hospital evaluation for behavioral/psychiatric or medical reasons had negative experiences and unwanted outcomes.[4] The lack of communication, education, and experience of the ED personnel evaluating and treating individuals with ASD may contribute to the prevalence of these negative experiences. This lack of training causes difficulty in differentiating ASD diagnostic features from the onset of acute medical or psychiatric symptoms.

Symptoms of ASD

The presence of the core communication and social impairments unique to the ASD population complicates their behavioral, psychiatric, and medical management. Specifically, ASD represents a class of life-long neurodevelopmental disorders characterized by impairments in reciprocal social interactions; communication skills; and restricted, repetitive, and stereotyped patterns of behavior, interests, and activities.[5] In addition to these core diagnostic features, a range of other nonspecific atypical behaviors, such as anxiety, depression, sleeping and eating disturbances, attention issues, temper tantrums, and aggression or self-injury, are common. It has been found that features of ASD are often accompanied by impairments in cognitive and adaptive functioning, learning styles, attention skills, and sensory processing abilities.[6] Gabriels[7] (2011) reviewed the ASD diagnostic and associated issues that can affect presenting behaviors in children, adolescents, and adults with ASD.[7] For example, individuals with ASD generally have a unique pattern of markedly low adaptive functioning levels even though their intelligence levels may be higher compared with their levels of adaptive functioning.

Individuals with ASD display great variability in the range and severity of the core diagnostic features.[5] For example, some individuals may isolate themselves because of their focus on engaging in their own restricted interests or repetitive behaviors, whereas others may seem social but are odd or inappropriate in their social approaches to others and unaware of the impact of their behaviors on others. Behavioral expressions of ASD will also vary. Some individuals with an ASD may engage in stereotyped and repetitive body movements, manipulation of object parts, or self-injurious behaviors, whereas others are preoccupied with compulsive or ritualized behaviors, have a rigid insistence on sameness of the environment, or engage in circumscribed interests. Finally, individuals with ASD may also display a variety of associated impairments in intelligence and adaptive abilities, comorbid medical and psychiatric diagnoses, and sensory sensitivities, all of which can complicate the evaluation of presenting crisis behaviors seen in an ED setting.[8–11]

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