Acute Behavioural Disturbance

Sandy Hopper
RCH, Melbourne
Oliver

- 10 year old
- PHx: autistic spectrum disorder
- Having a blood test
- Becomes very agitated
- Bites the doctor doing the test
Chelsea

- 14 year old
- PHx: in state care, substance use, social
- Becomes angry and aggressive in rooms
- Screaming and shouting
- Raises a chair above her head
Xavier

- 16 year old
- Found wandering outside a party
- Shouting, swearing, coherent
- Lashing out with his fists
Mr Jones

- Around 40 years old
- Child has leukaemia
- Upset by the wait in clinic
- Yelling at the receptionist
Sam

- 13 year old
- PHx: acquired brain injury, seizures, OSA, obese
- Seizure at his accommodation
- As he’s waking up he shows a fearsome display of aggression
Emergency Department

Autonomy

Duty of care

Beneficence

Behavioural disturbance

OH&S

Zero tolerance

Mental Health law

Mental Health law
An approach to acute behavioural disturbances
Describe an approach to acute behavioural disturbances

- Prevention
- Management-
  - Verbal de-escalation
  - Restraint
  - Use of medication
Prevention

- Prediction: Not always possible
- Environment
- Systems
Acute behavioural disturbance

Imminent or actual
Emergency Department

Universal approach

Acute brain/intoxicated

Verbal de-escalation

Collaborative sedation

Behavioural Resuscitation
Team approach
Verbal De-esc
Show of force
Physical restraint
Mechanical restraint
Chemical sedation
Containment
Ejection

Actively violent

N

Y

Acute brain/intoxicated

N

Y

Verbal de-escalation

fails

fails

Collaborative sedation

After Hilt RJ, 2008
Verbal de-escalation

You cannot reason with an unreasonable person
de-escalation

- Non-verbal: position, posture, body language
- Verbal style: low slow and quiet
- Verbal content: care and understand, appeal to reason
understand the problem

- I am here to help you.
- Tell me how I can help
- Tell me what’s bothering you
active listening

- I can see you want to....
- That must really upset you
clarify goals

- I can help you…. But first I need to make sure you are safe.
simply rephrase

- Let’s make sure you are OK and then you can....
externalise the problem behaviour

- The anger I am seeing here makes it hard for me to help you.
externalise your response

- The law tells me/ it is my job to make sure you are OK, so I need to…… before you can.

- I am not happy about the long wait either. It is very frustrating for me too.
become part of the solution

- If you help me to make sure you are safe, then I can......
suggest/request an alternative, positive solution

- It’s OK to be angry/disappointed/frustrated.
- Tell me how angry… you are.
meet some needs

- Food
- Nicotine
- Water
- Elimination
offer choices to give control

- Cool drink/warm drink
- Orange/ lemon
- Straw/ no straw
- Sitting down/ standing up
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After Hilt RJ, 2008
Collaborative medication

Whatever they are on
Whatever worked last time
Diazepam, Olanzapine
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N

Y

N

Reception and assessment

Y

N

After Hilt RJ, 2008
Behavioural Resuscitation

- Enhanced verbal de-escalation
- A show of overwhelming force
- Containment
- Ejection
- Physical restraint
- Mechanical restraint
- Chemical restraint
Team approach

- 7-8 persons
- skill mix
- Trained
- Equipped
Enhanced verbal de-escalation

A show of overwhelming force

Require a reasonable person
Ejection/ Police

- behaviour is unequivocally not due to mental health or medical concern.
  - “Acting out”
  - Criminality
Containment: A goldilocks option
Seclusion
Not too sleepy

Not too agitated
Must be searched
Most patients will require physical and chemical restraint
Physical restraint

- 5 person
- Trained
- Universal precautions
- Supine

Roles may vary but must be negotiated prior to approaching the patient and in conjunction with the team leader.
Chemical restraint

- O vs S/L vs IM vs IV
- Choice of agent:
  - Midazolam
  - Diazepam
  - Haloperidol
  - Droperidol
  - Olanzapine
- Midazolam: rapid onset, short duration, amnestic, commonly used in acute health
- Diazepam: longer acting, oral or IV, not IM
- Haloperidol: onset 20’, duration 2 hrs, sedating, risks EPS and NMS
- Droperidol: shorter acting than HPD, ?risk of long QT?
- Olanzapine: similar profile to HPD perhaps less sedating, less EPS, NMS
Choice of agent

- Anxiety, acute brain, intoxication: benzo
- All others: benzo plus antipsychotic
Olanzapine vs Haloperidol

- Khan: Olanzapine: effective in 90%, no AEs apart from sedation, restraint time 40 minutes
- Sonnier: EPS less common in atypicals- 8% (long term use)

- All give rise to sedation, all can prolong QT
- Bottom line: Olanzapine is a little less unpleasant, and possibly safer
Sedation: complications

- Respiratory depression
- Hypotension, tachycardia.
- Extra pyramidal reactions

- Titrated to effect
- Close care: monitoring, 1:1 nursing
Mechanical restraint

- Slow to settle: whilst waiting for chemical restraint to take effect
- Likely to wake up agitated or violent
- Sole method in special circumstances
Mechanical restraint: complications

- Distressing and crude
- Caution with risk of vomiting, aspiration, asphyxiation.
- Attention to skin and elimination
- Close care: monitoring, 1:1 nursing
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behaviour

fails

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After Hilt RJ, 2008
Summary

- Prevention
  - Environment, Self
  - Verbal de-escalation

- Behavioural resuscitation
  - Ejection
  - Containment
  - Restraint
  - Use of medication
Assessment

- By mental health staff.
- Downstream care
Background

- Epidemiology
- Administrative framework
Acute brain syndrome

- Drugs, infection most common
- Suspect when delirium, young, rapid onset, no psychosocial setup, abnormal examination
references


references


references
