

Acute Behavioural Disturbance

Special Notes

Patients with Acute Behavioural Disturbance (ABD) pose a significant clinical risk to themselves and the health care professionals treating them. The causes of ABD are usually multifactorial and include mental illness, intoxication with drugs and/or alcohol and organic illnesses such as hypoglycaemia.

ABD can be classified into four general categories:

- Psychiatric Disorders - Schizophrenia, bipolar, PTSD, psychosis
- Substance related - psychostimulants, cocaine, ketamine, LSD, cannabis, alcohol
- Organic disorders - hypoglycaemia, sepsis, hypoxia, head injury, dementia
- Situational - grief, overwhelming stress

Common ABD presentations include: panic, agitation, anxiety, delusions, hallucinations, or thought disorders.

The primary management of ABD should always focus on de-escalation of the situation and the correction of underlying organic aetiologies.

An individual with ABD can be impulsive, unpredictable and a risk to themselves or others and so may require emergency management and treatment. Assessing the cause of the ABD may sometimes only occur after immediate management of the behavioural disturbance.

Main Principles of Management

- S Safety:** threat assessment, constantly reassess the safety of the patient, paramedic and others
- A Aggression:** be aware of the common triggers of aggression and violence
- F Fix:** underlying organic illness, focus on de-escalation strategies
- E Evaluate the patient:** VSS, PSA, RSA, NSA, SAT Score, SAMPLE
- T Tactical communication:** active listening, empathy, rapport, influence, behavioural change
- Y Yes I have the right resources:** including TasPol, CATT Team or Mental Health Helpline, ICP and other AT resources

Strategies for de-escalation:

- 1 Approach the situation with the right attitude and maintain your self-control.

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- 2 Non-aggression - ensure that you communicate non-aggression with your voice and body language.
 - 3 Match energy levels - respond appropriately, and use 'voice for occasion'.
 - 4 Empathise and listen actively - empathy can help to defuse a conflict situation.
 - 5 Focus on the issue at hand - help the patient focus on how to solve their problem.
- Accurate and timely recording of information relating to the patient is essential and should include: consent/capacity, indication of sedation, applications of physical restraints, medications administered, and observations/assessments undertaken.

Sedation Assessment Tool (SAT)

- The Sedation Assessment Tool (SAT) is a simple, rapid and useful scale used to measure the degree of agitation or sedation of patients with acute behavioural disturbance (ABD).

Score	Responsiveness	Speech
+3	Combative, violent, out of control	Continual loud outbursts
+2	Very anxious and agitated	Loud outbursts
+1	Anxious/restless	Normal/talkative
0	Awake and calm/cooperative	Speaks normally
-1	Asleep but rouses if name is called	Slurring or prominent slowing
-2	Responds to physical stimulation	Few
-3	No response to stimulation	Nil

- Using the patient's responsiveness and speech as described in the table above;
- Allocate the appropriate SAT score (+3 to -3) by determining the highest ranking (example a patient who displays very anxious and agitated behaviour but who speaks normally will receive a score of +2).
- A SAT Score of +2 or +3 is a good predictor of the need to administer sedation.
- The documentation of regular SAT scores is mandatory for all patients presenting with Severe Behavioural Disturbances.
- The aim of treatment is a SAT Score of 0 to +1.

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- This CPG is for utilisation in adults only, all paediatric presentations of ABD MUST be consulted prior to management.

Mental Health Act/Detaining for the Purposes of Assessment

Paramedics may sedate a patient when detaining for the purposes of assessment if:

- The paramedic considers it necessary or prudent to do so; and
- The paramedic has exhausted other means of getting the patient to hospital in a less restrictive manner.

A paramedic may detain a patient for the purposes of assessment if they reasonably believe that:

- The person has a mental illness; and
- The person should be examined to see if he/she needs to be assessed against the assessment or treatment criteria; and
- The persons safety or the safety of other persons is likely to be at risk if the person is not detained for the purposes of assessment.

Stop

- ⚠ **Only paramedics authorised by the Chief Civil Psychiatrist to perform the functions of a Mental Health Officer (MHO) with consent of the Director of Ambulance Services are allowed to detain patients for the purposes of assessment.**

Stop - Mental Health Patients

- ⚠ **The mental health patient has to be detained for the purposes of assessment prior to administration of sedation or restraint.**
- ⚠ **Paramedic safety is to be considered paramount at all times.**
 - Do not attempt any element of this guideline unless appropriate resources (police and/or ambulance) are on scene.

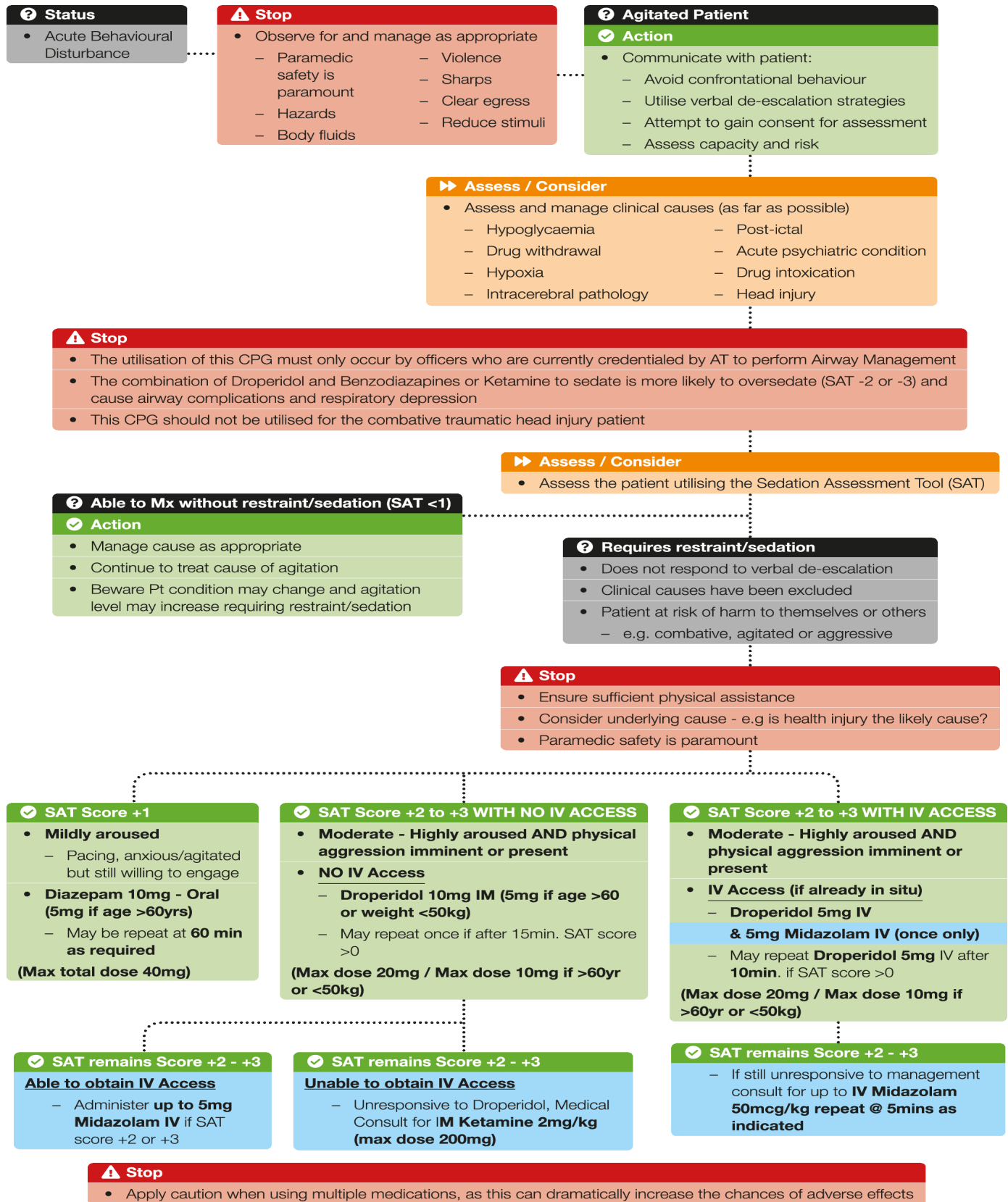
General

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- The indications for the use of sedation and/or restraint must be clearly documented on the patient care report.
- The type of restraint used and its time of application and/or removal must be clearly documented on the patient care report.
- Restraint is considered a use of force and must only ever be applied when reasonable in all the circumstance after exhausting other options (where safe).

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Flowchart



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