



Acute behavioural disturbance: guidelines on management in police custody

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This guidance is written in the following context:

This guidance represents the view of the Faculty of Forensic and Legal Medicine, which was reached after careful consideration of the evidence available. Forensic health care professionals (HCPs), doctors, nurses and paramedics, are expected to take it fully into account when exercising their clinical judgement.

However, as with any clinical guideline, recommendations may not be appropriate for use in all circumstances. It is recognised that a limitation of a guideline is that it simplifies clinical decision making. It is the HCP's responsibility to ensure that recommendations are appropriate to the circumstances of the individual patient, in consultation with the patient, the detainee in these circumstances, and/or any guardian or carer.

Decisions to adopt any particular recommendation must be made by HCPs in the light of:

- available resources
- local services, policies and protocols
- the patient's circumstances, safety, dignity, privacy, wishes and human rights
- the age of the patient
- available personnel
- the risk to personnel including the practitioner
- clinical experience of the practitioner
- knowledge of more recent findings.

The assessment of risk should be as full as possible in circumstances where information may be limited and time of the essence.

Introduction

Acute behavioural disturbance is not a diagnosis as such. It is the 'umbrella' term for a number of conditions and hence the importance of considering differential diagnosis. It may occur secondary to substance misuse (both intoxication and withdrawal), physical illness (such as post head injury, hypoglycaemia) and psychiatric conditions (including psychotic and personality disorders). Where the cause is unknown the term is of similar diagnostic status to the term 'pyrexia of unknown origin' (which may be a feature of acute behavioural disturbance).

Of all the forms of acute behavioural disturbance what has become known as 'excited delirium' is the most extreme and potentially life threatening. This is a controversial term and can probably be applied to delirious states resulting from a number of different clinical conditions. However, the commonly associated features of a state of high mental and psychological arousal, agitation, tactile warmth or hyperpyrexia associated with sweating, tachypnoea, violence, aggression and hostility with insensitivity to pain and to irritant sprays should be regarded as indicative of a medical emergency and the need for immediate hospitalisation. Likewise, the mortality of untreated delirium tremens, in the order of 15 – 30 per cent, should not be overlooked. The clinical picture is similar: dehydration, seizures, hypotension and hyperthermia are poor prognostic signs.

Where there is evidence of, or reason to suspect, a serious underlying medical condition, such as neuroleptic malignant syndrome, heat exhaustion, septicaemia, head injury or a delirious state of whatever cause, consideration should be given to immediate transfer to hospital as a medical emergency.

Differential diagnosis of ABD

- Psychiatric disorders
- Sepsis
- Substance misuse (intoxication/withdrawal)
- Serotonin syndrome
- Neuroleptic malignant syndrome
- Heat exhaustion
- Anticholinergic syndrome (e.g. antihistamines)
- Head injury
- Hypoglycemia
- Hypoxia



Ideally, individuals with acute behavioural disturbance should not be taken to a custody suite but directly to an emergency department. However, on occasions, individuals will be detained by the police and taken to the police station, when the HCP will be called for advice. In these circumstances, the HCP may consider that immediate hospitalisation is required and advise the police to telephone 999 for an ambulance. Otherwise, the HCP should attend and assess the detainee.

In such circumstances, the HCP may need to take advice from a senior colleague if tranquillisation is considered necessary and if other approaches have failed to de-escalate the acutely disturbed behaviour. Rapid tranquillisation¹ involves the use of medication to calm the patient without more than light sedation; the induction of a state of rest and reduction of psychological activity in which alertness and verbal contact are maintained. It is to be distinguished from sedation. Although some people with acute behavioural disturbance are so seriously ill as to require sedation, this should only be undertaken in hospital or by an appropriately trained paramedic prior to transfer to hospital.

The aims of rapid tranquillisation are threefold:

- a. to reduce further suffering for the patient: psychological and physical (through, for example, self-harm, accidents, hypoxia or metabolic acidosis)
- b. to reduce the risk of harm to others
- c. to do no harm (by prescribing safe regimes and monitoring physical health).

Rapid tranquillisation may need to be considered when:

- a. the HCP decides that the detainee needs to be transferred to hospital and tranquillisation is required to facilitate that transfer
- b. it is necessary to reduce suffering for the detainee and prevent a further deterioration in their health prior to further assessment or appropriate disposal.

The decision to employ rapid tranquillisation must be a reasonable and proportionate response to the risk it seeks to address.

The use of medication for rapid tranquillisation in the police station is a serious step. This is particularly so because detainees may have taken other drugs which interact with those used for rapid tranquillisation, leading to serious additive effects in terms of CNS depression. Therefore, extreme caution needs to be employed before sedating any such patient and adequate safeguards must be in place to ensure the individual's safety.

Preliminary steps – diagnosis and causation

The HCP should endeavour to establish the underlying diagnosis behind the acute behavioural disturbance before making any treatment decision.

Preliminary steps – communication and de-escalation

Appropriate verbal and non-verbal techniques should be employed. The HCP should avoid responding to aggression with aggression. 'No pain techniques' should be used wherever possible as pain acts as a stimulus. A reassuring and non-judgmental attitude is required, conveying respect and empathy, with an appropriate, measured and reasonable response and the avoidance of provocation. Care should be taken to avoid verbal and non-verbal expressions of anxiety or frustration.

The HCP should consider allowing a period of time-out where the detainee may calm down (away from the arresting officers) such as in a suitable cell or in the exercise area.

Although it may be difficult in the custodial setting, efforts should be made to use distraction and calming techniques, and relaxation.

Only when de-escalation has failed to curb the disturbed behaviour should the HCP consider giving medication.

The use of medication

Medication for rapid tranquillisation should be used with caution owing to the following risks:

- loss of consciousness instead of tranquillisation
- sedation with loss of alertness
- compromised airway and breathing
- cardiovascular and respiratory collapse
- interaction with medicines already prescribed or illicit substances taken (can cause side effects such as akathisia, disinhibition)
- possible damage to patient-clinician relationship
- underlying coincidental physical disorders.

There is evidence that drugs given orally can be as effective as those administered intra-muscularly and, because of the greater risks associated with parenteral treatment, rapid tranquillisation in police custody should be restricted to oral therapy. In any event it is not considered that what may be only a few minutes shorter onset of action or more rapid time to peak effect justify the risks attendant upon the use of parenteral medication. The proposed treatment should be explained to the disturbed patient, as most individuals will cooperate with an oral dosing regime with appropriate explanation and support from the HCP. In circumstances where the detainee lacks capacity to consent to the treatment, the HCP may still administer oral medication provided the HCP considers it to be in the person's best interests and the individual complies.



Use of the Sedation Assessment Tool (SAT- see Appendix) may assist in deciding whether to administer medication (for example, with a SAT score of +2 or +3) and in communicating the seriousness of the detainee's condition when communicating with call centre call handlers or other health professionals.

If rapid tranquillisation is considered necessary, particularly prior to formal diagnosis and where there is any uncertainty about previous medical history (including history of cardiovascular disease), uncertainty regarding current medication, or possibility of current illicit drug/alcohol intoxication, lorazepam is the drug of choice. The dosage should be the minimum necessary to achieve the desired effect. Appropriate adjustments to dosage should be made in the case of detainees who are children, young persons, or elderly. Where the detainee is unresponsive to the maximum British National Formulary (BNF) recommended dose, it may be more preferable and safer to consider a transfer to hospital than to prescribe in excess of the recommended maximum.

Specific risks in association with the use of lorazepam in these circumstances are:

- loss of consciousness
- respiratory depression or arrest
- cardiovascular collapse (particularly detainees who may be receiving both clozapine and benzodiazepines)
- disinhibition
- paradoxical excitation, although uncommon (less than 1% of people given benzodiazepines).

Other benzodiazepines, such as midazolam, antipsychotics, such as haloperidol and droperidol, and ketamine may be administered parenterally in order to achieve sedation. However, such medical management of acute behavioural disturbance where the aim is not just tranquillisation but sedation and carried out, usually in hospital, by appropriately trained health professionals, is not the same as rapid tranquillisation.

In view of the potential risks involved in rapid tranquillisation of detainees with acute behavioural disturbance, the effect of any treatment administered should be carefully monitored. The HCP needs to make a positive decision about who should monitor the detainee based on the individual circumstances of the case.

The HCP should ensure that either he/she or another appropriately trained healthcare professional remains in attendance to monitor level of consciousness (AVPU/GCS), respiration, pulse, blood pressure and temperature until the situation has resolved (i.e. the detainee has been safely transferred to hospital or has fully recovered). Where rapid tranquillisation is ineffective or where these observations indicate a deteriorating physical condition, consideration should be given to transfer to hospital as a Level 2 emergency.

It is vital that HCPs should also be trained in immediate life support and be familiar with the use and location of any available resuscitation equipment in the police station. They should be able to put a detainee in the recovery position protecting his or her airway.

The use of physical restraint

A number of physical skills may be used in the management of disturbed or violent detainees. The level of force applied must be justifiable, appropriate, reasonable and proportionate to a specific situation, should be applied for the minimum possible amount of time and be the least restrictive option to meet the need. However, it must be recognised that restraint per se is dangerous. Whenever a HCP considers that restraint may be required it should be discussed with a senior police officer who should take the lead in any procedures adopted. However, it is the responsibility of the HCP to advise how and to what extent allowances should be made for the detainee's physical health, degree of frailty or developmental age.

Documentation

The HCP's record should include a description of the behaviour that resulted in the use of rapid tranquillisation. The steps that were taken unsuccessfully to de-escalate the situation should be noted. If the detainee did not consent then the grounds, in terms of best interests, for administering the medication to a detainee who lacked the capacity to consent must be set out in detail. Other information should be documented, as would allow an independent reviewer to find that the administration of medication was justified, appropriate, reasonable, proportionate, and the least restrictive option to meet the need. Where a decision has been made to prescribe in excess of the recommended maximum dose, the reasons should be clearly documented.

Audit and review

It is essential that the management of cases of acute behavioral disturbance are reviewed as part of the clinical governance framework. These cases can be used for the audit of an area of clinical practice which at present does not have a clear evidence base and where clinical experience is more influential than research findings. Cases of rapid tranquillisation should be included in the case-based discussions which form part of many HCPs' continuing professional development. In cases where maximum British National Formulary doses have been exceeded, where there has been injury to the detainee or others, or where physical restraint has been required, it is recommended that a 'sudden untoward incident' or similar multiprofessional review should take place. It is recommended that such a review should include participation of the police if injury has occurred or physical restraint been employed.



Rapid tranquillisation of detainees in police custody		
Step	Intervention	Notes
1	Attempt de-escalation with appropriate techniques	Use the cooling off period to try and establish the cause of the disturbed behaviour
2	Offer oral lorazepam Adult: 1 – 2 mg Children: 50 mcg/kg Older person: 500 mcg – 1 mg Ensure that an appropriately trained HCP is present to monitor the effect of the drug	If there is insufficient effect the drug can be repeated up to two times at 45 minute intervals up to a maximum dose in 24 hours of 4 mg for adults and 2mg for children and 2 mg in the elderly.

Note:

Before transferring to a mental health facility, an acute medical condition should be ruled out, in particular intoxication, CNS disorders, head trauma, epilepsy, stroke, cardiopulmonary disorders, metabolic disorders, systemic illness, delirium, etc

The College of Emergency Medicine have published 'Guidelines for the Management of Acute Behavioural Disturbance (ABD)' (2016) to provide a guideline for Emergency Departments to safely and effectively manage individuals who attend or are brought in by the police/ ambulance personnel with suspected Acute Behavioural Disturbance.

Appendix A: Sedation Assessment Tool

(LA Calver, B Stokes & GK Isbister, Sedation assessment tool to assess acute behavioural disturbance in the emergency department. Emerg Med Australas 23(6): 732-740, 2011)

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/ co-operative	Speaks normally
-1	Asleep but rouses if name is called	Slurring or prominent slowing
-2	Responds to physical stimulation	Few recognisable words
-3	No response to simulation	Nil

Appendix B: The Guideline Review Panel

The members of the Guideline Review Panel, who oversaw the development of these guidelines, were:

- Dr Vivek Agarwal
- Dr Chris Miller
- Professor Keith Rix
- Dr Margaret M Stark

In developing the guideline, the Guideline Review Panel took account of the view expressed by members of the Faculty of Forensic and Legal Medicine following a formal consultation process.

References

1. NICE (nice.org.uk/guidance/ng10) defines 'Rapid tranquillisation' as 'Use of medication by the parenteral route... if oral medication is not possible or appropriate and urgent sedation with medication is required'. The Faculty, in common with other organisations and authorities uses the term to encompass the use of medication by the oral route. As is indicated, rapid tranquillisation in police custody should be limited to oral therapy.