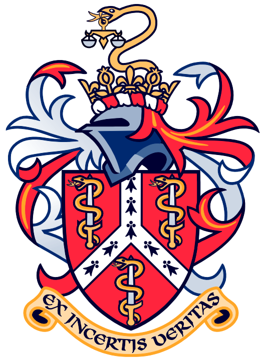

Faculty of Forensic & Legal Medicine

Acute behavioural disturbance (ABD): guidelines on management in police custody

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The medico-legal guidelines and recommendations published by the Faculty are for general information only. Appropriate specific advice should be sought from your medical defence organisation or professional association. The Faculty has one or more senior representatives of the MDOs on its Board, but for the avoidance of doubt, endorsement of the medico-legal guidelines or recommendations published by the Faculty has not been sought from any of the medical defence organisations.

This guidance is written in the following context:

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

The FFLM recognises that this is an area of clinical practice that has aroused controversy, particularly with regards to terminology. Its intention is to employ non-controversial terminology that is understood and accepted across the relevant professional groups, and which is non-discriminatory. Its intention is to provide guidance which will ensure that everyone, regardless of ethnicity or any other protected characteristic, will receive the best care available. It is our intention that the application of this guidance will reduce the need for force or restraint and ensure that, where it is necessary, the risks are minimised.

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 and is not a substitute for clinical judgement. 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 recommendation must be made by HCPs in the light of:

- available resources
- local services
- protocols and policies
- 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 research findings.

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

Cases of suspected ABD should be taken directly to the Emergency Department (ED) of the local hospital.

If a detainee exhibits any of the following signs:

- **Tactile hyperthermia (hot to touch)**
- **Constant or near constant physical activity**
- **Extreme agitation/aggression**

THIS IS A TIME CRITICAL MEDICAL EMERGENCY

What is Acute Behavioural Disturbance (ABD)?

Acute behavioural disturbance (ABD) is not a diagnosis as such. It is the 'umbrella' term for the clinical presentation of several conditions. Therefore, it is essential to consider the range of differential diagnoses. ABD may be associated with fatality even when appropriately treated, but the likelihood of successful treatment is increased with immediate appropriate medical interventions.

Clinicians should be cognisant of the problematic evolution of terminology in this field and that these historical issues may hamper communication between services. Whilst controversy surrounds the term ABD it remains a recognised umbrella term amongst front line emergency care providers/first responders including police to describe someone at high risk of potentially fatal deterioration.

It is essential that commissioned providers liaise with local ambulance service to ensure that services work together in recognising ABD as a time critical medical emergency so that delayed transfers to the ED are avoided.

The differential diagnoses of ABD include the following (either in isolation or combination):

- Akathisia (an inability to remain still, particularly affecting the lower extremities, associated with an extreme sense of unease)
- Anticholinergic syndrome (e.g. antihistamines)
- CNS infection (meningitis/encephalitis)
- Head injury
- Heat exhaustion
- Hypoglycaemia
- Hypoxia
- Neuroleptic malignant syndrome
- Psychiatric disorders
- Sedative (e.g. alcohol, benzodiazepine, GHB and related drugs, rarely, opioid) withdrawal
- Seizures
- Sepsis
- Serotonin syndrome
- Stimulant or synthetic cannabinoid receptor agonist (SRCS) intoxication
- Thyroid storm

In the past the terms ABD and 'excited delirium', or 'excited delirium syndrome' (ExDS), were sometimes used interchangeably but only about a third of cases of ABD present as having ExDS when it is defined according to features which have proved controversial and without consideration of the presence or absence of delirium.[1] Mindful of this controversy and having regard to the fact that deaths have occurred in cases where there is no evidence of delirium, we consider it more appropriate to concentrate on the recognition of ABD in general and how the sub-group most at risk of significant morbidity and mortality can be identified and managed.

Whilst in some areas, terminology has been misused and misapplied there is little doubt that some individuals have an atypical reaction associated with stimulants driving them to a 'metabolic storm' (metabolic storm in this case means a situation akin to an extreme reaction with subsequent physiological overload).

There is a risk of sudden arrest-related death[1] in patients who present with ABD. How high a risk depends on the definitions used and given the limitations of the research we do not consider it helpful to be specific.

What is important is that the Healthcare Professional (HCP) should recognise that a combination of some or all of these clinical features in someone who is acutely behaviourally disturbed represents a presentation that requires prompt and careful evaluation:

- Tactile hyperthermia ('hot to touch')
- Does not fatigue
- Naked/inappropriately clothed
- Rapid breathing
- Sweating profusely
- Disproportionate strength
- Pain tolerance
- Constant/near constant activity
- Glass attraction destruction[1]
- Not responsive to others' presence (e.g. the police)

With regard to disproportionate strength and pain tolerance it is particularly important that the HCP is aware of the subjectivity that may affect their evaluation and the risk of being influenced by racist stereotypes.

The HCP needs to try to identify those detainees who are at risk of significant morbidity and mortality in order that they can be transferred early and fully assessed and treated promptly in an ED.

As hyperthermia suggests severe physiological disruption, probably resulting from high levels of endogenous catecholamines released in response to stress or physical exertion, this should be recognised as a particularly ominous sign necessitating hospitalisation as a medical emergency.

Clinical experience in the UK suggests that the same applies to detainees exhibiting either constant, or near constant physical activity, extreme agitation, or aggression, insensitivity to irritant sprays, and other forms of restraint, such as conducted electrical devices (CED).

ABD may have a similar pathophysiology to delirium tremens which has an untreated mortality in the order of 15 – 30% and for which dehydration, seizures, hypotension, hyperthermia and restraint in the first 24 hours are poor prognostic signs.[2] With growing understanding and appropriate treatment, mortality in delirium tremens has been reduced to around 5% with treatment.

If it is concluded that the differential diagnosis includes a serious underlying medical condition, as outlined below immediate transfer to hospital as a medical emergency should be the priority.

Individuals considered to have ABD should never be taken to a custody suite but should be taken directly to the ED. However, on occasions, individuals with possible ABD will be detained by the police and taken to a police station, or ABD may develop whilst the person is detained in police custody.

At the police station the appropriately trained HCP, will be called for advice. In such circumstances, the HCP should advise that immediate hospitalisation is required and tell the police to telephone 999 for an ambulance. In the meantime, and especially if there is likely to be any delay in the attendance of the ambulance, an HCP should attend and assess the detainee.

In such circumstances, the HCP may need to take advice from a senior colleague if efforts to de-escalate the acutely disturbed behaviour have failed and some form of tranquillisation is considered necessary.

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[1] In the recent consensus statement[3] it was recommended that this should not be used to identify ABD but in research by Baldwin et al[1] it was felt to be a distinguishing feature.

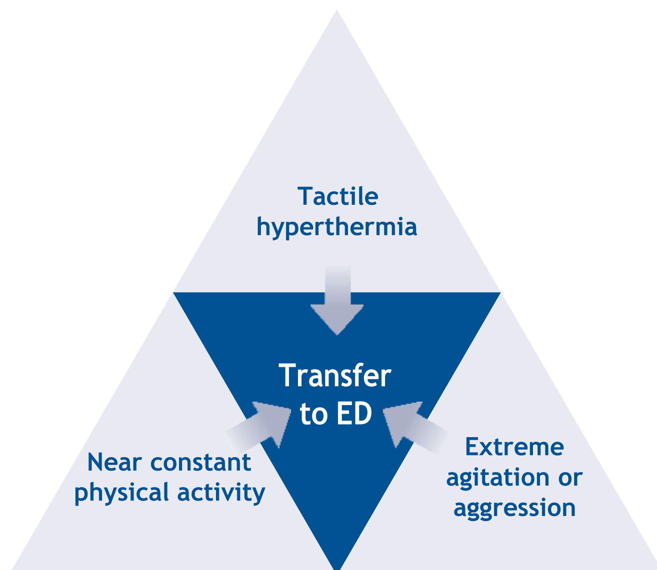
Preliminary steps – diagnosis and causation

The HCP should endeavour to establish the underlying diagnosis behind the ABD before making any treatment decision **but delay to definitive treatment (hospital transfer) should be avoided. Any detainee with altered mental status and ABD requires formal medical assessment at the hospital.**

If a detainee exhibits any of the following signs:

- **Tactile hyperthermia (hot to touch)**
- **Constant or near constant physical activity**
- **Extreme agitation/aggression**

Then immediate transfer to the ED is mandatory.



The HCP should make a telephone referral direct to the ED Charge Nurse/Consultant advising that the detainee is not fit to be detained in police custody.

The above triad has been recognised as being less vulnerable to racial or gender stereotyping.[3]

Preliminary steps: De-escalation

De-escalation is a collaborative process involving verbal and non-verbal techniques designed to reduce agitation and distress.[4] The detainee may be very frightened and/or angry. It is important to note that for severe ABD, de-escalation (and medications) may be ineffective or impossible, and the decision for immediate transfer to the ED should be made as outlined above.

In all cases, de-escalation should be attempted, but the HCP should continually risk assess the situation, given that de-escalation will not be possible or effective in all cases. The HCP should convey empathy, respect and reassurance. This is more likely if the HCP is adept at managing their own emotional response to the disturbance and presents as calm, with a non-judgmental attitude and avoidance of provocation.

Certain psychiatric and substance induced states can reduce a person's ability to communicate verbally or receive information, so it is important to:

- Keep verbal communication brief and clear
- Allow them time to express themselves/answer

De-escalation techniques such as understanding the patient's perspective, negotiation, re-framing what has happened, setting boundaries in a non-confrontational manner and distraction should be used if appropriate.[4] More psychologically based relaxation and calming techniques may also be employed if the expertise is available and the person is practiced in their use.

The HCP may want to consider utilising the environment, however limited the options, by allowing the detainee a period of time-out (to de-escalate). The location and supervision level for the detainee should be considered with safety in mind.

Pain-inducing techniques should be avoided. As well as being inappropriate in a health emergency scenario, such measures are likely to exacerbate the risks, as pain acts as a stimulus.

If de-escalation has failed to manage the disturbed behaviour, the HCP should consider giving medication.

Drug therapy in Custody

Pre-rapid tranquillisation (pre-RT) has the aim of offering oral medication to agitated patients pre-emptively to address acute disturbance and to avoid escalation and the need for parenteral medication and physical restraint.[4]

Rapid tranquillisation (RT)[4,5] involves the use of medication by the parenteral route (usually intramuscular, or exceptionally intravenous) if oral medication is not possible or appropriate and urgent sedation with medication may be required. **RT is not recommended in police custody.**

Whilst antipsychotic medication may be more effective for sedation in cases of ABD we do not recommend their use in the custody setting because of cardiotoxicity and other adverse effects.

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, 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 in this setting.

Some people with ABD are so seriously ill as to require sedation but this should only be undertaken in hospital, or by an appropriately trained paramedic and/or pre-hospital physician prior to transfer to hospital.

The aims of any form of pre-RT are threefold:

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

Pre-tranquillisation (pre-RT) may need to be considered when:

- the HCP decides that the detainee needs to be transferred to hospital and tranquillisation is required to facilitate that transfer;
- 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 pre-RT must be a reasonable and proportionate response to the risk it seeks to address but always bearing in mind that the pathophysiology of ever-increasing agitation and exertion can ultimately lead to worsening outcomes and an increased risk of sudden death.

The use of medication for pre-RT 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 pre-RT, leading to serious additive effects in terms of CNS depression. Therefore, caution needs to be employed before tranquillising any such detainee and adequate safeguards must be in place to ensure their safety.

Medication for pre-RT 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 acute dystonia (conventional antipsychotics given to those who have used stimulants), akathisia, disinhibition). A number of prescribed (e.g. methadone) and illicit drugs (e.g. cocaine) and novel psychoactive substances (e.g. synthetic cannabinoid receptor agonists) can cause QT prolongation.
- paradoxical excitation, although uncommon (less than 1% of people given benzodiazepines).
- possible damage to patient-clinician relationship
- underlying coincidental physical disorders.

The proposed treatment should be explained to the disturbed detainee, 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 they comply.

If pre-RT 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 substance intoxication or withdrawal, lorazepam is the drug of choice. The dosage should be the minimum necessary to achieve the desired effect. Failure to reduce agitation suggests tolerance and/or severe ABD and mandates the expedition of transfer to hospital.

Transfer to hospital should be by ambulance in preference; that said, if ABD is escalating and the patient is hot to touch/ hyperthermic, and the emergency ambulance is not available consideration for police vehicle transfer should be made (blue light) and pre-alert the receiving hospital.

Appropriate adjustments to dosage should be made in the case of detainees who are children, young persons, or elderly. Where the detainee fails to respond to near maximal doses as recommended in the British National Formulary (BNF) it may be more preferable and safer to consider the expedition of transfer to hospital than to prescribe in excess of the recommended maximum.

The HCP should ensure that either they or another appropriately trained HCP remains with the detainee to monitor, where possible, the level of consciousness (using ACVPU (Alert/Confused/Voice/Pain/Response) and/or/ GCS (Glasgow Coma Scale)), 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 pre-RT is ineffective or where these observations indicate a deteriorating physical condition, transfer to hospital as an emergency is mandated. Any evidence of fast respiratory rate, panting, heralds imminent deterioration.

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.

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* Ensure that an appropriately trained HCP is present to monitor the effect of the drug	If there is insufficient effect the medication drug can be repeated up to two times at hourly intervals up to a maximum dose of 4mg in 24 hours (for adults).±

* Lower oral doses are to be used in children and older adults – please seek medical advice in such circumstances.

± If the detainee is very agitated and does not respond to repeated doses of lorazepam that may indicate tolerance and an increased likelihood of potentially fatal sedative (alcohol or GHB/GBL) withdrawal; transfer to hospital needs to be expedited.

The use of medication for Rapid Tranquilisation (RT)

Medical management of ABD where the aim is not just tranquillisation but sedation, should be carried out by appropriately trained healthcare professionals in hospital with direct access to full resuscitation facilities.

Advanced care practitioners (ACP) and paramedics with enhanced skills may attend the police station to assist. These appropriately trained practitioners may have access to benzodiazepines, such as midazolam, and ketamine (use of which requires formal airway skills due to risk of loss of airway reflexes) which may be administered parenterally in order to achieve sedation. The choice of drug and dosage used for RT will then be based on the individual clinician's familiarity with the use of drugs in this setting and the attending clinician will take charge of, and be responsible for, this stage in the detainee's treatment.

Under no circumstances should a person be transported to hospital by police vehicle if they have received parenteral medication as there will be limited space and no appropriate equipment to deal with a deteriorating patient.

The use of physical restraint[6]

Restraint should be used to achieve a definitive purpose e.g. transfer to hospital/cell/vehicle and not used as a method to 'contain' the individual. The application of restraint may result in sudden cardiac arrest secondary to a rise in catecholamines and on a background of possible acidosis.

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 the specific situation, and should be applied for the minimum possible amount of time and be the least restrictive option to meet the objective. 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, developmental age, or any other significant clinical feature

The College of Policing Authorised Professional Practice provides advice for officers and staff on the principles of using force in custody and the prone position. This states that '*officers and staff should avoid using the prone restraint position unless it is proportionate to the threat and necessary in the circumstances. Officers should keep the period for which it is used to a minimum.'*

Documentation

The HCP should fully document the management of the patient including a description of the behaviour that resulted in the use of pre-RT. 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 such 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. Documentation of physical observations over time is important to establish when the condition of the detainee deteriorated and/or monitor the effects of medication provided. Where measurement of all the observations is not possible, the HCP should document why they have not been done.

Audit and review

It is essential that the management of cases of ABD are reviewed as part of the clinical governance framework, especially if RT is used in police custody. 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 pre-RT should be included in the case-based discussions which form part of many HCPs' continuing professional development. In cases where maximum BNF 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 multi professional 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.

Note:

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

The Royal College of Emergency Medicine has published Best Practice Guidelines for Acute Behavioural Disturbance in Emergency Departments' (2023) 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. See here: https://rcem.ac.uk/wp-content/uploads/2023/10/Acute_Behavioural_Disturbance_in_Emergency_Departments_Oct2023_V2.pdf

References

1. Baldwin S, Hall C, Bennell C, et al (2016) Distinguishing features of Excited Delirium Syndrome in non-fatal use of force encounters *Journal of Forensic and Legal Medicine* 41: 21-27
2. Khan A, Levy P, De Horn S. et al. Predictors of Mortality in Patients with Delirium Tremens. Academic Emergency Medicine 2008; 15: 8: 788-790 https://onlinelibrary.wiley.com/doi/10.1111/j.1553-2712.2008.00187.x
3. Humphries C, Kelly A, Sadik A, et al. Consensus on acute behavioural disturbance in the UK: a multidisciplinary modified Delphi study to determine what it is and how it should be managed. Emergency Medicine Journal 2024;41:4-12 https://emj.bmj.com/content/41/1/4.long
4. National Institute for Health and Care Excellence (NICE), 2015 *Violence and Aggression: Short-term Management in Mental Health, Health and Community Settings*
5. Patel MX, Sethi FN, Re Barnes T, et al. (2018) Joint BAP NAPICU evidence-based consensus guidelines for the clinical management of acute disturbance: De-escalation and rapid tranquillisation *J Psychopharmacology* 32: 597-636;
6. Independent Advisory Panel IAP on Death in Custody *IAP on Deaths in Custody, Restraint & Use of Force*

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

ABD Guidelines on Management in Police Custody were first produced by the Association of Forensic Physicians in 2003 (Norfolk G & Stark MM)

Further Reading

Royal College of Psychiatrists. 2022 'Acute Behavioural Disturbance' and Excited Delerium'. Position statement PS02/22

Mental Capacity Act https://www.nhs.uk/conditions/social-care-and-support-guide/making-decisions-for-someone-else/mental-capacity-act

The Resus Room Podcast Nov 2022 Acute Behavioural Disturbance; Roadside to Resus

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Patient identified as possible ABD

Pending hospitalisation
de-escalation and continued constant observation for signs of ABD

Signs of ABD?
- Tactile hyperthermia (hot to touch)
- Constant or near constant physical activity
- Extreme agitation/aggression

Yes → **Expedite emergency hospitalisation** → **Pending transfer, review and establish cause** → Offer oral Lorazepam 1-2mg (adults)

No → **Review and establish cause** → **Cause identified?**

Yes → Treat any identified causes as appropriate and safe within custody setting with low threshold for hospital transfer
NB If ABD signs or unstable, transfer to hospital is mandatory

No → **Expedite emergency hospitalisation**

Offer oral Lorazepam 1-2mg (adults)

Review, monitor and re-consider cause

>60 min passed: Offer oral Lorazepam (if max of 4mg not reached)

Review, monitor and re-consider cause

>120 min passed: Offer oral Lorazepam (if max of 4mg not reached)

Review, monitor and re-consider cause

Seek additional medical support

Pending transfer to hospital

Cases of suspected ABD should be taken directly to the Emergency Department (ED) of the local hospital.

THIS IS A TIME CRITICAL MEDICAL EMERGENCY