



Guidelines

Acute behavioural disturbance: guidelines on management in police custody

The medico-legal guidelines and recommendations published by the FFLM are for general information only. Appropriate specific advice should be sought from your medical defence organisation or professional association. The FFLM has one or more senior persons from each of the three medical defence organisations on its Board, but for the avoidance of doubt, endorsement of the medico-legal guidelines or recommendations published by the FFLM 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 and Legal Medicine, which was arrived at after careful consideration of the evidence available. Forensic physicians 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. Furthermore, it is recognised that a limitation of a guideline is that it simplifies clinical decisions appropriate to the circumstances of the individual patient, in consultation

with the patient and/or guardian or carer.

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

- available resources
- local services, policies and protocols
- the patient's circumstances and wishes
- available personnel
- clinical experience of the practitioner
- knowledge of more recent findings.

Introduction

Acute behavioural disturbance 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). Of all the forms of acute behavioural disturbance, excited delirium is the most extreme and potentially life threatening. The clinical features of excited delirium include a state of high mental and psychological arousal, agitation, hyperpyrexia associated with sweating, violence, aggression and hostility with insensitivity to pain and to incapacitant sprays.

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 forensic physician (FP) will be called for advice. In these circumstances, the FP may consider that immediate hospitalisation is required and advise the police to ring 999 for an ambulance. Otherwise, the FP should attend and assess the detainee.

In such circumstances, the doctor may have to consider tranquillisation if other approaches have failed to de-escalate the acutely disturbed behaviour. Rapid tranquillisation involves the use of medication to calm the patient, inducing a state of rest and reduction of

psychological activity in which verbal contact is maintained.

The aims of rapid tranquillisation are threefold:

- a. to reduce further suffering for the patient: psychological and physical (through self-harm or accidents)
- 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 forensic physician decides that the detainee needs to be transferred to hospital and sedation is required to facilitate that transfer
- b. it is necessary to reduce suffering for the detainee 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.

Rapid tranquilisation – preliminary steps

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

The doctor should then consider allowing a period of de-escalation (time-out) where the detainee may calm down (away from the arresting officers). The FP should avoid responding to aggression with aggression and adopt a reassuring and non-judgmental attitude.

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

The use of medication

Medication for rapid tranquilisation 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–doctor relationship
- underlying coincidental physical disorders.

There is evidence that drugs given orally can be as effective as those administered intramuscularly and, because of the greater risks associated with parenteral treatment, rapid tranquilisation in police custody should be restricted to oral therapy. The proposed treatment should be explained to the disturbed patient, as most individuals will co-operate with an oral dosing regime with appropriate support from the doctor. In circumstances where the detainee lacks capacity to consent to the treatment, the forensic physician may still administer oral medication provided the doctor considers it to be in the person's best interests and the individual complies.

If rapid tranquilisation is considered necessary, 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 should be used as the first-line drug of choice.

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.

In view of the potential risks involved in rapid tranquilisation of detainees with acute behavioural disturbance, the effect of any treatment administered should be carefully monitored. The FP needs to make a positive decision about who should monitor the detainee (i.e. doctor or an appropriately trained healthcare professional, such as custody nurse or paramedic) based on the individual circumstances of the case.

However, it is vital that FPs should also be familiar with basic first aid procedures and 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, and ensure that either they or the appropriately trained healthcare professional remain in attendance to monitor respiration, pulse and blood pressure until the situation has resolved (i.e. the detainee has been safely transferred to hospital or has fully recovered).

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 and should be applied for the minimum possible amount of time. Whenever a FP considers that restraint may be required it should be discussed with a senior police officer who should take the lead in any procedures adopted.

Rapid tranquillisation of detainees in policy custody

Step	Intervention	Notes
1	Attempt de-escalation with time out in a protected area (eg police cell) out of sight of arresting officers, etc.	Use the cooling off period to try and establish the cause of the disturbed behaviour
2	Offer oral treatment : Lorazepam 1-2mg Ensuring that an appropriately trained healthcare professional is present to monitor the effect of the drug	If there is insufficient effect, the drug can be repeated up to 2 times at 45-minute intervals, up to a maximum dose of 4mg

Appendix A: The Guideline Review Panel

The members of the Guideline Review Panel, who oversaw the development of this guideline, were:

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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 and Legal Medicine following a formal consultation process.

Produced by the Academic Committee
of the Faculty of Forensic & Legal Medicine