***Pharmacological Management of Behavioural Disturbances in Mental Health Consumers***

*Guidelines for above 18 years age group*

**Level I**

**Definition:** Aggressive behaviour monitored and controlled by the individual with clinical support. **Behaviours:** Anxiety/Agitation – non-psychotic. Mildly aroused, pacing, and still willing to talk reasonably or may be moderately aroused.

**Action:** Pre-empt and intervene early. Use Safewards interventions

**Level 2**

**Definition:** Escalation of aggression with reduced capacity to control emotions and behaviour. Clinical intervention required. Could be due to psychosis.

**Behaviours:** Verbal Aggression Not dangerous or violent: Moderately aroused, agitated, becoming more vocal, unreasonable and hostile or maybe highly aroused.

**Action:** Co-ordinate intervention. Monitor the effectiveness of continued engagement. Continue to address concerns and fears.

**Level 3**

**Definition:** Aggressive behaviour is overt and poses an imminent threat to the safety of all. Crisis intervention is required.

**Behaviours:** Violence or dangerousness is imminent or physically aggressive. Highly aroused, possibly distressed and fearful, violent toward self, others or property 0R patient refuses all medication and status is judged to be potentially aggressive or violent.

**Action:** Senior Clinician coordinates Emergency Response - Ensures safety of others in care.

**Per Oral benzodiazepines Offer one of the following:**

**Lorazepam tab** 1-2 mg every 2 hrs/TDS; max= 8mg/24hrs (If no contraindications eg. respiratory de- pression, elderly, delirium). or

**Caution re: cumulative toxicity due to longer half life**

If signs of deranged LFT or COPD, consider Loraze- pam as above or Oxazepam tab 15-30mg QID

For patients with psychosis or manic agitation: Consid- er early treatment initiation with oral antipsychotics (Refer Level 2)

Higher doses of Lorazepam / Oxazepam is permitted to treat Alcohol withdrawal states.

**Per oral Level 1 + Per oral Level 2**

Per oral Level1 Benzodiazepine

**with Oral atypical antipsychotics One of the following options**:

(Caution: See Notes)

**Olanzapine** (tablets/wafers) 5-10mg every 2 hrs ; max= 30mg/24hrs

OR

**Quetiapine Immediate release** 25-100mg TDS,

max= 200mg/24hrs on day 1; increasing by 100mg/ day, up to 400mg/day.

OR

**Risperidone** (tablets/solution) 0.5-3mg bd; max= 6mg/24hrs.

Consider for patients above 65yrs.

Use with caution in delirium/elderly patient with dementia and use lower doses.

**Parenteral options: Intramuscular**

**Injection Olanzapine** 10 IMI; May repeat after 2 hours with dose of 5-10mg, and then 4-6 hours after 2nd dose with dose 5-10mg. Maximum dose is 20mg/24hours

OR

**IMI Haloperidol** 5-10mg + IMI **Promethazine** 25- 50mg. Further doses after 4 to 6 hours ( Max dose in 24 hours - Haloperidol 20mg and Promethazine 100mg)

In Dementia BPSD or delirium:

0.5-1mg IM Haloperidol alone. **Avoid Promethazine. AVOID CONCOMMITANT ANTIPSYCHOTICS**

**See below for IMI Zuclopenthixol acetate :**

**If there is inadequate response to any of the above options or if you are considering doses exceeding limits recommended above, discuss with the Consultant Psychiatrist, who may at their discretion, recommend higher doses or suggest alternatives where indicated. The reasons for this decision should be documented in the medical notes.**

**Alert:**

**Parenteral sedation should only be administered under conditions in which monitoring of vital signs is possible including pulse oximetry, persons trained in cardiopulmonary resuscitation**

**Zuclopenthixol acetate (‘Acuphase’) - Zuclopenthixol acetate is not recommended due to long onset and duration of action, however, may be considered if authorised by consultant psychiatrist after considering the following factors:**

* **The patient is not antipsychotic naïve, previous history of requiring repeated parenteral injections and there is a previous documented history of good response**
* **Patient choice (e.g. advance statement)**
* **Administration is early in the day. Administration late afternoon onwards not recommended due onset of potentially serious adverse events later on in the evening or at night.**
* **Usual dose- 50-100 mg IMI (Dose determined by patient's age, gender, size, physical health).**
* **Should not be used as a prn medication. At least 48 hrs must lapse between 2 injections.**
* **Allow enough time to assess full response to previously administered medications (60min after IMI)**
* **Current medications to be reviewed, especially if the patient has received other antipsychotics or is on a depot antipsychotic.**
* **Dose can be repeated after every 48-72 hours to a max of 400mg over 2 weeks. The patient needs to be medically reviewed prior to each dose.**
* **Small females/elderly may require lower dose (25 mg). It is usually not used for 1st episode psychosis. Caution in patients with cardiac disease.**

**Monitoring**

**1.**

**2.**

**3.**

**4.**

**Monitor Pulse, BP, Respiratory rate, FBC,LFTs and ECG at earliest opportunity possible and document reasons if unable to monitor.**

**If respiratory rate falls below 10 per minute– treat with Flumazenil ( 0.3mg to 1mg IV, repeat at 60 sec intervals until patient is awake.– max total dose of 2mg) and initiate med call or code blue according to your site policy. Be aware of respiratory suppression due to opiates– may require Naloxone.**

**Monitor closely for acute dystonia, akathisia, neuroleptic malignant syndrome and other extrapyramidal side effects. Laryngospasm is one life threaten- ing dystonic adverse effect with antipsychotics.**

**Benztropine 2mg IMI may be required for acute dystonia ( max 6mg /24 hours)**

***aaronf***

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resuscitation ?

**Precautions**

**1.**

**2.**

**3.**

**4.**

**5.**

**6.**

**Be aware of cumulative dose of the antipsychotics and benzodiazepines. Always use the minimum effective dose.**

**Certain special groups like drug naïve patients, patients under the influence of drugs or alcohol and medically compromised /medical comorbidity may need lower than recommended dose. Seek advice from consultant psychiatrist.**

**Be familiar with the adverse effects of the drugs you prescribe.**

**These are guidelines only and treatment may need to be tailored to the individual patient as advised by the consultant psychiatrist.**

**This document is to be read in conjunction with the Management of clinical aggression policy and behavioural management of acute arousal.**

**References:**

**1.**

**2.**

**The Maudsley Prescribing Guidelines in Psychiatry 14th Edition, 2021.**

**Maxine X Patel et al: Joint BAP NAPICU evidence based consensus guidelines for the clinical management of acute disturbance: de– escalation and rapid**

CPP0133: Pharmacological Management of Acute Arousal. August 2022