Aegis

NHS Security Info

Free Download #4

Acute Behavioural Disturbance/
Excited Delirium in the ED

Acute Behavioural Disturbance / Excited Delirium

It's like trying to restrain the Incredible Hulk, the strength is unbelievable……

"He was growling with every breath he exhaled. The sound and tone didn't suggest he had difficulty breathing, more something on the inside of him, an aggression and a ferociousness that couldn't be controlled."

PC Adam Mitchell at Inquest of Olaseni Lewis

Is your ED ready?

Practically every hospital Emergency department has its tale(s) of the patient(s) with super-human strength, animal-like aggression, un-ending endurance and total insensitivity to pain, who assaulted staff and needed six or more police officers and security staff to physically retrain and sedate them.

The chances are that on many of those occasions the patients were probably experiencing a form of severe mania, known as Acute Behavioural Disturbance (ABD).

Worryingly, it is unlikely the healthcare staff or security staff involved in the care and treatment of these patients would have received any prior training in how to recognise the symptoms as ABD, or about the high risk of death to the patient if they are physically restrained or allowed to continue in a manic and violent state un-sedated. The absence of suitable training will have meant that in each case the patient's survival may have been more a matter of luck than anything else!

What is Acute Behavioural Disturbance?

Acute Behavioural Disturbance (ABD) has previously been known as Acute Behavioural *Disorder* and Excited Delirium Syndrome (ExDS) and before that, Bell's Mania.

Acute Behavioural Disturbance is an umbrella term used to describe a state of excitement, agitation and mental confusion, characterised by the sudden onset of a triad of features:

- Acute delirium
- Severe agitation/aggression and
- Hyper-adrenergic autonomic dysfunction.

ABD is now the accepted terminology adopted by the UK Police Forces, the Ambulance Services and the Faculty of Forensic and Legal Medicine, to describe **the presentation of a spectrum of behaviours, signs and symptoms that together indicate an increased risk of death occurring if the subject is physically restrained, or if the symptoms are not controlled.**

ABD is a potentially deadly, time critical, medical emergency!

ABD is a spectrum of behaviours and patients may present with varying degrees of delirium, agitation and aggression. But, at the extreme end of ABD is a condition referred to as Excited Delirium Syndrome (ExDS) and it is the most potentially life threatening, with an elevated risk of cardiac arrest, or death due to organ failure if the symptoms are not controlled and alleviated.

Note: About 1 in 3 ABD presentations are ExDS.

The longer ExDS symptoms persist, the greater the risk of death resulting; and death can happen very suddenly with little or no warning.

Sudden death occurs in around 10% of ExDs presentations at Emergency Departments.

Those who die from the condition are typically male with an average age of 36.

The causes of ABD

The cause(s) of ABD symptoms is still being understood, but ABD is most commonly associated with acute on chronic drug use, mainly cocaine and methamphetamine [ICE], PCP, LSD and synthetic drugs like MDPV, aka 'Monkey Dust', aka 'Bath Salts', or acute substance withdrawal.

The difficulty is, ABD can also be caused by serious psychiatric illness, a head injury and other medical conditions, such as hypoglycaemia (low blood sugar) or sepsis and ABD Symptoms can overlap with multiple other severe and life-threatening presentations such as serotonin syndrome and heat stroke.

There is no definitive diagnostic test for ABD, so it can be challenging clinically.

Hallmark signs and symptoms of ABD include:

- High mental and psychological arousal, impaired thinking, disorientation and incapacity.
- Acute psychosis – a loss of contact with reality e.g. seeing or hearing things that other people cannot see or hear (hallucinations) and believing things that are not actually true (delusions).
- Restless, agitated, manic, bizarre, erratic behaviour.
- Paranoia - feeling that they're being threatened in some way.
- Panicking – feeling they have to get away from someone or something that is after them.
- An attraction or aversion to vehicle headlights, glass, mirrors and other reflective surfaces.
- Nonsensical speech, incoherent babbling, shouting, screaming, howling, keening
- Aggressive, hostile, combative.
- Constant, or near constant physical activity.
- No sign of fatigue.
- Fast pulse.
- Rapid breathing.
- Hyperthermia - profuse sweating.
- Hyperpyrexia - an extreme fever, high temperature, usually more than 106°.
- Partial/total removal of clothing.
- Failure to respond to directives.
- Unexpected physical strength.
- Insensitivity to pain, including the effects of PAVA and Taser.
- Continues to resist restraint even when futile.
- Sudden tranquillity after frenzied activity or vice versa.

Note: The more of these symptoms present, the more likely it is to be ExDS.

Differential diagnoses of ABD

- Heat Stroke
- Neuroleptic Malignant Syndrome
- Serotonin Syndrome
- Thyroid Storm
- Sepsis
- Substance intoxication / withdrawal
- Hypoxia (where not enough oxygen makes it to the cells and tissues in the body)
- Hypoglycaemia (higher than normal levels of potassium in blood)
- Head Injury / Seizures
- Akathisia (restlessness and mental distress)

Early recognition is crucial

A person experiencing ExDS is highly vulnerable to the risk of dying suddenly if subjected to physical restraint. Consequently, if practicable, subjects should NOT be physically restrained and instead be permitted comparative freedom of movement within a given area, i.e. a 'contained' situation.

Any necessary physical restraint (e.g. to facilitate chemical sedation) will need to be brief.

A presentation of ExDs is often immediately obvious from the level of agitation and, more usually than not, the person is accompanied by a team of Police Officers, (i.e. having come to notice as a consequence of bizarre/dangerous behaviour and concerns about their safety and/or public safety.)

A problem is that many of the signs indicating ABD/ExDS are common to anyone behaving violently.

So, staff need to be trained to recognise the difference between ABD and a violent outburst by a patient who is drunk and just needs to sleep it off.

ABD presents a significant threat to staff safety

People experiencing ABD present a significant threat to the safety of others including, other patients, clinical staff and Healthcare Security Officers, as well as themselves, being much more likely to be violent and combative. For example, a Canadian study (2018) looking at Police Officer safety involving subjects displaying ExDS discovered:

- Subjects are overwhelmingly male, around age 30 years old, (although with the use of synthetic drugs the age can vary drastically.)
- 89% of ExDS cases were perceived to be under the influence of drugs and alcohol.
- ExDS subjects are far more violent than drunk subjects
- 82% of ExDS subjects displayed assaultive behaviour or presented a threat of grievous bodily harm or death.
- In 89% of encounters with ExDS subjects there was a struggle between the subject and officer that went to the ground.
- The more the ExDS features displayed by a subject, the greater chance of assaultive behaviour.

Verbal de-escalation unlikely to work

People experiencing ABD/ExDS are known to be extremely difficult to manage.

These patients are unlikely to have capacity to make decisions regarding medical management.

Often, people experiencing ABD/ExDS are not just agitated, they are irrational, paranoid, panicking, aggressive, combative, incoherent and just totally un-engageable.

Verbal de-escalation and calming can be effective with patients exhibiting mild to moderate ABD symptoms, but are unlikely to be effective with ExDS.

Pain compliance techniques may not work either!

People experiencing ABD/ExDS can be physically very powerful and simultaneously, relatively insensitive to pain, meaning they may not respond to painful stimuli (including the effects of PAVA and Taser) in a compliant way.

This can leave no option but to contain the person where they are until either they eventually become calm (which may not happen for hours, or at all), or else administer a sedative (i.e. chemical restraint, aka rapid tranquilisation).

Administering Chemical restraint

Some people with ABD are so seriously ill as to require immediate sedation.

Sedation is often the best way to calm a person suffering with ABD, enabling earlier investigation and and initiation of potentially life-saving treatment.

However, administering a sedative may require the subject to be physically restrained in order to facilitate an intra-muscular injection (IMI).

If physical restraint becomes necessary for that reason, it should be for the briefest time possible.

Sedation should be with intravenous benzodiazepines, antipsychotics or ketamine. If the intravenous route is not immediately available, then intramuscular administration should be used.

Early and aggressive management of hyperthermia and acidosis should be instituted and a high index of suspicion for the development of rhabdomyolysis and Disseminated Intravascular Coagulation (DIC) should be maintained.

ABD is a lot more common than you might think

Police information systems do not provide for incidents to be categorised and searched for by 'Acute Behavioural Disturbance (ABD)' and neither has the Department of Health or any other NHS body specifically required NHS Trusts to keep a record of ABD incidents (a factor being that there is currently no standardised case definition to work from.) So, the exact incidence of ABD presentations is unknown (and no agency has yet taken responsibility for recording it.)

However, there is plenty of anecdotal evidence to suggest that ABD presentations at ED are actually fairly common and also on the increase, coinciding with increasing use of prohibited drugs and an increasing incidence of mental ill health.

For example, at the beginning of his presentation at ASPiH 2018 on 'simulation training for the Management of Acute Behavioural Disturbance in the Acute Hospital', Dr. Michael Yousif, Consultant Psychiatrist at Oxford University Hospitals NHS Foundation Trust (Trent Simulation & Clinical Skills Centre) said:

"Nurses get virtually no training on ABD in Acute Hospitals, but it is very, very common, especially in A&E."

(Click on the image to view the presentation on YouTube.)

Note: Michael Yousif went on to cite research findings suggesting there are about 3.6 violent patients per 1000 attendances at ED. In 2018/19 there were 24.8 million attendances at English NHS Emergency Departments – the equivalent of 68,000 attendances each day. Doing the maths, (68 x 3.6 = 244.8), **something like 240 violent patients are attending Emergency Departments across the NHS in England every day!**

Emergency Departments need to be prepared for ABD

Over the years, a series of deaths of individuals displaying features of ABD and ExDS have occurred whilst they have been in 'police custody'. These cases attracted a lot of news media coverage and have resulted in IPCC Investigative Reports and Regulation 28 Reports by Coroners following inquests.

Relevant examples of Regulation 28 Reports include:

1. Oluseni Lewis – died 2010

2. Kingsley Burrell – died 2011

3. Michael Sweeney - died 2011

4. Rafal Delezuch – died 2012

Subsequently, in February 2014, the Crisis Care Concordat (CCC) came into being. This was a national agreement between services and agencies involved in the care and support of people in crisis and it was closely followed, the same year (2014), by the production of a Memorandum of Understanding on the Police Use of Restraint in Mental Health & Learning Disability Settings.

Then, in May 2015, NICE published (NG10) Violence and aggression: short-term management in mental health, health and community settings. This Guidance, as the title suggests, focusses on prevention, recognition and reducing the risk of violence but, strangely, it does not deal in any detail with Excited Delirium/ABD.

In fact, the NG10 Guidance, only mentions ABD/ExDS once, at 5.7.2.5:

"Healthcare provider organisations should train staff in emergency departments to distinguish between excited delirium states (acute organic brain syndrome), acute brain injury and excited psychiatric states (such as mania and other psychoses)."

However, in January 2016, the Faculty of Forensic & Legal Medicine of the Royal College of Physicians & RCEM revised and updated their 'Guidelines for the management of people with ABD in police custody' and changes to standard operating procedures were introduced in police forces across the UK to reflect new mental health procedures and training provided to help officers to be able to identify ABD in people. So, police officers are better informed about ABD than ever before.

(Note: The Guidelines were updated in 2019.)

Then, in May 2016, apparently provoked by the absence of any official guidance from NICE on ABD/ExDS, despite it being '*a very specific presentation of violence and aggression carrying significant clinical risk*', the Royal College of Emergency Medicine (RCEM) published its own Guidance on the Management of Acute Behavioural Disturbance/ Excited Delirium. This was followed, in January 2017, by the Report of the Independent Review of Deaths and Serious Incidents in Police Custody, by Rt. Hon. Dame Elish Angiolini DBE QC, (the 'Angiolini Report') was published.

Here is an excerpt from the Recommendations - Health and wellbeing – section of the Angiolini Report

20. ***Healthcare professionals should take primary responsibility for the conduct and safe management of restraint of patients in any healthcare setting.*** *This should be part of NHS and police policy. In the absence of support from other agencies the police may have to intervene with some form of restraint, but its use should be strictly limited and subject to robust monitoring and training.*

21. An NHS initiative at the national level should examine whether to prohibit the refusal of access to A&E or to health-based places of safety under section 136 Mental Health Act 1983 (section 136) on the basis of intoxication. It should also consider the redesign of A&E facilities to allow for safe areas, to protect the safety of other routine patients and staff from those suffering from severe intoxication.

(Note: The Crisis Care Concordat (CCC) states: *People intoxicated as a result of alcohol or drug misuse who have been assessed as mentally disordered or are currently being treated by a mental health service will be accepted into the designated health based place of safety. Intoxication should not be used as a basis for exclusion from places of safety, except in locally defined and agreed circumstances, where there may be too high a risk to the safety of the individual or staff*.)

22. The Government should give consideration to the viability and cost-effectiveness of drying out centres, and consider piloting a centre or centres in large urban areas where it is most likely to be cost-effective, and linking such centres to existing A&E departments. An alternative would be the fundamental redesign of A&E departments to take into account this challenging situation.

23. Joint local protocols should be established between police forces, ambulance services and hospitals to ensure appropriate medical care for intoxicated people in the appropriate environment.

A wing and a prayer just won't cut it anymore

The existence of all the case histories, the Regulation 28 Reports by Coroners following inquests and the RCEM Guidance, coupled with the predictability of ABD presentations at Emergency Departments and the elevated risk of death occurring, mean that Hospital Risk Managers cannot legitimately ignore (or defer) the need ensure Emergency Departments are appropriately prepared.

Clinical staff need ABD training

Following the Inquest into the death of Kingsley Burrell, the Coroner noted in her report:

"Medical evidence at the Inquest confirmed that Mr Burrell was suffering from Acute Behaviour Disturbance. As a result, he continued to struggle against restraint. Patients with this condition are at risk of death through prolonged restraint and struggle against restraint. Most training in relation to restraint deaths focuses on positional asphyxia. Position in this case was not a major consideration. ***It was clear from the Inquest that there was a lack of understanding of how to treat someone with Acute Behavioural Disturbance****."*

So, training Security Officers in how to physically restrain resisting patients is not on its own sufficient to mitigate the risks associated with ABD. If more lives are not to be lost, it is imperative that clinical staff working in Emergency Departments (as well as Healthcare Security Officers) receive training to be able to recognise ABD, how to treat it and how to mitigate to a minimum the dangers it presents to not only the patient, but everyone else too.

The thing is that, despite awareness of the risks, **there is currently no NHS standard training programme for ABD** and NHS Improvement has not indicated that there will be. So, the training will need to be defined by a (full and sufficient) Health and Safety Risk Assessment at each individual ED.

However, on its own, training won't be adequate preparation for ABD.

Sufficiency of numbers

NICE GUIDANCE (NG10) at 1.5.6, page 44, 'Staffing' states:

"Healthcare provider organisations should ensure that, at all times, there are sufficient numbers of staff on duty in emergency departments who have training in the management of violence and aggression in line with this guideline."

In his (2016) presentation on 'Emergency Management of the Agitated Patient', Reuben Strayer, EM practitioner at Mount Sinai Hospital in New York said **five** strong people would be required to safely restrain a patient with ExDS. One at each limb and one at the head, not including the nurse preparing and providing the medications, not including the (healthcare) provider who is attending the patient.

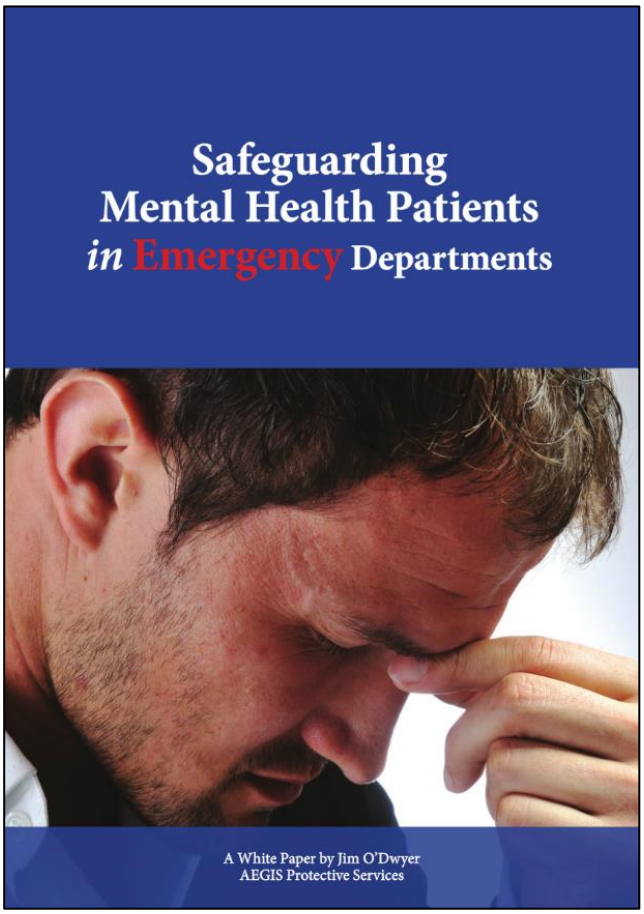
What does your Risk Assessment say about it?

I do appreciate, of course, this is an 'inconvenient and unpalatable truth' that will present a lot of Hospital Risk Managers with logistical problems but, given the likelihood of a presentation of ABD/ExDS in an Emergency Department, ensuring there is always going to be appropriate resource just in case physical restraint becomes necessary, is an unavoidable, legal requirement.

Other additional measures will be needed too

In a previous publication, I highlighted a range of additional measures that would be needed in preparation for a presentation of ABD / ExDS at an Emergency Department and, rather than repeat it all here, I will respectfully refer the reader to the publication, which can be accessed free online.

Click on the image below to open the document as a .pdf.



Other useful ABD resources

Click on the links below.

"DISRUPTION, DANGER, AND DROPERIDOL: EMERGENCY MANAGEMENT OF THE AGITATED PATIENT"
By: Reuben J Strayer, EM practitioner, Mount Sinai Hospital, New York

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"Managing Acute Behavioural Disturbance," in St.Emlyn's by: Chris Gray

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RCEM LEARNING PODCAST ON ACUTE BEHAVIOURAL DISTURBANCE (21/12/2016)
Features an interview with Cian McDermott, an Irish trained EP working on protocols and pathways for managing the agitated and aggressive patient in the ED.

RCEM LEARNING PODCAST ON ABD (Part 1) 01/12/2017
Chris Connolly and Becky Maxwell

Security in the assessment room or not?
11:29:00
Chris Connolly: "You do feel a lot safer as a member of staff with a couple of big burly chaps in the corner, but at the same time that can put people on edge I've found because of that feeling that the place is an intimidating place enough to require Doormen."

Becky Maxwell: "I think in this situation, having two security standing there is not going to stop this person getting in their Excited Delirium. They're going to get into it anyway. Having them standing there may mean they get there a couple of minutes faster but, probably in the grand scheme of things, it doesn't make that much of a difference in this condition."

Chris Connolly: "Absolutely!"

RCEM LEARNING PODCAST ON ABD (Part 2) 01/12/2017
Chris Connolly and Becky Maxwell
The two experts discuss the medication aspects of ABD.

Reality Training How to Handle Excited Delirium cases
This PoliceOne video shows a real case of ABD/ExDS and how to handle it calmly and professionally.

More info

If you would like to discuss any aspect of Healthcare Security, please contact the author:

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