- being exploited
- reputational damage
- non-adherence to treatment
- causing damage to property
- poor physical health

A risk assessment is performed by collecting information from the patient and relevant stakeholders, which may include the person's family/support system, healthcare providers (including community health workers, or social workers who have knowledge of the person's home), as well as past clinical and forensic history.

Close attention must be given to women in the perinatal period, people who care for others (e.g., parents, grandparents, teachers, and health and social care providers), and those with previous high-risk behaviour.

While the clinical judgement may not always be accurate, it should be justified by the available information. The clinical judgement serves to inform precautionary interventions, e.g., close clinical follow-up after hospital discharge with increased attention by the Ward-Based Outreach Teams (WBOT), referral to social welfare/statutory services, advice regarding a protection order, and/or further psychoeducation.

A useful clinical guideline on how to conduct a risk assessment is available at: https://www.seslhd.health.nsw.gov.au/sites/default/files/documents/SESLHDGL%20082%20-%20%20Clinical%20Risk%20Assessment%20and%20Management%20-%20Mental%20Health2.pdf

LoE:IVb[2]

16.1 AGGRESSIVE DISRUPTIVE BEHAVIOUR

16.1.1 ACUTE CONFUSION - DELIRIUM

See Section 21.2.4: Delirium.

16.1.2 AGGRESSIVE DISRUPTIVE BEHAVIOUR IN ADULTS

R45.1/R45.4-6

DESCRIPTION

Agitation may escalate to overt aggression and often manifests with restlessness, pacing, and loud or demanding speech. Aggressive behaviour includes verbally abusive language, specific verbal threats, intimidating physical behaviour, and/or actual physical violence to self, others, or property. All agitation and aggression must be considered an emergency, and violence should be prevented or minimised wherever possible.

Causes for aggressive, disruptive behaviour include:

» **Physical:** acute medical illness, delirium and its causes (See Section 21.2.4: Delirium), epilepsy (pre-, intra-, and post-ictal), intracerebral lesions, traumatic brain injury.
» **Psychiatric:** psychosis, mania, agitated depression, neurocognitive disorders (e.g. dementias, traumatic brain injury), developmental disorders (e.g. intellectual disability and autistic spectrum disorder – See Section 16.8.1 Intellectual disability), severe anxiety.
» **Substance misuse:** alcohol, cannabis, methaqualone (mandrax) intoxication or withdrawal, stimulant (cocaine, methamphetamine [tik], methcaninone [cat] intoxication, benzodiazepine withdrawal.
» **Psychological factors:** high levels of impulsivity and antagonism, hypersensitivity to rejection or insult, poor frustration tolerance, and maladaptive coping skills may contribute to aggression and rage.

CAUTION

» Psychiatric and intellectually disabled patients often have medical conditions, trauma, and substance misuse.
» **Do not assume aggressive behaviour is due to mental illness or psychological factors**

GENERAL MEASURES

» Be prepared:
  - Be aware of high-risk patients e.g. those known with previous violence, substance misuse, State patients.
  - Have a step-wise protocol available to ensure safety of the patient and all in the clinic.
  - Establish clear roles for all staff members.
  - Have a triage plan for early signs of aggression.
  - Have available backup – security, SAPS, and Emergency Medical Service (EMS).
  - Prepare a designated calming area – suitable for regular monitoring.
» De-escalate and contain:
  - Be calm, confident, kind and reassuring. Listen to the patient.
  - Maintain a submissive posture with open hands; do NOT turn your back.
  - Do NOT argue, confront delusions, or attempt to touch the patient.
» Be vigilant for delirium, medical, and other causes while calming the patient.
» Manual restraint:
  - Manual restraint refers to interventions done with hands or bodies without the use of any device, to limit a user's movement of body or limb. It is sometimes called “holding”.

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  - May be necessary to administer medication – must be respectful, controlled, kept to a minimum, and should preferably be applied by personnel of the same sex as the patient.

  - Report any injuries or death associated with the restraint to the Mental Health Review Board and health facility quality assurance department.

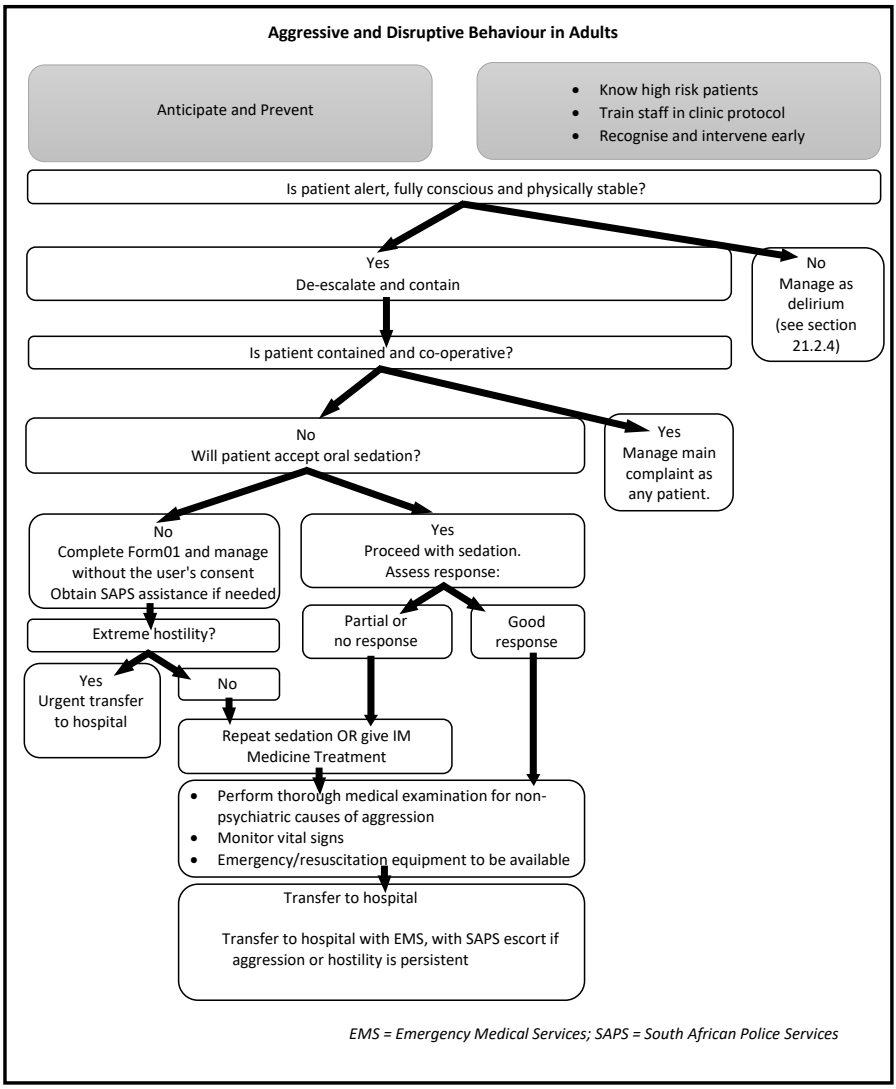
» Mechanical restraint:
  - Only use when absolutely necessary to protect the patient and others in an acute setting for as short a period of time as possible and as prescribed by a doctor. See national policy guidelines: https://www.knowledgehub.org.za/elibrary/policy-guidelines-seclusion-and-restraint-mental-health-care-users-2012

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  - Record type, sites, and duration of any restraints used, with 15-minute monitoring of vital signs, mental state, restraint sites, and reasons for use.
  - For people managed under the MHCA, complete and submit MHCA Form 48, along with reports of any injuries or death incurred, to the Mental Health Review Board and health facility quality assurance department.

» Pregnant women:
  - Never leave unattended.
  - Use restraint sparingly and with care, with mother in a supported, semi-seated position (not supine or prone).

» Counsel the family/friend/patient escort regarding:
  - Possible causes for the behaviour.
  - Reasons for restraints if used.
  - Importance of their continued support of the patient after hospital discharge.



MEDICINE TREATMENT

Oral treatment:

- Benzodiazepines, e.g.: (Doctor prescribed)
- Diazepam, oral, 5 mg immediately.

OR

- Midazolam, buccal, 7.5–15 mg immediately, using the parenteral formulation.

If response to oral benzodiazepine (after 30–60 minutes) is inadequate, or oral treatment refused, administer parenteral or orodispersible olanzapine:

- Olanzapine, orodispersible tablet or IM, 5–10 mg immediately (Doctor prescribed)
  - Repeat after 30–60 minutes if needed.

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Note:

» Use lower doses of olanzapine (2.5–5mg) in elderly, frail, or medically unwell patients.
» Repeated doses may result in excessive sedation.

If previous intolerability to olanzapine (e.g., previous neuro-malignant syndrome), administer parenteral benzodiazepine:

- Short-acting benzodiazepines, e.g.: (Doctor prescribed)
- Midazolam, IM, 7.5–15 mg immediately.
  - Repeat after 30–60 minutes if needed.

Note:

» To avoid inappropriate repeat dosing allow at least 30 minutes for the medication to take effect.

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» Do not administer IM olanzapine and IM benzodiazepines at the same time.
» Midazolam IM has a rapid onset of action (10–20 minutes) and very short duration of sedation (approximately 1 hour and 20 minutes).

Note: Long acting injectable antipsychotics e.g., flupenthixol decanoate and zuclopenthixol decanoate have no role in rapid tranquillisation.

CAUTION

» Rapid tranquillisation may cause cardiovascular collapse, respiratory depression, neuroleptic malignant syndrome, and acute dystonic reactions.
» The elderly, children, intellectually disabled and those with comorbid medical conditions and substance users are at highest risk.
» **An emergency trolley, airway, bag, oxygen, and intravenous line equipment must be available**.

If alcohol use is suspected:

ADD

- Thiamine, oral, 300 mg immediately and daily for 14 days.

Note:

» Always monitor vital signs of sedated patient:

» Vital signs: pulse, respiratory rate, blood pressure, temperature, level of consciousness and hydration.
» Monitor particularly for respiratory depression: if respiratory rate drops to < 12 breaths/minute, call doctor urgently and ventilate with bag-valve mask (1 breath/3-5 seconds) attached to oxygen at 15 L/minute.

REFERRAL

» All cases.

16.1.3 AGGRESSIVE DISRUPTIVE BEHAVIOUR IN CHILDREN AND ADOLESCENTS

R45.1/R45.4-6

As with adults, agitation among children and adolescents may escalate to overt aggression and violence. However, aggression may also occur suddenly, without warning signs, particularly in children with neurodevelopmental conditions such as intellectual disability and autism spectrum disorder. All children and adolescents should be treated respectfully and calmly, especially if seen in a busy, noisy clinic environment.

Possible causes for aggressive, disruptive behaviour include:

» **Physical:** epilepsy (pre-, intra-, and post-ictal), acute medical (e.g. encephalopathy, infection, metabolic disease, medication adverse effects) or surgical conditions, injuries (including traumatic brain injury).
» **Neuropsychiatric:** severe anxiety, distress, and/or acute or chronic traumatic stress, especially in children with neurodevelopmental disorders (which may be mild and missed clinically; See Section 16.8.1 Special considerations: Intellectual disability).
» **Substance use:** alcohol, cannabis, methaqualone (mandrax) intoxication or withdrawal, stimulant (cocaine, methamphetamine [tik], methcaninone [cat]) intoxication or withdrawal.
» **Psychological factors:** high levels of impulsivity and antagonism, hypersensitivity to rejection or insult, and poor frustration tolerance may contribute to aggression and rage.

CAUTION

» **An unsafe home, school, or community environment must always be considered**
» Children who have been abused, and/or have a neurodevelopmental or other psychiatric condition may also have medical conditions, trauma, and substance misuse.
» **Do not assume that aggressive behaviour is due to abuse, mental illness or psychological factors**

GENERAL MEASURES

» Be prepared – have in place: