Nurses with authorisation as provided by Section 56(6) of the Nursing Act 33 of 2005 may initiate and/or maintain treatment with medicines as per the STGs and in accordance with their scope of practice.

Precepts of the Mental Health Care Act (MHCA) No. 17 of 2002 include:

» All people with mental illness and/or intellectually disability must be managed under the Act and its regulations as either Voluntary, Assisted or Involuntary Mental Health Care Users.
» All registered medical practitioners, professional nurses, psychologists, occupational therapists (OTs), social workers, and registered counsellors whose training includes mental health are designated Mental Health Care Practitioners.
» At the PHC level, familiarity with MHCA Forms 01, 02, 04, 05, 07, 11, 13A, 22, and 48. An understanding of the related processes is required by all mental health practitioners.
» Specific obligations of the South African Police Service (SAPS) to protect, apprehend, and assist with transfer, people with mental illness.
» For children that present with mental health conditions at a primary care setting:
  - Identify and manage sensory impairments and underlying medical conditions.
  - Consider developmental delay and refer for educational interventions.
  - Ask about family/psychosocial stressors and/or potential abuse, and refer to social worker.

Meaning of selected terminology used in this chapter:

» **Psychoeducation** (psychological education) involves informing a patient and their family or support system about their illness and providing problem solving, communication, and assertiveness skills training. The goals are to enable understanding, self-care, crisis management, suicide prevention, and relapse prevention. Information on aetiological factors, signs and symptoms, early signs of relapse, treatment options, need for adherence to treatment, and long-term course and outcome should be provided with consideration of the individual and their family's culture, beliefs, and coping mechanisms. Myths and misconceptions regarding the illness and its treatment are identified and managed in a person-centred manner. Advice on managing difficult behaviour and emergency situations is provided, and stigma should be dispelled.

  Psychoeducation may require several individual, family, or group sessions, depending on the complexity of the illness, understanding of the problem by the individual, and their family/support system. Involvement of a registered counsellor, occupational therapist, and/or social worker is advised.

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» **Risk assessment** refers to a clinical judgement of the patient's potential for:
  - suicide or self-harm
  - aggression or violence towards others
  - being assaulted by others
  - high risk impulsive or addictive behaviour for e.g. high-risk sexual intercourse
  - severe self-neglect

- 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: