DRUG TREATMENT OF ACUTE BEHAVIOURAL DISTURBANCE IN ADOLESCENT (12-17YRS) PSYCHIATRIC IN-PATIENTS

This algorithm is a good practice guideline developed by multidisciplinary staff in NHS Lothian. You are strongly encouraged to adhere to it, circumstances permitting.

Preventative skilled management (e.g. de-escalation techniques) is obviously preferable to the use of medication. Medication prescribed in an emergency should be reviewed at least daily to prevent subsequent inappropriate escalation of dose.

Completion of the relevant Mental Health Act (MHA) documentation (consent to treatment certificate T3/T4) is required if IM medication is to be administered. If prescribed for patients who are not detained under an order authorising treatment e.g. informal patients, there must be a clear and detailed rationale documented in the notes. This must include a statement on the patient's capacity to consent to treatment. For these patients IM medication should only be prescribed as a once only dose on the front of the prescription and administration record and discuss with an approved medical practitioner (AMP) regarding requirement for detention under the MHA.

Consider non pharmacological measures first

- Consider and treat possible precipitants: metabolic problems e.g. sodium, calcium, hypoxia, hypoglycaemia; infection; urinary retention ; drug withdrawal e.g. alcohol, benzodiazepine, recent medication change
- Modify environment: one to one nursing; move to quiet side room, could family stay with patient, consider interaction of environment with patients condition e.g. Autistic Spectrum Disorder (ASD), trauma

Rationale for choice of regimens for algorithm

- Lorazepam is an appropriate choice for acute behavioural disturbance in both psychotic and non-psychotic episodes. Lorazepam is the preferred first choice if patient is already receiving another antipsychotic, in order to avoid antipsychotic polypharmacy.
- Neuroleptic naïvety is more likely in adolescents. As a patient population they are more sensitive to ADR and side effects. Olanzapine is considered most appropriate antipsychotic for acute behavioural disturbance as low risk of extra pyramidal side effects (EPSEs), little effect on QTc interval. N.B. use in the adolescent population is outside product license (off-label use)
- First choice in Learning Disability (LD) patients is usually risperidone or aripiprazole. Consider previous use and response to this and use first line in this patient group, if indicated.

Potential risks associated with antipsychotic injections

Acute hypotension; seizures (caution with antipsychotics in alcohol withdrawal as they lower seizure threshold); cardiovascular complications; respiratory complications; extrapyramidal symptoms, especially acute dystonia; CNS depression; Neuroleptic Malignant Syndrome - a medical emergency - stop antipsychotics and seek advice from Consultant or Specialist Trainee.

- Resuscitation facilities must be available as per local guidelines.
- Use the minimum effective doses to achieve symptom resolution.
- Question aetiology if no response to repeated doses. Consider referring to other guidelines e.g. Alcohol Detoxification.
- If patient loses consciousness because of administration of benzodiazepines, monitor as for a full anaesthetic procedure. Give flumazenil if respiratory rate drops below 10 per minute. Flumazenil should be given by IV injection, 200 micrograms over 15 seconds, repeated at 1 minute intervals if required; maximum total dose 1mg.
- Flumazenil has a short half-life as compared to the benzodiazepines, over-sedation and consequent respiratory depression can re-emerge.
- Procyclidine can be given for acute dystonia by IM injection, 5mg repeated if necessary after 20 minutes; maximum 20mg daily; by IV injection, 5mg usually effective after 5 minutes; occasionally 10mg may be needed.
- PRN oral and IM doses of the same medication should be written separately on the prescription sheet.
- Repeated prn doses may increase total antipsychotic daily dose above BNF maximum. Consider need for monitoring according to High Dose Antipsychotic Guidelines.
- There is no evidence of additional benefit from increasing doses of medication. Seek further advice. Consider further non-pharmacological interventions. Consider increasing security.

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ADOLESCENT (12-17YRS) PSYCHIATRIC IN-PATIENTS
ALGORITHM FOR DRUG TREATMENT OF ACUTE BEHAVIOURAL DISTURBANCE
NB TO BE USED IN CONJUNCTION WITH THE NOTES OVERLEAF

Assess situation fully including collateral history, review of past notes, current care plan etc. Try to make a diagnosis; consider concurrent medication (new or recently stopped), drug misuse or withdrawal (e.g. adequate management of alcohol and benzodiazepine withdrawal)

Consider non-drug measures: talking down, distraction and change of environment. Remember seclusion must be prescribed, may be a preferred first option in some circumstances e.g. ASD or LD

Having taken age, weight, cardiac status (has ECG been done?) and previous exposure to antipsychotics into account (consider any previous beneficial or adverse response to medication used for behavioural disturbance) a decision is made on which treatment route to use following guidance from Consultant and MDT.

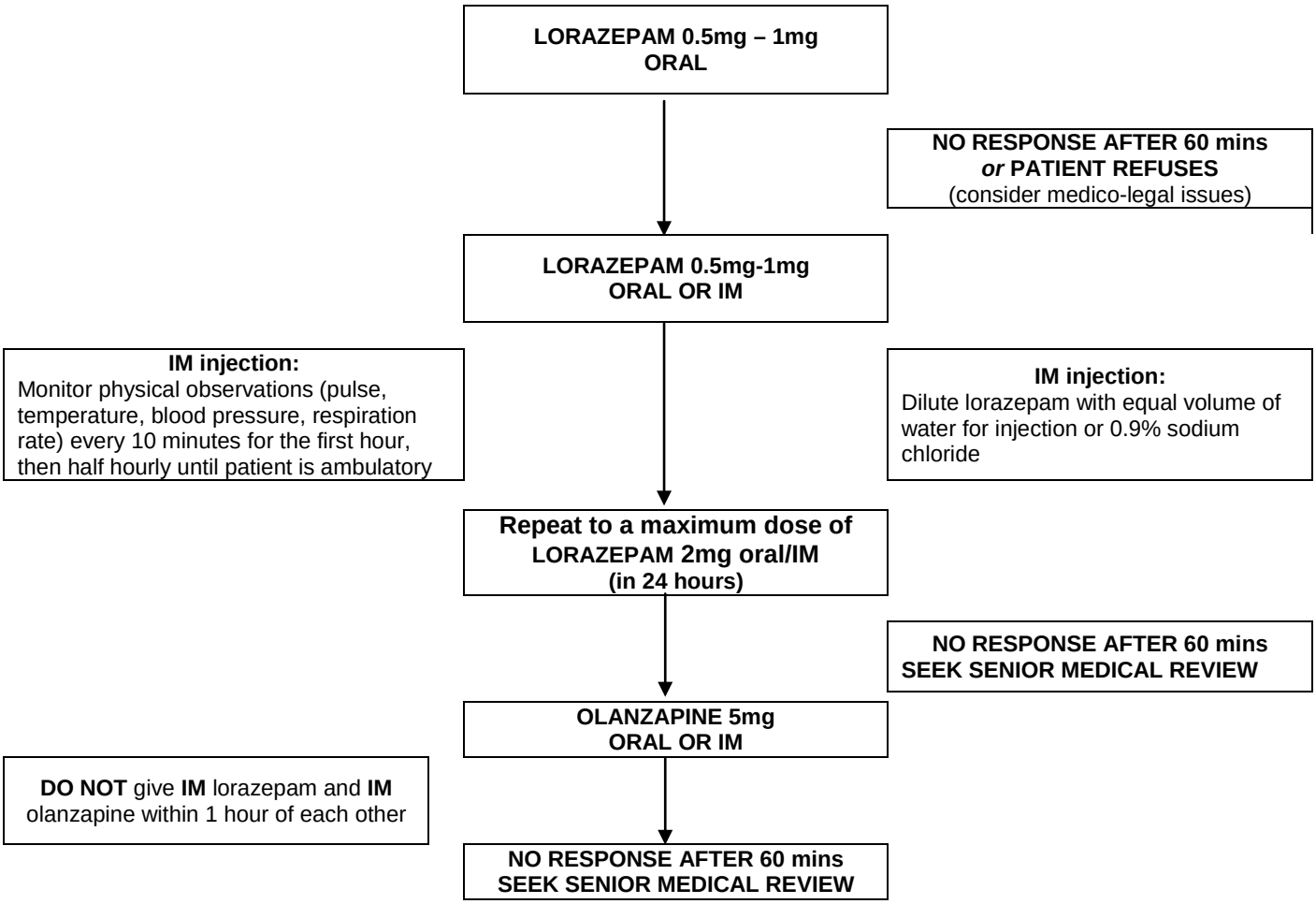
Choice of therapy

Consider care plans in place, use of already prescribed as required medication, any previous good effect from other medications. If good clinical reasons exist to consider either algorithm choice not suitable then discuss with Consultant Psychiatrist for alternative treatment strategies.

An appropriate dose of medication should be selected according to patient age, weight and diagnosis. Do not prescribe a dose range on the prescription; select the most appropriate dose for the specific patient.

Route of administration

IM is only indicated if oral medication is refused (consider medico-legal issues e.g. common law or MHA). However, if given, then use the same doses as oral. **DO NOT** give IM lorazepam and IM olanzapine within 1 hour of each other.



REMEMBER

- This is a general guideline- your patients have *individual* problems
- Seek and manage precipitants
- Try to modify the environment
- Give medication time to work

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