Complex Acute Severe Behavioural Disturbance - impact and issues

A/Prof Sally McCarthy
Medical Director NSW Emergency Care Institute
Clinical Lead Whole of Health Program
Sydney ASBD workshop
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ASBD Definition

Acute Severe Behavioural Disturbance:

*Behaviour that puts the patient or others at immediate risk of serious harm*

*May include threatening or aggressive behaviour, extreme distress, and serious self-harm which could cause major injury or death*
Scope of the problem

- Concerns raised by the community
- Concerns raised by emergency departments, pre-hospital services, police
- Impacts: on patients, staff, families
- ASBD predominantly associated with alcohol, methamphetamine and other drugs, and mental health presentations
- Data not comprehensive, however is consistent
I CAN’T FIGHT FOR YOUR MATE’S LIFE
IF I’M FIGHTING FOR MINE
"It required six wardsmen, myself and two doctors to restrain the patient and get a drip into her so we could anaesthetise her and get her to sleep ... and even then we gave her enough of the drug that it would have put a horse to sleep. It was that much."

Mr Stanton is a veteran of the heroin epidemic of the late 1990s. He remembers the emergence of ecstasy and speed.

He says he never feared heading out on shift to treat drug patients. Not until the rise of ice.

"This is one of the worst drugs I've seen as a paramedic. There is no safe level of this drug," he said.

"We've had quite a few colleagues who have been assaulted due to methamphetamine taking."

"The violence comes out of nowhere — unpredictable, superhuman strength."

Paramedic Julie Hughes
Most emergency doctors and nurses have been threatened by drunk patients. Ninety per cent of emergency staff have been assaulted while on duty.

Nine out of 10 emergency department (ED) nurses and doctors have been physically threatened or assaulted by drunk patients, while almost all ED staff have been verbally abused, according to a new report.

Violence in emergency departments: under-reported, unconstrained, and unconscionable

Marcus P Kennedy

Violence in health care: the contribution of the Australian Patient Safety Foundation to incident monitoring and analysis

Klee A Benveniste, Peter D Hibbert and William B Runciman

• AIMS analysis highlights the importance of understanding the contributing and precipitating factors in violent incidents, and supports a variety of preventive initiatives, including de-escalation training for staff; violence management plans; improved building design to protect staff and patients; and fast-tracking of patients with mental health problems as well as improved waiting times in public hospital emergency services.
Emergency Department environment

- 24/7 activity
- Crowded
- Bright lights, noise
- All age groups, all illnesses
- A stressful time for patients and families
- Not designed for calm, privacy, security
Challenges identified by NSW EDs 2013

Figure Q10: The top challenges as they relate to your Emergency Department

- Access block: 39%
- Increased demand for services: 29%
- Inefficient hospital systems/poor communication: 27%
- Introduction of NEAT: 26%
- Lack of staff: 23%
- Overcrowding: 20%
- Lack of senior clinicians: 18%
- Transfer of patients: 16%
- Mental health: 13%
- Health bureaucracy: 13%

Source: NSW Emergency Care Institute Stakeholder Survey 2013
Challenges identified by EDs

Table 10.3 Top challenges – Met / Rural and regional

<table>
<thead>
<tr>
<th>Challenge</th>
<th>Rural/Regional</th>
<th>Met</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access block</td>
<td>3</td>
<td>1</td>
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<tr>
<td>Increased demand for services</td>
<td>4</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Inefficient hospital systems/poor communication</td>
<td>6</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Introduction of NEAT</td>
<td>9</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Lack of staff</td>
<td>1</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>Overcrowding</td>
<td>10</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Lack of senior clinicians</td>
<td>5</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>Transfer of patients</td>
<td>2</td>
<td>14</td>
<td>8</td>
</tr>
<tr>
<td>Mental health</td>
<td>7</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>Health bureaucracy</td>
<td>12</td>
<td>10</td>
<td>10</td>
</tr>
</tbody>
</table>

Source: NSW Emergency Care Institute Stakeholder Survey 2013
Managing patients with ASBD: Issues raised frequently

- Threatening for staff and other patients
- Variability of medication used for sedation
- ED environment problematic
- Difficulty accessing emergency detox and rehab
- Often “no bed” for patient post-ED
- Searches, seclusion and restraint issues
- Few on-site staff in small hospitals
- Transfers: difficult to co-ordinate all services
- Competing police and ambulance duties
- Prolonged LOS in EDs
- Multiple similar patients concurrently
- No face-to-face mental health clinician in most MPS
Violence fears at hospital

Clare Kenyon

The Health Department says regular police patrols are not needed at Kalgoorlie Hospital, despite figures revealing a “code black” occurring an average of once a fortnight at the hospital’s emergency department.

“We have a zero-tolerance policy across the WA Country Health Service on violence or aggression towards staff,” he said. “Staff are provided with training on how to manage aggressive patients. Police are called to assist when patients with known violent tendencies present at the ED… and would occur to what’s already happening, despite a hugely growing problem,” he said.

“The ANF believes significant measures such as having separate drug tanks or isolation areas attached to hospitals staffed by both medicos and police should be considered for the worst-affected hos-
Alcohol

Figure 1. Total weekly counts of Emergency Department presentations for alcohol problems, for 2016 (black line), compared with each of the 5 previous years (coloured lines), persons of all ages, for 59 NSW hospitals.
“Nothing’s changed,” – 18 months on and violence in the ED is still too common

Over a year ago the largest survey of alcohol harm in Australasian emergency departments (EDs) was carried out by the Australasian College for Emergency Medicine (ACEM). It revealed the devastating impact that alcohol was having on patients and clinicians.

Today, as the peer-reviewed survey is published in the Medical Journal of Australia, many doctors and nurses in Australia and New Zealand are still suffering from the unacceptable burden of alcohol-fuelled violence.

“We still see terrible things on a Friday and Saturday night or even during the week, nothing’s changed,” says Dr Andrew Walby, Director of the Emergency Department at St Vincent’s Hospital Melbourne, “There’s a lot of alcohol fuelled assaults happening out there, it seems like just as many as before.”
Study links ice to violence

May 7, 2014

The study, published in the journal *Addiction*, found only 10 per cent of the users were violent when they were not taking the drug, but 60 per cent were violent when they used the drug heavily.

"We found that the drug dramatically increases the risk of violence," Dr McKetin said. "It is clear that this risk is in addition to any pre-existing tendency that the person has toward violence."

Dr McKetin said heavy ice use altered the chemicals in the brain that are responsible for controlling emotions such as aggression.
Drug ice fuelling violent crime, funding international gangs, harming communities: Australian Crime Commission

By political reporter Matthew Doran
Updated 25 Mar 2015, 8:02pm

Violent crime is on the rise, gangs are raking in profits and "untold" harm is being done to communities because of the increased use of the "mind-eating" drug ice, according to a national report.

The Australian Crime Commission's report is the first to paint a picture of the growing crystal methylamphetamine problem across the country.

"Of all illicit drugs, the Australian Crime Commission report assessment is that methylamphetamine, and in particular the crystalised form, commonly known as 'ice', is the most dangerous and the highest risk

PHOTO: Australia's growing addiction to ice has serious consequences, as a new report details. (AFP)
Methamphetamine user profile

- At risk occupations and industries
- Peer communities
- Indigenous communities
- Socially disadvantaged
- Experimentation
Key drivers for demand

- Availability
- Affordability
- Purity and potency
- Social factors
**Physical and Psychological Effects of methamphetamine**

<table>
<thead>
<tr>
<th>Low dose</th>
<th>High dose</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Physical</strong></td>
<td><strong>Physical</strong></td>
</tr>
<tr>
<td>- Increases in systolic and diastolic blood pressure</td>
<td>- High blood pressure</td>
</tr>
<tr>
<td>- Sweating</td>
<td>- Rapid or abnormal heart action</td>
</tr>
<tr>
<td>- Palpitations</td>
<td>- Seizures</td>
</tr>
<tr>
<td>- Chest pain</td>
<td>- Cerebral haemorrhage</td>
</tr>
<tr>
<td>- Shortness of breath</td>
<td>- Jaw clenching and teeth-grinding</td>
</tr>
<tr>
<td>- Headache</td>
<td>- Nausea, vomiting</td>
</tr>
<tr>
<td>- Tremor</td>
<td></td>
</tr>
<tr>
<td>- Hot and cold flushes</td>
<td></td>
</tr>
<tr>
<td>- Increases in body temperature</td>
<td></td>
</tr>
<tr>
<td>- Reduced appetite</td>
<td></td>
</tr>
<tr>
<td><strong>Psychological</strong></td>
<td><strong>Psychological</strong></td>
</tr>
<tr>
<td>- Euphoria</td>
<td>- Confusion</td>
</tr>
<tr>
<td>- Elevated mood</td>
<td>- Anxiety and agitation</td>
</tr>
<tr>
<td>- Sense of wellbeing</td>
<td>- Performance of repetitive motor activity</td>
</tr>
<tr>
<td>- Increased alertness and concentration</td>
<td>- Impaired cognitive and motor performance</td>
</tr>
<tr>
<td>- Reduced fatigue</td>
<td>- Aggressiveness, hostility and violent behaviour</td>
</tr>
<tr>
<td>- Increased talkativeness</td>
<td>- Paranoia including paranoid hallucinations</td>
</tr>
<tr>
<td>- Improved physical performance</td>
<td>- Common delusions including being monitored with a hidden electrical device, and preoccupation with ‘bugs’ on the skin</td>
</tr>
</tbody>
</table>
Methamphetamine: Impact on the health system

- Community
- Pre-hospital, ED and hospital services
- Rehabilitation and AOD services
- High risk behaviours, HIV impact
- Pathway from occasional use to dependence
As a mother of a daughter with an ice addiction I felt helpless and alone. You can't talk to anyone because you feel shame and there are not enough resources to help. The pressure being placed on families is immense. Do I throw my child out of her home thereby condemning her to a life of homelessness and crime? She has an addiction to a vile drug and they can't just stop no matter how many threats are made against them.  

Our son is a recovering Ice addict, he is well now but we have been through 14 years of hell. There have been car accidents, suicide threats and attempts and, of course, as with the great majority of addicts theft from us and his siblings. Our other two children have been distressed by seeing the impact of our son's behaviour on us as his parents. The emotional toll of trying to keep him alive has been enormous for me and I suffered an emotional breakdown. I continue to struggle with depression and anxiety.  

The police attended a situation where a 17 year old and friends as young as 14 were breaking into cars at 6.00 am to purchase Ice. When confronted the boy attacked anyone coming close to him with a machete. I wrote to crime stoppers and the local council advising this house was a danger to the community. No response. I believe the young man living there could have been helped with his addiction, removing the supply from our area.  

Ice use by our 29 year old son has had a devastating effect on our family. This is the worst thing to ever happen to anyone, it just destroys everything, and your whole life is just chaos. We have had lots of things we have worked hard for smashed or broken, with holes punched in walls and doors. There seems to be no end to it all and it's very frustrating when there is no help and no one to turn to for help.
Effects of methamphetamine on users

- Social isolation
- Shame
- Hopelessness
- Family
Figure 3.1: Annual number of hospital separations where the principal or additional diagnosis was methamphetamine related \(^{254}\)
Figure 1.1: Methamphetamine-related Emergency Department presentations, by sex, persons aged 16 years and over, 59 NSW hospitals, 2009 to 2014
Figure 1.2: Methamphetamine-related Emergency Department presentations by age group, persons aged 16 years and over, from 59 NSW hospitals, 2009 to 2014

- 16-34 years
- 35-54 years
- 55+ years

Number of presentations over time.
Figure 1.3: Methamphetamine-related Emergency Department presentations by admission status*, persons age 16 years and over, 59 NSW hospitals, 2009 to 2014

- Admitted
- Not admitted
Methamphetamine related ED presentations

Table 1.3: Methamphetamine-related Emergency Department presentations by admission status*, persons age 16 years and over, from 59 NSW hospitals, 2009 to 2014

<table>
<thead>
<tr>
<th>Year</th>
<th>Admitted</th>
<th>Not admitted</th>
<th>Total</th>
<th>% admitted</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>124</td>
<td>270</td>
<td>394</td>
<td>31.5</td>
</tr>
<tr>
<td>2010</td>
<td>189</td>
<td>432</td>
<td>622</td>
<td>30.4</td>
</tr>
<tr>
<td>2011</td>
<td>266</td>
<td>672</td>
<td>941</td>
<td>28.3</td>
</tr>
<tr>
<td>2012</td>
<td>427</td>
<td>1032</td>
<td>1467</td>
<td>29.1</td>
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<tr>
<td>2013</td>
<td>665</td>
<td>1451</td>
<td>2134</td>
<td>31.2</td>
</tr>
<tr>
<td>2014</td>
<td>963</td>
<td>1897</td>
<td>2963</td>
<td>32.5</td>
</tr>
</tbody>
</table>

*Admission status was missing in 1.5% of records so numbers in “Admitted” and “Not admitted” columns may not add up to the total number of presentations.
Methamphetamine-related hospital admissions, by metropolitan Local Health District of Hospital, persons aged 16 years and over, NSW, 2009-10 to 2014-15

Notes:
• Data for 2014-15 are preliminary
• St Vincent’s Hospital is included in South Eastern Sydney
• The number of admissions can be affected by availability of services
### Number of methamphetamine-related hospital admissions, by hospital*, persons aged 16 years and over, NSW, 2014-15

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Number of admissions 2014-15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nepean Hospital</td>
<td>379</td>
</tr>
<tr>
<td>St Vincent's Hospital, Darlinghurst</td>
<td>367</td>
</tr>
<tr>
<td>Private hospitals in Eastern Sydney LHD</td>
<td>294</td>
</tr>
<tr>
<td>Hunter New England Mater Mental Health Service</td>
<td>250</td>
</tr>
<tr>
<td>Royal Prince Alfred Hospital</td>
<td>208</td>
</tr>
<tr>
<td>Concord Hospital</td>
<td>206</td>
</tr>
<tr>
<td>Liverpool Hospital</td>
<td>206</td>
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<tr>
<td>Prince of Wales Hospital</td>
<td>177</td>
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<tr>
<td>Fairfield Hospital</td>
<td>146</td>
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<tr>
<td>Belmont Hospital</td>
<td>138</td>
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<tr>
<td>Royal North Shore Hospital</td>
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<tr>
<td>Campbelltown Hospital</td>
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<tr>
<td>Shellharbour Hospital</td>
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<tr>
<td>Wyong Hospital</td>
<td>103</td>
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<tr>
<td>Westmead Hospital</td>
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<tr>
<td>Wollongong Hospital</td>
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<tr>
<td>St George Hospital</td>
<td>74</td>
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<tr>
<td>Cumberland Hospital</td>
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<tr>
<td>Maitland Hospital</td>
<td>71</td>
</tr>
<tr>
<td>The Tweed Hospital</td>
<td>69</td>
</tr>
</tbody>
</table>

* the 20 hospitals in NSW with the highest number of admissions where methamphetamine use was recorded
Methamphetamine-related hospital admissions, by rural Local Health District of hospital, persons aged 16 years and over, NSW, 2009-10 to 2014-15

Notes:
• Data for 2014-15 are preliminary
• Albury Base Hospital is not presented
• The number of admissions can be affected by availability of services
ED MH Presentations and ASBD

- ASBD evident in 12.5% of total mental health cases
- 14% of presenting males and 11% females have ASBD

Martin Davis CNC MHECS WNSWLHD
ABSD in MH patients in ED

- Only 1 in 13 cases of ASBD does not involve initial verbal abuse
- ASBD patients are intoxicated in 50% of cases
- The majority of patients are mentally disordered rather than mentally ill
- Age range from 18 to 53 years of age
- Patient physical restraint sees 1 in 30 cases resulting in staff injury*
- 1 in 252 leads to patient injury*
- Average length of stay just over 6 hours

Primary Diagnosis in MALE presentations

- 49% Personality disorder
- 26% Depression
- 10% Psychotic illness
- 5% Drug use disorder
- 3% Mania
- 1% Dementia
- 1% ADHD
- 5% ETOH dependence
Primary Diagnosis in FEMALE presentations

- 54% Personality disorder
- 26% Depression
- 13% Psychotic illness
- 4% ETOH dependence
- 2% Mania
- 1% Drug use disorder
Suicidal Vs Homicidal Thinking in Mental Health

- 67% have thoughts to Suicide or have harmed themselves
- 0.5% of patients have thoughts to harm others
- 33.5% have no thoughts to harm
Intoxicated presentations

Males
- 42% Intoxicated
- 58% Not intoxicated

Females
- 34% Intoxicated
- 66% Not intoxicated

Martin Davis CNC MHECS WNSWLHD
Type of Intoxicant

- 57% ETOH
- 24% THC
- 15% ICE
- 4% Prescription drugs
Rates of admission to Mental Health Units

- 69% Discharged after MH review
- 27% Admitted to MHU
- 4% Discharged after MPS overnight stay

Martin Davis CNC MHECS WNSWLHD
Average LOS of patients in ED 14/15 and YTD

Hospitals

Hours

MH YTD
MH Last year
D&A YTD
D&A Last year
All ED pts YTD
All ED pts Last year
Conclusion

- ASBD is becoming more frequent
- EDs not set up to manage ASBD patients in line with current best practice
- Delays, and lack of streamlined services and processes for this group of patients
- More broadly, need appropriate resources and pathways for “dual diagnosis” presentations
- Need to think from community through to destination for definitive care and ongoing care
Violence in health care: the contribution of the Australian Patient Safety Foundation to incident monitoring and analysis

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- AIMS analysis highlights the importance of understanding the contributing and precipitating factors in violent incidents, and supports a variety of preventive initiatives, including de-escalation training for staff; violence management plans; improved building design to protect staff and patients; and fast-tracking of patients with mental health problems as well as improved waiting times in public hospital emergency services.
Clinical Guideline

Emergency Department Physical Assessment for patients with a primary mental health problem

Name: Patient's Details (or sticker)
Age: ______________________
DOB: ______________________
Address: ______________________

Brief description of presenting problem

__________________________________________________________________________

Physiological Observations

<table>
<thead>
<tr>
<th>Heart rate</th>
<th>BP</th>
<th>Temp.</th>
<th>Resp. Rate</th>
<th>O2 Sats</th>
<th>BSL</th>
</tr>
</thead>
</table>

☐ Orientated to: Time, Place, Person

Comments: ________________________________________________________________

Meets low risk criteria (all required)
☐ Age 15-66 years (60 for Aboriginal patients)
☐ No altered level of consciousness (e.g. no delirium)

Purpose
To provide a standardised, evidence based approach to the physical assessment of people presenting to the Emergency Department (ED) with a primary mental health problem.

Key Principles
People with mental illness often experience high levels of complex medical comorbidity and poorer health outcomes.
People with mental illness are entitled to quality, evidence based care and treatment for all aspects of their health, including their physical health.
Physical assessment of people presenting to the ED with a primary mental health problem should be guided by history and specific presenting symptoms and will vary from a brief examination including physiological observations and history through to a comprehensive work-up.
The aim of the ED physical assessment is to reasonably exclude a physical health issue as...