PHARMACOLOGICAL MANAGEMENT OF ACUTE DISTURBANCE`

3rd & 10th November 2023

CMHP
College of Mental Health Pharmacy

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Meet our Course Trainers

BERNARD J. FOX

JULES HASTE

LAURA WOODS

CAROLINE PARKER

JAMES MCCARTHY

BERYL NAVTI

House Keeping

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- Please mute your computer, unless speaking
- Ensure the name on zoom is your registered name (for the certificate)
- Cameras on please (if it does not affect your connection)
- Use the chat option to ask questions for the speakers – which will be addressed at the end of each presentation
- We will have tea breaks, lunch breaks and breakouts groups.

Course Programme

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Friday 3rd Nov

1.00pm - 1.30pm	Introduction to the day and the patient experience of acute disturbance	Jules Haste & Bernard Fox
1.30pm – 2.00pm	Restrictive practice legal, ethical issues and de-escalation techniques	Laura Woods
2.00pm – 3.00pm	Evidence for the use of oral and IM RT medication in acute disturbance. Including time for Q&As	Caroline Parker
3.00pm – 3.30pm	Pharmacokinetics of oral and IM RT medicines	Jules Haste
3.30pm – 3.45pm	*Tea Break*	
3.45pm – 4.15pm	Adverse effects and risks associated with medication used in acute disturbance (HDAT risks)	Jules Haste
4.15pm – 5.00pm	Clinical scenarios	Caroline Parker & Jules Haste

Friday 10th Nov

1.00pm - 2.30pm	Use of oral and RT medication in special populations Including time for Q&As	
	→ Pregnancy	Caroline Parker
	→ Learning Disabilities	James McCarthy
	→ Children and Adolescents	Beryl Navti
	→ Older age and frailty including dementia	Beryl Navti
	→ Pre-hospital and acute hospital settings	Jules Haste
2.30pm – 3.00pm	Other interventions including the use of Acuphase for acute agitation	James McCarthy
3.00pm – 3.15pm	*Tea Break*	
3.15pm – 4.00pm	Clinical scenarios including comfort break → Practical scenarios including switching, next choice and the administration of medication	Jules Haste, James McCarthy & Beryl Navti
4.00pm – 4.45pm	→ Monitoring of physical health, review of response and debriefing	Laura Woods
4.45pm	Questions, Summary & Close	Jules Haste

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A Patient's Perspective

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A Patient's Perspective

BERNARD J. FOX

Bernard suffered his first major psychotic episode in 2004. Sectioned, he spent time both in PICU and Acute care. Over three main admissions, Bernard has had direct experience of two PICUs and four Acute Wards. Since joining the NAPICU Executive Committee over a decade ago, Bernard has visited numerous PICUs across the country with NAPICU interest in mind. Bernard has been involved in NAPICU's collaboration with BAP (Rapid Tranquillisation Guidance) Design in Mental Health and the NAPICU/RCPSYCH PICUS Accreditation scheme. Most recently assisting the UEA with Psychology training and examination. Fervently pro uniform for Hospital settings he remains very keen to share his experience where it might help to improve Patient/Care providers outcomes and job satisfaction.

A Patient's Perspective

Patients so acutely disturbed to be considered for RT are **extremely fearful** of almost anything they cannot easily understand. All comparisons are likely iniquitous; **trust** in almost everything is virtually impossible. Worse still, if such **fragility of trust is dashed**, this can **lead to aggression, or even violence**. This emphasises the importance that RT should only be used when severe disturbance, aggression or violence is deemed to be imminent. Within this context, we consider how we might most effectively bring about a **calmer state** avoiding further harm to the patient, others or objects.

To be rapid, the efficacy of tranquillisation is fostered by the route of least ambiguity, measured by the willingness of both the patient and clinician to engage. Deviation from a clear simple approach may have the effect of loading years to the process of recovery.

Consequently, **listening and careful observation** of the patient and environment are advised as this may yield clues to what triggered the **heightened anxiety**. Recent change of people or objects may be exacerbating factors and addressing these may help calm the patient. Extreme care in introducing **no more anomalies is advised.** Ideally, changes should be explained by whoever is **considered most trusted** and a **single communicator** will reduce confusion.

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A Patient's Perspective

However stressful the situation becomes, clinicians should be **easily identifiable, well trained** and **presenting positively** and confidently in their actions as **lack of confidence** will exacerbate the anxiety of the patient.

Further, only medicines and routes of administration that clinicians are **confident** and sure of should be used. Lack of confidence can reduce effectiveness. **Communication** with the patient as soon as is sensible is key and should include an explanation of the procedure they have been through and why, with great care given to **instil feelings of hope**. Carefully tailored reward for **patient participatio**n towards manageable and **sustainable goals** can be considered.

Post-treatment sharing of both patient and clinician experience is essential to evolve improved specific and general protocols. Clinicians from **all disciplines** across all health services should share common practices (Allen et al., 2003; NICE, 2012) as this will result in **fewer patient presentations through greater understanding**.

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What Do Consumers Want and Need

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- Patients want to be listened to, spoken to, treated with respect and given oral medication of their choice
- Rated distraction highly, such as art or music and access to staff they knew and spiritual counsellors
- Preferred space to be able to walk about and access to food & drink
- Although over 50% wanted medication they complained of forced administration and unwanted side effects
- Benzodiazepines were preferred option, haloperidol the least preferred option
- Supported increased use of advance directives and care planning around what helps them
- Allen MH, Carpenter D and Sheets JL (2003)
  What do consumers say they want and need during a psychiatric emergency?
  J Psychiatr Pract 9: 39–58.