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|  <p>PRIMARY HEALTH CARE/SHARED CARE MENTAL HEALTH PRACTICE GUIDELINE</p> | Practice Guideline: Management of Behavioural Emergencies Toolkit (ADULT) | Guideline Number PCPG #14 |
| | Approved By: Community Primary Care Council | Pages: Page 1 of 10 |
| | Approval Date: November 9, 2016 | Supersedes: September 22, 2016 |

1.0 INTENT:

- To identify the prevention and management of behavioural emergencies in the Adult population based on evidence informed practice. This guideline does not cover suicide prevention, or the Provincial Healthcare Violence Prevention Program, but is aligned with and developed in accordance with regional work that is currently underway.
- To develop and maintain an individual / family / caregiver Wellness Recovery Action Plan© with the focus towards self-management to prevent, detect and treat further episodes and optimize functioning and coping.
- To provide a consistent response to address an individual's behavioural emergency. To establish a course of prevention and treatment within an interprofessional team that both supports and manages a behavioural emergency in any environment (includes primary care setting and midwifery services).
- To apply the least restrictive possible method over the shortest period of time and within the context of the individualized plan of care and aligned with the [WRHA Restraints Minimization Acute Care Facility Policy 110.000.025](#) ^{2,3}

NOTE: The behavioural emergency would not provide the response in a Primary Care Clinical Setting or Midwifery service as outlined in the [WRHA Moderate \(Conscious\) Sedation \(Adult\) Policy 110.000.010](#)


- To reduce the risk of harm to individual / staff by promoting clinical team learning opportunities from these events which are aligned with an evidence informed framework to support a non - blaming approach during defusing and event reviews.

2.0 DEFINITIONS:

Behavioural Emergencies: Also known as a 'behavioural crisis', a 'psychiatric emergency' or individuals exhibiting 'challenging responsive behaviours'. A behavioural emergency is a series of events and a combination of circumstances in which a person appears to be impaired in judgement and / or exhibiting highly disturbed mental or physical behaviours. It is a situation that may involve serious and imminent risk to the health and / or safety of the person or another person.⁴ These behaviours can arise from underlying physiological (e.g. head injury, malignancy) or mental health (e.g. acute psychotic state) problem, or from an intoxication (e.g. alcohol or amphetamines). The risk of harm can be exacerbated by the environment (over-stimulation) or interactions with others (including treating staff).^{1,5}

De-escalation: An umbrella term referring to the defusing of an agitated individual into a calmer state with the intention of preventing an occurrence of violent or challenging behaviour. It may involve the use of strategies (i.e., verbal de-escalation, physical restraint, seclusion, or pharmacological interventions) with the goal of resolving a potentially violent and/ or aggressive incident. Wherever possible the goal is to avoid more coercive strategies in favor of verbal de-escalation which is defined as using communication techniques to reduce the person's distress so that discussion and problem-solving become possible.^{2,3}

Defusing: An important check in with all clinic team members involved after an event / incident (i.e. code white). The purpose is for the team to provide emotional support to each other to facilitate a return to pre-crisis status, discuss openly about any immediate safety concerns and identify any injuries or near misses and determine who will complete the necessary reporting and / or documentation. Ideally, this would occur immediately post event.

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|--|---|--|
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| | Approved By: Community Primary Care Council | Pages: Page 2 of 10 |
| | Approval Date: November 9, 2016 | Supercedes: September 22, 2016 |

Delirium: An acute disturbance of consciousness, attention, cognition and perception, commonly due to an organic (physical) cause that is treatable and associated with challenging behaviour. Although it can occur in all age groups, it is most common among older people, and is often overlooked or misdiagnosed. Delirium is predictable, preventable and treatable.⁵

Event Review: A collaborative process to review a patient event, discuss interventions used, and interventions that may be tried in the future to facilitate an improved outcome in a non – blaming approach. The focus during Event Review should be identifying potential barriers and solutions to preventing or reducing a behavioural emergency, as well as a discussion on future care planning.

Oral Sedation: An oral pharmaceutical agent given to control or prevent aggressive or agitated behaviour when that behaviour may place the individual or others at risk and when de-escalation and other preventive strategies have failed and there is potential for harm to the service user or other people if no action is taken.

Responsive behaviours (RBs): are challenging behaviours exhibited by individuals with developmental disabilities, mental illness, addictions, brain injury, dementia and other neurological conditions. Forms of communication expressed in actions, sounds, words and gestures, RBs may be a reaction or response to a person's personal, social or physical environment, state or experience (adapted from Murray Alzheimer Research and Education Program [MAREP] 2004). RBs can include wandering, verbal and physical abuse, social inappropriateness, resisting care or inappropriate sexual behaviour (Buhr and White 2006, Canadian Institute for Health Information [CIHI] 2010). RBs that result in the person, caregiver or co-resident being harmed or mortally injured are the most severe (CBC 2012; The Star 2013).


Trauma Informed Care or Trauma-informed services: Alert teams to the possibility of the existence of trauma in the lives of all individuals, regardless of whether it is known to exist in individual cases. Key principles of trauma informed care include safety, trustworthiness, choice, collaboration and empowerment (Fallot & Harris, 2009).

Triage Scale for Behavioural Emergencies: Adapted from Australia to use in Primary Care settings, it is a scale designed to measure agitation and provide the clinic team with guidance to ensure the level of agitation and the appropriate intervention to implement in the process of de-escalation.^{2,3}

Wandering: Aimless or purposeful motor activity that results in getting lost, leaving a safe environment or intruding in inappropriate places.

Wellness Recovery Action Plan (WRAP)®: Addresses for an individual / caregiver supports with serious behavioural emergencies and helps prevent, or prepare for a crisis. It describes how to recognize the individual's patterns of escalating behaviours. It identifies responses that are usually effective for this individual to prevent (if possible) a behavioural emergency, or to manage it when it occurs. The Wellness Recovery Action Plan 'is best developed by an interprofessional team with the individual (family / supports) when appropriate'. WRAP® is very much an individual – driven recovery approach.

SACCIT: An acronym used to describe assessment and management of points of care. Clinicians should become well versed in “**SACCIT**”. **S = Safety, A = Assessment, C =Confirmation of Provisional Diagnosis, C= Consultation, I = Immediate Treatment (Biological, Psychosocial & Social), T= Transfer of Care**

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|--|---|--|
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| | Approved By: Community Primary Care Council | Pages: Page 3 of 10 |
| | Approval Date: November 9, 2016 | Supersedes: September 22, 2016 |

3.0 **BACKGROUND:**

Primary Care clinic settings and Maternity services are considered high risk for where behavioural emergencies can occur:

All settings have the potential for behavioural emergencies to occur, and a team requires basic knowledge and skills to deal with these situations safely. A health care setting can be considered to be 'high risk' and a relatively common occurrence as care is provided:

- in emergency, traumatic, stressful or emotional situations, where self-control and behaviour is tested
- in situations where there is limited access to assistance for clinic teams

Primary Care clinical settings and maternity services have been identified as one of the high risk settings and services. Childbirth, illness and injury to infants and children evoke strong emotions among families and caregivers, and may have cultural and religious significance. Families of children with chronic conditions have long term involvement with health services.⁵

High Risk Clinical Conditions

Mental illness

For people with a mental health disorder or illness, the thought of or actually being admitted to hospital can be a distressing experience, particularly when this occurs in the context of a behavioural emergency and is done under a mental health order. Even in a less acute stage of illness, and in community-based services, behavioural emergencies including self-harm, intrusive or sexualised behaviours, wandering, offensive language or physical assault may occur and these behaviours are at times, difficult for staff to manage. As with many physical health issues, a mental illness can limit the capacity of individuals to engage effectively with the treatment process and to communicate their needs.


- Individuals presenting with a mental health complaint or symptoms may have an underlying physical illness that precipitates their condition (i.e. aggressive behaviour or visual hallucinations may be secondary to delirium).
- Mental illness may prevent the effective communication of physical symptoms (e.g. an individual with schizophrenia who is very thought disordered or preoccupied with delusions may not be able to describe their chest or abdominal pain).
- Physical illness may be a stressor that could exacerbate a person's mental illness.⁵
- This population may be at greater risk to be victims of violence and at increased risk for falls, of which could result in undiagnosed head injuries

Drug and Alcohol Abuse

Drug-affected states refer to temporary alterations in the person's mental state or behaviour as a result of drug or alcohol use, resulting in distress or impairment.

Adverse reactions can lead to a medical emergency;

- physical reaction after drug use, such as deteriorating or loss of consciousness, overheating, dehydration and over hydration; trauma, seizure or head injury (this population is at greater risk to be victims of violence and at increased risk for falls, of which could result in undiagnosed head injuries)
- adverse psychological reaction to drugs include panic attacks, psychosis, suicidal thoughts and behaviours, and aggression

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| | Approved By: Community Primary Care Council | Pages: Page 4 of 10 |
| | Approval Date: November 9, 2016 | Supersedes: September 22, 2016 |

Combined mental health disorders and drug use are associated with a host of social, behavioural, psychological and physical problems, including: increased symptom severity and suicidal behaviour; less compliance with treatment; more hostile and aggressive behaviours; drug-seeking behaviours; increased risk of violence to others; and longer duration of admission to psychiatric inpatient units. Withdrawal syndrome and co-morbidity can exacerbate these. Individual with these problems may be treated in a variety of settings such as emergency departments, drug and alcohol services, mental health and general wards.⁴

Geriatrics – Dementia

Cognitive impairment is common within the hospital and also in aged care services, both residential and community-based. Dementia can limit the capacity of individuals to engage effectively with the treatment process and to adequately communicate their needs. For individuals with dementia, being admitted to hospital can be a confusing and frightening experience, and this may lead to an escalation of responsive behaviours that are difficult for staff to manage, including wandering, disruption or intrusion, aggression and delirium. Delirium can occur in all age groups, it is most common among older people, and is often overlooked and misdiagnosed. It is both predictable and preventable.

Pre-existing dementia is one of the most common predisposing risk factors for the development of delirium. Others include age 70 years or over, severe medical illness, depression, abnormal sodium, and visual impairment and undergoing orthopaedic or neurosurgery.⁵

Intellectual Disability, Acquired Brain Injury and Neurodegenerative Conditions

Approximately 4-17 per cent of people with an intellectual disability demonstrate responsive behaviours that can result in injury to self and / or others, or property damage. There are other groups of individuals who have long term acquired or degenerative neurological disorders or intellectual impairment, where responsive behaviours are manifested.⁵


Major risks in Behavioural Emergency presentations related to the above populations includes:

- Individual at risk who abscond,
- Aggression to self or others, self – harm /suicide,
- Mental illness not being recognized,
- Misdiagnosis or missing a physical cause for the problem
- Severity of risks unidentified,
- Attempting to manage risks without available resources⁴

Addressing Major Behavioural Emergency Risks using a Person Centred Care Approach:

Communication and Culturally Competent Care

- Individuals, staff and the general public are entitled to be protected from harm or injury in all settings.
- Individuals presenting with responsive behaviours may pose a safety risk to themselves and others.
- De-escalation is always the preferred approach to managing safety risks.
- Communication and diversity - engaging with people and the development of a therapeutic relationship are the basic fundamentals of health care. The entire Primary Care Clinic team need to consider their voice, body language, and consideration of the individual's language and cultural needs and personal space are all important in conveying respect. Being polite, respectful and using empathic listening in all interactions with individual and family or caregiver, and meeting immediate needs are important. Failing to achieve these can be early triggers for the escalation of challenging

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|--|---|--|
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| | Approved By: Community Primary Care Council | Pages: Page 5 of 11 |
| | Approval Date: November 9, 2016 | Supersedes: September 22, 2016 |

behaviours. Timely, relevant information and knowledge can avoid or reduce anxiety and agitation for the individual / family.

- Individuals receiving health services, families and caregivers, and the health workforce itself, reflect the diversity in culture, language, values, needs and health literacy that is found across Winnipeg. People from different cultural groups may have different understanding, interpretation and expectations of health care, and their role.
- If the individual speaks a language other than English at home, it may be helpful to use Language interpreter service.
- It is not uncommon for stress to increase the likelihood that a person from a culturally and linguistically diverse community may revert to their language of origin. Consider contacting [WRHA Language Access Interpreter Services](#)
- Where de-escalation is not working or severe risk is imminent, other crisis management strategies should be utilized. See Appendix A Triage Scale for Behavioural Emergencies and Appendix C Wellness Recovery Action Plan which may include activating the Site [WRHA Community Disturbance Response Guidelines](#)

Trauma Informed Care or Services – A Standard of Care for all Individuals

- Regardless of the cause, managing safety relies on a comprehensive assessment of the individual's underlying problem, contributing environmental factors and triggering events.
- Sensitivity of care is a standard requirement to support all individuals, whether a new arrival with recent experience of trauma, or for someone with particular religious or cultural interpretations of illness, rehabilitation or childbirth⁵

4. PRACTICE GUIDELINE:

4.1 PREVENTION and PREPARATION

4.1.1 The reality of living with any illness that may cause a behavioural emergency involves having to navigate the fluctuating severity of symptoms. An intensification of symptoms for short periods of time is a common element of moving toward recovery.


4.1.2 Interprofessional teams should explore with the individual / family / caregiver ways to prevent this by striving for a healthy daily routine and developing and maintaining a Wellness Recovery Action Plan if symptoms should worsen (See Wellness Recovery Action Plan© Appendix C).

De-escalation Strategies to Decrease Agitation

When responding to a behavioural emergency, attention is paid in any environment to the safety of the agitated individual, the clinic staff and others that may be in the area. The behaviour does not have to occur in individuals with a mental illness. The intent is to assist the individual to manage both emotions and behaviour. The use of restraint is avoided when at all possible. Preparation for engagement involves consideration of the environment as well as the adoption of strategies to decrease risk prior to or during behavioural emergencies.

Stages Involved in De-escalation:

1. Individual vents feelings
2. Any Clinic team member acknowledges problem
3. Any Clinic team member empathizes with situation to help defuse tension
4. Clinician explains when a particular demand cannot be met

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|  <p>PRIMARY CARE/SHARED CARE MENTAL HEALTH PRACTICE GUIDELINES</p> | Practice Guideline: Management of Acute Mental Health Behaviours (ADULT) | Guideline Number PCPG #14 |
| | Approved By: Community Primary Care Council | Pages: Page 6 of 11 |
| | Approval Date: November 9, 2016 | Supersedes: September 22, 2016 |

5. Clinician negotiates to reach a compromise

4.2 ASSESSMENT AND MANAGEMENT AT POINTS OF CARE

The entire Clinic team should become well versed in the acronym 'SACCIT' which is as follows:

S – SAFETY: ensuring the individual's risk of harm to self or others are well managed for the duration of their clinic appointment (vital signs and physical examination) or during phone triage assessment.

A – ASSESSMENT: comprises: a clear and reliable history, mental state examination, risk assessment, vital signs, and physical examination. NOTE: the accuracy of the history may be affected by mental state impairment.

C – CONFIRMATION OF PROVISIONAL DIAGNOSIS: obtaining the vital information to assist in reaching a provisional or working diagnosis.

Comprised of two key elements:

- a) Obtaining collateral history:
 - Clear history and a reliable collateral history are essential components of any behavioural emergency assessment.
 - It is vital to obtain a history (recent and past) from family, friends, accompanying agencies. There should be clear recognition that the absence of such information reduces the confidence a clinician can place in their assessment.
- b) Performing investigations to confirm or exclude organic factors


C – CONSULTATION:

- Primary Care Provider to consider consulting with the Crisis Response Services.
- Accessing mental health services to which the individual may be already connected, or which may be of assistance during the behavioural emergency. Clinicians should not hesitate to seek Mental Health consultation or referral. See Stepped Care Navigation Guide (*to be hyperlinked when available*)
- Seeking advice and assistance is an exercise in sound judgment and an opportunity to learn.

I – IMMEDIATE TREATMENT: providing the right short-term intervention in the following areas:

- **Biological:** For example, treating any underlying cause, pharmacological treatment of presenting symptoms and medication for oral sedation See Pharmacologic Treatment for Behavioural Emergencies in Primary Care Settings See Appendix B
- **Psychological:** For example, therapeutic engagement, supportive counseling, using de-escalation.
- **Social:** For example, mobilizing social supports, family and others to provide care post-discharge and finding emergency accommodation.

T – TRANSFER OF CARE: ensuring the safe and effective transfer of care. This will require appropriate documentation and communication. Discuss with individual the recommendation for voluntary or involuntary assessment. If involuntary assessment is required, Physician to complete Form 4 under [Manitoba's - Mental Health Act](#) for involuntary admission (Application by Physician for Involuntary Psychiatric Assessment (Form #4 (triplicate) which authorizes that an individual be taken to a psychiatric facility for an assessment by a psychiatrist. See Appendix D Guide to Complete Form 4 Application by Physician for Involuntary Psychiatric

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|--|---|--|
|  <p>PRIMARY CARE/SHARED CARE MENTAL HEALTH PRACTICE GUIDELINES</p> | Practice Guideline: Management of Acute Mental Health Behaviours (ADULT) | Guideline Number PCPG #14 |
| | Approved By: Community Primary Care Council | Pages: Page 7 of 11 |
| | Approval Date: November 9, 2016 | Supersedes: September 22, 2016 |

Assessment and Form 21 Certificate of Capacity

4.3 Clinic Team Defusing of a Behavioural Emergency

4.3.1 Involves a non – blaming conversation that occurs right after the event. The focus here is of an informal nature and provides a venue to recognize and process the emotional intensity of having participated in responding to a behavioural emergency.

- evaluate the physical and emotional impact on everyone involved, including witnesses
- help service users and staff to identify what led to the incident and what could have been done differently
- determine whether alternatives, including less restrictive interventions, were discussed

4.3.2 Once the clinic has returned to pre-crisis, (i.e., individual has been deescalated or transferred to hospital) the entire clinic team comes together to check in with one another.

4.3.3 The lead for defusing the situation will be at the discretion of the members present. Generally, the Manager or Site Medical Lead would lead the conversation; however this can vary based on the situation and the individuals present and involved. Time spent for defusing the situation will vary, generally the process may take anywhere from 5-10 minutes. No documentation of the defusing is necessary. While participation for defusing is strongly encouraged, it is a voluntary process. It is recognized that people process events differently and immediate post-event defusing is not a fit for everyone. If you require support at another time, please speak to the Manager, or utilize services through WRHA Occupational Environmental Safety & Health or the MB Blue Cross Employee Assistance Program.

Questions found on the Defusing – Event Review Card can be used as a guide:


- How is everyone doing?
- How is everyone feeling?
- Is anyone injured?*
- Are there any immediate safety concerns for any clinic team members and patients?
- Does anyone need a break?
- Do we need to schedule an Event Review to debrief?

***If needed:** Complete RL report, Contact Injury/Near Miss Intake line: 204-940-8482, Seek support from WRHA Occupational Environmental Safety and Health: 204-926-1018 or MB Blue Cross Employee Assistance Program: 204-786-8880.

4.4 Clinic Team Event Review of a Behavioural Emergency

4.4.1 An Event Review is a collaborative process to review a patient event, discuss interventions used, and interventions that may be tried in the future to facilitate an improved outcome. The focus during Event Review should be identifying potential barriers and solutions to preventing or reducing a behavioural emergency, as well as a discussion on future care planning.

- To identify any organizational barriers to reducing behavioural emergencies and make appropriate changes

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|--|---|--|
|  <p>PRIMARY CARE/SHARED CARE MENTAL HEALTH PRACTICE GUIDELINES</p> | Practice Guideline: Management of Acute Mental Health Behaviours (ADULT) | Guideline Number PCPG #14 |
| | Approved By: Community Primary Care Council | Pages: Page 8 of 11 |
| | Approval Date: November 9, 2016 | Supersedes: September 22, 2016 |

- To minimize the potential of behavioural emergency with the individual in the future
- To ensure all members of the treatment team consider if there is a need for or are aware of the Wellness Recovery Action Plan ©
- To elicit information from the entire clinic team regarding the Wellness Recovery Action Plan ©. There may be modifications that the individual needs to make to the plan in preparation for future use. It may be important to consider which parts of the plan were successful and which require changes. There may have been new warning signs or triggers that need to be taken into account.

The Manager or Site Medical Lead will arrange an Event Review within 48 hours of the event excluding weekends or statutory holidays. Ideally those involved in the event will attend the event review. All members of the individual's treatment team are invited to participate in the Event Review regardless of being involved in the event or not. The idea is to work together as a team to discuss the Wellness Recovery Action Plan and to share information with each other. If you witness an event but are not scheduled when the Event Review occurs, the option to participate via conference call can be discussed with the Clinic Manager.

Manager of Patient Care or designate will lead discussion with team using the following Event Review questions as a guide:

- Describe the event:
- Antecedent behaviours (patient history, past events, behavior immediately prior to the event)
- Environmental factors
- Interventions used
- What worked well?
- What were the challenges?
- Does a Debriefing need to occur with the individual? Yes? Review who needs to be present. Does a Wellness Recovery Action Plan need to be developed? or
- Are there any changes that need to be made to the Wellness Recovery Action Plan?


Where possible this conversation should include both staff and the individual. This allows the message to be given to the individual that the clinic remains committed to addressing a crisis in a way that does not take away his or her control. In some circumstances, this may require a separate meeting with the individual or inviting him or her to invite an advocate so as to maximize a sense of safety. Appendix E - Defusing / Event Review ID Card – laminated pocket card

NOTE: This is not the same approach as that of the WRHA Critical Incident Stress Management model which has been developed as a part of disaster planning initiatives.

4.4.2 Ensure the individual and his/her family has been provided with an initial or updated written Wellness Recovery Action Plan Appendix C (located in EMR) post event that includes consideration of medication adjustment as required post event.

4.4.3 Document treatment on a ***“Clinical Note Template”*** and place on the individual's medical record.

EDUCATIONAL RECOMMENDATIONS:

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|  <p>PRIMARY CARE/SHARED CARE MENTAL HEALTH PRACTICE GUIDELINES</p> | Practice Guideline: Management of Acute Mental Health Behaviours (ADULT) | Guideline Number PCPG #14 |
| | Approved By: Community Primary Care Council | Pages: Page 9 of 11 |
| | Approval Date: November 9, 2016 | Supersedes: September 22, 2016 |

| | |
|---|---|
| Clinic Team Educational Resources to support | <ul style="list-style-type: none"> • Management of Behavioural Emergencies Quick Reference Guide (1 pager) • Triage Scale for Behavioural Emergencies See Appendix A located in EMR • Pharmacologic Treatment for Behavioural Emergencies in Primary Care Settings See Appendix B • Wellness Recovery Action Plan Appendix C • Guide for Family Physician / Nurse Practitioner to access Mental Health Services See http://www.wrha.mb.ca/professionals/familyphysicians/files/CRC_FP_Guide_2014_FINAL.pdf • Canadian Mental Health Association, Mental Health Resource Guide, Winnipeg Region for latest edition See http://mbwpg.cmha.ca/mental-health/finding-help/ • WRHA Mental Health First Aid http://www.wrha.mb.ca/education/WRHAMental-Health.php • Trauma Informed Workshops http://www.klinic.mb.ca/workshops.htm • Provincial Healthcare Violence Prevention Program • Surrey Place Centre: Developmental Disabilities Tools for Primary Care Providers http://www.surreyplace.on.ca/primary-care • Dementia Toolkit for Primary Care http://www.mountsinai.on.ca/care/psych/patient-programs/geriatric-psychiatry/prc-dementia-resources-for-primary-care/dementia-toolkit-for-primary-care |
| Individual / Family Resources | <ul style="list-style-type: none"> • Wellness Recovery Action Plan© http://mentalhealthrecovery.com/wrap-is/ • WRHA Crisis Response Centre information Sheet See http://www.wrha.mb.ca/professionals/familyphysicians/files/CRC_Information_Sheet_Jan2014.pdf • Canadian Mental Health Association, Mental Health Resource Guide, Winnipeg Region latest edition See http://mbwpg.cmha.ca/mental-health/finding-help/ • Surrey Place Centre: Developmental Disabilities Tools for Caregivers http://www.surreyplace.on.ca/resources-publications |

5.0 EQUIPMENT/SUPPLIES:


Defusing / Event Review ID Card – laminated pocket card HSC Printshop W-00638
Lorazepam 1 mg tablets (to cover all dosing strengths)
Olanzapine 5 mg ODT – orally-disintegrating tablet (to cover all dosing strengths)

6.0 SOURCE/REFERENCES:


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|  <p>PRIMARY CARE/SHARED CARE MENTAL HEALTH PRACTICE GUIDELINES</p> | Practice Guideline: Management of Acute Mental Health Behaviours (ADULT) | Guideline Number PCPG #14 |
| | Approved By: Community Primary Care Council | Pages: Page 10 of 11 |
| | Approval Date: November 9, 2016 | Supersedes: September 22, 2016 |

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 6. Caring for a person who is aggressive or violent <http://www.health.qld.gov.au/mentalhealth/docs/aggressive.pdf>
 7. What do consumers say they want and need during a psychiatric emergency?
<http://www.namigainessville.org/images/Good%20report%20on%20psych%20emergency%20experiences.pdf>
 8. Managing violence in primary care: an evidence-based approach
<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1314649/pdf/14694671.pdf>
 9. Medical Evaluation and Triage of the Agitated Patient
<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3298208/pdf/wjem-13-01-3.pdf>
 10. Primary Clinical Care Manual 2013 mental health and substance misuse
<http://www.health.qld.gov.au/pccm/pdfs/pccm-menthlth-subsmis.pdf>
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<http://www.mountsinai.on.ca/care/psych/patient-programs/geriatric-psychiatry/prc-dementia-resources-for-primary-care/dementia-toolkit-for-primary-care>
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|  <p>PRIMARY CARE/SHARED CARE MENTAL HEALTH PRACTICE GUIDELINES</p> | Practice Guideline: Management of Acute Mental Health Behaviours (ADULT) | Guideline Number PCPG #14 |
| | Approved By: Community Primary Care Council | Pages: Page 11 of 11 |
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7.0 PRIMARY AUTHORS:

- Dr. Sheldon Permack, Family Medicine and Primary Care Program, Medical Director
- Dr. Randy Goossen, Community Mental Health, Medical Director
- Jo-Anne Kilgour, Family Medicine Primary Care Program Specialist
- Jaik Josephson, Shared Care Mental Health Manager
- Kevin Mozdzen, Family Medicine Primary Care Program Specialist

8.0 ALTERNATE CONTACTS:

- Margaret Kozlowski, Family Medicine Primary Care Program Director, Community
- Greg Reid, Community Mental Health Services Director

9.0 APPENDICES:

- APPENDIX A - Triage Scale of Behavioural Emergencies (located in EMR)
- APPENDIX B - Pharmacologic Treatment of Behavioural Emergencies in Primary Care Settings
- APPENDIX C - Wellness Recovery Action Plan
- APPENDIX D - Guide to Complete Form 4 Application by Physician for Involuntary Psychiatric Assessment and Form 21 Certificate of Capacity
- APPENDIX E - Defusing / Event Review ID Card – laminated pocket card

SCOPE: Applicable to all WRHA Primary Care Direct Operations Clinics, Quick Care Clinics and WRHA Fee for Service Staff (Interprofessional Team Development Initiative (ITDI) staff), Midwifery Services