

Acute Excitement / Acute Behavioral Disturbance

1. Purpose

To guide health workers in **assessment, risk management, and immediate intervention** for individuals presenting with **acute behavioral disturbance**, including shouting, aggression, threats to self or others, or other antisocial behaviors.

Note: In extreme situations involving weapons, potential suicide from height, or hostage situations, **call police/security immediately**. Do **not** risk your own or others' lives.

2. Definition

Acute excitement:

- Sudden **qualitative change** in normal behavior.
 - May manifest as: shouting, screaming, aggressive outbursts, disruptive activity, or threatening violence.
 - Causes can be **psychiatric, neurological, substance-related, or situational**.
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3. Common Causes

- **Acute confusional states / delirium**
 - **Drug/alcohol intoxication**
 - **Acute psychiatric symptoms** (anxiety, panic, mania, psychosis)
 - **Challenging behavior** in brain-injured or intellectually disabled individuals
 - Situational stressors, personality traits, or antisocial tendencies
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4. Assessment

Step 1: Context & Information Gathering

- Identify **setting and triggers**: ward, outpatient, emergency, or community
- Seek **collateral information** from carers, staff, or family
- Look for **physical causes** (infection, intoxication, metabolic disorder)

- Look for **psychiatric causes** (mania, psychosis, panic, delirium)

Step 2: Immediate Risk Assessment

- Assess for **risk to self or others**
 - Check for **access to weapons** or dangerous objects
 - Determine **ability to safely manage** the patient on-site
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5. Management

Step 1: Address Physical Causes

- If a **physical cause is suspected** (delirium, intoxication, infection):
 - Follow **delirium / medical management protocols**
 - Ensure **monitoring and supportive care**

Step 2: Behavioral and Psychiatric Causes

- Attempt **verbal de-escalation first**: calm tone, clear instructions, safe distance
- **PRN (as-needed) sedative medication** may be used if verbal de-escalation fails
- Consider **rapid tranquillization (RT)** if urgent:

Rapid Tranquillization Protocol

Before RT:

- Ensure **patient and staff safety**
- Check for **physical conditions** (renal, liver, cardiac, respiratory, pregnancy)
- Review **recent medications and maximum doses**
- Offer **oral medication first**, if possible

Non-psychotic context:

- IM lorazepam 1–2mg (or IM promethazine 50mg if respiratory risk or BDZ sensitivity)
- Wait 30 min, reassess

Psychotic context:

- IM lorazepam 1–2mg (or IM promethazine 50mg)

- Wait 30 min, reassess
- If insufficient:
 - IM haloperidol 5mg (wait 1 hr to assess response)
 - OR IM olanzapine 5–10mg (do **not** give lorazepam within 1 hr of IM olanzapine)
 - OR IM aripiprazole 9.75mg (wait 2 hrs to assess response)

Alternative options (with senior consultation):

- IM clonazepam 0.5–2mg/hr (max 4mg/24hr)
- IM chlorpromazine 25–100mg every 30–60min (monitor closely; avoid IV)

Repeat if necessary **up to BNF limits**.

If no response: **urgent team review / senior consultation**.

Table 23.2 Pharmacokinetics of RT injectables

Drug	Usual dose ^a	Max/24hrs	Pharmacokinetics		
			Onset	Peak	t1/2
Lorazepam	1/2mg 30mins	4mg	15– 30mins	60– 90mins	12–15 hrs
Haloperidol	5mg hourly	18mg ^b	15– 30mins	20– 45mins	21hrs
Olanzapine ^c	5/10mg 2-hourly	20mg	15– 30mins	15– 45mins	30– 50hrs
Aripiprazole ^c	9.75mg 2-hourly	Three doses/30mg	30mins	1–3hrs	75– 146hrs
Promethazine	50mg 30mins	100mg	1–2hrs	2–6hrs	7– 15hrs

^a As a general rule, doses in adults aged >65yrs, those with ID, and other groups sensitive to side effects of medication will be 25–50% of the usual adult dose—always check the *BNF* for guidelines.

^b The bioavailability of PO and IM haloperidol is different—when considering the total dose per 24hrs, 5mg PO = 3mg IM. IV use has a high risk of arrhythmias and is not recommended.

^c Not approved for the treatment of dementia-related psychosis or behavioural disturbance.

Step 3: Physical Monitoring During and After RT

- Record **vitals**: temperature, pulse, BP, O2 saturation, respiratory rate
 - Every 15 min for 1 hr
 - Then hourly for 4 hrs
 - Then every 4 hrs for 12 hrs (or as clinically needed)
 - Monitor **sleeping patient** at minimum for **pulse and respiratory rate**
 - Watch for **side effects**:
 - Extrapyramidal symptoms (dystonia)
 - Neuroleptic malignant syndrome (NMS)
 - Hypotension (lie flat, raise legs)
 - Respiratory depression (O2, ventilatory support, flumazenil for BDZ overdose)
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Step 4: Dangerous or Irresponsible Behavior Without Clear Cause

- If **no physical or psychiatric cause** is identified and behavior is **dangerous**:
 - Contact **security or police** for safe removal
 - Document clearly
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6. Documentation

- Record:
 - **Assessment findings**
 - **Triggers identified**
 - **Medication administered** (dose, time, route)
 - **Patient response and side effects**
 - **Follow-up plans**
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7. Key Points

- **Safety first**: patient, staff, and public

- **Identify cause:** physical vs psychiatric vs situational
- **Use verbal de-escalation first**
- **Rapid tranquillization** only if urgent or dangerous
- **Close monitoring** is mandatory after medication

Escalate to senior staff or police if situation exceeds scope