Managing Aggressive & Violent Behaviour In Young People/ Children- Full Clinical Paediatric Guideline – Derby only

Reference no.: CH CLIN C 48/ April 22/v002

1. Introduction

This guideline is designed to be an aid to the management of children (12 years and under) and young people (YP aged 13-17 years) presenting/developing violence or aggression within the Children's Emergency Department. It has been developed using the NICE guideline NG10 'Violence and aggression: short term management in mental health, health and community settings' (May 2015).

The same general principles can be applied to children as to young people, but adjustments need to be made based on their development, understanding and physical size. Please use this guideline in conjunction with the CAMHS Pathway guideline CH CLIN C 47 located on Koha.

2. Main body of Guidelines

There are a variety of reason why children/young people (YP) may present with violence and aggression. These include a primary medical pathology causing their symptoms, drug/alcohol intoxication, antisocial behaviour/conduct disorders, mental health conditions, or have a primary diagnosis of learning disability or autistic spectrum disorder (ASD) (Box 1).

POSSIBLE CAUSES OF VIOLENCE/AGGRESSION (BOX 1)	
Encephalitis/meningitis	**Drug/Alcohol intoxication**
Space occupying lesion	**Conduct disorders/antisocial**
Acute brain injury	**behavioural**
Autistic spectrum disorder	**Learning Disability**
Cerebral Oedema (e.g. DKA)	**Mental Health disorder**
DO NOT assume all patients have a mental health disorder/diagnosis	

Violence and aggression refers 'to a range of behaviours or actions that can result in harm, hurt or injury to another person, regardless of whether the violence or aggression is physically or verbally expressed, physical harm is sustained or the intention is clear' (NICE guideline NG10).

Violence and aggression can put the patient, other patients and members of staff at risk and every effort should be made to anticipate, intervene and put appropriate steps in place before violence and aggression occur. It is not always possible to avoid violence and aggression in patients and this guideline (which is based on NICE recommendations) contains a set of graded interventions designed on trying to prevent the escalation of violence behaviour within the hospital (See Flowchart 1 & 2).

REMEMBER. Key points about violence and aggression (BOX 2)
• **DO NOT exclude violence/aggressive patients from the emergency department** • **Can be a manifestation of a primarily medical illness** • **Can be caused by or contributed to be child abuse/maltreatment** • **Physical, intellectual, emotional and psychological maturity needs to be considered** • **Do not use seclusion** • **Aggression can related to previous trauma/abuse and may represent a response of the child/YP to a perceived threat**
Violence and aggression should be considered a psychiatric emergency

Mental Health triage/assessment

It must not be assumed that mental health causes are necessarily the primary cause of a child/YP with violent and aggressive behaviour. Remember that medical causes such as encephalitis/meningitis, space occupying lesions or other infections could cause such behavioural disturbances. Observations and a medical assessment should be completed when possible to do so. These should be repeated on a regular basis should the patient have a prolonged CED stay.

On arrival to CED a mental health triage and assessment should be carried out. This should attempt to assess; the risk of violence or aggression, consider previous episodes of violence (if already known), aggression trigger factors and any previous de-escalation techniques that have worked (if known).

MENTAL HEALTH TRIAGE/INITIAL ASSESSMENT (BOX 3)
• **On arrival a mental health triage should be completed (Consider Room 6 if available and safe to do so). Consider the most appropriate safe space available.** • **It may be appropriate to use Bay E in adult pitstop to manage an older-aged young person (PLAN accredited room). This should be done in liaison with adult ED staff and with a joint agreement about nursing responsibility. A Paediatric- trained nurse should accompany the patient.** • **An attempt to perform basic observations should be made (when safe to do so)** • **A history including PMH, drug history (prescribed and illicit) should be attempted, as this may impact on any medications used,** • **Consider urine dipstick and baseline bloods in all acutely disturbed patients (when safe to do so and depending on initial assessment)** • **Factors contributing to violence/aggression are complex and multi-factorial** (including constitutional, mental, physical, financial, environment, social, communicational, functional and behavioural factors).

Management

Flowcharts 1 & 2 are the suggested algorithm for managing these challenging patients. The management needs to be adapted based on individual circumstances.

KEY MANAGEMENT POINTS (BOX 4)

- **Always aim for verbal de-escalation** (see subsection below)
- Always notify a member of staff and take a chaperone with you
- Consider **where** the most appropriate safe space is to nurse the patient is dependent on staffing/ other needs within the department at the time (liaise with senior nurses)
- **1:1 observation** within CED
- Discuss management with the consultant psychiatrist on call ASAP (in concerning cases)
- Pharmacological management should only be used where other techniques have failed or there is risk of harm
- Always consider any primary medical illness and treat accordingly
- **Restrictive interventions (e.g. rapid tranquilisation or manual restraint) should be avoided/minimised whenever possible. If used an incident form needs to be completed.** Any RI used should be discussed with those with parenteral responsibility whenever possible.
- Consider discussing violent/aggressive patients with **social services**.
- Consider a post-incident de-briefing for staff after significant incidents of violence/aggression.
- Consider discussing those with moderate/severe learning disabilities with the complex behaviours team for advice on management
- If under 16 years, the family or carers should also be given information and support to help the child or young person to make decisions about their treatment. Professionals should follow the Department of Health's advice on consent (see further notes under RI section).
- A drug and alcohol risk assessment should occur during the patient's stay when possible to do so.
- Conduct disorders or associated antisocial behaviour commonly coexist with mental health, neurodevelopmental conditions, especially ADHD, learning disability or substance misuse.
- The mental capacity act 2005 applies to young people aged 16 and over.
- **Section 136:** If brought in by police under this section the patient needs to have a mental health assessment by an approved doctor and approved mental health practitioner. The psychiatry team will need to assess the patient acutely in CED whilst the police are still present. (This section can last for up to 24 hours & this can be extended for 12 hours).

Those with more prolonged CED stays;

- Should have an individualised management strategy agreed with the CAMHS team (inc. max daily doses & intervals)
- Consider a strategy/discharge planning meeting to coordinate the further management
- Should have twice daily documented medical review during their stay by the CED team.
- Quality sleep is an important factor affecting behaviour. The use of Melatonin could be considered in conjunction with other environmental factors
- Where a possible conduct disorder or antisocial behaviour problems have escalated leading to admission, a comprehensive assessment with the help of CAMHS and social care will be needed (as an inpatient or outpatient) to plan further interventions/programmes with the parents/guardian or child, whilst considering comorbid conditions (see NICE guideline CG 158)

University Hospitals of Derby and Burton NHS Foundation Trust

Managing violence or aggression in children or young people in CED (Flowchart 1)

VIOLENCE/ AGGRESSION SHOULD BE CONSIDERED A PSYCHIATRIC EMERGENCY
Do not exclude from ED
Do not use seclusion

Child or YP booked into CED/identified as a risk of violence or aggression

Inform nurse in charge/senior nurse

Consider **Room 6** for mental health triage and further assessment. **ALWAYS TAKE A CHAPERONE**
If significant concern – remove potential weapons from the room and consider environmental risks.

Try to recognise early signs of agitation, irritation, anger & aggression

POSSIBLE CAUSES
Drugs/alcohol
Conduct/behavioural
Learning disability
ASD
Meningitis/encephalitis
Space occupying lesion
Mental health condition
Cerebral oedema
Do not assume there is a mental health diagnosis

SIGNS OF AGGRESSION/RISK OF VIOLENCE OR ESCALATING BEHAVIOUR

VERBAL DE-ESCALATION

- Appropriate, measured & reasonable responses
- Reduce sensory input (low noise, reduce bright lights, on their level)
- Recognise the importance of personal space
- Non-confrontational & avoid provocation
- Use verbal & non-verbal skills
- Non-confrontational body language & calm tone of voice
- Use techniques for distraction & calming
- Do not use punishments
- One staff member should take the primary role
- Negotiate behavioural contract, rewarding cooperation e.g. visit to sensory room

IMMINENT THREAT
CONCERN ABOUT IMMINENT RISK OF PHYSICAL HARM TO PATIENT/STAFF OR OTHERS

CALL SECURITY TO ATTEND (Mobile 07799337791 OR call 3333 (switchboard) & fast bleep to security)

Urgent psychiatric Ax (when possible to do so)
Call consultant psychiatrist for advice (Paeds registrar & above)
Call CAMHS rise team to attend (8am- 8pm last referral, advice until 10pm) (03001233124, dhcft.rise@nhs.net)
Out of hours call SHO for psychiatry (based at Radbourne unit 01332623700) in conjunction with consultant psychiatrist.

IF CONTINUED ESCALATION OF BEHAVIOUR OR NON-RESPONSE TO VERBAL DE-ESCALATION

CONSIDER PHARMACOLOGICAL MANAGEMENT ORAL IF POSSIBLE, PARENTERAL IF IMMINENT AND SIGNIFICANT THREAT OF HARM (SEE FLOWCHART 2)

PHARMACOLOGICAL MANAGEMENT (Flowchart 2)

IF CONTINUED ESCALATION OF BEHAVIOUR OR NON-RESPONSE TO VERBAL DE-ESCALATION

ALWAYS AIM FOR VERBAL DE-ESCALATION
Continue verbal attempts throughout other management strategies
Appropriate steps should be made to involve with the parents/carers +/- patient in decisions about management whenever possible

OFFER ORAL/PRN MEDICATION (Doses 12yrs +)

1st Choice: Lorazepam 0.5- 2mg orally (Max 4mg in 24 hrs, consider repeat after 30-60mins)

Alternative: Risperidone 500mcg orodispersible *
Only used if Lorazepam contraindicated/unsuitable (or with advice from cons. psychiatrist)
Review medications administered within the last 24 hours (BNF limits & SE). Consider any known PMH. Tailor choice to individual patient, medication & previous response (If known).

(Recorded doses are for 12 years or older – see RI section for doses <12 years)

***NB: Risperidone is an antipsychotic medication**
Be aware of potential side effects including acute dystonia (see appendix 2)

For doses of Lorazepam above 1-2mg in children please consider age and weight +/- initial response

CONTINUED ESCALATION OF BEHAVIOUR OR NON-RESPONSE/FAILED
Consider repeating oral dose/other choice PO medication.
Parenteral if there becomes an imminent and significant threat of harm and PO unsuccessful/not possible

Manual restraint (only security)
AVOID PRONE RESTRAINT
Only to avoid imminent harm to patient/staff/others
Adapted for young person's weight, height & strength
Account for intellectual, emotional & psychological maturity
Avoid mechanical restraint in children
Complete IR1 if manual restraint used

RAPID TRANQUILLISATION (Doses 12 yrs +)
THIS IS A RARE EVENT
Only if verbal de-escalation & other preventative strategies (e.g. PO meds) have failed AND there is potential for significant harm if no action if taken.

1st Choice: IM Lorazepam 0.5-2mg (Max 4mg/24 hrs)
Alternative: Discuss with CAHMS/Psychiatric consultant. See main guideline text for further information. Doses for ≥ 12 yrs – see text for doses <12 years

Ensure adequate monitoring after using RT (see text)
Complete IR1 if RT is used

IF UNSUCCESSFUL THEN LIAISE WITH PSYCHIATRY CONSULTANT ON-CALL
(Repeat doses or alternative agents may be appropriate)
CONTINUE ATTEMPTS AT VERBAL DE-ESCALATION THROUGHOUT

Psychiatry advice/liaison

CAMHS RISE: Can be contacted during working hours 8am-9pm. Last referral is 8pm, but they are contactable until 10pm. CAMHS rise are a specialist team of nurses, social workers and OTs who can be contacted for advice regarding behavioural management and risk assessment of violent/aggressive patients. They are not psychiatrists and they cannot advise on the pharmacological management if needed. There are times when it is not possible to discuss with CAMHS RISE immediately and in very concerning cases it is appropriate to simultaneously discuss with the psychiatry/CAMHS consultant on call.

Psychiatry consultant on call: In concerning cases the psychiatry consultant on call can be contacted for advice in and out of hours. During the daytime hours a CAMHS consultant should be available for advice, although out of hours this may be a non-CAMHS consultant. Out of hours this should be done in conjunction with liaison with the SHO on call for Psychiatry based at the Radbourne unit (01332623700).

SHO on call for Psychiatry (out of hours 9pm -8am): Based at the Radbourne unit (01332623700). It should be remembered that the SHO on call for psychiatry is not necessarily a psychiatry trainee and may have minimal CAMHS experience. They cover several hospital sites out of hours.

Other Teams

Moderate/severe learning disabilities: Consider discussion with the Complex behaviours team (01332 254700).
Social/child protection concerns: Refer/discuss with social services.

Verbal de-escalation/Behavioural management

Verbal de-escalation is the use of skills, methods and techniques to reduce or avert imminent violence and defuse aggression.

GENERAL PRINCIPLES FOR VERBAL DE-ESCALATION (BOX 5)
• Try to recognise early signs of agitation, irritation, anger and aggression. • Reducing emotional arousal or agitation (low noise and reduce bright lighting). • Recognise the importance of personal space • Use verbal and non-verbal skills • Offer the chance to move away from the situation e.g. quiet room (ensure staff are not too isolated) • Use techniques for distraction and calming and ways to encourage relaxation • Consider using a mattress on the floor to manage these patients • Consider environmental risks e.g. pull cords, bedsheets, windows, door locks, potential weapons • Try to understand the likely causes • Respond in an appropriate, measured and reasonable way and avoid provocation • Consider the patient's preferred method of communication (e.g. British sign language) • Do not use punishments e.g. removing contact with parents/carers or access to social interaction • One staff member should take primary role in communicating with the patient, assess safety and negotiate to resolve the situation in a non-confrontational manner • Anticipate that restricting a patient's liberty or freedom of movement can trigger violence and aggression.

Restrictive Interventions

Definition of terms (NICE NG10)

Restrictive interventions are interventions that may infringe a person's human rights and freedom of movement, including observation, seclusion, manual restraint, mechanical restraint and rapid tranquillisation (NICE NG10).

Manual restraint - A skilled hands on method of physical restraint used by trained healthcare professionals to prevent service users from harming themselves, endangering others or compromising the therapeutic environment. Its purpose is to safely immobilise the patient.

Rapid tranquillisation- Use of medication by the parenteral route (usually intramuscular or exceptionally, intravenous) if oral medication is not possible or appropriate and urgent sedation with medication is needed (NICE NG10). According to the revised 2015 Mental Health Act (MHA) Code of practice rapid tranquillisation is the use of medication to calm or lightly sedate an individual to reduce the risk of harm to self or others and to reduced agitation and aggression. When used to manage acute behavioural disturbance, this should be a very short-term strategy and is distinct from treating any underlying mental illness.

- Restrictive interventions are RARE events, which can be used if there is an imminent risk of harm if no action is taken. Please see flowchart 1& 2.
- The decision to use restrictive interventions needs **careful clinical judgement.**
- Manual restraint if used should be adapted for child/young person's height, weight, physical strength, emotional and psychological maturity.
- If restrictive interventions are used resus equipment should be available.
- Prescribing in this context is generally 'off label' (outside the product licence)

TECHNIQUES AND METHODS USED TO RESTRICT A PATIENT SHOULD BE (BOX 6);
• Proportionate to the risk and potential seriousness or harm • The least restrictive option to meet the need • Are used for no longer than necessary • Take into account the patient's preferences if known and possible to do so • Take into account patient's physical health and developmental age.

MANUAL RESTRAINT (BOX 7)
• If manual restraint is used this should use a justifiable level of force, proportionate to situation and for the shortest time possible. Avoid prone restraint whenever possible. • One member of staff should lead the process and ensure there is adequate monitoring of the patient's airway, breathing and vital signs. If prolonged (>10 mins) consider other methods e.g. parenteral medication, if the patient still represents an on-going risk. • Do not interfere with the ability to communicate or with the airway, breathing or circulation. • If manual restraint has been used, any bruising or marks sustained should be documented • Do not use mechanical restraint in children. If already in handcuffs on arrival, these should be removed at

the earliest opportunity when safe to do so.

- Physical restraint may, on a rare occasion, be needed to administer rapid tranquillisation by IM injection to an unwilling patient, where the patient may lawfully be treated without consent. It must not be used unless;
  - Under provisions of the Mental Health Act (MHA chapter 24)
  - Under provisions of the Mental Capacity Act 2005 (≥16 years)
  - If above do not apply for the purpose of self-defense, defense of others, prevention of crime or to protect property. The same statutory and common law provisions apply within health and care services as elsewhere.

The decision to use this should be discussed, documented and justified clearly in the clinical notes

When prescribing medications;

- State the dose interval & maximum dose in 24 hours.
- Review other prescriptions in the last 24hrs.
- Only exceed BNF dosing if planned, documented & approved by a senior doctor.

Suggested doses (Flowchart 1 & 2) are for patients 12 years and over.

- If the patient is **<12 years old or <30kg** a dose of 0.5-1 mg of **Lorazepam** IM/PO can be used or **<12 years or <50 kg** a dose of 250mcg **Risperidone** PO can be used (see appendix 3 below).
- A paradoxical effect can be seen with Benzodiazepines (start with the lowest recommended dose if not previously used in the patient).
- **Risperidone** – In an anti-psychotic naïve patient a starting dose of 500mcg **(>12 years)** and 250mcg **(<12years or <50kg)** is a sensible starting dose for a calming effect. Oro-dispersible 500mcg tablets should be kept in CED. If the 250mcg dose is required, the 500mcg tablet can be halved or mixed with water and half the volume given.
- Risperidone can also be used for the short-term management of severely aggressive behaviour in young people with a conduct disorder, who have not responded to psychosocial interventions (CG158). If this is being considered outside of the indications in flowchart 2, the pros and cons of this should be assessed by the CAHMS team, in discussion with the young person and guardian. Baseline assessment & investigations should be done (as per CG158).

Alternative options- If medications suggested in flowchart 1 & 2 are unsuitable

- **Promethazine Hydrochloride** is not licensed for this indication hence should be discussed with the psychiatrist on call. Promethazine IM has a slower onset of action than other agents such as Lorazepam. **NB:** Promethazine is a phenothiazine, extra pyramidal side effects (EPSEs- more common in the young & female patients) & prolonged QTc are both risks. Dosage - **>12 years** 10-25mg PO/IM (max to 50mg in 24 hrs, consider repeat after 1 hr). **<12 years old or <30kg** 5-10mg IM/PO (max 25mg/24hrs) can be used.
- Both Lorazepam & Promethazine will accumulate with repeated dosing.
- **Haloperidol** is often avoided in children/YP due to EPSE risk, discuss with psychiatry. The SPC recommends a pre-treatment ECG and avoiding concomitant antipsychotics
- **Aripiprazole or Olanzapine** IM may be suggested by the psychiatry team (care will be needed if antipsychotic naïve).
- **IM Olanzapine and IM Lorazepam should not be given within 2 hours of one another** (risk of respiratory depression and bradycardia)
- There may be situations where IV sedation is necessary in order to gain more controlled and rapid sedation. In Paediatrics these events are rare.

Extra care should be taken in giving rapid tranquillisation in the following situations

- The presence of congenital cardiac conduction abnormality
- The concurrent prescription or use of another medication the prolongs the QTc or known QTc prolongation
- When there is a known presence of certain disorders that may affect metabolism e.g. hypothermia, hyperthermia, extreme physical exertion, dehydration or physically ill

- Unless a patient is detained under the Mental Health Act 1983 or subject to a deprivation of liberty authorisation or order under the mental capacity act 2005 (16 and over), health and social care provider organisations must ensure that the use of restrictive interventions does not impose restrictions that amount to a deprivation of liberty (NICE guideline NG10 1.1.4).

Useful free e-learning packages about mental health in young people, capacity and the mental health act can be accessed via the RCPCH MindEd e-learning at: http://www.rcpch.ac.uk/resources/minded.

If Parenteral medications are used;

- Monitor vital signs & responsiveness at least hourly. This should be at least every 15 mins if;
  - The max dose is exceeded
  - Asleep/sedated,
  - They have had other drugs/alcohol,
  - Pre-existing physical health problems
  - Or they have experienced any harm as a result of any restrictive intervention.
- After the first hour, continue to monitor at least hourly until there are no continuing physical concerns or the patient becomes ambulatory.
- If there is a partial response to IM Lorazepam a repeat dose could be considered (after 60 mins) or if there is no response an alternative repeat IM dose could be considered after discussion with the psychiatry/CAHMS consultant on call.

APPENDIX 1 SIGNIFICANT/POSSIBLE SIDE EFFECTS OF MEDICATIONS USED IN RAPID TRANQUILLISATION		
Benzodiazepines	**Antipsychotics**	**Antihistamines (e.g. Promethazine)**
Loss of consciousness Respiratory depression/arrest Paradoxical increases in aggression, disinhibition and restlessness. Hypotension	Loss of consciousness Cardiovascular and respiratory complications and collapse (risk of sudden death) Seizures Subjective experience of restlessness (akasthisia) Acute Muscle rigidity (dystonia) Involuntary movements (dyskinesia) Neuroleptic malignant syndrome Excessive sedation	Excessive sedation Painful injection Extrapyramidal effects including dystonia Additional antimuscarinic effects Hypersensitivity reactions Convulsions Hypotension Arrhythmias Bronchospasm

For full list of potential side effects – see BNF

APPENDIX 2 **Management of possible urgent complications of RT**	
Problem	**Specific Management**
Slow pulse/arrhythmia/hypotension	Assess and manage as per APLS algorithms
Acute dystonia (including oculogyric crisis)	Give **Procyclidine 5-10mg IM (or IV). Should be stocked in adult ED.** Review antipsychotic medication
Reduced respiratory rate (<10)	ABC & Respiratory support as needed. Give Flumazenil if Benzodiazepine induced. 10 micrograms/kg repeated at 1 min interval as required to max 1 mg. Monitor until RR returns to baseline. If induced by another agent respiratory support as needed.
Increase in temperature (>38 degrees)	Consider Neuroleptic Malignant syndrome Features: Fever/hyperpyrexia, Muscle rigidity, alterations in conscious level, autonomic disturbance, raised CK. Stop antipsychotic, check CK, Cool the patient, may require ITU.

APPENDIX 3: Medications Characteristics

Medicines that could be used to managed aggression/violence

Medication	Route	Suggested Dose	Onset of effect	Time to peak effect	Duration of effect	Reversing agent
Lorazepam	Oral	0.5-2mg (≥12 yrs), 0.5-1mg (<12 yrs)	20-30 mins	2 hrs	6-8 hrs	Flumazenil
Risperidone	Oro-dispersible	500mcg (≥12 yrs), 250mcg (<12yrs or <50 kg)	Review response after 45-60mins.	1-2 hrs (peak plasma conc^{n})	Approx 24 hrs	None
Promethazine	Oral	10-25mg (≥12 yrs), 5-10mg (<12 yrs)	20 mins	2.8 hrs (+/- 1.4hrs)	4-6 hrs (up to 12 hrs)	None
Haloperidol (**CAUTION**)	Oral	D/w Psych. Often avoided	1-2 hours	2-6 hrs	18-24 hrs	None
Lorazepam	IM	0.5-2mg (≥12 yrs), 0.5-1mg (<12 yrs)	20-40 mins	60-90 mins	6-8 hrs	Flumazenil
Aripiprazole	IM	D/w Psych	30-45 mins	1-3 hours	18-24 hrs	None
Olanzapine	IM	D/w Psych	15-30 mins	15-45 mins	24 hrs	None
Promethazine	IM	10-25mg (≥12 yrs), 5-10mg	30-60 mins	1-2 hours	10 hrs (2-8 hrs)	None

		(<12 yrs)				
Haloperidol (**CAUTION**)	IM	D/w Psych Often avoided	15-30 mins	20 mins	18-24 hrs	None

3. References (including any links to NICE Guidance etc.)

1. National Institute for Health and Care Excellence (NICE). *Violence and aggression: short-term management in mental health, health and community settings (NG10).* 2015. Available from: https://www.nice.org.uk/guidance/ng10 [Accessed 28th March 2022].
2. National Institute for Health and Care Excellence (NICE). *Antisocial Behaviour and conduct disorders in children and young people: recognition and management (CG158)* 2013. Available from: https://www.nice.org.uk/guidance/cg158 [Accessed 28th March 2022]
3. Cochrane S, Dewar L, Templeton L. Mental Health and learning disability drug and therapeutic committee. *Guideline for Intramuscular Medication for Acute Behavioural Disturbance in Mental Health and Learning disability Inpatient Services* (Version 1) NHS Lanarkshire. 2019.
4. *Management of acute distressed patient and rapid tranquilisation.* Penine Care NHS foundation trust (Version 9) CL014. 2020.
5. Henry R, Wells J, Webb M. *Rapid tranquillisation policy and guidance*. Southern Health NHS Foundation Trust. SH CP 48. Version 5, 2020
6. Parker C. Tranquillisation of patients with aggressive or challenging behaviour.*The Pharmaceutical Journal.* 2015; 294 (7868/9) Available from: DOI: 10.12111/PJ.2015.20068706
7. Paediatric Formulary Committee. *British National Formulary for Children* (online) London: BML Group, Pharmaceutical Press, and RCPCH Publications http://www.medicinescomplete.com [Accessed on 28th March 2022].
8. eMC.*Risperidone 0.5mg orodispersible tablets.* Available from: https://www.medicines.org.uk/emc/product/3138/smpc [Accessed on 28th March 2022]
9. Drugs.com. *Promethazine.* Available from: https://www.drugs.com/ppa/promethazine.html [Accessed on 28th March 2022]
10. Drugs.com. *Risperidone.* Available from: https://www.drugs.com/pro/risperidone.html [Accessed on 28th March 2022]

Other relevant documents

1. National Institute for Health and Care Excellence (NICE). *Challenging behaviours and learning disabilities* (NG11) 2015. Available from: https://www.nice.org.uk/guidance/ng11
2. Consent: Patients and doctors making decisions together. General medical council 2008. Manchester. http://www.gmc-uk.org/static/documents/content/Cosent_-_English_0617.pdf
3. 0-18 years: Guidance for all doctors. General Medical council. Manchester. 2007. http://www.gmc-uk.org/static/documents/content/0_18_years.pdf.
4. Mental Health Act 2007. www.legislation.gov.uk/ukpga/2007/12/contents
5. Mental Health Act (MHA) code of practice, revised 2015. https://www.gov.uk/government/news/new-mental-health-act-code-of-practice
6. Mental capacity Act 2005. www.legislation.gov.uk/ukpga/2005/9/contents.
7. Mental capacity Act Code of Practice.

www.gov.uk/government/publications/mental-capacity-act-code-of-practice
8. Human rights act 1998. http://www.legislation.gov.uk/1998?title=Human%20rights%20act
9. RCPCH MindEd elearning at: http://www.rcpch.ac.uk/resources/minded.

4. Documentation Controls

Reference Number CH CLIN C 48 – CED	**Version:** V2.0.0		**Status** Final	
Version / Amendment History	Version	Date	Author	Reason
	V001	Aug 18	Cat Hearnshaw	Guideline required updating
Intended Recipients: All Staff who work in Children's Emergency Royal Derby Hospital				
Training and Dissemination: Guideline is accessible on KOHA. Advice will be taken from senior staff and CAMHS team. Useful free e-learning packages about mental health in young people, capacity and the mental health act can be accessed via the RCPCH MindEd e-learning at: http://www.rcpch.ac.uk/resources/minded.				
Development of Guideline: Dr Cat Hearnshaw **Job Title: CED Consultant**				
Consultation with: CED consultants and CAMHS staff				
Linked Documents: NA				
Keywords: NA				
Business Unit Sign Off	**Group: Paediatric Guidelines Group** **Date:08/04/2022**			
Divisional Sign Off	**Group: Divisional Governance Group, Women and Children's** **Date: 26/04/2022**			
Date of Upload	May 2022			
Review Date	May 2024			
Contact for Review	Audit Co-ordinator			