

When is a diagnosis not a diagnosis?

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The term 'acute behavioural disturbance' (ABD) is contentious, tensions around its use being apparent across and between health and criminal justice agencies in the UK. This raises interesting questions. If it is not a diagnosis, what is it? And who gets to decide? This Delphi study by Humphries *et al*¹ goes some way to clarify the views of professionals and hopefully opens the door to the collaborative debate we owe to the patients labelled with the term.

THE IMPORTANCE OF LANGUAGE

Language is important—and shared language is especially important for health professionals in order to be able to communicate effectively with colleagues and to evaluate, audit and report the incidence and prevalence of health conditions. Shared language is also needed across agencies, such as at the medical criminal justice interface—arguably even more so than within the medical profession—but can be very challenging to achieve.

WHAT IS ABD?

The term ABD (in North America 'excited delirium') has evolved over the last 10 years to describe a situation in which an individual is agitated, accompanied by a physiological deterioration; but there is lack of clarity about how this is defined or described and data regarding its prevalence are not collected.

THE CONTROVERSY

Controversy surrounds both terms, largely because of their use by coroners in situations where people have died following the use of restraint, particularly men from ethnic minority backgrounds. In the UK, there was a public dispute between the Royal College of Psychiatrists and the College of Policing regarding the term ABD after a statement criticising its use was released then retracted by the Royal College of Psychiatrists in 2021.² One of the most challenging aspects of the 'ABD' debate is the lack of a shared understanding regarding the ontological framework—Is the term ABD being used

as a diagnosis, a syndrome, a disorder—or something else?

WHAT IS A DIAGNOSIS?

Social construction of diagnosis can include lay involvement, social movement, professional and organisational factors,³ all relevant here. According to McGuinness and Lipsedge, 'a diagnostic entity requires a standardised definition, a specific diagnostic test and a unique pathophysiological mechanism with a consistent morbid anatomical basis or a specific aetiology',⁴ but both ABD and excited delirium have been defined mainly on the basis of subjective descriptions of agitated behaviour, from a range of sources.

Who gets to decide? Traditionally, diagnosis has been the purview of the medical profession. There are tensions between health professions and other agencies working at the 'sharp end' especially as resources become more and more stretched. The question of ownership becomes especially challenging when, as we find here, the first responders to an agitated individual are likely to be the police and paramedics rather than psychiatrists; indeed, the police response to the original Royal College of Psychiatrists statement stated: 'ABD is a term used for police, ambulance trusts and emergency physicians'.²

THE DANGERS

Psychiatrists have been here before—and are wary as a result. There is a history nationally and internationally of being pushed into accepting 'diagnoses' suggested by external agencies. Scandals over many years emphasise the need as a medical speciality to take care to protect our patients from 'diagnoses' that endorse potentially restrictive practices. In the 90s, for example, there was a battle between the then government and the profession regarding the imposition of a 'category' of dangerous severe personality disorder despite psychiatrists' valid concerns at the time⁵ arguing that doctors should follow evidence, and treat based on that evidence, not because we are told to by the government of the time.

DO WE EVEN NEED A NEW TERM?

It is not entirely clear what the terms ABD (and excited delirium) achieve. In

this study, the consensus is that ABD is not, in the UK, considered a diagnosis or a syndrome, and refers to a presentation of an individual in a state of severe agitation, with numerous potential causes with features which suggest significant risk to physical health.¹ This study provides consensus that ABD is not a separate entity to agitation, but that there seem to be criteria which can be used to identify agitated patients at greatest risk of poor outcomes, raising the question about the value of using this terminology in policing and healthcare.

THE WAY FORWARD

We cannot have a discussion about the different rates of 'ABD' in different socio-demographic groups if we do not collect the data—we cannot collect the data unless we agree what we are collecting. It is important that agencies can agree to shared language, we owe this to the patients and families. This is clearly a situation that needs to be resolved and Humphries *et al*¹ have managed in this paper to get the conversation going.

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