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Emergency treatment of the acutely disturbed and aggressive patient

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Introduction

Agitated and violent behaviour has long been associated with mental illness in the public domain. This association is largely driven by stigma and misconception. It is important to remember that people with mental illnesses are far more often the *victims* of, than the perpetrators of violence. The wrongly held belief that they are dangerous has been used to justify unnecessary incarceration and human rights abuse, sometimes on a systematic and officially sanctioned scale, and sometimes in an informal but pernicious way at the level of communities. Challenging these popular but false beliefs and the promoting care and support based on the principle of ‘least restrictive practice’ is an essential component of service development.

Sometimes, however, disturbed and occasionally violent behaviour can occur in clinical settings, and studies have shown that aggression is a feature of 10% of psychiatric emergencies (most commonly associated with psychosis or substance misuse). Preparedness for such a situation thus needs to be a part of clinical training and practice.1 An appropriate and sensitive approach to these challenging situations will make it more likely that patients are able to receive care that maintains their dignity and autonomy, diffuse the immediate risks, and potentially improve long-term outcomes. The possibility of encountering hostile, uncooperative or violent patients is often one of the greatest causes for anxiety among clinicians, but if they are trained and equipped to manage such situations in a safe, calm and psychologically containing manner, it can significantly reduce their anxiety, as well as the risk of injury. The aim is to ensure that the person becomes calm enough to engage with so that a mutually agreed treatment process can move forward.

It is a reality of psychiatric care that there are certain times when patients (especially psychotic patients) do not want to receive treatment, even when most people would accept that it is in their best interest because their behaviour is posing a threat to themselves, to others, or to property. They may not accept treatment because the symptoms of their disorder make them irritable or aggressive, they may have false beliefs (delusions) which make them fear that those around them are trying to harm them, or they may not believe that they are sick (‘lack insight’). Medical ethics and international standards such as the United Nations Conventions on the Rights of Persons with Disabilities dictate that a patient has the right to autonomy in making decisions about their own care. Only when the right of the patient to consent to treatment is in conflict with other principles, such as the right of others not to be harmed, do many national legal frameworks allow clinicians to (temporarily) act against a person’s wishes, usually in what is assumed to be their ‘best interest’. Many countries have codified in law the circumstances under which this may happen. Usually this involves a combination of medical professionals and legal representatives defining the conditions under which a person is judged to lack the capacity to understand the situation, or its possible consequences of their actions. Any intervention must be shown to be proportionate, accepted by a body of professions to be of benefit to the patient in their condition, and temporary, being given against the person’s will only until they have mental capacity to make autonomous decisions again. It is worth noting that there is considerable dispute over whether professionals should ever be allowed to adopt the role of making decisions for patients in their ‘best interest’, ie, a patient always retains legal capacity even when judged to have a compromised mental capacity. One of the consequences of a paternalistic view about the perceived lack of capacity of people with mental illness has been long-term containment in institutions, still common in many countries. In many cases, insufficient efforts are made to seek the patient’s view prior to acting on their behalf, which is perhaps an inevitable result of the power imbalance in these circumstances. Various means of supportive decision making, use of advocates, or asking the person’s wishes in advance should play a more prominent role in managing these circumstances.

In many countries, such principles of best practice are either not established in law or not universally understood. It is therefore necessary for medical and social professionals to be particularly careful about protecting human rights in the course of their work. They are often in a position to exert a positive influence at times of great difficulty for patients and their families, and are respected enough by society to ensure that people with mental illnesses are treated with dignity even when they are at their most vulnerable (Box 1).

The most important thing is preparation. Institutions and organizations delivering mental healthcare should have good practice guidelines for the management of emergencies, and should ensure that their staff is adequately prepared for emergencies. For individuals at risk of presenting acutely in a disturbed way, it is possible to discuss with them in advance what their preferred means of management might be. This will ensure not only that considered decisions are taken with respect to human rights, but also that any treatment is appropriate and safely given.

Step-by-step approach to assessment and management

Here, we outline an approach to managing disturbed and aggressive behaviour in people with mental illness. The emphasis is on the safety of all concerned, respect for the rights of the person involved, and the promotion of engagement with the person and their family throughout what is often a distressing situation (*see* Flowchart on page 47).

Safety first!

The risks can be reduced significantly by attempting to obtain as much information as possible *before* having to act.

• Ask the family, referrer, etc. about the potential risk when taking the referral or planning a visit.

• Find out if the person is known to suffer from mental illness.

• Find out if the person is known to abuse any substance and when he last used anything.

• Ascertain if the patient is suffering from persecutory ideation (‘paranoid’). Find out the nature of any paranoid beliefs he may have so that you can attempt to allay his fears.

• Find out if the patient has access to potential weapons.

• Find out if the patient has been violent or aggressive in the past. Past violent behaviour is known to be the best predictor of future behaviour.

• Identify ways of leaving quickly, if necessary. When you are in an enclosed space, always place yourself nearer to the exit than the patient.

• Make sure that there are sufficient people available to help ensure your safety in case of violence. Determine whether it is necessary for the police to be involved.

• Ensure that you yourself are not carrying sharp implements, jewellery, neck ties or objects that can potentially be used by the patient to harm himself or others.

Share: Collaboration and consent come first

• Engaging the patient as much as possible, is of paramount importance. Try to talk to the patient directly rather than just to those around him, no matter how distracted he seems.

• Even the most apparently aggressive and hostile patients respond well to ‘talking down’ approaches, and feeling that their views and wishes are being taken seriously.

• Remember that patients may behave in a hostile and aggressive manner when they themselves are feeling vulnerable, threatened and attacked in some way. Make sure they feel understood and as if you are listening to them.

• Respectful engagement is important for the future therapeutic alliance, which may be a very long-term one. Patients often remember the initial interactions after the situation has been resolved.

• A patient’s experience in the initial encounter is likely to affect his future compliance with drugs.

• A collaborative approach is of vital importance. The clinician must always attempt to adopt such an approach as it makes the situation safer, as well as less traumatic for the patient and his family even if medications are administered eventually.

Step back (physically)

• When faced with a disturbed patient, it is important to maintain a distance that is both safe for you and non-threatening to the patient.

• Patients with persecutory ideas may perceive of encroachment upon their personal space as a form of confrontation or attack and may lash out in self-defence.

• Keep at arm’s length from the patient.

• Do not touch the patient as he may misinterpret the gesture, even if it was intended to be empathetic.

• Do not stare at the patient as this may be considered confrontational.

• Speak in a calm, slow and steady manner. Be reassuring, not confrontational and accusing.

Step back (mentally)

Think about how the circumstances might affect the patient’s behaviour and whether you can modify them for the better.

• When a patient is acutely disturbed, he and those around him are fearful and anxious.

• You may be the only one at the time to be in a position to view the situation with ‘a fresh pair of eyes’ and a clear mind, so take the time to step back mentally, think and assess the situation objectively.

• Try to determine what appeared to trigger the disturbed behaviour, or make it worse.

• Make an attempt to ascertain whether the agitation, irritability or aggression is related to mental illness or not.

• Give some thought to whether the patient’s condition could be secondary to pain, physical illness, a social problem or any other problem, even if combined with an underlying mental illness.

• Remember that even if a patient has a diagnosis of mental illness, he may be agitated for reasons other than psychosis or delusional beliefs.

• Consider whether there are any factors you can address to resolve the situation. This might include promising to look into issues troubling the patient after the immediate situation has been resolved.

Non-pharmacological approaches first

Try ‘talking down’. Encourage the patient to talk about his concerns and listen attentively. Try to address them if possible, and find alternative solutions to confrontation.

• Even the most apparently aggressive patient often collaborates if you devote time to him, remain calm and listen.

• Reduce any tension in the environment by removing anyone whose presence is counter-productive, anyone who does not have a relevant role to play (bystanders), and generally minimize the number of people involved. It may help, for example if in a very public or unsafe place, to suggest moving somewhere more appropriate, if possible.

• It is important to respect the patient’s wishes and human rights. Even in the difficult situation you are confronted with, it is often possible to obtain the client’s consent and proceed with treatment.

• Insist that the purpose of treatment is to improve the situation for the patient first (even when others may want to punish or harm the patient) and take care to avoid unnecessary treatment involving restriction, which might be abusive.

Pharmacological management

When all alternative methods have been explored, it may be necessary to use medication to prevent the patient from posing a further risk of injury to himself or others.

Background

The use of drugs to bring about sedation in an acutely disturbed patient is referred to as ‘rapid tranquilization’ or ‘RT’. One can use a number of agents, such as antipsychotics, benzodiazepines and antihistamines, alone or in combination.3 The use of an antipsychotic drug when there is evidence of psychosis has the advantage that it amounts to initiating treatment, but it is important to recognize that a single dose is not sufficient and long-term treatment will be necessary. Long-term treatment should include providing appropriate psychosocial care; advising the patient and his family on the need to avoid precipitating factors, particularly drugs such as cannabis, if it is a factor involved; and prescribing appropriate medication to avoid relapses, if the patient is diagnosed with chronic psychosis.

Different medication is available in different places, and hospitals or community services may have different policies or traditions. Worldwide, guidelines are often influenced by local practice and there is limited evidence to argue that one regimen is universally the most appropriate. Here, we present some different treatment options. It is essential that before the need to administer emergency treatment arises, any service should decide which treatment option its staff should use. It should also ensure that the staff is trained to administer the treatment. Further, the necessary equipment and drugs should be available.

Rapid tranquilization guidelines in the UK and the USA recommend the oral or intramuscular administration of lorazepam, often combined with haloperidol.2

Many high-income countries are increasingly using atypical antipsychotics such as olanzapine as they are said to be ‘calming’ rather than sedating, but such medications are expensive or unavailable in some low-income countries. In general, there is little evidence published on the most appropriate approaches to use in low-income countries.1,3,4

Haloperidol alone or a combination of haloperidol and lorazepam is commonly used in low- and middle-income countries such as India and Brazil.1 A common practice in these countries is to add promethazine, a sedative antihistamine with anticholinergic properties, to haloperidol to accelerate the onset of sedation and minimize the adverse effects of antipsychotics, such as acute dystonic reactions.1 Haloperidol and promethazine are both on the WHO’s list of essential drugs.5

Benzodiazepines alone, such as intramuscular lorazepam, 4 mg, have been shown to be as effective as haloperidol, 10 mg, plus promethazine, 25 mg or 50 mg; however, if rapid sedation is required, the latter is superior to benzodiazepines alone.3 There is good reason to administer an antipsychotic in combination with a benzodiazepine if there is evidence of psychosis and the patient is very disturbed.

Best practice guidelines have changed significantly in recent decades, but a recent study in Africa showed that prescription patterns had changed minimally and most psychiatrists continued to prescribe chlorpromazine and diazepam as according to them, prescribing habits were more likely to be influenced by the availability of these drugs than by cost or preference.6 Some bad practices remain in use, including the intramuscular administration of diazepam (which is unpredictably absorbed by this route), rather than the oral administration of diazepam or other benzodiazepines. The lack of availability of intramuscular anticholinergic medications for use in cases of acute dystonic reactions is also a problem in some countries.

Intramuscular paraldehyde should no longer be used as it is painful, and more humane and effective options exist.

*Offer oral medication to the patient.* Remember that the medication being given to the patient is for the treatment of mental illness, and not for punishment. It might happen that the patient becomes so sedated as to sleep, but this is not the aim of intervention.2

• Oral treatment is just as effective as injections. If medical treatment is necessary, it is much better if oral or injected medication is given with the patient’s consent.

• Keep explaining to the patient that you have his best interest in mind, and that giving him medication is not a punishment. Tell him that threatening or dangerous behaviour is not acceptable and that he needs treatment for his own good.

• Explain to the patient that you want to seek his consent to give him treatment.

• If the patient does not consent and the situation is judged to require treatment without his consent, explain this to him.

Rapid tranquilization

If all efforts to calm the patient down have failed, and he is judged to need medication but refuses to take it, then rapid tranquilization should be considered.

Before administering rapid tranquilization (Box 2)

• Ask yourself, ‘Have I exhausted all other possibilities?’

• Ascertain whether the patient has had the drug before and if he suffered any side-effects.

• Make sure the drug you will use has not expired and has been prepared for administration.

• Try to persuade the patient to accept an oral dose first or to consent to intramuscular treatment.

• If it is necessary to treat the patient without his consent, ensure that you explain what you are about to do before you do it, particularly making it clear that it is not a punishment.

• Explain why you are giving the drug and what it will do.

• Ensure that there are enough people at hand to help you administer the drug safely, particularly to hold the patient still if he struggles. If a patient is very disturbed, five people will be required.

• Make sure the team is prepared in advance and each person knows his role. One person (usually the senior clinician) should have the role of coordinating the administration of the medication in a well-organized and calm manner.

• In order to be able to do the job safely and quickly, the person administering the medication should not need to worry about holding the patient still.

• The helpers should be warned not to obstruct the patient’s airway or hurt him while holding him.

• Try to maintain a calm environment and preserve the patient’s dignity while he is being held until he is sedated.

After-care: Patient

• Emphasize the importance of regular monitoring (e.g. every 15 minutes for the first hour and every 30 minutes after that) to check the patient’s breathing, mental state, and side-effects of medication (Box 3).

• Tell the patient and his caregivers about the side-effects that may occur and what they can do about these.

• Make a plan for the long-term care of the patient and support of the family. Set a date for the first review.

• Arrange a meeting with the patient to discuss his experience of rapid tranquilization. This will help to engage him and make him more amenable to treatment.

• Consider making a joint contract with the patient with respect to any future episodes in which rapid tranquilization may be necessary. Though this may not be legally binding, it helps empower the patient and makes him feel that he is involved in his own care.

• Note whether any serious adverse effects have been mentioned in the patient’s case notes and share these with the team

After-care: Clinical team

• Managing acutely disturbed patients can provoke anxiety and be unpleasant for the clinicians involved, so it is important to arrange for a meeting with peers or supervisors to share experiences, develop knowledge and skills, and promote reflective learning.

• Ensure that the learning from experiences is integrated into policy development and training so that practice improves with time.

Summary

Preparation for emergency treatment is a necessary precaution, given that there are occasions when such treatment will be necessary in a mental health service. It is essential that staff should be aware both of the ethical considerations and the medical options for dealing with aggression when it occurs. Of primary importance is to preserve a patient’s dignity and autonomy as much as possible, whilst following a methodical process, which ensures that any necessary treatment is given in the least restrictive and way that preserves dignity. This in turn will ensure the best long-term outcome for the patient.

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Box 1

Treatment should never be given against a person’s will unless they are likely to pose a serious risk to themselves or others, if they do not receive treatment. In most cases, if sufficient skill and time are used, it is possible to find a solution that is acceptable to all parties.

Remember that it is against a person’s human rights to force them to take treatment against their will, and forcing treatment will only make them suspicious of the care you might provide them in the future.

Box 2

Rapid tranquilization can be extremely traumatic psychologically for the patient and his family. It is not without serious risks and adverse effects, including heart and breathing problems. Therefore, the decision to administer rapid tranquilization must not be taken lightly and all other possibilities must be explored first. The risks are higher among children (who should not be given rapid tranquilization), the elderly and pregnant women, as well as those with significant heart disease, dementia, or epilepsy. Doses of medication suggested in this chapter may need to be adjusted for these groups.

Box 3

If the patient has a dystonic reaction (painful muscle spasms, such as flexing of the neck to one side and rolling of the eyes) or other side-effects, such as rigid muscles, anticholinergic medication, such as procyclidine or benzhexol, should be used to treat the problem.

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|  | **Medication and dose\*** | **Notes** |
| Choice 1 | Lorazepam, 4 mg, PO or IM | Effective, particularly when there is no clear evidence of psychosis |
| Choice 2 | Olanzapine, 10 mg, PO or IM | To be given for psychosis, where available |
| Choice 3 | Haloperidol, 10 mg, with promethazine, 25–50 mg, PO or IM | Best choice for rapid effect in psychosis |
| Choice 4 | Haloperidol, 10 mg, IM or PO with diazepam, 5–10 mg, PO | If other benzodiazepines are not available, diazepam should not be given IM.  Beware of the risk of dystonic reaction. |
| PO oral | IM intramuscular |  |

\* These doses are for a healthy adult of average build. Seek advice of an experienced doctor or pharmacist when treating other groups as treatment options or doses may need to be adjusted.

