

# Managing the violent patient

## Introduction

Managing the violent or acutely disturbed patient can be a difficult and stressful task. Most doctors are likely to encounter such patients in the emergency department or in inpatient psychiatric settings, but such patients may also present on medical or surgical wards. The principles outlined below relate predominantly to the accident and emergency (A&E) setting, but they may be applied to other settings. If the patient presents to A&E or a medical ward, the mental health liaison team should be consulted immediately for a psychiatric assessment of the patient.

## Safety

Personal safety and the safety of others are of paramount importance when assessing a potentially violent patient. Always ensure that there is adequate back up from security staff. The patient may have been admitted under section 136, a section of the Mental Health Act 1983 which permits a police officer to remove a disturbed patient in a public place to a 'place of safety' for assessment, which may be the police station or A&E department. If this situation arises, ensure that the police remain with the patient until the situation is under control.

All emergency departments should have at least one designated interview room located close to the main treatment area, which should be equipped with an alarm, an outward opening door and a window for observation. The exit should be clear and the room should not contain any potential weapons. A senior member of the nursing team should be informed before starting the interview and a member of staff should be present at all times.

**Dr Afia Ali** is Senior House Officer in Psychiatry, St Luke's Hospital, London and **Dr Angela Hassiotis** is Consultant Psychiatrist for People with Learning Disabilities and Senior Lecturer, Department of Mental Health Sciences, Royal Free and University College London Medical School, London W1W 7EY

Correspondence to: Dr A Hassiotis

If there are concerns about safety, leave the situation immediately and alert nursing staff and security. The police may need to be contacted, particularly if the patient is in possession of a weapon.

## Assessment of agitated patients

In an emergency situation it is not always possible to obtain a full history from a disturbed patient. Attempt to gather as much information as possible from the patient, relatives and the police, and review any medical notes. Always consider the possibility that the patient may be suffering from an acute medical or surgical problem, the treatment of which may resolve the disturbed behaviour. Drug and alcohol intoxication or withdrawal are common causes of agitation and violence. Other causes of violent behaviour are outlined in *Table 1*.

Aggression may arise as a direct result of psychiatric symptoms (e.g. persecutory ideas) or may arise as a result of a breakdown in communication or because of a real or perceived injustice. The strongest risk factor associated with violence is a previous history of violence. *Table 2* describes other important risk factors associated with violence. Enquire about the precipitants of previous episodes of violence, the nature of the violence and the

**Table 1. The causes of violence**

Delirium (e.g. as a result of hypoglycaemia, diabetic ketoacidosis, cerebrovascular accident, head injury, meningitis, hypoxia, post-ictal confusion)

Urinary retention

Side effects of medication (akathisia caused by antipsychotics)

Drug and alcohol intoxication or withdrawal

Frontal lobe damage

Dementia

Schizophrenia

Mania

Depression

Acute stress reaction

Personality disorders: dissocial, emotionally unstable, paranoid

**Table 2. Risk factors for violence**

Past psychiatric history	History of aggressive or violent behaviour
	Verbal threats of violence
	Previous expression of intent to harm others
	Severity of previous attempts
	Previous use of and access to weapons
Clinical variables	Misuse of alcohol or illicit substances
	Recent stressful event
	Active symptoms of psychosis (especially command hallucinations, delusions of passivity, thought insertion/withdrawal/broadcast)
	Agitation or excitement
	Impulsive personality traits
	Poor treatment compliance
	Side effects of medication (akathisia with antipsychotics and disinhibition with benzodiazepines)
Personal history	Cruelty to animals, fire setting, bedwetting
	Loss of parent at a young age
Social history	Evidence of rootlessness
	Lack of social support

use of weapons. Conduct a mental state examination, observing for any signs suggestive of imminent aggression:

- Tense and angry facial expressions
- Prolonged or refusal of eye contact
- Dilated pupils, increased breathing and heart rate
- Pacing, restlessness
- Increased volume or pressure of speech
- Verbal threats or gestures
- Delusions or hallucinations with violent content.

A physical examination should be conducted if possible to identify any organic causes. In most situations a definitive diagnosis of the cause of violent behaviour may not be apparent until the situation and disturbed behaviour is under control.

### Managing violent behaviour

It is important to calm the patient down and to regain control of the situation. In all situations de-escalation should be used before other interventions such as rapid tranquillization or physical restraint are considered.

#### De-escalation

De-escalation involves the use of techniques aimed at calming down the patient and reducing disturbed behaviour. A

potentially difficult situation may be averted through careful planning and showing some consideration for the patient. Placing disturbed patients in a quiet or private room can decrease external stimuli. Providing clear information, and offering food and drink or blankets may improve the patient's willingness to cooperate. All potential weapons should be removed at an early stage.

The main principles of de-escalation involve acknowledging any grievances that the patient may have, conveying concern and empathy for the patient, and ensuring the safety of the patient and others.

It is recommended that one member of staff, preferably someone who knows the patient well, takes overall control of the situation. This will involve removing other patients from the area, enlisting the help of other colleagues and ensuring there is adequate space. Clear assertive instructions should be given and the patient should be moved to a safe place where possible. An attempt should be made to establish rapport. Open questions such as 'What has caused you to become upset?' and statements emphasizing empathy such as 'I understand that you are feeling frustrated' are helpful and show interest in the patient's wellbeing. Avoid rushing the

patient and make it clear that you have time to listen to his/her concerns.

It is important to be aware of one's own non-verbal communication. Crossed arms, a forward leaning posture, or prolonged or intense eye contact may be perceived as hostile or threatening. Appearing confident and using a calm and controlled tone of voice, without appearing dismissive, is essential. Where possible, the patient's needs should be met and alternative options should be stated clearly.

Despite attempts to de-escalate the situation, the behaviour may continue to deteriorate. It may then be necessary to consider other options such as rapid tranquillization.

#### Rapid tranquillization

This is the administration of medication to calm or sedate a disturbed patient. The principle is to reduce patient suffering, to facilitate improved communication and to reduce the risks to the patient and others. Most trusts will have local policies on rapid tranquillization. Benzodiazepines such as lorazepam, and antipsychotics such as haloperidol, are commonly used. Be aware of the adverse side effects associated with these drugs (*Table 3*).

Before administering these drugs always ensure that resuscitation equipment is at hand. Flumazenil should be available to reverse the effects of benzodiazepine-induced respiratory arrest and should be administered if the respiratory rate falls below 10 breaths per minute. Procyclidine or bextropine can be used to treat acute dystonic reactions caused by antipsychotics. Following administration, there should be ongoing monitoring of pulse, respiratory rate, oxygen saturation and blood pressure until the patient is ambulatory.

Oral medication should be offered in the first instance. Lorazepam should be considered as the first-line choice in patients where there is uncertainty about the patient's previous medical and psychiatric history and in those who have not previously been treated with antipsychotics. Lorazepam is safer than antipsychotics where there is a history of cardiac disease. Haloperidol may be preferable in those who have a history of psychosis and have previously been exposed to antipsychotics. Often a combination of both drugs is used and produces a better response.

**Table 3. Adverse effects associated with rapid tranquillization**

Benzodiazepines	Loss of consciousness
	Respiratory depression or arrest
	Cardiovascular collapse
	Paradoxical disinhibition and agitation
Antipsychotics	Excessive sedation
	Loss of consciousness
	Cardiovascular collapse
	Seizures
	Acute dystonic reactions (muscular rigidity, e.g. oculogyric crisis, torticollis)
	Akathisia (subjective experience of restlessness)
	Neuroleptic malignant syndrome (muscular rigidity, pyrexia, impaired consciousness)

If oral medication fails or the patient refuses to give consent, proceed to the next stage, which involves intramuscular administration of drugs. *Figure 1* outlines the various stages of rapid tranquillization. Where possible, the patient's consent should be obtained. However, intramuscular medication can be given under common law, without the patient's consent, if considered to be in the patient's best interests. This is only applicable in an emergency situation where the patient is a danger to him/herself or to others. Should this

**Figure 1. Rapid tranquillization for disturbed or violent patients. From Taylor et al (2005). IM = intramuscular; IV=intravenous.**

**Step 1: De-escalation, time out**

**Step 2: Offer oral treatment**

Haloperidol 5 mg, olanzapine 10 mg or risperidone 1–2 mg with or without lorazepam 1–2 mg (or lorazepam can be given alone) repeat after every 45–60 minutes if insufficient response.

If three doses fail:

**Step 3: Consider IM treatment**

Haloperidol 5 mg or lorazepam 1–2 mg or both together or olanzapine 5–10 mg (do not combine with benzodiazepine)

Repeat up to two times after 30–60 minutes.

If this fails:

**Step 4 (consult senior colleagues): IV treatment**

Diazepam 10 mg over at least 5 minutes

Repeat after 5–10 minutes if no effect (up to three times)

**Step 5: seek expert advice**

Amylobarbitone 250 mg IM or paraldehyde 5–10 ml IM

situation arise and the patient is suspected of having a mental disorder, a Mental Health Act assessment should be arranged.

If intramuscular medication fails to control the disturbed behaviour, senior colleagues should be consulted immediately for advice. The next step in the algorithm is intravenous diazepam. This should be used with caution in the elderly or those with organic brain damage. The majority of cases are unlikely to reach this stage. In extremely rare cases, amylobarbitone, a powerful respiratory depressant, may be required to control disturbed behaviour which has failed to respond to the above measures. It will be necessary to seek the advice of experts and to have facilities for mechanical ventilation available.

### Physical restraint

'Control and restraint' procedures may need to be used for the administration of parenteral medication, where the patient is refusing medication, or where it is necessary to contain the patient to prevent imminent harm to the patient or to others. They should be used for the shortest period possible. Because physical restraint is potentially dangerous to the patient and staff, only those who have received adequate training should be involved and it should not be undertaken unless there is a sufficient number of staff available.

During the procedure, one staff member should be responsible for protecting the head and neck and should ensure that the airway and breathing is not compromised. The amount of force that is used should be proportionate to the situation and direct

force should not be applied to the neck, thorax, abdomen, back or pelvic area. The patient and the family should be provided with an explanation of the reasons for the procedure.

### Further management

Once the situation is contained, a full history and physical examination should be conducted, if not already performed. A urinary drug screen and blood tests may reveal an organic cause for the behaviour. If the patient is suspected of a psychiatric disorder, an admission to a psychiatric unit, possibly to a psychiatric intensive care unit, should be arranged for further assessment of the patient's mental state, diagnosis and management. This may need to be under a section of the Mental Health Act if the patient refuses to consent to a hospital admission and where there is sufficient risk to the patient and others. Debriefing following the event may be helpful for staff involved in the incident, and victims should be offered support and sympathy. **BJHM**

*Conflict of interest: none.*

Taylor D, Paton C, Kerwin R (2005) *The Maudsley 2005–2006 Prescribing Guidelines*. 8th edn. Taylor & Francis, Oxon

#### Further reading

- Davison SE (2005) The management of violence in general psychiatry. *Adv Psychiatr Treat* **11**: 362–70
- Macpherson R, Dix R, Morgan S (2005) A growing evidence base for management guidelines: revisiting guidelines for the management of acutely disturbed psychiatric patients. *Adv Psychiatr Treat* **11**: 404–15
- National Institute of Clinical Excellence (2005) *The Short Term Management of Disturbed/Violent Behaviour in In-patient Psychiatric Settings and Emergency Departments*. NICE Guideline 25. National Institute of Clinical Excellence, London ([www.nice.org.uk](http://www.nice.org.uk))

### KEY POINTS

- Always consider safety first and avoid placing oneself and others in danger.
- Consider both organic and psychiatric causes for the disturbed behaviour.
- Commence with de-escalation measures before considering rapid tranquillization or physical restraint.
- Have resuscitation equipment ready where rapid tranquillization is being considered.
- Use small doses of drugs where possible and monitor the patient's vital signs.