The Patient with Agitated or Aggressive Behaviour

May be related to mental illness or organic disorders, such as delirium, HI, ↓BSL, epilepsy
NB: Early recognition and intervention may prevent escalation to violence.

Precipitants of behavioural disturbance

Fear

- Psychosis/paranoia
- Anxiety
- People who feel threatened

Decreased inhibition

- Confusion e.g. delirium, dementia
- Neurological disorders
- Intoxication/disinhibiting medication
- Poor impulse control

Anger/Frustration

- Humiliation
- Rejection
- Antisocial/borderline/paranoid personality disorder/trait
- Being ignored or needs/concerns not being addressed
- Extended waiting times

Stress

- Grief
- Frustration/helplessness
- Pain
- Agitation

Management

Follow SACCIT

Safety
Assessment
Confirmation of provisional diagnosis
Consultation
Immediate treatment
Transfer of care

Safety

- Ensure adequate back-up
- Seek help if you feel threatened or at risk
- Allow patient to settle if indicated
- Do not threaten or challenge or attempt to disarm by yourself
- Approach in a calm, confident manner and avoid sudden or violent gestures
- Be respectful, avoid prolonged eye contact, do not confront, corner or tower over
- Focus on the here and now, and do not delve into long-term grievances or issues

Assessment

It may not be appropriate to get a detailed history & exam immediately.
Rapid history and assessment of mental state, while attempting to diffuse the situation.

Assess

- Signs of impending/actual aggression: Can include angry facial expressions, loud speech, refusal to communicate, withdrawal, overt threats, restlessness, persecutory ideation, violent delusions or hallucinations, intoxication.
- Details of aggressive behaviour and thinking:
    - What are the patient main concerns?
    - Is the patient making specific threats to harm self?
    - Is there an intended victim?
    - Is there a (potential) weapon accessible?
- Risk factors
    - History of violence (most important factor)
    - Impulsiveness
    - Young men
    - History of childhood abuse
    - Substance abuse/intoxication
    - Personality disorder (antisocial, borderline)
    - Psychosis (especially command hallucinations, persecutory delusions or systematised delusions focused on a particular person)
    - Organic cause/delirium (head injury, metabolic disturbance)
- Current mental state (affect, psychosis, impulsivity, intoxication, delirium/confusion)
- Physical examination: May be limited to observation initially + any vital signs obtained. When possible full exam esp CNS, HI, metabolic insult, substance abuse.

Confirmation of provisional diagnosis

Corroboration:

- A history of violence is one of the best predictors of future violence.
- Consult medical records, staff, GP, police, family & friends before approaching patient.

Investigations

- Consider: Urinalysis ± drug screen, FBC, UEC, TFT, ± CT/MRI, ±LP

Consultation

If assessed as mentally ill or mentally disordered → will probably require admission. Involve Mental Health early to assist with immediate Mx & transfer to the mental health facility.

Immediate treatment

Maintain safety

As for Safety above. In addition ensure:

- If police present, that they have searched patient for weapons,
- You wear duress alarm, maintain safe distance (2m) & you can be seen by other staff
- Use open area or one with >1 exit (don't block an exit from the patient).

Verbal de-escalation/distraction

- Single person should talk to the patient in calm controlled manner.
- Approach in an empathic, confident manner and avoid sudden or violent gestures.
- Emphasise your desire to help.
- Have a non-aggressive stance with arms relaxed, do not confront or corner patient.
- Allow patient time to state concerns, acknowledge them and try to focus on the present and what can be done now.
- Offer courtesies, cup of tea (lukewarm), sandwich, phone access, etc
- Do not touch the patient without their permission to do so.

- Encourage the patient to choose help such as agreeing to talk to a mental health professional or accepting medication voluntarily
- If aggression escalates and violence seems imminent, withdraw and mobilise help. If trapped, a submissive posture with eyes averted, hands down and palms toward patient may help. If all else fails, lift arms to protect head and neck, shout 'NO' very loudly and try to escape.

Legal Issues

- Duty of care allows for involuntary sedation &/or restraint if acutely behaviourally disturbed and a perceived immediate danger to patient or others.
- Consent should be sought whenever possible.
- Mental Health Act allows for involuntary psychiatric Rx for acute episode of dangerous mental illness or disorder.

Medical/Sedation

- Oral Rx may be preferred if patients can be safely and quickly talked down, are compliant and are not at imminent risk of harm to self or others. Aim is for relief of distress.
- Parental Rx may be given IM or IV. IV may be more predictable and faster but requires access which if not incur a delay if not already achieved. Aim for rousable sleep.
- Ideally in area where access to patient, monitoring and resus equip is maximized.
- Staff to wear PPE.
- Check for allergies, pregnancy, previous adverse reactions if possible
- First line options suggested in NSW: (See below for more details)
    - Adult: IV **diazepam±droperidol** or IM **midazolam±droperidol** or PO **diazepam** or **olanzapine**. [In practice IV **midazolam** often preferred]
    - Elderly: PO **lorazepam** or **olanzapine** or **resperidone** or IM **olanzapine**
    - Children & Adolescents: PO **diazepam** or **olanzapine** or **resperidone** OR IV **diazepam±droperidol**
- Use lower doses, in those who are frail or medically compromised. Seek & treat:
    - Respiratory depression, hypotension and dystonia
- Beware:
    - Excess pressure on neck/chest/abdomen
    - Biting, spitting, scratching and flailing limbs,
    - needle-stick injury
- Monitor post-sedation (initially q15m) ± O_2
- Documentation

Physical restraint

Last resort: applied safely & in appropriate way by trained staff, for min time with close obs.
Brief manual restraint used in most acute parenteral sedations for sev behavioural disturbance.

- At least 6 people req (4 limbs, 1 controlling head/neck & 1 Rx giver).

Use of devices (mechanical restraint) should only be used in extreme circumstances

Calling for security or police assistance

If not medical/psychiatric cause for aggression or situation too extreme → Security ± Police.

Transfer of care

Transfer only when stable.
If calm and fully assessed (incl by MH) as safe for D/C → ensure follow up arranged.
If assessed as mentally ill or mentally disordered → transfer to the mental health facility.
If sig. medical reason (HI, infection, intoxication) may need medical admission.

Drug Details

ADULTS ROUTE	MEDICATIONS		INITIAL DOSE	NOTES	CAUTION
IV [1]	BENZODIAZEPINE (preferred)	Diazepam [3] or Lorazepam	5–10 mg 2–4 mg	Titrate 5 mg boluses every 3-5 min, (up to max 60 mg total per event). For Lorazepam, 2 mg bolus, max 8 mg per event[5]	Respiratory depression
	Or				
	BENZODIAZEPINE & ANTIPSYCHOTIC[2]	Diazepam [3]	5–10 mg	Titrate 5 mg boluses every 3-5 min, (max 60 mg total per event)	Respiratory depression
		Droperidol [4]	5–10 mg	Repeat after 20 min (max of 15 mg total per event)	Hypotension Dystonic reactions
IM [7]	BENZODIAZEPINE (preferred)[7]	Midazolam[6] or Lorazepam	5–10 mg 2–4 mg	Repeat q 20 min (up to 20 mg total per event) For Lorazepam, 2 mg bolus, up to 8 mg per event	Respiratory depression
	Or				
	BENZODIAZEPINE & ANTIPSYCHOTIC[4]	Midazolam [6]	5–10 mg	Repeat q 20 min (up to 20 mg total per event)	Respiratory depression
		Dropiderol	5–10 mg	Repeat q 20 min (up to 15 mg total per event)	Hypotension Dystonic reactions
ORAL	BENZODIAZEPINE (preferred)	Diazepam or Lorazepam	5–20 mg 2–4 mg	Diazepam (up to 60 mg total per event) Lorazepam (up to 20 mg total per event)	Diazepam: Respiratory depression, & it may take 20–40 minutes until desired effect
	And/or				
	ANTIPSYCHOTIC [4]	Olanzapine wafer	5–10 mg	Max dose 20 mg total per event	

[4] Haloperidol (up to 15 mg per event) can be substituted if droperidol is not available

OLDER PERSONS ROUTE	MEDICATIONS		INITIAL DOSE	MAXIMUM DOSE IN 24 HOURS	CAUTION
ORAL	BENZODIAZEPINE (preferred)	Lorazepam	0.5–1.25 mg	Max dose 7.5 mg (total per event)	Respiratory depression, confusion, ataxia
	And/or				
	ANTIPSYCHOTIC[1]	Olanzapine wafer OR	2.5–5 mg	Max dose 10 mg (total per event)	Confusion, hypotension, bradycardia, ataxia
		Risperidone	0.5–1 mg	Max dose 4 mg (total per event)	Hypotension, sedation, ataxia
IM [7]	Antipsychotic	Olanzapine[2]	2.5 mg	2.5 mg increments to max dose of 7.5 mg (total per event). **DO NOT** use if delirious; seek specialist advice	Confusion, hypotension, bradycardia, ataxia

CHILDREN AND ADOLESCENTS*					
ROUTE	MEDICATIONS		INITIAL DOSE	MAXIMUM DOSE	CAUTION
ORAL	BENZODIAZEPINE (preferred)	Diazepam	0.2 mg / kg	Max dose 10 mg	Diazepam: Respiratory depression, & it may take 20-40 minutes until desired effect
	And/or				
	ANTIPSYCHOTIC[1] (Usage of already prescribed antipsychotic medication preferred)	Olanzapine wafer	2.5–5 mg for children 20–40 kg 5–10 mg for children > 40 kg	Max dose 10 mg	Hypotension Dystonic reactions
		Risperidone	0.02–0.04 mg/kg	Max dose 2 mg	Hypotension Dystonic reactions
IV [1]	BENZODIAZEPINE (preferred)	Diazepam[2]	0.1–0.2 mg/kg	Administer boluses slowly over 2–3 min, max 10 mg total per dose	Respiratory depression
	Or				
	BENZODIAZEPINE & ANTIPSYCHOTIC[1]	Diazepam[2]	0.1–0.2 mg/kg	Administer boluses slowly over 2–3 min, max 10 mg total per dose	Respiratory depression
		Droperidol[3]	0.1–0.3 mg/kg	Max dose 10 mg	Hypotension Dystonic reactions