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PATIENT VIOLENCE

Safety in patients with violent behavior

- The aggressive and/or violent patient presents unique challenges.
- Like suicidal patients, aggressive individuals are difficult to treat and they tend to elicit strong negative reactions in hospital personnel ranging from anger to fear.
- Workplace violence is unfortunately commonplace within the health care setting, and is particularly prominent in the inpatient psychiatry ward and emergency department settings.
- Workplace violence occurs so frequently that there is a perception among health care workers that violence is “the norm” and an expected part of their job.

- The assessment and management of the violent patient should include provisions for patient and staff safety as well as a thorough search for the underlying cause of violent behavior.
- The section below addresses the differential diagnosis of violent behavior, predictions of violence, the pharmacotherapy for the treatment of aggressive and/or agitated behavior, and the use of seclusion and physical restraint. It also provides an overview of potential risk factors for violent behavior.

Differential Diagnosis

- There are many causes of violent behavior; some are social, medical, or biological in nature.
- The most common characteristic of the violent patient is alteration in mental status.
- Factors such as metabolic derangements, exposure to xenobiotics (both licit and illicit), withdrawal syndromes, seizures, head trauma, stroke, psychosis, cognitive impairment, and personality disorder all predispose a patient to aggression and violence.
- Additionally, patients with severe pain, delirium, or extreme anxiety often respond to the efforts of emergency personnel with resistance, hostility, or overt aggression.

Prediction of Violence

- Although there is a high expectation that violence is predictable, there are no proven predictors of violence.
- Prior history of violence is postulated as a risk factor for future violence.
- Patients in police custody are involved in 29% of shootings in emergency departments.
- Predicting violent behavior based on medical diagnosis (eg, patients with HIV) is unfruitful and leads to bias or discrimination.
- Studies of emergency department violence show the following risk factors: the presence of guns, area of gang activity, low socioeconomic status, and interacting with patients who were recently given bad news.

Substance Use and Violence

- The association between substance use and violence is well established. Alcohol is found in the offender, the victim, or both in one-half to two-thirds of homicides and serious assaults.
- Substance use is seldom the sole cause, but it contributes to violence in a number of ways. Substance use interacts with other physiologic, cognitive, psychological, situational, and cultural factors including any underlying mental illness.
- Toxicity causes disinhibition, impulsivity, perceptual disturbance, paranoia, irritability, misinterpretation, affective instability, and/or confusion. For example, synthetic cannabinoids, synthetic cathinones, and phencyclidine are well known to cause agitation, which is often accompanied by violent and uncontrollable behavior.
- Withdrawal syndromes also promote aggressive behavior for a multitude of reasons, including physical discomfort, anticipatory anxiety, irritability as a direct result of withdrawal, and withdrawal-related delirium.
- Well-known xenobiotics that cause irritability and associated behaviors in withdrawal include ethanol, benzodiazepines, and opioids.

Mental Illness and Violence

- The relationship between mental illness and violence is also complex.
- In one large epidemiologic study, the prevalence of violence for those without mental illness was 2%, whereas schizophrenia was associated with an 8% rate of violent behavior.
- In addition to substance abuse and severe mental illnesses, researchers have consistently found a greater prevalence of personality disorders among individuals who become violent in an inpatient setting as compared to nonviolent inpatients.
- Patients with either borderline or antisocial personality disorders

- Hallucinations lead to aggression, such as when patients explicitly follow the instructions of a violent command auditory hallucination.
- Paranoid ideation that leads an individual to believe that she or he is at imminent risk of bodily harm (“They’re trying to kill me”), sexual victimization (“Men and women are raping me”), or humiliation (“Everyone is laughing at me”) or feeling physically trapped are examples of thoughts that lead psychotic patients to be aggressive.

Alternative Etiologies

- **Delirium from any underlying condition is a cause of aggression.**
- **Violence risk is also associated with cognitive dysfunction such as traumatic brain injury and dementia.**

Assessment of the Violent Patient

- The comprehensive evaluation of the violent patient include a complete physical examination with the intent of revealing the underlying cause of the violent behavior as well as ensuring the discovery of secondary patient injuries.
- It is important to attempt to differentiate toxicity or withdrawal, cognitive impairment, delirium, and mental illness as treatment differs depending on etiology.
- Recommended laboratory analyses include blood chemistries (glucose, electrolytes), a complete blood count, liver function tests, renal function tests, thyroid function tests, and urinalysis.

Treatment

- There are 3 main approaches to controlling aggressive behavior in order of escalation: First and foremost, there is verbal de-escalation.
- When this has failed, medical anxiolysis and sedation will be the next approach.
- Finally, under the most extreme circumstances where there is significant risk for harming self or others, the use of physical restraints are indicated.

Verbal De-escalation

- Because of several high-profile deaths involving restraints, there is a continued focus on advancing techniques and training in de-escalation.
- These techniques use both verbal and nonverbal communication, and include talking to a patient, building rapport, listening and understanding in a calm and compassionate manner, using a calm voice, making eye contact, and focusing on the person and not the behavior.

pharmacologic Interventions

- The goal of acute pharmacologic intervention for agitated or violent behavior is to target the suspected cause of the agitation while regaining behavioral control and ensuring safety.
- Sedation alone may frighten and/or anger the patient and does not address the underlying etiology of the problematic behavior. For example, the patient in ethanol withdrawal presenting with agitation would benefit from a benzodiazepine, whereas, an antipsychotic could be detrimental and lead to unnecessary side effects .
- Chemical restraint is defined as “chemical measures for confining a patient’s bodily movements, thereby preventing injury to self or others and reducing agitation.”

- Haloperidol is safely used in the treatment of agitation and aggression in patients with psychoses and delirium. It can be administered orally, intravenously, or intramuscularly. Dosing intervals range from 30 minutes to 2 hours, with a usual regimen of haloperidol 5 mg given every 30 to 60 minutes; most patients respond after one to 3 doses. It is important to take the individual patient into consideration. For example, in elderly and/or medically compromised patients, behavioral control is often achieved at doses as little as 1 to 2 mg.

- Various benzodiazepines are quite effective for sedation; their use has been examined in patients with psychoses, stimulant toxicity, sedative–hypnotic and alcohol withdrawal, and postoperative agitation.
- Diazepam is given intravenously (IV) 5 to 10 mg, with rapid repeat dosing titrated to desired effect. Because diazepam is poorly absorbed from intramuscular (IM) sites, its preferred route of administration is either IV or oral.
- Lorazepam 1 to 2 mg or midazolam 5 to 10 mg is given orally or parenterally and repeated at 15- or 30-minute intervals, respectively, until the patient is calm. Midazolam is frequently used in the emergency department because of its rapid onset of action and short duration of effect of 1 to 4 hours, but it has a significant amnestic effect. Diazepam has a rapid onset of action intravenously and has a prolonged duration of action. The disadvantage of lorazepam is its delay to effect, which limits the rapidity of clinical response.

- If a patient is agitated in the context of alcohol intoxication, we recommend antipsychotics and we suggest that benzodiazepines should be avoided because of the potential to cause additive respiratory depression. In contrast, benzodiazepines have a unique role in the treatment of agitation secondary to cocaine toxicity .
- Antipsychotics, particularly low-potency antipsychotics (such as chlorpromazine), lower the seizure threshold in animals, so their use for patients with cocaine/amphetamine toxicity or alcohol/sedative–hypnotic withdrawal is not recommended.
- In general, concerns regarding respiratory depression mandate careful observation and monitoring of patients receiving sedation with any xenobiotic .

Physical Restraint

- Isolation and mechanical restraints are also used in the treatment of violent behavior.
- it is not indicated for patients with unstable medical conditions, delirium, dementia, self-injurious behavior such as cutting or head banging, or those who are experiencing extrapyramidal reactions as a consequence of antipsychotics such as an acute dystonic reaction.
- Mechanical restraint is used to prevent patient and staff injury, although it does occasionally lead to patient and staff injury itself.

Violence Warning Signs

- ❑Agitated movements
- ❑Body posturing, rapid/shallow breathing
- ❑Clenched fists
- ❑Loud vocalizations
- ❑Pacing
- ❑Staring
- ❑Striking at inanimate objects
- ❑Threatening statements

thank you for your attention