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Editorial

On Managing Violent Psychiatric Inpatients

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Editorial

The literature on restraint and seclusion is very large, and can be gleaned from the American Psychiatric Association's 1980 Task Force Report on the subject [1]. Since that time, 30 years ago, little has changed regarding the employment of physical restraints in clinical practice, though regulations promulgated by the Joint Commission for Accreditation for Healthcare Organization and the Center for Medicaid and Medicare Services have emphasized stringent limits on how long a patient can be restrained and what kinds of observations should take place. A recent resource document from the Journal of the American Academy of Psychiatry and Law summarizes these matters [2].

Advocates for the mentally ill and families of patients exhibit a never ending wishfulness that violent patients can be fully controlled with verbal redirection, behavior therapy paradigms or medication. Yet some forms of restraint are used in most psychiatric facilities [3]. The problem, of course, is that even when used properly, mishaps occur. Within U.S. hospitals, thousands of patient/patient and patient/staff injuries occur each year [3,4]. Death following restraint also occurs; each year, one such case is brought to our attention. Typically, the case involves overzealous restraint when many mental health workers, as opposed to one per extremity, struggle to contain a severely violent and often overweight patient who thrashes about and ultimately dies of asphyxiation. Often, an observer is not present to monitor the patient's breathing. Are these deaths preventable? Sometimes, but not always, even in the best of facilities. Any facility which boasts that they do not ever restrain a psychiatric patient typically does not accept such a patient or transfers the case to another place.

Most assaults are impossible to predict. They may stem from simple altercations between two patients, or reflect psychotic episodes with paranoid states or organic impairment [5]. Some assaults are more predictable and are the product of patients know to be chronically aggressive. Within any hospital, staff typically recognize impulse-prone persons known to frequently strike out at staff or other patients. Keeping these patients in the mainstream of an inpatient community is difficult, and 1:1 watchfulness may be required. We have seen 2:1 and 3:1 staffing used in cases of deeply psychotic patients, but this exhausts manpower and cannot be continued indefinitely. Ambulatory restraints can be used, but only for a short time as state and government standards prohibit restraints without clear indication. Thus, using an arm restraint tethered to the waist for a patient who frequently swings out and hits others cannot be utilized prophylactically, even if the probability of assault is very high. Paradoxically, there are no limits on the use of tranquilizing medications. In theory, a patient could receive anesthetic dosages of drugs without consequence. But to use any kind of chronic physical device puts the hospital at risk for sanctions by accreditation agencies. Adverse publicity and litigation can ensue.

Prophylactic ambulatory restraints are one issue. A more common issue is the non-standardized use of restraints when a patient becomes violent and must be subdued by staff. Typically, the procedure for restraint (and subsequent seclusion, if needed) is taught in-house. There exist proprietary manuals on how to physically restraint patients and what holds to employ, but each hospital has its own methods and there are no national standards regarding usage as there are for Cardiopulmonary Resuscitation (CPR) techniques where trainees are taught how to perform chest compressions and how to do mouth-to-mouth breathing. Curiously, the American Psychiatric Association's published guidelines for restraint and seclusion furnishes no pictures or diagrams depicting actual take-down procedures. In clinical practice, nurses and aides are typically the people who restraint the violent psychiatric patient. Strangely, the very physicians who order restraints know little or nothing about their employment. Doctors get no training in the use of restraints and relegate the procedures to ancillary staff. But this disavowal of involvement goes deeper. Psychiatric residents in training get extremely limited formal instruction on the management of violence. Unlike depression or schizophrenia, aggression remains a stepchild entity which the American Psychiatric Association wishes to deemphasize because it is the dark side of the profession; in contrast, depression and schizophrenia are the more noble clinical entities. If residency programs actually wished to teach students about violence, they would sponsor rotations through forensic facilities where the most violent patients are generally housed. Here, the hybrid existence of prison and hospital allows for the employment of guards who are better trained to contain violent outbursts. The point to be made is that awareness of restraint needs and techniques must move from professional darkness into light. At one time, we gave aggression management courses at the annual meetings of the APA. We taught such things as how to talk down a weapon wielding patient and some basic restraint paradigms. Attendees rolled up their sleeves and took part in the various holds. The attendance at these courses was high, and participation generated robust discussions about safety in the workplace.

In older days, restraint devices included strait-jackets, cold wet sheet packs, special restraint chairs, and hoods to cover the heads of combative patients. These devices have fortunately fallen into disrepute with the advent of psychopharmacology. Still, the

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regrettable fact remains that some form of physical restraint still has a place in the management of violent psychiatric patients.

References

1. Seclusion and Restraint. Task Force Report #22, American Psychiatric Association, 1985.
2. Metzner J, Tardiff K, Lion J,Reid WH, Recupero PR, Schetky DH, et al. Resource Document on the Use of Restraint and Seclusion in Correctional Mental Health Care. J Am Acad Psychiatry Law. 2007; 35: 417-425.
3. Lion J. Commentary on Regulation, Wishfulness, and Denial. J. Am Acad. Psychiatry Law. 2011; 39, 465-476.
4. Lion J. Training for Battle: Thoughts on Managing Aggressive Patients. Hosp. Community Psychiatry. 1987; 38, 882-884.
5. Tardiff K, Lion J. Seclusion and Restraint. In: RI Simon, K.Tardiff (Eds) Textbook of Violence Management and Assessment: American Psychiatric Assn Inc., Washington DC. 2010.

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