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RECOGNITION AND MANAGEMENT OF AGITATION IN ACUTE MENTAL HEALTH SERVICES

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Abstract:
Introduction: *Agitation among patients is a frequently cited behavioural problem across a variety of health settings.* ***Objectives:*** *The main objective of the study is to analyse the recognition and management of agitation in acute mental health services.* ***Material and methods:*** *This analytical study was conducted in The Children's Hospital and Institute of Child Health, Lahore during November 2029 to July 2020. Consenting participants were non-randomly assigned to one of four semi-structured focus group interviews.* ***Results:*** *Nurses described various signs and symptoms related to agitation. In every focus group pacing, restlessness and raised voices were identified. Banging on the nurses' station or slamming doors was mentioned in two groups, while another group said agitated patients could be uncooperative and engage in anti-social behaviour.* ***Conclusion:*** *It is concluded that nurses adopted an individualised approach to management by engaging patients in decisions about their care.*

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INTRODUCTION:

Agitation among patients is a frequently cited behavioural problem across a variety of health settings. While it is considered to be distinctly different to aggression, without timely assessment and management it can quickly escalate to a loss of personal control, aggression and violence and result in injury to patients and staff. Agitation can also lead to increased periods of hospitalisation and episodes of readmission resulting in increased health care costs. There is limited epidemiologic evidence on the prevalence of agitation in mental health settings [1]. Estimates range between a high of 47.5% among newly hospitalised adults with schizophrenia in China to a low of 4.6% among psychiatric emergency presentations in Europe. This variation is due in part to the ongoing debate over a standardised definition of agitation and the use of appropriate measurement scales to aid the assessment of agitation in the clinical setting [2].

Medication, restriction within a safe environment and physical restraints are available options to calm an agitated patient. Medication can be given orally (including aerosol or swiftly dispersible tablet), intravenously (IV) or intramuscularly (IM). Often oral and IV medications are impossible when the patient is lashing out aggressively [3]. Restriction or restraints may include the use of a seclusion room or safe space, physical restraints by binding the patient safely to a bed, straitjackets, or holding the person down with or without physical restraints. All options are unpleasant and infringe freedom; all have advantages and disadvantages [4]. For example, IV medication may work faster when tranquilising an agitated patient but may also lead to cardiac and respiratory problems – not to mention extreme difficulties of delivering the treatment intravenously into an aggressive patient. IM medications are easier to administer making them more efficient in terms of implementation but the time to onset of effect is longer and less predictable than for IV. Physical restraints prevent aggressive patients from physically assaulting staff or themselves [5]. Their use may have the advantage allowing safer delivery of IV or IM medication and, perhaps lower and less frequent doses of the latter. An additional advantage is that they allow control of difficult behaviour in a situation where staff numbers are not high and provision of high staff attendance to one patient will result in relative neglect of others. The disadvantages, however, are considerable, with the overt restriction of people's freedom. Restraining a person is associated with the danger of death via asphyxiation, trauma or cardiac event [6].

Objectives

The main objective of the study is to analyse the recognition and management of agitation in acute mental health services.

MATERIAL AND METHODS:

This analytical study was conducted in The Children's Hospital and Institute of Child Health, Lahore during November 2029 to July 2020. Consenting participants were non-randomly assigned to one of four semi-structured focus group interviews. The focus group interviews were conducted in a room within the hospital's Mental Health Unit during working hours. At the start of each session participants were reminded of the need to respect the privacy and confidentiality of all group participants and that the group discussion would be audio recorded and augmented with the observer's notes on the participants' responses.

Data segments were sorted, categorized, summarized, and then organized into labels and themes. All authors reviewed verbatim transcripts and discussed the coding and themes until consensus was reached.

RESULTS:

Nurses described various signs and symptoms related to agitation. In every focus group pacing, restlessness and raised voices were identified. Banging on the nurses' station or slamming doors was mentioned in two groups, while another group said agitated patients could be uncooperative and engage in anti-social behaviour. Symptoms such as pallor, clenched fists, exaggerated hand gestures, sweating, and tightly pursed mouths were also described as signs of agitation in patients.

Most patients were male, in their early 30s, and presented with their families. In a few instances' restraints were used before admission (7%) and people had already received some sort of medical intervention (10%) such as being restraint or given medication by family, friends or self before being presented to the hospital. Taken alone, bipolar disorder, was the most frequent single diagnosis but the collective schizophrenia-like illness (schizophrenia, schizoaffective disorder, delusional disorder, brief psychotic episode).

Nurses described the involvement of patients in the management of their agitation as important. The Unit's 'Coping and Safety Plan' completed by the patient on admission was described as helpful for facilitating involvement, as well as a post-episode interview

between the nurse and the patient to discuss the incident and the management of it [7].

"I asked if she could have anything that would help her calm down in regards to, in terms of medications and she didn't want anything. After persuading her to eat, she agreed to a calmative medication in the form of a benzodiazepine…..maybe after thirty or so minutes, she had sort of like, calmed down."

DISCUSSION:

Mental health-related behavioural emergencies are reported to account for around 6% of the visits to the emergency department in USA. In this context, aggression and agitation are clinically relevant issues in both psychiatric and emergency department settings. Verbal and physical aggression may result from psychomotor agitation, of which restlessness, excitability and dysphoria are prominent symptoms. Violent behaviour has been reported to occur in 18.5% of participants with psychosis included in a recently published systematic review [8]. Consequences of this phenomenon may affect patients, their caregivers, healthcare personnel and community members, both in terms of harmful events towards self or others and stigma-driven victimisation of patients.

When facing acutely aggressive and agitated individuals, guidelines recommend clinicians to assess the feasibility of management with de-escalation techniques. Should this be deemed unpractical or proven ineffective, a pharmacological approach is the mainstay for rapid tranquillisation. Several systematic reviews have evaluated the comparative efficacy and safety of pharmacological interventions from randomised controlled trials (RCTs) in schizophrenia spectrum illness. These reviews contributed currently available policy-making policies: for instance, NICE guidelines recommend the use of lorazepam or the combination of haloperidol and promethazine as pharmacological interventions for aggression and agitation in the context of schizophrenia spectrum illnesses [9].

However, evidence supporting these recommendations is still fragmentary and a comprehensive ranking of all treatments evaluated in RCTs is still lacking. Also, several interventions lack of head-to-head comparisons with recommended and available treatment options. For example, none of the identified RCTs compared the intramuscular administration of the second-generation antipsychotic aripiprazole with either lorazepam or the haloperidol and promethazine combination [7].

Nurses' recognition of agitation was guided by their 'experience' and clinical understanding of the behavioural and verbal symptoms of agitation in patients (e.g., excessive restlessness, non-purposeful physical activity, pacing and shouting) which have been documented elsewhere [8]. In addition, nurses recognised the need to develop an awareness of the patient's base level behaviour and unique signs of agitation as patients did vary in their experience and expression of agitation. These descriptions reflect aspects of professional competency which are among the many attributes McCormack and McCance theorise nurses must possess to deliver person-centred care [10].

CONCLUSION:

It is concluded that nurses adopted an individualised approach to management by engaging patients in decisions about their care. In keeping with best practice recommendations, de-escalation strategies were the first-choice option for management, though nurses also described using both coercive and medication under certain circumstances.

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