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Coercive Interventions

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ABSTRACT

Coercion is threat of actions which compels the patient to behave in a manner inconsistent with his own wishes. Coercion is inevitable in psychiatric practices. Various coercive techniques are chemical and physical restraints, seclusion and isolation. This chapter deals with various types of coercive interventions. When and how to use coercive techniques and for what duration it is to be used and permitted. It mentions what safety measures to be used in crisis situation and how coercion can be minimised in psychiatric care.

Keywords: *Coercion, Chemical Restraint, Physical Restraint, Seclusion*

Coercion is defined as "any action or threat of actions which compels the patient to behave in a manner inconsistent with his own wishes" (Peter R. Breggin, 1982).

Persuasion is a form of discourse that attempts to convince others without hostility or threats. (For example, parents try to persuade their kids to clean their room. Alternately, kids may use persuasion to increase their allowance or borrow the car. With persuasion, there is no "do this or else" statement involved).

Coercive interventions

Coercive interventions such as involuntary medication, mechanical restraint and seclusion are common methods for managing violent behavior during psychiatric hospitalization,

1) Chemical restraint refers to the administration of a rapid tranquilizer without the consent of the patient and with or without physical restraint. Involuntary medication was also defined as the administration of a rapid tranquilizer without the consent of the patient, and with or without manual restraint. Forced medication is defined as the administration, with or without seclusion or restraint, of a rapid tranquilizer. By temporarily restricting the patient's freedom of movement, it is intended to control his or her behavior in a way that reduces the risk to their own safety or that of others (Ashcraft L, Anthony W, 2008).

Forced medication is the commonest method used on psychiatric wards to contain mentally ill patients who are violent toward themselves or others (Raboch J, Kalisova L, Nawka A, et al, 2010).

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Benzodiazepines are probably preferred for stimulant drug overdoses and for alcohol and benzodiazepine drug withdrawal syndromes, and antipsychotics are preferred for clear exacerbations of known mental disorders. Sometimes a combination of both drugs is more effective; when large doses of one drug have not had the full desired effect, using another drug class instead of continuing to increase the dose of the first drug may limit adverse effects.
Rapid tranquillization involved the oral or intramuscular administration of a combination of haloperidol and promethazine, or lorazepam to achieve rapid, short-term behavioural control of any extreme agitation, aggression or potentially violent behaviour that placed the individual and those around them at risk.

Initially, 10 mg haloperidol and 100 mg promethazine, or lorazepam 2.-5 mg was offered as oral medication to the agitated patients with psychotic or non-psychotic symptoms, respectively. Nevertheless, in some situations patients refused to take the medication orally, so IM medication (5mg haloperidol and 50mg promethazine or 2.-5 mg lorazepam) was used. Due to the coercive nature of the setting, administration of "as required" medication during a period of seclusion was also counted as involuntary medication, regardless of patient consent at the time.

If the patient can tolerate oral medications:
Diazepam - oral
0.2mg - 0.4mg/kg (Max 10mg/dose if benzodiazepine naive)
Lorazepam - oral
0.5mg - 1mg (<40kg)
1mg - 2.5mg (>40kg)
Olanzapine wafer - sublingual (SL)
2.5mg - 5mg (<40kg)
5mg - 10mg (>40kg)

If oral medication not possible:
Midazolam - IM / IV
0.1mg - 0.2mg/kg
(Max 10mg/dose)
Olanzapine - IM only
5mg (<40kg)
10mg (>40Kg)
Haloperidol - IM / IV
0.1mg - 0.2mg/kg (Max 5mg/dose, usually 2.5mg - 5mg/dose)
Ziprasidone
10‑20 mg IM (may repeat 10-mg dose q 2 h or 20-mg dose q 4 h; maximum, 40 mg/day)(Caroline Carney).

2. Physical or mechanical restraint was defined as any physical means or mechanical device, which limited temporally the patient's movement, physical activity, or normal access to his or her body.

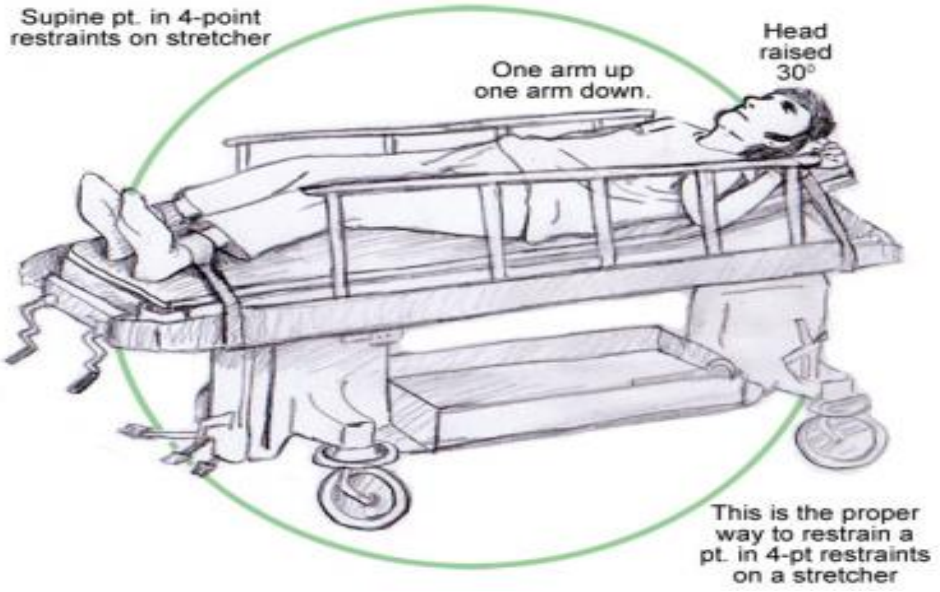
Physical Restraint Technique:

Four-point restraints may be required for patients with psychiatric illnesses or altered mental status that who become violent and dangerous in the emergency department.

Equipment for four-point restraint includes the following:

- Disposable gloves (latex-free if the patient has a known latex allergy)
- Soft nylon or leather restraints
- A hospital bed or sturdy stretcher
- Padding for any concerning pressure points
- Chemical restraints on standby (eg, haloperidol 5 mg IM, lorazepam 2 mg IM).

Patient Positioning For Four-Point Restraint



Positioning the patient in the supine position is the preferred option. The head of the bed should be elevated approximately 30 degrees to decrease the risk of aspiration. Positioning the patient in the prone position increases the risk of suffocation and should only be used as a secondary option. Do not use any pillows under the patient's head in this position.

Orders for behavioral restraints must be limited to the following:

- 4 hours maximum for adults.
- 2 hours maximum for children and adolescents ages 9-17.
- 1 hour maximum for children younger than 9 years.

It is the duty of the health care professional to discontinue the use of four-point restraints as soon as possible once it is deemed safe to do so.

Factors associated with fatality during restraint:

- Neck holds.
- Obstruction of nose and/or mouth.
- Mechanical restraints, for example garments or straps.
- Prone tying.
- Hyperflexion.
- Obesity.
- Heart disease.
- General ill health.
- Exhaustion
- Sedation without supervision (Paterson *et al*).

*Restrictive physical interventions that employ force should be used only**:***

- When other strategies have failed; even when restraint is required, it should comprise one component of an overall care plan for the service user.
- In an emergency situation when the risk of inaction outweighs the risks of restraint
- With the minimum amount of force.
- For the shortest duration of time.
- In the best interest of the service user and/or to prevent harm to third parties.
- By staff who have received specialist training and employ only the techniques for which they have received a preparation for practice (employer responsibility).
- In a way that minimises the risk of physical injury and loss of dignity.
- Ensuring avoidance of contact that could be construed as sexual.
- With subsequent debriefing for staff and, where possible, the service user.
- With formal recording and reporting of the incident.

3. Seclusion was defined as the placement of a patient in a locked room from which free exit is denied for a fixed period of time. Seclusion involves placing a service user in a locked room from which free exit is denied; it also involves isolation and the reduction of sensory stimuli (Mayers P, Keet N, Winkler G, et al, 2010). Seclusion is the preferred measure in the Netherlands.

These measures are controversial, because while they are intended to protect patients and those around them, they restrict freedom and are usually applied against a patient's will. This causes serious ethical dilemmas for patients, their caregivers, clinicians and policymakers.

Combined interventions should be avoided, especially the combination of seclusion and mechanical restraint, which was found to be associated with more distress.

- With regard to the speedy **termination** of coercion, Currier and Farley- Toombs found that the number of coercive episodes was reduced by over 50% and their duration by nearly 50% after the introduction of a legal regulation known as "the one hour rule", which requires a patient to be assessed face-toface by a physician or licensed independent practitioner within one hour of the initiation of restraint or seclusion (Currier GW, Farley-Toombs C, 2002).
- **Post-incident debriefing** performed after a coercive episode, makes it possible to discuss the patient's preferences for any coercive measures in future, and to discuss the early signs of patients' aggression. These signs can then be updated and registered in an advanced directive or in the individual crisis-management plan. In this way, patients' awareness of their early signs of aggression may increase, improving their capacity for self-control and helping to prevent further escalations. Earlier research by Fisher found that debriefing was one of the key elements in reducing seclusion and restraint (Fisher WA, 2003).
- Introducing a **Rapid Response Team (RRT)** specialized in the management of violent behavior may not only significantly reduce the use of coercive measures, as proved earlier (Prescott DL, Madden LM, 2007; Smith GM, Davis RH,2005; D'Orio BM, Purselle D, 2004), but may also improve the quality of care provided in conflict situations. RRTs quickly bring large group of workers to a crisis scene, the objective being to diffuse and safely resolve the crisis through conflict resolution, mediation, therapeutic communication, and violence-prevention skills (Smith GM, Davis RH, 2005).
- Engaging the patient in the decision of how best to intervene can help them get through the situation without resorting to seclusion or restraint.

Delaney, Pitula and Perraud developed the **Four S Model** as a way of reducing the use of seclusion and restraint. The 4 S's are safety, support, structure, and symptom management. In brief:

- *Safety* means assuring the individual's physical and emotional well-being via interventions such as modifying the environment to reduce stimuli and induce a calming ambiance.
- *Support* involves listening and talking in a supportive way, offering comfort measures or whatever is needed according to the individual, and using verbal de-escalation.
- *Structure* techniques, like limit setting, convey behavioral expectations and aid in constructive problem solving.
- *Symptom management* is aimed at specific symptoms including stress and relaxation measures, diversionary activities, or medication (Laura Stokowski RN, 2007).

Crisis situations can be successfully de-escalated only by staff who are extraordinarily skilled in the conscious management of their own verbal and non-verbal behaviors; this enables them to

avoid triggering aggressive reactions in patients, who – due to paranoid symptoms or previous traumatic experiences – are often hypersensitive to any form of threat .

Here is a partial list of de-escalation techniques that experienced mental health nurses find to be helpful in a crisis:

- Assess the situation promptly. If you see signs and symptoms of a person entering into crisis, intervene early.
- Maintain a calm demeanor and voice.
- Use problem solving with the individual -- ask "What will help now?"
- Be empathetic.
- Reassure individual that no harm will come to him or to others.
- Avoid an argumentative stance.
- Offer to help.
- Engage the individual.
- Use stress management or relaxation techniques such as breathing exercises.
- Don't crowd the individual; give him or her space.
- Be aware of yourself -- your look, your tone.
- Offer choices.
- Use open-ended questions.
- Give the individual time to think.
- Decrease the tension with relaxation techniques.
- Ignore challenges; redirect challenging questions.
- Tell them what you *can* do to help them.
- Allow venting.
- Allow pacing.
- Don't say "you must."
- Avoid power struggles.
- Set limits and tell them what the expectation is.
- Be careful with your nonverbal behaviors.
- Be aware of the individual's nonverbal behaviors.
- Be clear; use simple language.
- Language -- follow the rule of 5 (no more than 5 words in sentence, 5 letters in a word -- eg, "Would you like a chair?")
- Use reflective technique -- "Am I hearing you?"
- Agree to disagree.
- Be willing to break the rules.
- Consider using sensory modalities such as weighted blankets or calming rooms with stress reduction tools.

Guidelines to maintain safety of both yourself and others during situations of potential violence include:

- Take a position just outside the individual's personal reach (out of arm's reach) on the nondominant side.
- Maintain an open posture.
- Keep the individual in visual range.

- Make certain the room's door is readily accessible; avoid letting the individual get between you and the door.
- Summon help if the individual's aggression escalates to violence.
- If other patients are in the vicinity, ask them to leave the room to decrease distractions and protect the person's dignity (Laura Stokowski RN, 2007).
- To break the vicious cycle of coercion, three groups of patient should be transferred to a **PICU** that operates a special treatment policy focused on reducing seclusion and restraint: those who tend to pose a higher risk to themselves or others, those who have a bad treatment relationship with the nursing staff, and those whose periods in restraint are both frequent and prolonged.

Psychiatric Intensive Care Units (PICU) are small wards, designed for the most difficult-to-manage patients. They have higher levels of nursing and other staff, are often locked, and sometimes have facilities for seclusion. After patients' admission to PICU, the use of seclusion was almost completely eliminated, falling from 40% of admission days spent in seclusion before transfer to the PICU to 0.1% during their stay at the PICU. When a special non-coercive infrastructure and treatment policy is applied at a PICU, seriously disturbed patients can be treated without coercive measures (Georgieva I, Haan G de, Smith W, Mulder CL, 2010).

Ideally, a patient's individual preference of a particular type of coercive measure should therefore be taken into account and registered in a psychiatric advanced directive or in a crisis-management plan. This should preferably be done by the patient's case manager during a preadmission period of outpatient care. However, if an agitated patient's preferences are unknown at admission, and if no de-escalation interventions succeed in preventing the use of coercive measures, medication might be offered – preferably orally – rather than seclusion with or without mechanical restraint. This is not only because most patients seem to prefer it, but also because– it was associated with less distress than seclusion and mechanical restraint were.

Prevention of coercive incidents

- "Prevention is better than cure." Although agitated and violent behavior can never be predicted with 100% accuracy, assessing patients' uncooperativeness and psychological impairment that the likelihood of them being coerced could be predicted with 80% accuracy.
- Structured risk assessment should include tools that assess not only agitated and violent behavior, but also patients' psychological impairment and uncooperative behavior. This may lead to more accurate prediction and the successful prevention of coercive incidents.
- A recent research by Swanson *et al*. found that use of **advanced directives** reduced significantly coercive interventions (Swanson JW, Swartz MS et al. 2008). An advance directive is a document specifying a person's preferences for treatment should he or she lose capacity to make such decisions in the future (Campbell LA, Kisely SR, 2009).

- Research has emphasized the importance and efficacy of **de-escalation** techniques in preventing aggression and coercive episodes (Schreiner GM, Crafton CG, Sevin JA,2004 ; Gaskin CJ, Elsom SJ, Happell B,2007). There are various de-escalation techniques, such as observing patients for signs and symptoms of anger and agitation, approaching them in a calm and controlled manner, avoiding confrontation, and providing them with choices. In all cases, nurses should capitalize on the therapeutic use of their own personality and on their relationship with the patient (Muralidharan S, Fenton M, 2006).

CONCLUSION

Coercion though is part and parcel of psychiatry, and is inevitable in psychiatric treatment but still descalation techniques should be tried in crisis sitution before going for coercive measures, keeping in mind safety of self and others.As much as possible minimise use of coercive measures and try preventing use of it by assessing the situation appropriately.Prevention is always better than cure.

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