66 - Practical measures

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Schizophrenia and related psychoses CHAPTER 1 positive or negative effects and while adding a benzodiazepine to another drug may not be clearly advantageous it may lead to unnecessary adverse effects.49 With respect to those who are behaviourally disturbed secondary to acute intoxication with alcohol or illicit drugs, there are fewer data to guide practice. A large observational study of IV sedation in patients intoxicated with alcohol found that combination treatment (most commonly haloperidol 5mg and lorazepam 2mg) was more effective and reduced the need for subsequent sedation than either drug given alone.50 A case series (n = 59) of patients who received modest doses of oral, IM or IV haloperidol to manage behavioural disturbance in the context of phencyclidine consumption showed that haloperidol was effective and well tolerated (one case each of mild hypotension and mild hypoxia).51 A section on the treatment of behavioural disturbance caused by substance misuse is included in Chapter 9. Ketamine is widely used for agitation in hospital emergency departments. In a systematic review of 18 studies of ketamine,52 a mean dose of 315mg IM ketamine achieved adequate sedation in an average of 7.2 minutes. Over 30% of 650 patients were eventually intubated and more than 1% experienced laryngospasm. Ketamine is not suitable for RT where facilities for intubation are not available, although it may be the most effective treatment.3 Overall, the current broad consensus is that midazolam and droperidol are the fastest-acting single-drug, intramuscular treatments53 and that haloperidol alone should be avoided and perhaps abandoned completely even in combination.54 Second-line treatments are combinations of benzodiazepines and antipsychotics and third line would probably be intravenous benzodiazepines and then ketamine (2–5mg/kg IM), assuming intubation facilities are available. Practical measures Plans for the management of individual patients should ideally be made in advance. The aim is to prevent disturbed behaviour and reduce risk of violence. Nursing interventions (de-escalation, time out, seclusion),55 increased nursing levels, transfer of the patient to a psychiatric intensive care unit and pharmacological management are options that may be employed. Care should be taken to avoid combinations and high cumulative doses of antipsychotic drugs. The monitoring of routine physical observations after RT is essential. RT is often, of course, viewed as punitive by patients. There is little research into the patient experience of RT. The aims of RT are threefold: ■ ■To reduce suffering for the patient: psychological or physical (through self-harm or accidents). ■ ■To reduce risk of harm to others by maintaining a safe environment. ■ ■To do no harm (by prescribing safe regimens and monitoring physical health). Note: Despite the need for rapid and effective treatment, concomitant use of two or more antipsychotics (antipsychotic polypharmacy) should be avoided on the basis of risk associated with QT prolongation (common to almost all antipsychotics). This is a particularly important consideration in RT, where the patient’s physical state predisposes to cardiac arrhythmia.

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