Dealing with distressed and volatile people

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Overview

1. What do we know about the risk of aggression?
2. General principles and background knowledge:
    a) Anxiety, fear, agitation
    b) Complex trauma
    c) Preventive strategies
    d) Settling and de-escalation
3. Case vignettes

How frequent are aggressive incidents in our court and tribunal settings?

- Unknown (but a good topic for research)

From USA literature:

- Sources of judicial stress include:(1)
  - Excessive work loads
  - Time pressures to make significant, complex decisions
  - Traumatic cases
  - Safety concerns
- A survey of 1029 state judges: 52% experienced at least one incident of threatening communications, 70% inside the courtroom, (2)

- Sullivan surveyed 115 trial court judges in Arkansas in relation to recent security incidents (4):
  - 84% reported at least one security incident in the past 12 months
  - 64% reported at least one incident of disorderly behaviour requiring physical intervention
  - There was a concerning lack of emergency plans in place, e.g. only 18% had an emergency plan for a fire, only 6% had a plan for a medical emergency, and 1% for a hostage situation

Flores et al 2009

163 American trial judges

TABLE 5: RATINGS OF CONCERN FOR SPECIFIC SAFETY-RELATED THREATS

Specific Threat	M, Mdn, SD
Inappropriate letters	1.74; 2.00; .68
Inappropriate phone calls	1.83; 2.00; .68
Inappropriate faxes	1.59; 1.00; .75
Threatening letters	2.13; 2.00; .99
Threatening phone calls	2.10; 2.00; 1.03
Threatening faxes	1.90; 2.00; 1.03
Receiving a bomb or anthrax in the mail	1.52; 1.00; .89
Being inappropriately approached	2.46; 2.00; .97
Being followed	2.06; 2.00; 1.05
Being confronted face-to-face	2.26; 2.00; .99
Being physically assaulted	2.06; 2.00; .95
Being seriously injured by a defendant	1.85; 2.00; .95
Being seriously injured by a defendant's family	1.82; 2.00; .93
Being seriously injured by court personnel	1.13; 1.00; .18
Being seriously injured by random person in the courtroom	1.60; 1.00; .74
Having a gun pulled on you	1.88; 2.00; .95
Having a knife pulled on you	1.82; 2.00; .90
Bomb threats in the courthouse	1.74; 2.00; .98
Anthrax in the courthouse	1.35; 1.00; .71

Note: *(1 = not at all; 5 = extremely)*

In Flores et al's survey of American trial judges (1):

- Judges reported stress that led to:
  - Decreased productivity
  - Inappropriate courtroom demeanour
  - Decreased concentration
  - Compromised court decisions

- Female judges either experience greater levels of stress or are more open to reporting stress symptoms.

Aggression and violence in Mental Health settings

- A UK study found that 1 in every 500 contacts in general practice involved violent or destructive behaviour, 16% of GPs reported experiencing verbal abuse on a monthly basis.(6)
- NICE reported: 2013-14 there were 68,683 assaults against NHS staff in England (69% in MH or ID settings).(7)
- 19% of patients with acute schizophrenia had put the safety of others at risk in the month prior to admission(8)
- 26% of patients admitted to an inpatient unit had been assaultive in the previous 6 months and 36% had behaved in a manner that made others fearful(9)
- Swanson et al's re-analysis of the ECA data: violent acts were reported in 2.4% of the general population but in 12% of those with schizophrenia and 25% in those with alcohol and substance abuse disorders.(12)

Conclusions(10):

- There seems to be an association between having a mental illness, particularly schizophrenia and an increased propensity for violence,
- The association does not mean causation: marginalisation, social isolation, stigma, poverty and disadvantage, drug abuse may all be contributing factors,
- Active symptoms of mental illness, in particular being deluded is correlated with violence,
- Aggression associated with mental illness usually occurs when the person is acutely unwell, off medication and disengaged from MHSs.
- The emergence of irritable, threatening and scary behaviours is frequently the harbinger of a psychotic relapse,

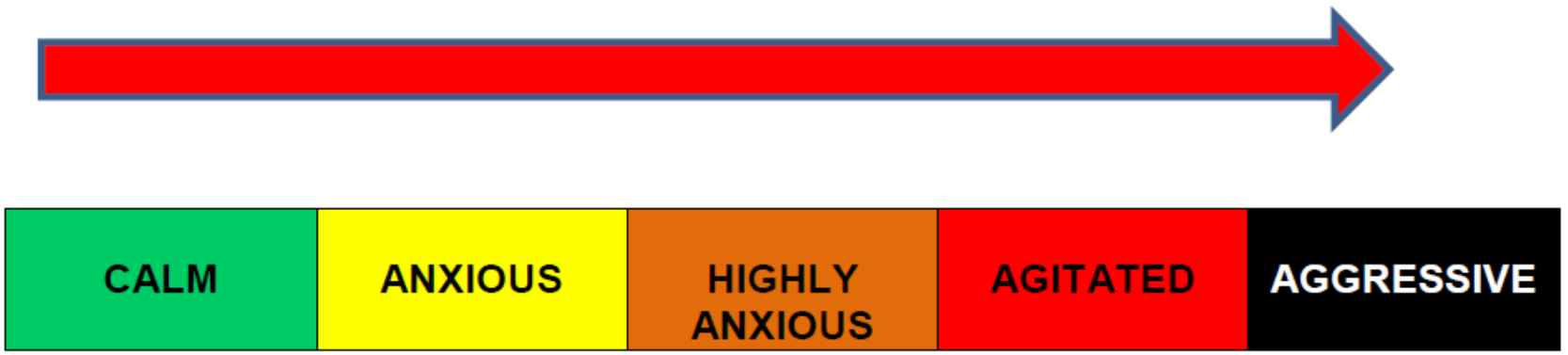
SOME GENERAL PRINCIPLES AND BACKGROUND KNOWLEDGE

- **Distress, fear, agitation**
- **Complex trauma**
- **Preventive strategies**
- **De-escalation**

Distress, fear and agitation

“In contrast to the commonly held view that inpatient violence occurs without warning or can be predicted by "static" risk factors, such as patient demographics or clinical characteristics, research indicates that violence is usually preceded by observable behaviors, especially non-violent agitation.”(16)

The Anxiety, Agitation, Aggression Continuum



The Agitation continuum

Aggression: behavioural antecedents and clinical features (16)

- Tense and angry facial expressions,
- Impulsive or impatient behaviour,
- Hostility and anger,
- Labile mood,
- Irritability,
- Suspiciousness or paranoid delusions,
- Nonproductive, repetitious verbal activity (e.g. repeating the same question),
- Uncooperative or demanding behavior, resisting care,
- Intimidating or intrusive behavior (e.g. following, touching, standing too closely to another person),

- Restlessness, pacing, fidgeting, inability to sit still, erratic movements,
- General over-arousal (increased breathing and heart rate, restlessness, dilating pupils),
- Increased volume of speech, outbursts or abuse,
- Prolonged eye contact,
- Discontentment, refusal to communicate, withdrawal,
- Thought processes unclear, poor concentration,
- Delusions or hallucinations with violent content,
- Verbal threats or threatening gestures,
- Hostile or demeaning verbalizations,
- Behaviour similar to that which preceded earlier disturbed/violent episodes,
- Blocking escape routes.

Triggers, contributing factors and antecedents (16, 17)

- Clinical conditions (e.g. mental health illness, brain disorder, intellectual disability and cognitive impairment)
- Undesired interpersonal interactions
- Personally interpreted stress
- Environmental disturbances (e.g. noise, confined space).

Common situational antecedents: ‘flashpoints’

- Staff denial of a patient request or privilege
- Reinforcement of rules by staff / limit setting
- Demands by other patients and staff to cease an activity or to complete a task
- Patient provoked by another patient

Agitation (14)

- A syndrome that can be due to a wide range of psychiatric and behavioural conditions.
- A state of poorly organised and aimless psychomotor activity stemming from physical or mental unease.
- Hallmarks include:
  - Motor restlessness,
  - Irritability,
  - Heightened responsivity to external or internal stimuli,
  - Inappropriate and usually purposeless verbal and physical activity
  - +/- sleep disturbance
  - +/- unstable course with rapidly fluctuating symptoms

Proposed mechanisms for agitation:
(14),(15)

Becoming flustered: The catastrophic reaction

“In a catastrophic reaction, a person feels overwhelmed by a task, usually something they know they were once capable or should be capable of doing and their emotional response, (anxiety, shame, anger, distress) reduces the ability to function and generates its own arousal feedback loop.”(18)

The catastrophic reaction

- A behaviour and experience that is a general reaction to brain damage
- Non-specific in terms of brain localisation
- More often seen in vascular cognitive impairment than Alzheimer's disease
- Often reduced emotional control: lability and/or disinhibition
- May also occur as a quiet, bewildered withdrawal

THE TAKE HOME MESSAGES

- Aggression is usually preceded by recognisable antecedent behaviours that indicate the person is on the anxiety-agitation continuum.
- Contributing factors often include interpersonal interactions and unconducive environments.
- Intervention early in the anxiety-agitation continuum can avoid progression to violence.

Understanding complex trauma

- Trauma is a widespread, harmful and costly public health problem. It occurs as a result of violence, abuse, neglect, loss, disaster, war and other emotionally harmful experiences.
- Although many people go on with their lives with no lasting negative effects, others will have more difficulty and experience traumatic stress reactions.
- The public institutions and service systems that are intended to provide services and supports to vulnerable people are often themselves trauma-inducing.

SAMHSA Concept of Trauma:

“Individual trauma results from an event, series of events or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual’s functioning, and mental, physical, social, emotional or spiritual well-being.”(19)

The impact of complex trauma includes(20):

- dysregulation of stress response systems via the hypothalamic–pituitary–adrenal axis;
- lowered cortisol levels and hippocampal volume impairing the deactivation of the survival response;
- a reduced corpus callosum impairing integration between hemispheres with significant implications for mood and personality;
- disrupted regulation, reception, expression and communication of emotion;
- significant lifelong implications including emotional dysregulation and impaired the development of ‘self’.

SAMHSA's Trauma-Informed Approach: Key assumptions and principles:

- Safety throughout the organisation,
- Trustworthiness and transparency,
- Peer support and self-help,
- Collaboration and mutuality,
- Empowerment, voice and choice,
- Cultural, historical and gender issues

- Kezelman and Stavropoulos have developed guidelines for clinicians and for Human Services organisations so that service delivery will be less traumatic and more supportive for those who continue to suffer the impact of complex trauma. (21)

THE TAKE HOME MESSAGES

- The need to understand and address trauma is increasingly viewed as an important component of effective human services delivery.

Court aggression prevention strategies:

- North American literature, and Court procedure manuals(22) focus on preventing violent incidents, including shootings, IEDs, and hostage situations.
- Court safety and security policies and procedures,
- Regular staff training, including drills,
- Proactive approaches including deterrence, detection and risk management

Potential Violent Offender Profile		
White Male	25-40 years of age	Loner
Exhibits Delusions of Grandeur	Experienced Prior Successes	Experienced Recent Setbacks
Has Violent Fantasies	Angry / Paranoid	History of Violence
Religious / Political Expounding	Blames Others For Failures	Abuses Drugs / Alcohol
Unstable Work History	Overt Obsessions	Inappropriate Physical Actions
Low Self-Esteem	Occupation-Based Self-Esteem	Seeks to Control by Intimidation
Perceived / Actual Job Stress	Misperception of Others	Resists Change / New ideas
Prolongs Grievances	Empathy for Violent Persons	Exhibits Suicidal Tendencies
Marital / Financial Problems	Misinterprets Acts of Kindness	Overly-Sensitive to Criticism

From Colorado District Court Manual: "*This information was gathered from data provided by the Federal Bureau of Investigation*.(22) "

Risk assessment and management

- There is some evidence that structured risk assessment can reduce aggressive incidents(23),
- The Agency for Healthcare Research and Quality (USA) found(24): that risk assessment was associated with reduction of violence and coercive measures.

- Therefore, there may be value in liaison and inter-agency agreements in relation to ‘preparation’ and risk assessment of clients/patients coming to a tribunal or hearing setting.

The importance of culture and milieu

In a study of nursing staff and patient attitudes to the strategies employed for preventing and managing aggressive incidents on a psychiatric unit, Duxbury found(25):

“Patients view themselves as victims of the controlling style of nursing staff within the context of a restrictive environment. Nurses feel they are the victims of patient aggression and an inadequate organisation.”

“This leads to a large number of ‘reactive aggressive incidents’ precipitated by patients and a reliance on approaches that are reactive by staff.”

- Targeted initiatives, particularly nursing initiatives focusing on engagement and the therapeutic relationship are likely to lead to improved patient outcomes, reduced aggression and greater satisfaction for health professionals.
- The 3 important factors for the production of low-conflict, high therapeutic units are:
  - the positive appreciation of patients by staff,
  - the ability of the staff to regulate their own emotions towards patients,
  - and the creation of effective structure (rules and routines) for unit life.

THE TAKE HOME MESSAGES

- Court procedures and training,
- Assessment of risk of aggression: understanding the person's predicament, mental state, perceptions and fears,
- Preparation, engagement and support for people prior to coming to a court or tribunal,
- Liaison and partnership between agencies,

Settling and de-escalation

- The main responsibility for managing a potentially volatile situation and restoring a workable partnership is with the professional.
- The real challenge is understanding what lies beneath the hostility and how best to deal with this.
- Agitated people can be provocative and may challenge the authority, competence, or credentials of the professional.
- To work well with agitated people, staff members must be able to recognize and control their own negative reactions. These include the professional's understanding of his own vulnerabilities, tendencies to retaliate, argue, or otherwise become defensive and ‘‘entrapped’’ with the client. (13)

Settling and de-escalation

“The most essential skill is a good attitude, starting with positive regard for the patient and the capacity for empathy. Staff should be able to recognize that the patient is doing the best he can under the circumstances.”(13)

Another important clinician characteristic associated with successful de-escalation is **patience**. Rushing or prematurely closing efforts at de-escalation in favour of coercive measures is likely to be more time-consuming and to consume the time of significantly more personnel.

Courtroom discourse: (27)

- Informative in that it seeks to find out the truth through language,
- Often non-reciprocal, and adversarial
- Unequal power relationships
- Distancing forms of politeness

  – Politeness in discourse: processes and procedures aimed at minimizing the risk of confrontation, or if confrontation occurs, reducing the likelihood that it will be perceived as overwhelmingly threatening.

“These function almost as incantations, magical enclosures of the courtroom, it procedures and its participants, indicating that the world is different from what is known and familiar.”(27)

“Discourse of any type works well and is intelligible for all participants only to the degree that all: agree on the necessity for politeness, ……(and) on the form politeness is to take. Otherwise one person’s meaningful contribution will be read by another as anomaly, craziness or worse.”(27)

De-escalation Goals and Techniques After Hankin (16) and Richmond et al(13)

- Help the person calm himself and rapidly develop his own locus of control
- Restore the helping/therapeutic partnership
- Diffuse the situation before they lose control
- Decrease their feelings of fear, inadequacy, and hopelessness
- Avoid escalation or progression to an assaultive state
- Provide them with alternatives to aggression
- Assure their safety and the safety of others
- Model calm behaviour

The 10 Domains of De-escalation: (13)

1. Respect personal space
2. Do not be provocative
3. Establish verbal contact
4. Be concise
5. Identify wants and feelings
6. Listen closely to what the person is saying
7. Agree or agree to disagree
8. Lay down the law and set clear limits
9. Offer choices and optimism
10. Debrief the person and staff

1. Respect personal space

a. Professional’s safety
b. Respect for person
c. Trauma background is common

2. Do not be provocative

a. Avoid iatrogenic escalation
b. Convey that you want everyone to be safe
c. Body posture and language
d. Congruence between what is being said and body language
e. Do not confront, challenge, or in any way humiliate the person

3. Establish verbal contact

a. One staff member takes the responsibility for dealing with the person,

b. A back-up person whose role is to affirm, be a goffer, offer to locate and liaise with family and occasionally clarify if the primary professional is missing an obvious communication from the patient,

c. Introduce yourself, and provide orientation and reassurance,

d. Ask how the person would like to be addressed,

e. Emphasize that his concerns are important and that you want to keep him and everyone safe,

f. From the beginning the person should feel that they have some control in the situation

4. Be concise and keep it simple

a. Use short sentences and simple language. More complex verbalisations can increase confusion and lead to escalation

b. Repetition is the key to successful de-escalation (The verbal loop)

c. Give the person time to process the information

The ‘verbal loop’

De-escalation frequently takes the form of a verbal loop in which:

- listen to the person,
- find a way to respond that agrees with or validates the person’s position, and
- then state what you would like the person to do, e.g. accept a drink, move to a more appropriate place, etc.

The loop repeats as you listen again to the person’s response. You may have to repeat your message a number of times before it is heard and accepted.

5. Identify wants and feelings

- Ask the person about their expectations, wants, feelings
- Use ‘free information’
  - Body language
  - Trivial conversation
  - Knowledge of ‘the system’
  - Previous experience with the person

6. Listen closely to what the person is saying

a. Active listening,
b. Clarifying: “Tell me if I have this right?”
c. Suspend your judgements/reactions,
    - Miller’s law: “To understand what another person is saying, you must assume that it is true and try to imagine” the person’s predicament.
d. Telling one’s story and feeling that the other person is really listening is containing and empowering

7. Agree or agree to disagree

3 ways to agree with the patient:

a. **Agree with the truth**: “Yes, the JMO did botch that attempt to take your blood, would you like Dr Smith to do it, he’s really good?”

b. **Agree in principle**: (to the patient who alleges he has been abused by the police) “Well if that happened that’s not right. I think everyone has the right to be treated with respect and decency”

c. **Agree with the odds**: “I think most people would be upset to wait so long before being seen in the emergency department”.

d. Agree to disagree: on issues where there is an irreconcilable difference.

8. Lay down the law and set clear limits

a. Establish basic working conditions,
   - Place
   - Etiquette e.g. shouting is not acceptable
   - Civility and respect
   - Discussion of concerns

b. Tell the person if his behaviour is frightening or provocative,

c. Emphasize that you just want everyone to feel safe,

d. Coach the person in how to stay in control,
   - Take things slowly
   - Start at the beginning
   - Calm breathing
   - Modeling, mirroring

9. Offer choices and optimism

a. Never offer something or an option that cannot be delivered,
   - Small acts of kindness, drinks, food, phone, cab voucher

b. Broach the subject of the person's options, choices,
   - Outline the options as you see them
   - Ask if they have any other ideas
   - Be honest about options that you know are not possible or realistic

10. Debrief patient and staff

General techniques

- Approach the person with caution (not fear) and avoid startling them,
- Move them to a calm area that is visible to other staff,
- Offer them drink, something to eat,
- Avoid provocative, confrontational behavior (e.g. hostile language, direct arguing, threatening, ignoring them, using prolonged or intense eye contact, standing directly in front of or over a seated person, crossing arms over chest),
- Allow the patient ample personal space (visualize an oval zone 4–6 feet around);
- Mirror the person's posture (sit if they sit, stand if they stand, if they walk, walk with them),

General techniques

- Speak in a calm, respectful manner,
- Use simple language and short sentences,
- Be honest and precise,
- Avoid promises,
- Show empathy,
- Make it clear that you expect them to maintain civility, and that you will help them,
- Reassure the person that no harm will come to him,
- Redirect the conversation to less charged topics.

Set limits

- Let the person know if their behavior is frightening to you and others,
- Clearly identify unacceptable behaviors that must be altered and the consequences if inappropriate behavior persists; offer the person a choice of consequences,
- When setting limits, offer the person several acceptable options,
- Avoid or manage **'flashpoint' situations** without provoking aggression(7).

Retreat and back-up options

- Move self and staff to a safer area,
- Call for support from senior staff or clinician,
- Use of a duress alarm or initiation of the duress response,
- Activation of the local emergency response (i.e. Code Black).

CASE VIGNETTES

*The names and stories in these case vignettes are fictional.

Joe*, 25

Joe has presented to the magistrate's court seeking to have the date changed of his hearing in relation to repeated fare evasion. He has been asked to wait until his request can be dealt with.

Your first impression of Joe is when you had to request security to ask Joe to be quiet because his loud telephone conversation outside the Hearing Room is disrupting proceedings.

While Joe was waiting to be attended to, his loud telephone conversation could be heard throughout the building:

(Shouting) "*What? I have already told you my name you dingbat! Joe, 'J' 'O' 'S' 'E' 'P' 'H'. Smith, 'S' 'M' 'I' 'T' 'H'. Date of birth: 1 April 1997*".

"*I was in there last Thursday, now have you fixed up my account yet?*"

(Getting louder) "*I don't have my account number on me. I just gave you my name and date of birth, look it up! You f- - -ing drongo.*"

(Very loud) "*Look mate, how difficult is that? This is a customer service line, how about some f- - -king service?*"

Managing Joe

- Instrumental aggression, not driven by a mental illness or distress
- Likely complex trauma, limited repertoire of appropriate role models
- Setting limits: firm, clear, respectful
- Procedures: duress alarm, back-up

Melissa*, 20

Melissa is a second year university student studying commerce. She has an unremarkable history prior to this presentation. She is the eldest of 3 sisters. Her parents are both teachers. There is no history of trauma or significant adverse events during her childhood. She was in the top third of her class in the HSC results, has a group of close friends from her school days and a boyfriend, Paul, an engineering student.

Melissa presented with a 6 week history of insomnia, difficulty thinking, and ideas that her phone and computer had been hacked and that her mind was being controlled. She is thought disordered, at times to the point of incoherence and distressed, suspicious and emotionally labile.

Melissa comes before the Mental Health Inquiry as a mentally ill person. The medical team are requesting an 8 week order.

At the Inquiry Melissa is crying, distressed and agitated. Melissa is talking to herself while you introduce yourself and try to explain the procedures of the Mental Health Inquiry. Melissa's parents are in attendance.

Settling Melissa

- Understand the nightmare that Melissa is experiencing
- Concentration and understanding likely to be poor
- Calm the situation
- Reassurance
- Explanation
- Use parents as partners

Michael*

Michael is a 42 year old man living in public housing and receiving the disability support pension for chronic schizophrenia. Michael was brought to hospital after he breached his community treatment order. Michael has been living in squalor, not eating adequately, and has severed all ties with his family, neighbours and friends. Michael has been scheduled as mentally ill and the treating team are seeking a twelve week order to treat his psychotic relapse and assess his rehabilitation needs.

Michael is irritable, hostile and quick to take a paranoid interpretation of even the most reasonable and tactful attempts to assist him. He has made allegations that staff have been sexually interfering with him while he sleeps and says he is only prepared to discuss this and other complaints with the hospital's CEO. He does not trust anyone in the MHS. Michael has formally requested discharge.

At the MHRT Michael initially presents with a calm demeanour and listens to the Tribunal member's explanation of how the inquiry will proceed. However, during the hospital team's presentation, he quickly becomes agitated and loudly protests that: "these are lies and falsehoods", "this man (the registrar presenting the case) is not a qualified doctor". After the Tribunal member asks Michael to calm down and be silent until it is his turn to talk, Michael begins verbally attacking the Tribunal members: "you are in with them", "you're part of this whole fiasco".

Helping Michael

- MHRTs and MH Inquiries are very stressful for patients like Michael
- Recognise the potential humiliation and paranoia Michael is experiencing
- Explanation about the hearing process, ‘distancing’ strategies of the hearing may be helpful or may feed Michael’s ideas of a conspiracy
- Listen to Michael’s fears, wants
- Structure, process, the ‘verbal loop’
- The granting of an order is likely to be a ‘flashpoint’
- Safety and security procedures, back-up
- Michael will remember how people spoke with and responded to him when he is recovered from his illness (attitude always matters)

Neil*, 62

Neil is a divorced electrical engineer who has been prosecuting a complex complaint against the local health district for the past three years. He has complained to the HCCC, the NSW Privacy Commissioner, the NSW Medical Council, appealed to the Ombudsman, and written to his local member and the Minister for Health.

The original complaint was in relation to an acknowledged accidental breach of Neil's privacy. He had presented to the ED one night with a lesion on his penis and demanded testing for STD and HIV. The results of his tests, which were all normal, were mistakenly sent to another patient of similar name and that patient's GP. The hospital and the CEO of the LHD have acknowledged the error and breach of privacy and have apologised to Neil. However, Neil is not satisfied and is demanding the doctors involved be sacked. He is now threatening a complaint of "maladministration" against the LHD Chief Executive.

He presents as neat and organised. Although at first he appears very articulate, his language is overly formal and he becomes bogged down in his preoccupation with detail. He demands minutes be taken and insists on taking his own audio recording and notes. He carries a briefcase full of "evidence and statements" each of which is marked up with yellow high-light and multiple tabs and place-markers.

Today Neil is meeting with the LHD Chief Executive and the patient liaison officer who has been handling the complaint.

Containing Neil

- Unusually persistent complainants and vexatious litigants.(29)
- Wants those involved dismissed (which is unrealistic, inappropriate and not an outcome that proper processes and natural justice will allow).
- Very unlikely that there will be a mutually acceptable resolution.
- Usually associated with a cognitive rigidity not amenable to explanation or confrontation.
- **Explanation of the agency's limitations in relation to his demands.**
- **One small team deals. Single point of contact.**
- **A line is clearly drawn beyond which the agency will provide no further action or response.**
- **Persistent intrusive actions or threats may precede serious violence**

Tom*, 77

Tom is a widower and a retired carpenter/builder. He is described by his son as a very cheery and good-natured man. He has always had fairly rigid daily routines and has been a "stickler for everything being neat and tidy". There is no history of mental illness, however, Tom has high blood pressure and in the last five years has had 2 minor strokes from which he seemed to make a good recovery. His son describes increased forgetfulness, loss of interest in social contacts and uncharacteristic "clutter", especially in the kitchen and bedroom.

Tom is before the magistrate to respond to an AVO that his next door neighbour is bringing against him. The incident that led to this situation occurred 2 weeks ago. Tom had backed his car out of his drive knocking over the garbage bin of his neighbour, Margaret. No damage was apparent to either Tom's car or the empty otto bin. Margaret, a sprightly 82 year-old, had come outside to investigate the racket and found Tom repeatedly kicking the empty bin, cursing and agitated. Tom was foully abusive to Margaret and threatened to "knock (her) block off".

In the court Tom has given his account of the incident. The facts as Tom has related them are at odds with Margaret's account and that of Margaret's daughter who was at Margaret's house that morning. The magistrate asks Tom if he can explain this discrepancy. Tom is silent for a full minute and then begins to talk in a rambling and confused manner, mixing up even the facts that he has previously stated. He is shaking and appears to be crying, repeatedly saying "but that's not right, that's not right".

Recognising the problem with Tom

- Catastrophic reaction, due to vascular dementia
- Tom needs some time to settle and recompose himself,
- Further participation may not possible today
- Support of a relative (Tom’s son)
- Specialist assessment, “tests”

Summary

- Dealing with distressed and potentially agitated people is common in human services organisations
- There are a wide range of predicaments and situations that may underlie the distress and hostility of a person
- We need to manage these situations in ways that maximize the person's control and minimize the potential harms
- Agencies need to have appropriate procedures and staff training in place

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