

## ORIGINAL PAPERS

### Dealing With The Disturbed Soldier In Primary Care

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#### ABSTRACT

**Medical Officers are often called to review violent or disturbed soldiers in barracks or in their homes.**

**Management of the acutely disturbed soldier differs from the acutely disturbed civilian in that, whilst drug therapy will be largely similar, application of the Mental Health Acts (1) varies depending on the soldier's situation and, in some cases, the Acts do not apply at all. In addition, the rules on the arrest and detention of soldiers have changed considerably since the introduction of Human Rights legislation (2).**

**Keywords:** *Military Medicine, Mental Disorders, Violence.*

#### Aim

The aim of this article is to provide Medical Officers, and others involved in providing primary and emergency care to soldiers, with some guidance on the treatment of the acutely disturbed soldier.

#### Causes

Whilst there are a large number of causes for acute psychotic episodes, very few present regularly in military practice. It is likely that substance abuse, including alcohol use and withdrawal, is the most common presentation with the major psychotic illnesses, such as schizophrenia and bipolar affective disorder, being reasonably rare.

#### Assessment

The General Medical Council gives clear guidance that violent patients should not be excluded from treatment but it also recognises that it is prudent to take "reasonable steps to protect yourself before investigating [the patient's] condition or providing treatment" (3). The Royal College of General Practitioners goes further, stating that violent patients may compromise their "right to access general medical services in normal locations" (4).

Where you are providing care for a patient who may be dangerous you must plan their care in order to minimise the risk to yourself. Table 1 lists some 'Golden Rules' for assessing potentially violent or dangerous patients. It is important that help is easily and rapidly accessible in the event of an emergency and it is strongly

recommended that the police force with appropriate jurisdiction (Civilian Police Service, MOD Police or RMP) be summoned prior to any consultation with the potential for violence. Try to ensure that the situation is as calm as possible as violent situations are most likely to arise when the patient feels threatened. Drugs and alcohol are significant factors predisposing to violent and aggressive behaviour, as are attempts to engage in self-harm (5). Be particularly careful with patients who have a previous history of violence or threatened violence.

The cornerstone of the assessment of any disturbed patient is the Mental State Examination. It provides for a structured commentary on the patient's mental health at the time of the examination and should be as complete as time and circumstances allow. Given that Mental State Examinations are often referred to at a later date by third parties it is recommended that as much detail as possible is recorded and that the term 'normal', without further explanation, be avoided. Table 2 outlines the examination.

#### Golden Rules for Assessing Disturbed Patients

- Introduce yourself, greet the patient and remain polite throughout the interview.
- Acknowledge that the patient may be anxious, angry or frightened.
- Ensure that the patient does not get between you and the door.
- Try to sit at the same level as the patient.
- Try to have another health care professional in the room with you.
- Avoid touching the patient
- Never turn your back on the patient.
- Try to avoid having heavy or sharp objects on your desk.
- Carry a personal alarm and know how to use it.
- Ensure that help is quickly available and that they know what your alarm sounds like.
- Factors predisposing to violent or aggressive behaviour include agitation, drug abuse, alcohol and attempts at self harm.

Table 1.

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### Treatment

Many situations can be diffused by effective communication and non-drug therapy should always be considered as first-line treatment. There will, however, be a number of situations where medication is necessary. It is always preferable that, when drug treatment is necessary, it is given orally and with the patients consent. If, however, a patient is unable to give consent because of mental illness it is possible to act against that patients stated wishes to administer medication to save life or prevent serious harm to the patient or others. Ideally such treatment should be under the provisions of Mental Health legislation but, in an emergency, treatment can be administered under common law. It is worth considering that it takes five appropriately qualified people (one for each limb and one for the head) to adequately and safely restrain a patient. In such cases contemporaneous notes are vital as are details of witnesses who could be called in your defence against an accusation of assault. Any patient treated against their will should be reviewed by a psychiatrist as a matter of urgency.

The Cochrane Collaboration have recognised that the use of antipsychotic medication in emergency situations is an “important and surprisingly under-researched area” (6). Haloperidol is often the preferred antipsychotic of choice in acute psychosis (7) and the Drug and Therapeutics Bulletin has recommended it as an appropriate drug for GPs to carry in their bags (8). Haloperidol use is limited, however, by a high incidence of extrapyramidal symptoms (9) although it can be given with prophylactic procyclidine to prevent severe dystonic reactions. Chlorpromazine is also

widely used for its marked sedating properties and is less likely to cause acute dystonia but may cause hypotension and arrhythmias. Benzo-diazepines have been used in the past but concerns over the absorption of intra-muscular diazepam, the paradoxical effects which have been reported in patients taking benzodiazepines (9) and its respiratory depressant effects have previously limited its use. More recently intramuscular lorazepam has been used. Table 3 summarises the drugs discussed. Local psychiatric hospitals are a good source of advice and may have locally agreed protocols or guidance on rapid tranquillisation. Once parenteral treatment has been administered, the patient will require close monitoring by medically qualified staff.

### Detaining The Disturbed Soldier

Detaining disturbed soldiers is a complicated area, which may involve applying elements of the Mental Health Acts, the Army Act, and Human Rights legislation.

Unit provost staff are often reluctant to arrest and detain disturbed soldiers, as pre-charge detention in Military Custody is only permissible in order to secure or preserve evidence or to gather evidence by questioning (10). Violent or disorderly soldiers may be arrested and restrained but, again, their detention can only be authorised for the purposes outlined above.

In the United Kingdom, mentally ill soldiers may be detained in hospital under the terms of the Mental Health Acts. Table 4 details the Mental Health Act for England and Wales. The Act specifically precludes detention under its provisions for promiscuity, sexual deviancy or dependence on alcohol or drugs, although patients with these behaviour traits can be detained if they also display signs and symptoms of a mental illness as defined by the Act. Where, after an initial medical assessment, it is believed that a mentally ill patient requires hospitalisation but refuses to consent to admission it is normal practice to request a domiciliary visit by a consultant psychiatrist, or other doctor approved under section 12 of the Mental Health Act (11). Where the consultant agrees with the need to admit, the soldier’s Medical Officer is likely to be asked to undertake an examination in order to provide the ‘second medical recommendation’ required by the Act. In cases of emergency, where a domiciliary visit is not possible, the Medical Officer should contact the local Approved Social Worker directly and it is the Social Worker who will make the application for compulsory admission. It should be noted that section 136 of the 1983 Act cannot apply in barracks as a military establishment is, by definition, not a public place. Northern Ireland and Scotland have their own provisions and Medical Officers

MENTAL STATE EXAMINATION	
Heading	Description
APPEARANCE	Dress, Smoking, Level of Consciousness, Mannerisms, Expressions, Gait, Tremor, Cuts, Needle Marks, Tattoos
BEHAVIOUR	Hyperactive, Subdued, Threatening, Frightened, Preoccupied, Sexually Inappropriate
MOOD	Grandiose, Elated, Depressed, Anxious, Guilty
THOUGHTS	Rate and quantity of speech, Style of utterances, Flow of speech Disordered thinking, Flight of Ideas, Thought Insertion, Thought Blocking
PERCEPTIONS	Hallucinations (eg visual, auditory, somatic), Illusions, Depersonalisation, Somatic Symptoms
BELIEFS	Delusions, Reaction to testing beliefs, Assessment of how strongly the beliefs are held. Assessment should take place against the norms of the patient’s cultural background.
INSIGHT	How does the patient explain their symptoms? Does the patient recognise their illness? Have friends and family noticed a change? <b>Will they accept treatment?</b>
COGNITIVE ASSESSMENT	Orientation, Attention and Concentration, Memory, and Intelligence.
CNS ASSESSMENT	

Table 2.

Rapid Tranquillisation		
Drug	Dose	Remarks
Haloperidol	2-10mg I.M.	Repeated hourly if necessary.
Procyclidine	5-10mg I.M.	To prevent serious dystonic reactions.
Chlorpromazine	25-50mg I.M.	Sedating. May cause hypotension and arrhythmias.
Lorazepam	25-30mcg/kg I.M.	Paradoxical increase in aggression possible

Table 3.

serving in these countries should familiarise themselves with the appropriate legislation. The Duchess of Kent's Psychiatric Hospital in Catterick admits approx 450 voluntary patients each year (12) but it is not able to accept compulsory admissions and these must be sent to the most appropriate local NHS facility.

When serving outside the United Kingdom, detention of mentally ill soldiers and civilian dependants in hospital for the purposes of compulsory assessment and treatment is covered by the Armed Forces Act 1981 (13,14). This Act states that anyone subject to military law serving in a country outside the United Kingdom may be admitted to and detained in a service hospital outside the United Kingdom for assessment and treatment on the authority of the patient's Commanding Officer. The Commanding Officer must base his opinion on the recommendations of two registered medical practitioners that the patient is suffering from a mental disorder, as defined by the Mental Health Act 1983, of a nature or degree which warrants their detention in hospital and that detention is necessary in the interests of the patient's health and safety or the protection of others. In an emergency the recommendation of a single medical practitioner will suffice where obtaining a second opinion would cause "undesirable delay".

Detention in hospital under this Act lasts for 28 days, or 5 days in the case of an emergency recommendation. Any order made under the Armed Forces Act 1981 cannot be extended and, where ongoing

compulsory admission is required, the patient should be repatriated to the United Kingdom, where continued admission should be under appropriate civilian Mental Health legislation.

If a disorderly soldier is judged not to be mentally ill then it is entirely appropriate to refer him back to the unit's own disciplinary procedures as he no longer represents an acute medical emergency.

### Drunk Soldiers

Drunkenness without any additional features is not generally a medical problem. Medical Officers are, however, often asked for their opinion on intoxicated soldiers.

There is no absolute requirement for a Medical Officer to review a drunken soldier, unless there are signs of illness or injury. Indeed, putting a soldier suspected of drunkenness through any form of test is prohibited, except where an offence has been committed under the road traffic legislation (15).

Where a soldier who appears to be under the influence of alcohol or drugs does not require admission to a medical facility he or she may be ordered to the nearest 'suitable accommodation' for the purposes of supervision to prevent illness or injury (16). Where a soldier merely requires the supervision of a 'responsible adult' it is often appropriate to accommodate these soldiers in the unit guardroom overnight (17). It is important that when a soldier is spending the night in the guardroom the guard are issued written orders stipulating that the soldier is to be checked every quarter of an hour and

The Mental Health Act 1983			
Sect	Uses	Requirements	Duration
2	Compulsory Admission for Assessment	Approved Social Worker 2 doctors, one of whom must be recognised under sect 12 of the Act, and one of whom should have prior knowledge of the patient.	28 days
3	Compulsory Admission for Treatment	Approved Social Worker 2 doctors, one of whom must be recognised under sect 12 of the Act, and one of whom should have prior knowledge of the patient.	6 months
4	Emergency Admission for Assessment	Approved Social Worker 1 doctor who, ideally, should have prior knowledge of the patient.	72 hours
135	Warrant to Search for and Remove patients	Authority, issued by a magistrate to the police, to enter private premises to search for and remove patients	
136	Removal from a Public Place	A police officer may remove to a place of safety, such as a police station, a person in need of immediate control who he suspects of suffering from a mental disorder.	72 hours

Table 4.

woken every half hour. The guard should always have the ability to call on medically qualified advice in an emergency and the Medical Officer should review the patient after 4 hours if the soldier has not recovered. It should be stressed that, in these circumstances, the guard have no power to detain the soldier against his wishes.

### Suicidal Patients

It is not unusual for distressed and unhappy soldiers to admit to suicidal thoughts. Suicide is a significant cause of death within the Army. In 1999 20% of deaths in the Army were as a result of suicide or deliberate self-harm (18) and any such feelings should be taken seriously. Certain groups have an increased risk of suicide. Social isolation, recent bereavement or relationship difficulties and previous self-harm are all important predisposing factors in suicide and self harm. Within society suicide rates are rising in young men, particularly in those from low socio-economic backgrounds. The Mental State Examination may reveal features associated with increased risk of suicide including feelings of hopelessness, depression and agitation and it is important to ask specifically about suicidal thoughts. The degree of planning can also indicate the seriousness of any suicidal intent.

Soldiers who have harmed themselves or attempted suicide should receive appropriate treatment for their physical injuries. Where a drug overdose is suspected they should be transferred to a facility where testing, monitoring and treatment can be undertaken. Following an episode of deliberate self-harm or parasuicide early psychiatric follow-up is essential.

### The Future

On 25 June 2002 the Government announced a draft Mental Health Bill in the House of Commons (19). The draft bill, which can be viewed on the Department of Health website ([www.doh.gov.uk](http://www.doh.gov.uk)), aims to broaden the definition of mental disorder to include untreatable personality disorders, which are excluded from current legislation, and to alter the legal framework for compulsory assessment and treatment, allowing for compulsory treatment in the community as well as in hospital.

### Summary

Acutely disturbed soldiers are uncommon but when they do present it can be frightening for both the patient and the Medical Officer. It is paramount to ensure your own safety and that of your staff and other patients without denying the soldier medical care. Prior to any consultation with the potential for violence it is necessary to identify a safe place where the consultation can take place and that the appropriate

police force is summoned so that they can provide rapid assistance if necessary. Drug therapy is often not necessary but where it is used this should ideally involve the patients consent. Where consent is not forthcoming, treatment under common law is possible. Detention of acutely disturbed soldiers is now much more difficult and Medical Officers working in primary care must familiarise themselves with the appropriate Mental Health legislation.

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The responsibility for all errors within this article rests with the authors and the authors' opinions, where stated, do not necessarily represent those of the Ministry of Defence or the Army Medical Services.

### Conflicts Of Interest

None.

### References

1. The Mental Health Act 1983.
2. The Human Rights Act 1998.
3. Good Medical Practice, GMC, London.
4. Good Medical Practice for General Practitioners, RCGP, London.
5. Powell G, Caan W, Crowe M. What Events Precede Violent Incidents in Psychiatric Hospitals? *British Journal of Psychiatry* (1994); **165**: 107-112.
6. Cure S, Carpenter S. Droperidol for Acute Psychosis (Cochrane Review) *The Cochrane Library*, Issue 2, 2002.
7. The Drug Treatment of Patients with Schizophrenia. *Drug and Therapeutics Bulletin* Nov 1995.
8. Drugs for the Doctor's Bag Revisited. *Drug and Therapeutics Bulletin* Sept 2000.
9. BNF March 2002.
10. Army Act 1955 section 75.
11. The Mental Health Act 1983 – Guidance for General Practitioners: Medical Examinations and Medical Recommendations under the Act. Dept of Health, July 2001.
12. Greenberg N, Temple M, Neal L, Palmer I; Military Psychiatry. *Psychiatric Bulletin* (2002); **26**: 227-9.
13. Armed Forces Act 1981 section 13.
14. Army General Administrative Instructions para 66.161-66.186.
15. Queen's Regulations for the Army para 6.023.
16. Queen's Regulations for the Army para 6.024.
17. Army General Administrative Instructions para 64.097.
18. DGAMS Annual Report on the Health of the Army 1999.
19. Draft Mental Health Bill, Dept of Health, London, 2002.