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Case Report

Tasers and psychiatry: the use of a Taser on a low secure unit

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Abstract

The exceptional use of a Taser by the police on a low secure unit, and the extent to which the clinical team had gone to in managing the man, is described. A companion article discusses clinical and ethical aspects to taser use in psychiatry.

Keywords

Taser; low secure unit; severe mania

The only use of a Taser on our unit in three years has prompted a description of the circumstances that led to this police decision. The unit is a warm, home-like, low secure unit for 14 men. The ward has a full time, multidisciplinary team with a weekly, externally facilitated, reflective practice group and a philosophy committed to understanding the person and enabling their return to the community. All staff are trained in the therapeutic management of violence and a 12 month audit revealed 200 patient and eight room searches per month with three random drug tests per person per month. Pro re nata medication was used on 11 occasions only (Little & Burt, in press).

When well, OD was a pleasant and reasonable 58 year-old man. When unwell, his family visited and were watchful of psychiatric practice. He had been transferred from the psychiatric intensive care unit (PICU) where he had been continuously secluded for 400 hours prior to eventually settling on haloperidol 40 mg plus diazepam 60 mg per day. His 42 year, 26 volume history of rapid cycling, bipolar affective disorder began at age 16 with labile, irritable and elated moods, 1–2 hours sleep, sexual disinhibition, flight of ideas and pressure of speech. Rarer depressive phases were characterized by early morning wakening and psychomotor retardation. OD had been continuously hospitalized for five years, cycling typically between the acute and rehabilitation wards and PICU. He correctly observed that neither medication nor ECT had a sustained effect. Treatment had been complicated by hypothyroidism, grade 3 renal failure and marked elevations in creatine kinase following the use of zuclopenthixol acetate (Acuphase). However, he had been stable for two years on fluphenazine decanoate 100 mg fortnightly plus haloperidol 40 mg plus carbamazepine 1200 mg whilst in a supportive relationship. OD had consistently declined clozapine and newer treatment combinations. He partially acknowledged his institutional identity as being known by many and as having a reputation for complexity and difficulty.

Without warning, OD became unwell. In progressively increasing waves of disturbance,

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this powerful, 183 cm, 83 kg, afebrile man became labile, hostile, intrusive, disinhibited and assaultive, his language both vitriolic and offensive. As he became increasingly agitated, he tore his clothes, hit himself and complained to his solicitor that he had been assaulted by staff. He set off fire alarms, head butted doors and charged at the airlock. He hit, bit, kicked and grabbed at staff, their breasts and their crotches and openly masturbated. He urinated in the courtyard, smeared faeces, flooded his room and covered his body with shower gel to foil restraint attempts. As his speech became increasingly incoherent, he was eventually reduced to roaring. He slept for 19 hours in the first 15 days. Sadly, there were brief lulls when he became quieter, cooperative and tearful. Investigations, medication, food, fluid and offers of help were able to take place before he was again overtaken by illness.

The clinical team wished to avoid a repeat of protracted seclusion. Over the next 24 days staff who were familiar with OD were continuously rotated as they accompanied him on the ward and in the garden; keeping him distracted and his peers protected. Head massages, hand massages, reflexology, aromatherapy and music were attempted. Sitting and holding him in a dimly lit seclusion room with his own duvet and textured objects was briefly helpful as he struggled to stay awake. The team, increasingly aware of safety and risk concerns, had to consider whether their intensive commitment and a reluctance to return OD to PICU was unwittingly delaying a more effective intervention. Daily team meetings were held to brainstorm ideas, record what had and had not been useful, liaise with PICU and acknowledge achievements, including the continued use of oral medication.

On day 24, OD was again returned to seclusion as he flew at staff with indiscriminate aggression. Following staff discussion, Acuphase 150 mg was given intramuscularly, a decision that OD welcomed. However, OD continued to be disturbed. He removed the heavy metal plate from the intercom and began to use it as an axe against the door and indicated by gesture, his intention to sever his throat. Having exposed the electrical wires, he simultaneously threatened to electrocute anyone who entered the room. In the presence of a weapon, the police were alerted and attended swiftly. They discussed the clinical situation with the staff and attempted to engage OD over a 20 minute period. The police considered the use of capsicum spray within a confined space with the use of riot shields, but on independent discussion with their base commander, elected to use a Taser instead. The seclusion door was opened, OD was tasered, secured by the police and transferred to the PICU. No one was injured; OD remained in PICU, rambling, incoherent, disinhibited and assaultive, and slowly began to settle over 17 days. Although manageable, he remained hospitalized, irritable, argumentative and intrusive for five months before he settled. Although OD has contributed to, and agreed to become a co-author on this paper, his recurrent relapses have prevented him from signing off on the final version.

OD had little recollection of the incident although remembers breaking the seclusion camera, seeing the police and, on inquiry, being aware of the care given by the team. He was clear that he felt no pain from the Taser, shrugging his shoulder to indicate a quick twitch. In contrast, he vividly recalled two previous police restraints which he described as 'torture'. He tearfully reported that he hadn't been that unwell and although unable to elaborate, had just wanted to talk. We discussed his initial request for Acuphase on day four when he was manageably manic. We subsequently agreed that OD knows how unwell he becomes and that Acuphase should be administered at his request, even if it appears too early for a team that also values non-pharmacological alternatives. We also explored circumstances in which people become seriously unwell. OD partly acknowledged there may be occasions when decisive action, including police involvement, is required but wasn't able to see how it may apply to himself.

Following the incident, the clinical team felt it had been an exceptional circumstance that occurred without physical or psychological injury to OD or to staff. The decision, albeit of the police, felt right. At the patient meeting a factual account was given, and the men were again thanked for their tolerance and perseverance. OD's family were informed and understood the police decision. The hospital organization was initially anxious, but subsequently reassured on learning

the details of the case. In this issue, Little et al. (2012) consider the clinical and ethical implications of the use of a Taser on a low secure unit.

Acknowledgements

To all of the staff on Bowman: exceptional, protracted care, thank you.

References

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