Disturbed or violent behaviour by an individual in an in-patient psychiatric setting poses a serious risk to that individual, other patients and staff. Immediate management of such situations is necessary to ensure the safety of other patients and staff and to reduce the patient's level of distress. Although non-pharmacological and oral pharmacological solutions should be attempted first, sometimes rapid tranquillisation (RT) is required. NICE (2015) and BAP guidelines define rapid tranquillisation as 'the use of medication by the parenteral route if oral medication is not possible or appropriate and urgent sedation with medication is needed'. The interventions used should be the minimum required to calm the patient.

Aims, policies and training issues

- RT has a defined objective of controlling the acutely disturbed behaviour without causing any harm to the patient.
- RT is not aimed at treating underlying causes of agitation or violent behaviour.
- It should be used only when non-pharmacological measures have been used and proven unsuccessful.
- Staff delivering RT should be trained regularly to ensure good standards of care.

Step-by-step approach to RT

- The first two steps in a step-by-step approach to RT are: step 1 – assess the situation using an MDT approach, and step 2 – restraint.
- Rapid tranquillisation should be carried out using a multidisciplinary team approach.
- Before giving medication, one should be aware of relevant issues such as physical illness, concurrent medications and if possible, causes of agitation to determine the choice of medication.
- Wrong restraint positions have resulted in positional asphyxia-related death and unwanted injuries, hence it is vital to restrain the patient appropriately.

Legal framework

- The legal framework for a patient's detention, treatment and use of RT can differ according to the situation and setting.
- In any situation where RT is required staff members should assess the capacity of the patient to be able to agree to the treatment, be able to demonstrate that less restrictive interventions were tried first and document these in detail.

Medication used in RT

- Oral medication should be used first whenever possible.
- If parenteral treatment proves necessary, the intramuscular route (IM) is safer than intravenous (IV). The intravenous route should be used in exceptional circumstances only.
- Medications used in RT include benzodiazepines, antipsychotics and antihistamines. NICE and BAP/NAPICU guidelines give recommendations on the choice of medication.
- The patient should never be left unattended and resuscitation facilities should be easily accessible in case of any adverse events.
RT in special circumstances

- RT should be avoided in secluded patients, but it is not absolutely contraindicated. If the patient is secluded, the potential complications of RT should be taken particularly seriously.

- Issues likely to influence decision making when giving RT to a person with intellectual disability include the person’s ability to understand information and give valid consent. Behavioural disturbance may be due to the surrounding environment or an inability to communicate needs or suffering appropriately.

- The majority of episodes of behavioural disturbance in children and adolescents should be dealt with by environmental modification, behavioural modification, one-to-one observation, or seclusion. When non-pharmacological strategies have failed, the lowest possible dose of medications should be used. A senior medical staff should be involved in decision-making for using medications.

- Physical health comorbidities are more common in elderly patients and they are likely to be on a number of non-psychiatric medications, hence the risk of medication interactions is high.

- Existing RT guidelines give only general advice about the principles of management during pregnancy due to a lack of evidence in this population.

Monitoring after RT

- Regular monitoring of blood pressure, pulse, temperature, respiratory rate, oxygen saturation, hydration and level of consciousness after administering rapid tranquillisation minimises immediate complications.

- Easy availability of emergency medications and equipment must be ensured before using rapid tranquillisation.

Risk associated with RT and care after RT

- Every patient on high dose antipsychotics should undergo recommended investigations and monitoring of physical parameters regularly.

- There is a fine balance between the potential risk of violence due to inadequate tranquillisation and the risks associated with administering RT.

- After management of acute behavioural disturbance, the patient’s overall care should be reviewed and regular treatment should be optimised as soon as possible.

Further reading


Royal College of Psychiatrists (2014) Consensus statement on high-dose antipsychotic medication, CR190. Royal College of Psychiatrists. [PDF]