Episode 040: Reducing Inpatient Violence in a Psychiatric Hospital

Nate Hoyt (MS4), David Puder, M.D., Gillian Friedman, M.D.

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There are no conflicts of interest for this episode.

In this week's episode of the podcast, I interview Gillian Friedman and was joined by Nate Hoyt, a fourth year medical student.

Violent aggression in the inpatient psychiatric setting has developed into an important issue that negatively affects patients and staff. There are some simple and surprising treatments different clinics are taking to prevent violent aggression. It's time we paid attention to this issue so we can prevent injury of both patients and hospital staff.

Check out these startling facts:

- Greater than **75% of nursing staff on acute psychiatric reported being assaulted by a patient** at least once over the course of their careers (Iozzino et al., 2015).
- One in four psychiatric nurses report **disabling injuries** from patient assaults (Quanbeck, 2006).
- Aggression, when present, works against discharge planning and typically prolongs patient stays (Quanbeck, 2006).

How widespread is inpatient violence? Can it be predicted and prevented? What are the best measures for managing it? And how do we fix the issue? Traditional methods of responding to aggression, such as seclusion or restraints could result in physical and psychological harm to patients.

Clearly, a discussion of inpatient violence would be beneficial.

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Prevalence & Risk Factors

How often is this happening? Studies show that a smaller percentage of the patients cause most of the violence, and that there are predictive risk factors that can determine if a patient will be more likely to be a first time offender, or a repeat offender.

A meta analysis of 35 studies including 23,972 patients admitted to acute psychiatric units in 31 high-income countries found that about 17% committed at least one act of violence while hospitalized (Iozzino et al., 2015). It is important to note, however, that **a small percentage of aggressive psychiatric patients, cause 10 times more serious injuries** than those who less frequently assault (Convit et al., 1990, Cheung et al., 1997). Six percent of aggressors are responsible for 71% of incidents according to Barlow, Grenyer & Ilkiw-Lavalle, 2000).

Targeting these so called "recidivistic assaulters" could lead to the greatest decrease in aggressive incidents.

To an extent, the risk of inpatient aggression can be predicted.

Here are some of the risk factors:

- The most significant risk factor for physical violence was **history of aggression**, **and violence 1 month before admission further increased risk** (Amore et al, 2008); number of past violent acts is correlated with an increase in violence risk (Quanbeck, 2006)
- **Males** are associated with greater aggression (Amore et al, 2008)
- Certain psychiatric diagnoses are associated with higher rates of aggression:
    - **Schizophrenia**
    - **personality disorder**
    - **impulse control disorder** (eg, anger/temper control problems)
    - **bipolar** and **schizoaffective** disorder is also associated with aggression (Amore et al, 2008, Barlow, Grenyer & Ilkiw-Lavalle, 2000, Quanbeck, 2006)

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- A high percentage aggressors have a secondary diagnosis of **substance use disorder** (50% according to Olupona et al., 2017) (Barlow, Grenyer & Ilkiw-Lavalle, 2000)
- Aggressive patients are likely younger, with **age <32 years** (Barlow, Grenyer & Ilkiw-Lavalle, 2000)
- Aggression is associated with history of **being the recipient of abuse**; 67% of assaultive patients had been victims of violence themselves according to Flannery et al. (2002); 66% of assaultive patients suffered abuse as children according to Hoptman et al. (1999)
- Dr. Friedman gave some incredible clinical wisdom on this episode: She says she often notices increased violence:
    - When patients return after losing a hearing (either having to stay in the hospital on a 5250 or having to take medications involuntarily—a Riese hearing)
    - During times where they demand to leave and are told no (especially early on in the hospital stay) prior to discharge
    - When things change

How to clinically assess psychiatric violence

The risk factors above emphasize the need to carefully assess patients for aggression risk.

There are many different assessment models in the literature. **The California State Hospital Violence Assessment and Treatment (Cal-VAT)** (Stahl et al., 2014) is a good example of a standardized model used over multiple sites.

It is recommended that patients The Cal-VAT assessment process recommends the following:

- Assess for **etiology of aggression**; we've mentioned the types of aggression in previous podcast episodes, but here is a quick reminder:
    - Psychotic violence patients: misunderstand/misinterpret stimuli, experience paranoia, command hallucinations

    - Impulsively violent patients: are hyper-reactive to stimuli, have emotional hypersensitivity, and autonomic arousal
    - Predatory violence: is planned, they show a lack of remorse, autonomic arousal absent
- **Assess for medical conditions** that could contribute to risk for aggression
    - psychomotor agitation
    - akathisia
    - Pain
    - Delirium
    - Intoxication/withdrawal
    - Complex partial seizures
    - Sleep issues
    - Abnormalities with glucose/calcium/sodium/thyroid, or cognitive impairment
- Be conscious of **environmental factors** that could contribute to aggression
    - lack of supervision/structure
    - waiting in line
    - Crowding
    - excessive noise
    - poor staff teamwork
- **Violence risk assessment** (should be systematic and performed by trained individual)
    - Includes violence history
    - Screen for common comorbidities
        - Psychosis
        - Substances
        - Psychopathy
        - emotional instability
        - borderline personality disorder
        - intellectual disability
        - TBI
    - Some good assessment tools are:
        - Historical Clinical Risk Management-20 (HCR-20)
        - Short-Term Assessment of Risk and Treatability (START)
        - Violence Risk Screening-10 (V-RISK-10)

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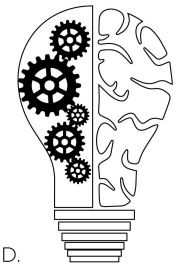

- Brief Psychiatric Rating Scale (BPRS) (Amore et al., 2008)

How can we help violent psychiatric patients?

Traditional Methods

Isolation, restraints, and especially psychopharmacology form the backbone of inpatient violence prevention. While these serve an important role, heavy reliance on them has been perceived by patients as "controlling" (Duxbury, 2002). It can be very useful to augment these methods with newer strategies that promote cooperation and partnership with patients.

We won't delve into the traditional methods here other than to direct the reader to the Cal-VAT guidelines (Stahl et al., 2014) for an excellent discussion of the psychopharmacologic treatment of violence including off-label medications and higher-than-normal dosages.

De-escalation Strategies

Diligent attempts to deescalate can result in reduced use of traditional methods. Below we've included Dr. Puder's resources from the podcast.

1.Richmond et al. (2012):

- 1st patient is verbally engaged
- 2nd collaborative relationship established
- 3rd: verbally de-escalated
    - Verbal loop: listen to the patient-> find ways to respond that agrees with or validates the patient's position-> tell the patient what you want (take meds, sit down, ect)
        - May take a dozen times (requires patience)
        - Each cycle may take 1 minute, so 10 minutes for 10 cycles

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2. Fishkind, A. (2002), 10 domains of de-escalation:

1. Respect personal space
    1. 2 arms distance at least
    2. Understand many have been sexually abused
2. Do not be provocative
    1. Not fist clenched, not closed off body language, not excessive staring
3. Establish verbal contact
    1. Only one person (trained person)
    2. Explain who you are and your goal is to keep everyone safe
4. Be concise
    1. Simple language, simple vocabulary, bit sized info at a time
    2. Persistently repeat message
5. Identify wants and feelings
    1. “Even if I can’t provide it, I would like to know so we could work on it.”
6. Listen closely to what the patient is saying
    1. Through body language, verbal acknowledgement, repeat back to their satisfaction
    2. “To Understand what another person is saying, you must assume that it is true and try to imagine what it could be true of.”
7. Agree or agree to disagree (find things to agree with)
    1. Agree with the truth
    2. Agree with the principle
        1. “I believe everyone should be treated respectfully”
    3. Agree with the odds
        1. “There would probably be other patients who would be upset also…”
8. Lay down the law and set clear limits
    1. Lay down the expectations for expected behavior matter of fact (not as a threat)
9. Offer choices and optimism
    1. Propose alternative to violence
    2. Offer kindness (blankets, magazines, access to phone, food, drink)
10. Debrief the patient and staff

3. Dr. Friedman recommends all doctors on her unit to have prn (as needed) medications available as part of the initial order set. Then nurses can administer them if a patient starts escalating.

Alternate Measures

Literature suggests significant decreases in inpatient violence from some interventions further off the beaten path than those we've mentioned thus far.

Surprisingly simple interventions working toward **improving staff relationships with patients can lead to significant decreases in inpatient violence**. Two British studies offer some opportunity for reflection.

Bowers et al. 2015 tested 10 Safewards interventions in a randomized controlled trial that included 31 wards at 15 hospitals in London. The interventions tested included a requirement to say something good about each patient at nursing shift handover, emphasis on de-escalation, structured, innocuous, personal information sharing between staff and patients (favorite music/sports), anticipating and talking through bad news patient may receive, and display of positive messages about the ward from discharged patients. **The test sites that used the interventions experienced a 15% reduction in conflict events and a 23.2% reduction in containment events.**

Antonysamy (2013) reported that one inpatient adult unit in Blackpool, England began taking patients on weekly trips to the local zoo. Over the course of 12 months, aggressive incidents dropped from 482 to 126, and average length of stay reduced by about 50%. Furthermore, the rate of staff taking sick time was reduced by more than 50% (they attributed this to increased enthusiasm).

Conclusions

Inpatient psychiatric violence poses a significant risk to patient and staff health. Risk factors offer staff an opportunity to predict and prevent aggression through thorough violence assessments.

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Pharmacotherapy, isolation, and restraints provide a valuable core of intervention options that will likely never be replaced, but is could be beneficial to begin to view these as more of a last line of defense. When we resort to these interventions by default, patients perceive entering into a very control-oriented power dynamic with staff, and patient-staff relationships suffer. When we utilize alternative interventions that emphasize the humanity of patients and foster cooperative partnerships with staff, the need for traditional interventions is reduced.

Antonysamy's (2013) intervention of the weekly trip to the zoo is well nigh impossible to test in the United States, but it offers an important opportunity for reflection. If simple, humanizing interventions like this can be so effective, where should we place our emphasis in future research?

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