Reducing Violence Risk in the Hospital and Developmental Center

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Learning Objectives

Understand: Understand risk factors for violence in various settings, including hospital, developmental center, and community.


Discuss: Discuss violence risk management strategies in various settings.
Institutional Violence: A Growing Problem

• Increasing problem for mental health workers worldwide

• Huge costs:
  • Patient, staff morbidity and mortality
  • Costs to society
  • Stigma
  • Recruitment
  • Litigation
Institutional Settings

- Acute
  - New hospital admission; short-term general psych unit
- Sub-acute
  - Longer-term admission (forensic psych); developmental center
- Longer-term
  - Community placement
- **Forensic psychiatry hospital units**: most violent mental health setting
  - Almost 2x general psych units, and almost 3x longer-term units
    (T. Ramesh et al)
Institutional Violence

- Three types: reactive > instrumental > psychotic
Violence in MH/DD: Misconceptions

- Most are NOT violent
- More likely to be victims than perpetrators
- Violence is associated with acute symptoms/distress
Violence in MH/DD: Reality

Fear

Anger

Due to...

Thoughts: Paranoia, Persecution

Behavior: Impulsivity/low frustration tolerance

Personality: Externalization, inability to tolerate criticism

Developmental: Trauma, cycle of violence
WARNING
Escalating fear and anger
Assessing Violence

“Accurate assessment depends on the availability of accurate information.”  (Buchanan et al, 2012)
Assessing Violence

- History (arrests, fights, domestic violence, weapons)
- Current Acts (magnitude, frequency, patterns/triggers)
- Factors (static, dynamic, protective)
- WHY? (reactive/instrumental/psychotic)
Factors in Violence

- Risk Factors
  - Static: cannot be altered through intervention
  - Dynamic: can theoretically be altered through intervention

- Protective Factors
  - Stability: marriage, job, military, parenthood

- Other (environment, situational)
Assessment Approaches

• Unstructured Professional Judgment
  • Clinical Interview
  • Collateral Information
  • Consultation

• No better than chance!
Assessment Approaches

- Unstructured Professional Judgment
  - Clinical Interview
  - Collateral Information
  - Consultation

- Structured Risk Assessment Tools
  - Analyze Factors

- Integrated Approach
Clinical Interview

- WHAT is the magnitude/lethality/severity?
- WHO is at risk?
- WHERE: situational factors
- WHEN: dynamic risk factors and time frame—immediate, short-term, intermediate, long-term
- WHY?
Collateral

- Medical records
- School records
- Family/roommates/colleagues
- Police reports
- Psychological testing
- Specialist colleagues

* Treatment team!
Risk Assessment Tools: What Works?

- Meta-analysis by T. Ramesh et al. 2018
- 78 studies looked at 7705 patients in 14 countries
- Examined nine most common violence risk assessment instruments of inpatient violence
  - Actuarial
    - Broset Violence Checklist (BVC) - dynamic
    - Dynamic Appraisal of Situational Aggression (DASA) – dynamic
    - Hare Psychopathy Checklist, Revised (PCL-R) – mostly static
  - Structured professional judgement
    - HCR-20
    - START
Findings

• **Imminent** violence: Dynamic scales such as Broset Violence Checklist (BVC) or Dynamic Appraisal of Situational Aggression (DASA) good predictors

• **Longer-term** prediction: HCR-20 only moderate predictor, despite most widely used instrument internationally

• PCL-R: highlights traits that predispose to violence, but poor predictor
• Six behavioral changes that are most frequently recorded by nursing staff in the 24 hours preceding violence: confusion, irritability, boisterousness, physical threats, verbal threats, attacks on objects

• Numerous studies show good sensitivity and specificity

• Hvidhjelm 2014: 40% of patients with a BVC score of 3 or higher could be expected to commit a physical attack in next 24 hours

• For patients scoring less than 3, the risk of violence was 0.1%
• Now version 3
• Risk assessment tool in OhioMHAS
• Historical, Clinical, Risk Management
HCR: Historical

- History of violence
- Age at incident
- Mental illness
- Psychopathy
- Personality disorder

- Substance use disorder
- Early adjustment problems
- Relationship
- Employment
- Prior supervision failure
HCR: Clinical

- Insight
- Attitude
- Impulsivity
- Active symptoms
- Treatment response
HCR: Risk Management scale

- Destabilizing influences
- Stress
- Lack of support
- Noncompliance
Short-Term Assessment of Risk & Treatability:

- structured violence risk assessment instrument
- risk domains & protective factors for inpatient psychiatry
- solely dynamic factors

Chu et al, 2011

- N=50 forensic inpatients, follow-up over 1 month
- Risk scale predicted interpersonal violence, verbal threats, inpatient aggression
- Strength scale predicted violence, inpatient aggression
Violence Reduction Plan

Dynamic Risk Factors

Plan to reduce risk from each factor
<table>
<thead>
<tr>
<th>Dynamic Risk Factor</th>
<th>Management/Treatment</th>
<th>Status</th>
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<tbody>
<tr>
<td>Drug use</td>
<td>Sobriety, attendance at AA</td>
<td>Sober, being monitored</td>
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<tr>
<td>Access to weapons</td>
<td>Removal of weapons from home</td>
<td>Removed</td>
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<tr>
<td>Delusions about mother</td>
<td>Antipsychotic agents</td>
<td>Compliant &amp; responding</td>
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</table>

(e.g. Ostermeyer et al, 2016)
That you...

- Performed a risk assessment
- Checked collateral information
- Consulted (if indicated)
- Assessed level of risk that led to decision
- Assessed risk factors & how to mitigate in violence reduction plan
- Communicated recommendations
Assessing and Managing Other Factors

• Environment
• Staff
• Overall risk
Environmental Factors

• Low social density

• High patient control

• Decreased negative stimulation

• Increased positive stimulation

(R. Ulrich, 2018)
In wards with stress-reducing features, episodes of both stat medication administration and seclusion/restraint decreased.

Features to reduce social density and increase individual control: private room/bathroom, large communal area, noise reduction, control in patient rooms, garden, window view daylight exposure, good observation line of sight (R. Ulrich, 2018).
Staff Factors

- Training
- Counter-transference
- Boundaries
Various levels of staff experience, motivation, training

Key training item: De-Escalation (vs. Escalation)

Observe for early signs of agitation & why

Do not argue and agree when possible

Use interventions to give patients a sense of control and choice

Provide personal space

Remove upset patient from the milieu

(Quanbeck & McDermott, 2008)
Counter-transference and patient manipulation
Counter-transference

1. Anxiety management
2. Self-integration
3. Empathy
4. Conceptualizing skills
5. Self-insight

(Hayes et al, 1991)
Counter-transference

- Supervision/consultation if experiencing sexual/romantic thoughts about patient
- Beware of red flags & patterns
- Boundaries
- Recognize warnings of countertransference including: “uncharacteristic mood changes, encouraging acting out behavior or acting out with the patient, dismissal of the reaction as realistic, feeling a need for the patient’s approval, or repeated arguing with the patient”
- Always address inappropriate behavior/comments (Faulkner et al, 2011)
Patient Manipulation: Staff Seduction

• Obtaining information
  • “If they’ll talk about things outside the prison, they’ll get personal”

• Overhearing staff conversations

• “Grooming”

• “The Demand & the Lever”
  • “campaign of bonding” giving praise, favors
  • ‘if you want someone to cross a line, it is important to make the line small’... quickly escalates...blackmail

(Salter, 2003)
Poor Boundaries:

- Sharing personal information
- Special favors
- Sharing other staff or patient information
- Special access

• Staff should model desired behaviors
“Very few mentally ill persons are violent, & the pattern of mental disorder most commonly associated with violence, comorbid psychopathic personality & substance abuse, is not considered particularly treatable.”

(Freedman et al, 2007)
Strive for Secure Recovery
Patient Engagement

• Ray and Simpson, 2019 literature review

• Regardless of methodology, shared patient involvement in risk assessment helpful
  • Early Recognition Method (ERM) most successful – risk analysis and structure intervention

• Guided process in which staff and patients develop a shared understanding of early signs of aggression and create plans to reduce violence
Secure Recovery

Recovery Paradigm

Consumers’ movement & rehabilitation movement

Hope, empowerment, healing & connection

Patient choice, responsibility, self-determination

Not coercion

(Simpson et al, 2011)
The focus of rehabilitation? 

- Mental Health
- Risk Reduction
- A pro-social, happy life!
Rehabilitation programs (Lindquist & Skipworth, 2000)

• To understand risk.
• To understand mental health.
• Family circumstances and poor socio-cultural circumstances.
• Substance misuse.
• Anti therapeutic systems dynamics e.g. stigma (disclosure).
• Evidence?
Hospital Treatment Team and Programs

- Multidisciplinary
- Collaborative
- Progression through movement levels
- Development of a treatment/recovery plan, safety plan
Safety Plan

5. Crisis Plan

When I’m losing control, staff can best help me by...

As a last resort, seclusion and restraint may be used to keep you and others safe. Is there anything the staff could do to avoid this?

If you have to be restrained and/or secluded, what would help to minimise the amount of time this lasts?

If you have to have medication, which medication do you prefer?

Medical Conditions:
Do you have any physical conditions, disabilities, or medical problems such as asthma, high blood pressure, back problems, etc., that we should be aware of when caring for you during this time?

Have you been restrained and secluded previously? Yes / No

If yes, what did you learn from that experience?
Recovery Plan

I am

What’s going well in my recovery

This is important to me

What gives me hope
Triggers

Outside events, people, places or items that may cause me to start sliding down the slippery slope.

Warning Signs

Those changes in thoughts, feelings, experiences or behaviours that tell me I've started to slide
Action Plan

If I notice a trigger or early warning sign, this is what I will do:

Talk
Think
Act

In Emergencies

When things get out of control I will...

After a Slide

Once I get back on track I will...
Resources

People, places, organisations, strengths, items, programmes and information that will help me recover

Achievements

These are some of my key achievements in recovery
## Safety Plan

**Mason Clinic 101**

<table>
<thead>
<tr>
<th>Alcohol and Other Drugs</th>
<th>Mental Health</th>
<th>Emotion Regulation</th>
<th>Attitudes &amp; Beliefs</th>
<th>Sexual Offending</th>
<th>Protective Factors</th>
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<tr>
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<td>Mind / Mood 1</td>
<td>A Seed of Faith</td>
<td>Sex Ed</td>
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<td>Mind / Mood 2</td>
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### Pathways to Safety

- Moving On
- Recovery Support Group
- Literacy
- Wananga: Te Ao Maori
- Cog Rehab
- Wananga: Te Reo Maori
- Creative Expression
- Wananga: Kapa Haka
- Disclosure
- PI Cultural Programme
- Bible Study
- Women’s Group
- Work & Education
Recovery/Treatment Plan

- Medication
- Counseling
- Group activities (at least 4 hours per day, on unit if needed)
- Discharge planning and transition
- Rehabilitation activities
  - Music therapy
  - Art therapy
Psychodynamic

- Encourage “pro-social” behaviors
- Establish meaningful connections to community
- Address underlying issues such as trauma
Music Therapy

• Hakvoort, 2002: Netherlands
• For personality disorder & anger management
• Music allows anger in controlled setting, building awareness
• Gallagher et al, 2002: Cleveland, USA
• Successful music therapy program in community treatment program for dual diagnosis offenders (SAMI)
Yoga in Forensics

Sistig, Friedman, McKenna & Consedine. (2015)

• N=26 patients; 92% rated acceptable
• Weekly 1 hour sessions x 8 weeks
• +CD/Mp3 + poster of poses
• Key themes: decreased tension, increased relaxation, breathing
• Trends over time: improved anxiety & mindfulness
Personal Recovery

Focus on . . .

Healthy eating

Exercise

Yoga

Meditation
The role of recovery? (Simpson et al, 2011)

- ‘A life worth living’
- Self determination.
- Empowerment
- Knowledge
- Quality of life
- Hope and optimism
- Social inclusion
- Citizenship
The role of therapeutic security? (Colins & Davies, 2005)

- Less restrictive alternative
- Physical security (e.g. fences, locked doors)
- Procedural security (e.g. checks, cutlery counts)
- Relational security (managing risk through relationship)
Summary

1. Consider common risk factors
2. Also consider other factors: environmental, situational
3. Use a structured approach
4. Document thinking & planning in a risk reduction plan
5. Aim for (secure) recovery