Assessment and Treatment of Inpatient Aggression: The Changing Face of Public Psychiatry

page 223 in syllabus

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Individual Disclosure Statement

Faculty Author / Presenter

Katherine Warburton, DO, is the acting Medical Director and Deputy Director of Clinical Operations for the California Department of State Hospitals.

No financial relationships to disclose.
Learning Objectives

- Understand the epidemiology and heterogeneity of violence
- Utilize assessment tools to predict violence risk
- Apply evidence-based treatment strategies to individuals with violent, impulsive, and aggressive behaviors
Prevalence of Inpatient Aggression

- Underreported?
- Definition of Aggression?

- Short-Term Hospitalization – 17.4% within 3 days (Binder and McNeil 1990)
- Long-Term State Hospitalization – 7% (Tardiff 1984)
## Department of State Hospitals (DSH)

<table>
<thead>
<tr>
<th></th>
<th>FY10-11 Rate</th>
<th>FY10-11 UniqueAgg/New admits</th>
<th>FY11-12 Rate</th>
<th>FY11-12 UniqueAgg/New admits</th>
</tr>
</thead>
<tbody>
<tr>
<td>DSH-A</td>
<td>28.8%</td>
<td>353/1224</td>
<td>23.6%</td>
<td>240/1019</td>
</tr>
<tr>
<td>DSH-C</td>
<td>41.7%</td>
<td>25/60</td>
<td>15.6%</td>
<td>22/141</td>
</tr>
<tr>
<td>DSH-M</td>
<td>43.0%</td>
<td>230/535</td>
<td>34.7%</td>
<td>176/507</td>
</tr>
<tr>
<td>DSH-N</td>
<td>25.4%</td>
<td>148/583</td>
<td>25.9%</td>
<td>179/690</td>
</tr>
<tr>
<td>DSH-P</td>
<td>35.0%</td>
<td>345/986</td>
<td>30.8%</td>
<td>318/1031</td>
</tr>
</tbody>
</table>
DSH: Eight Psychiatric Facilities

Vast differences

- Patient populations
- Physical plants
- Geography
DSH: Atascadero

- Central Coast
- Opened in 1954
- 1033 **male** patients
  - 277 Correctional Inmates
  - 112 Incompetent to Stand Trial
  - 559 Mentally Disordered Offenders
  - 121 Not Guilty by Reason of Insanity
  - 4 other
- Maximum security
- Completely self-contained within a security perimeter
- Built as a forensic facility
DSH: Coalinga

- Central Valley
- Opened in 2005, state of the art
- 1500 beds, 1001 filled
- 861 sexually violent predators
- 87 Mentally Disordered Offenders
- 48 Correctional Inmates, 5 other
DSH: Metropolitan LA

- Greater Los Angeles
- Opened in 1915
- 644 patients
  - Male:female ~ 5:1
  - 289 Incompetent to Stand Trial
  - 200 Civil
  - 43 Mentally Disordered Offenders
  - 109 Not Guilty by Reason of Insanity
  - 3 other
- Large open campus
DSH: Napa

- Opened November 15, 1875
- 1226 patients
  - Male:female 9:1
  - 300 Incompetent to Stand Trial
  - 207 Civil
  - 113 Mentally Disordered Offenders
  - 531 Not Guilty by Reason of Insanity
  - 4 Department of Juvenile Justice
  - 71 other
- Large open campus
DSH: Patton

- San Bernardino, California
- Opened August 1, 1893
- 1529 Beds
  - 6 Correctional Inmates
  - 1 Juvenile Justice
  - 487 Incompetent to Stand Trial
  - 95 Civil
  - 346 Mentally Disordered Offenders
  - 537 Not Guilty by Reason of Insanity
  - 56 other
  - 1 female Sexually Violent Predator
- Large open campus
DSH: Vacaville

- 373 Inmate-Patients
- Committed to Correctional Department
- Penal Code 2684
DSH: Salinas Valley

- 336 Inmate-Patients
- 317 PC 2684
- 19 Incompetent to Stand Trial
DSH: Stockton

- 1,722 bed medical and mental health care facility
- 480 DSH beds
Found that one type of forensic patient exhibited the majority of aggression in hospital:
- High scores on risk assessments
- High scores on measure of anger
- High scores on measure of impulsivity
Cluster Scores

Cluster 1: n=19
Cluster 2: n=25
Cluster 3: n=27
Cluster 4: n=37

VRA Elements:
- Violence Risk
- Impulsivity
- Anger
- Cognitive Planning
- Motor
- Cognitive Arousal
- Behavioral Provocation

Z Scores for each cluster are represented in the graph.
Rate of Aggression

Rate per year

Cluster1  Cluster2  Cluster3  Cluster4
Physical aggression - Client  Physical aggression - Staff

- Physical aggression - Client
- Physical aggression - Staff
Typology of Inpatient Aggression

- Videotaped inpatient assaults were studied at a New York psychiatric hospital
- Assailant, witnesses, and victim were interviewed separately as soon as possible after each incident

• Three primary categories of assaultive behavior were described
  – Disordered impulse control
  – Psychopathic (planned/predatory) behavior
  – Underlying psychotic symptomatology
• Only 20% were directly related to positive psychotic symptoms

Types of Aggression at Napa State Hospital

- UC Davis researchers studied the inpatient assaults at Napa State Hospital
- Studied over 1000 acts of aggression
- Attempted to replicate the work of Nolan et al.
- Developed a classification system to categorize aggressive acts into motivation and subcategorize them into provocation
- Based on a review of Special Incident Reports

Quanbeck et al. 2007.
Aggression Subtypes at Napa State Hospital

13% Impulsive
15% Organized
27% Psychotic
45% Not Classified
Further research examining type of aggression found that:

- **Impulsive aggression** occurs most frequently in individuals who exhibit combinations of psychiatric symptoms (especially anxiety and hostility) and anger.

- **Psychotic aggression** was related to psychotic symptoms.
UC Davis Napa Research

- Predatory aggression occurs most frequently in individuals who exhibit psychopathic/antisocial characteristics and heightened affect (anger).

- UC Davis research indicates that this type of aggression results in more injury and often more severe injury.
UC Davis Napa Research: Injury by Type of Assault

<table>
<thead>
<tr>
<th>Type of Assault</th>
<th>Injury</th>
<th>No injury</th>
</tr>
</thead>
<tbody>
<tr>
<td>Impulsive</td>
<td>48</td>
<td>52</td>
</tr>
<tr>
<td>Predatory</td>
<td>69</td>
<td>31</td>
</tr>
<tr>
<td>Psychotic</td>
<td>38</td>
<td>62</td>
</tr>
</tbody>
</table>
Type of Aggression by Primary Axis I Diagnosis

Percent Exhibiting Type of Aggression

<table>
<thead>
<tr>
<th>Type of Aggression</th>
<th>Schizophrenia</th>
<th>Schizoaffective</th>
<th>Substance Dx</th>
<th>Other Psychotic</th>
<th>Mood</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Impulsive</td>
<td>32</td>
<td>35</td>
<td>44</td>
<td>31</td>
<td>30</td>
<td>23</td>
</tr>
<tr>
<td>Predatory</td>
<td>9</td>
<td>15</td>
<td>28</td>
<td>31</td>
<td>19</td>
<td>4</td>
</tr>
<tr>
<td>Psychotic</td>
<td>17</td>
<td>11</td>
<td>9</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
Type of Aggression by Axis II Diagnosis

- Impulsive: 49, 36, 3
- Predatory: 73, 22, 3, 3
- Psychotic: 50, 41, 0, 9

Legend:
- No Axis II
- ASPD
- Borderline PD
- Other PD
• Fully 73% of individuals exhibiting an act of predatory aggression were diagnosed with antisocial personality disorder.
UC Davis Napa Research

- Rate of psychopathy in our system
  - N=277
  - All NGRI/MDO
  - 19% of men scored 25 or above on PCL-R
UC Davis Napa Research

Committing offense (N=298)

- Assault 40%
- Murder 23%
- Lewd and lascivious 9%
- Theft 7%
- Rape 6%
- Arson 4%
- Criminal threats 3%
• In sum, these data suggest that predatory aggression:
  – Results in the most injury
  – Is committed by individuals with substance use disorders, ASPD, high scores on the psychopathy checklist, and anger/impulsivity problems

• Individuals with this combination of characteristics may be better treated in a more secure environment
Impulsive Assaults by Legal Class

- IST: 15
- NGI: 10
- Civil: 43

Percent of Total Number of Assaults
Predatory Assaults by Legal Class

<table>
<thead>
<tr>
<th>Legal Class</th>
<th>Percent of Total Number of Assaults</th>
</tr>
</thead>
<tbody>
<tr>
<td>IST</td>
<td>4</td>
</tr>
<tr>
<td>NGI</td>
<td>7</td>
</tr>
<tr>
<td>Civil</td>
<td>1</td>
</tr>
</tbody>
</table>
Psychotic Assaults by Legal Class

<table>
<thead>
<tr>
<th>Legal Class</th>
<th>Percent of Total Number of Assaults</th>
</tr>
</thead>
<tbody>
<tr>
<td>IST</td>
<td>4</td>
</tr>
<tr>
<td>NGI</td>
<td>2</td>
</tr>
<tr>
<td>Civil</td>
<td>19</td>
</tr>
</tbody>
</table>
Where to Begin?

• Different hospitals = different issues
  – Physical plant security
  – Patient populations
  – Complex, multifactorial problem
Bifurcated Approach

- **Assessment**
  - Violence Risk Assessment
  - Assessment of Malingering

- **Intervention**
  - By Etiology
    - Psychotic
    - Impulsive
    - Predatory
Assessment

- Concept of violence risk assessment
- Culture change
- Selection of instruments
Violence Risk Assessment Committee

- Pre-admission violence risk screen
- START (Short-Term Assessment of Risk and Treatability)
- COVR (Classification of Violence Risk)
- HCR-20 (Historical, Clinical, Risk Management -20)
- PCL-R (Hare Psychopathy Checklist- Revised)
- VRAG (Violence Risk Appraisal Guide)
### Identifying Information

<table>
<thead>
<tr>
<th>1. Name of patient</th>
<th>1a. CII Number</th>
<th>2. Sex</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>3. Sending institution</th>
<th>4. DOB</th>
<th>4a. Place of Birth</th>
</tr>
</thead>
</table>

|----------------------------------------------------------|--------|

|-----------------------------------------------|---------------------|----------------------------------|

**Flag for follow-up** □

**Reason for follow-up**

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**For PC1370’s:** did court issue involuntary meds order? □ Yes □ No

**For MDO’s,** was inmate/patient on Keyhea order most recent term? □ Yes □ No

MDO’s/Other CDCR: Custody Points:

**Arrest History Information**: RAP sheet available: □ Yes □ No

- Number of arrests:
- Number of categories of arrests:
- Number of serious arrests:
- Number of arrests for Resisting/Obstruction:

**Narrative/Additional Notes**: Note positive risk factors from above

Circumstances of most recent arrest/summary of police reports of most recent arrest:

Factors that would further impact risk for aggression/violence:
**Based on review of admission packet documentation (no interview conducted):**

<table>
<thead>
<tr>
<th>10. Most recent documented aggressive/violent episode</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Date:</td>
<td></td>
</tr>
<tr>
<td>Severity:</td>
<td></td>
</tr>
<tr>
<td>☐ Murder/Attempted Murder/Rape/Kidnapping</td>
<td>☐ Yes</td>
</tr>
<tr>
<td>☐ Severe/GBI</td>
<td>☐ No</td>
</tr>
<tr>
<td>☐ Less Severe</td>
<td>☐ Info not available</td>
</tr>
<tr>
<td>☐ Threats only</td>
<td></td>
</tr>
</tbody>
</table>


| 10a.ii Weapon used: None hands/fist/feet “found” or makeshift weapon knife handgun or firearm |

| 10b. For episode with the most detailed documentation (usually most recent arrest), note: |
| i) Level of Criminal Planning: Opportunistic/Unplanned Planned/Predatory | ☐ Info not available |
| ii) Level of Thought/Organization: Psychotic Reactive Instrumental | ☐ Info not available |

| 10c. Serious Mental Illness factors noted at time of most recent aggressive episode: |
| None/Minor Symptoms Substance Abuse Factors Psychotic Symptoms Manic Symptoms | ☐ Info not available |
| Potential Feigning/Malingering |  |

| 11. Previous violence (Note all/as many as possible) |  |
| Date:                                               |  |
| Severity:                                          |  |
| ☐ Murder/Attempted Murder/Rape/Kidnapping           | ☐ Yes |
| ☐ Severe/GBI                                       | ☐ No  |
| ☐ Less Severe                                      | ☐ Info not available |
| ☐ Threats only                                     |  |


| 11a.ii Weapon used: None hands/fist/feet “found” or makeshift weapon knife handgun or firearm |

| 11b. For episode with the most detailed documented (usually most recent arrest), note: |
| i) Level of Criminal Planning: Opportunistic/Unplanned Planned/Predatory | ☐ Info not available |
| ii) Level of Thought/Organization: Psychotic Reactive Instrumental | ☐ Info not available |

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<tr>
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<tbody>
<tr>
<td>12. History of substance misuse</td>
<td></td>
<td></td>
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<tr>
<td>Note: ☐ previous substance related arrests</td>
<td>☐ substance use involved in most recent arrest</td>
<td></td>
<td></td>
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<tr>
<td>13. History of previous treatment for severe psychiatric mental illness ☐ previous DMH hosp ☐ previous CDCR ☐ previous 5150/invol. hold</td>
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<td>14. Diagnosed with personality disorder, or strong evidence of characterological traits (esp. Cluster B traits):</td>
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<tr>
<td>15. Shows current active symptoms of severe mental illness</td>
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<tr>
<td>16. Shows lack of insight into illness/behavior/need for treatment or need for medications</td>
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<tr>
<td>17. Cooperative with police / treatment providers / evaluations</td>
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<tr>
<td>18. Shows criminal attitudes / callousness / lack of empathy</td>
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<tr>
<td>19. Shows poor behavioral controls</td>
<td></td>
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<tr>
<td>20. Shows unrealistic attitudes towards self/situation, or unrealistic plans</td>
<td></td>
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<tr>
<td>21. Young age at first arrest</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age:</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>22. Young age at first violent arrest</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age:</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>23. Early maladjustment/destabilizing influences</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>24. Prior supervision or parole failure</td>
<td></td>
<td></td>
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<tr>
<td>25. Unresponsive to treatment/ Non-compliant with treatment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>26. Evidence of Poor Institutional Adjustment / Behavioral problems in structured environments, i.e., Jail, Prison, etc.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>27. Ever arrested for Battery on a Peace Officer/Emergency Personnel?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>28. Is potential low intellectual functioning/ low IQ noted or low cognitive functioning documented? ☐ Intellectual Deficits / Low IQ ☐ Neurologic Impairment (i.e., demential) or acquired brain injury (TBI)</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>
Challenges

- Role of psychology
- Training
- Implementation
- Consensus
Risk Assessment Unit

- Risk Assessment Unit
  - Embedded Psychologist at each facility
  - Pre-Admission Violence Risk Screening
  - Sophisticated Data Analysis
  - Research
  - Violence Treatment Guidelines
  - Training
  - Culture Change
Intervention

- Pharmacological
- Nonpharmacological
Develop Evidence-Based Medication Guidelines for Aggression

- UC Davis Guidelines
  - Literature review/prescribing guidelines for different types of aggression

- STOP-A Algorithm
  - Treatment for psychomotor agitation has been developed at PSH and approved by medical directors

- Establish a long-term "toolkit" for educating state hospital psychiatrists and ensuring their competency regarding the treatment of aggression
  - Implementation plan
  - Competency in the psychopharmacological treatment of aggression
  - Dr. Stahl's lectures
  - PRN
PRN

- Psychopharmacology resource network
- Dr. Stahl
- Embedded Psychiatrist at each facility
- Consultation
- Collaboration
- Culture Change
Optimize Nonpharmacological Treatment of Aggression

• Implementation of DBT statewide
• Treatment modalities for varying levels of cognitive abilities and impairments
• Targeting Impulsive Aggression
  – Behavioral/Cognitive Interventions
  – Specialized Units
Specialty Unit Pilots

- Enhanced Treatment Unit – Psychotic/Impulsive (Atascadero)
- Specialized Services Unit – Predatory/Impulsive (Coalinga)
- Substance Abuse Treatment (Napa)
- DBT Unit (Metro)
- Cognitive Unit (Patton)
Specialty Units

• Enhanced Treatment Unit
• Atascadero
• Impulsive and psychotic aggression
• Axis I
• Short term (30-90 days)
• Diagnostic clarification, intensive treatment
• Hospital Police presence
• Low population, enhanced staffing, physical plant modification
Specialty Units

- Specialty Services Unit
- Coalinga
- Psychopathic, predatory
- PCL-R
- Structure, Hospital Police, enhanced staffing
Target Substance Abuse

1. Routine, random urine drug screens
2. Implement formulary guidelines/restrictions to minimize trafficking in prescribed medications
3. Substance abuse treatment unit – NSH
Education

• Develop a statewide curriculum for the treatment of aggression
Education

• Establish independent forensic panels
"I have been able to come to no other conclusion than that the great stumbling block of the American superintendents is their most unfortunate and unhappy resistance to the abolition of mechanical restraint."

1876
This is an old policy statement issued by Dr. G. Lee Sandritter, former Medical Director of Atascadero State Hospital, during troubled times in 1961. It has been published previously in "Right On" and is again being published as it is still relevant.

**POLICY ON THERAPY VS. SECURITY**

The answer is not Security or Therapy. The answer is both.
This is a Security Hospital, whether we like this idea or not is beside the point, not the point.
The community thinks of it this way.
The Central Office thinks if it this way and has instructed me to maintain Security and to develop therapy programs.
The laws of California are written this way.

Therefore, we will maintain Security to the best of our ability.
We will develop therapy programs within this Security concept.

Therapy programs are not dependent on relaxation of Security.
Open doors do not make it a therapeutic community.
Therapy programs carried a on by personnel with the right attitude make a therapeutic community.
Doors are not opened and them patients get well; patients are treated and they improve and accept responsibility for their own and others behavior; and then they can come and go from closed wards.
Therapists working together with patients to develop understanding and control for the group, produce a therapeutic community.

When therapists, with patients, work out programs to meet the needs of all patients according to their various needs to become a part of a Unit group, then you have a therapeutic program.
You do not achieve a therapeutic program by hurrying it. You can go only so fast as Therapists and Patients can achieve behavior (ideas, feelings, and actions), which contribute to the group (Therapists and Patients) by allowing them to be relatively comfortable with each other in the given boundaries. In the case of Atascadero State Hospital, the boundaries are Security.

Security has been emphasized first during the past many months. We will continue to remember Security is necessary because we cannot treat the patient who has run away.
Therapy will now be emphasized, not first or second, but also and equal to Security.

We will develop therapy programs which emphasize Therapists and Patients working together in groups, especially at ward unit levels, in programs that enable patients to develop responsibility for their own and other patients' behavior.

These programs should be developed with both Therapists and Patients taking part in the development.
They should progress with simple programs and proceed to more complex ones.

Patients should progress from simple to more complex programs and not start with the complex ones.

Patient progress should be with programs, not with ward transfers primarily.
The ward physicians and the ward charge should work together to develop a schedule for every patient on the ward.
The patient's time should be blocked out for him as a student in college, as indeed, the patient is the student.
The psychological, social service, and rehabilitative programs should be added as the patient improves so he can profit by them.

*****
Environment

- There is no clinical intervention for predatory aggression in a hospital setting
Personal Duress Alarm System

- State of the art GPS alarm system at Napa
- Real Time Location System (RTLS)
- Entire campus
- Victim identification
- Metro and Patton next
- Policy implications
Stratification

• Maximize resources
  – Physical plant
  – Human Resources
  – Centers of Excellence

• Violence risk assessment

• Bed analysis

• Built-in behavioral contingencies
Transfer to Prison

- California Welfare and Institutions Code 7301
- Provides for the enhanced custody/security needs of a DSH patient that can be best met in a CDCR institution
- Limits to this option
Enterprise Thinking

- Clinical Operations Advisory Committee
- Stratification of patient placement
- Patient management unit
- Technology improvements; on our way to Electronic Health Records
- Staffing needs in a system environment
- Prioritizing needs across the system
Legislation

- Senate Bill 1281
- Sanity evaluations
- Court Appointed Evaluator must consider the defendant's substance abuse history, the police report for the offense, and any other material relevant to the facts of the offense
- Dr. Scott study
- Yet another example of the benefits of collaboration
Legislation, (cont.)

• Assembly Bill 366

• Implement on-site administrative law hearings for rapid involuntary medication of dangerous Incompetent to Stand Trial admissions
Change Management

New Mission

• Provide evaluation and treatment in a safe and responsible manner

• Seek innovation and excellence in hospital operations across a continuum of care and settings
Change Management

New Values

• Safety
• Treatment
• Responsibility
Change Management

New Goals

• Safe environment
• Responsible stewardship
• Excellence in forensic evaluation
• Excellence in treatment