

Assaults in Hospitals

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Psychiatric News reported several deaths of psychiatrists at the hands of their patients in 1982. This year a psychiatry resident was murdered by a patient in her office. Two years ago an intern was the fatal victim of a former psychiatric patient as he worked in a Kansas City emergency room.

These striking reports do little to describe accurately the incidence and severity of assaults in hospitals. There is a need for valid, reliable data concerning potential dangers to psychiatrists, other medical staff, and patients in medical care settings. It is important to know the baselines from which to measure deviations in assault incidence, to discuss what is being done to whom, and to prevent and manage such situations.

Unfortunately, most common sense approaches to this problem have limited usefulness. Bromides such as "paranoids are more dangerous" or "female staff hardly ever get assaulted" may have some merit in certain situations; however, our group is now fairly certain that one should put only very limited credence in any of them. One reason for the limited value of these sayings has to do with the great range of health care settings in which violence may occur. In addition, different ways of defining and reporting assaultive incidents significantly alter the form and content of one's results.

Recent studies have reported rates of significant assault as low as 25 cases per 27,000 patients per ten years.¹ Most studies have found a higher incidence.²⁻⁴ In a large survey of clinicians, one of us (W.H.R.) found data to agree with other investigators that up to one-half of all psychiatrists experience at least one serious assault during their careers.⁵ Tardiff and Sweillam⁴ report that about 7.5 percent of patients in the New York State hospital system have committed at least one assault in the hospital. Finally, unpublished data from the Veterans Administration indicates some 12,000 assaultive incidents were reported within the system over a recent five-year period.

The data described above are confusing because of the variety of survey methods used and the validity of each method. The most common way of

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counting assaults, by official incident report, documents only about one-fifth of the assaults in most settings.⁶ Our study has attempted to improve upon such methodology and thus help to establish the baseline data which have been sought.

Method

A twenty-two-page, two-part survey instrument was developed and tested. It addressed a number of characteristics of assaults in hospitals: assailants (personal and clinical data, current treatment, demographics), victims (personal and clinical data), assault setting (geography, programs, institution, weather, noise, crowding), the institution in which the assault occurred (geography, demography, administrative structure), severity of the assault, and sequelae of the assault to both assailant and victim.

Both general and psychiatric hospitals were sought for the study, without regard to location or type of institution (although this information is recorded). Five hundred sixty-six psychiatric and 898 nonpsychiatric beds, in 16 hospitals, were surveyed. Surveyors were physicians, nurses, or related professionals. All received careful instructions. Each became familiar with the ward staff of his/her assigned institutions, explained the purpose of the study, and assured anonymity and confidentiality to all concerned. All appropriate individual and institutional consents were obtained.

Surveyors reported to their wards every day for fourteen consecutive days and asked if there had been any assault within the past 24 hours. Assaults were defined as *any* unauthorized touching, including simple pushing or slapping. Positive answers were followed by interviews of victims when possible (and often of assailants) and with chart reviews in order to complete the extensive questionnaire. This fourteen-day survey period was repeated quarterly for a total of four survey periods (56 days) over the course of one year.

Control questionnaires were completed from random charts on the wards surveyed. All raw data were sent to the principal investigator (W.H.R.). There was little communication among the surveyors, since the hospitals were located in several different regions of the United States.

Results

The data presented herein reflect rates of assault (corrected to extrapolate from 56 days to 1 year) for a wide variety of psychiatric and nonpsychiatric units, comparisons of those rates, and trends with regard to severity of assaults. Table 1 shows average corrected rates of assault for psychiatric and nonpsychiatric units. Table 2 describes the only statistically significant differences among groups and subgroups.

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Table 1. Rates of Assault (Assaults/Bed/Year)

	No. of Units	No. of Beds	Rate	SD		Range
All psychiatric	20	566	2.54	2.93		0.00–12.60
Hospital types						
Public psych	16	463	2.88			0.00–12.60
Private psych	4	103	1.20			0.54–1.72
University psych	8	105	2.52			0.87–7.60
State hospital	8	358	3.24			0.00–12.60
Acute adult	10	202	1.98			0.54–7.60
Chronic adult	8	332	3.32			0.00–12.57
Security	3	64	6.88			3.91–12.57
Unit types						
Acute care	9	193	1.95			0.54–7.60
Chronic care	2	166	2.21			1.63–2.79
Child	1	18	2.17			—
Adolescent	1	14	2.33			—
Forensic	2	50	4.04			3.91–4.17
Alcohol (not detox)	1	60	0.00			—
Mental retardation	2	29	1.09			0.00–2.17
	No. of Units	No. of Beds	Rate	SD	Variance	Range
All nonpsychiatric	22	898	0.37	0.68	0.46	0.00–3.26
Unit types						
General medicine	6	293	0.24			0.00–0.47
General surgery	5	219	0.09			0.00–0.22
Obstetrics/gynecology	5	187	0.21			0.00–0.63
Pediatrics	1	16	0.00			—
Intensive care	2	52	1.72			0.18–3.26

Table 2. Significance by Student's *t* (one-tailed) test*

Group	<i>t</i>	df	<i>p</i>
All psychiatric v. all nonpsychiatric	3.092	37	<.005
Security psychiatric v. all other psychiatric	2.209	21	<.050
ICUs v. all other nonpsychiatric	2.224	22	<.025

* All other comparisons within or among the groups were nonsignificant.

Despite wide variation among institutions and across time, we found no differences in assault rate or severity that could be attributed to geographic, demographic, or seasonal factors.

Physical injury was quite rare. Just under six percent of the assaults led to an injury requiring even brief medical care ($n = 12$). Only three victims (<2%) missed work or were bedridden for one or more days. No victim required more than two days to recover.

Discussion

Our data appear to support a number of basic contentions:

1. There is a small but noticeable rate of assault in hospitals.
2. Almost all of these assaults—as found by our method of survey—are by patients, against staff or other patients.
3. Very few of the assaults led to significant or lasting injury in the

victim, although this is not to say that there may not have been additional emotional, administrative, or other personal effects. The number of assaults which led to medical treatment was so small that frequency analysis is useless; however, we suspect a trend toward more severe injury by child or adolescent psychiatric patients and by psychiatric patients within three days of admission to inpatient care.

4. Assaults were far less frequent on virtually all of the nonpsychiatric units surveyed. The only nonpsychiatric units which fell within the range found for psychiatric units were ICUs.
5. There is a great deal of variability from one hospital to another and from one unit to another, as reflected in the standard deviations in the unit distributions shown. Some of this variance appears to be accounted for by type of unit and patient population; however, units which appear on the surface to be fairly similar often reported quite different rates of assault. Other possible sources of the variance are subtle characteristics of the units (which would be expected to reveal themselves in future analysis of questionnaire items), differences in staff response from hospital to hospital, and differences in survey methods.

Every effort was made to control for differences in staff response and survey method. We believe that these are unlikely to have contributed a great deal to the variance, a position supported in part by the differences seen in the numbers of assaults reported by the same surveyor at different times of the year. These seasonal differences disappeared when all rates were averaged over the course of the year.

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