Assault in Hospitals and Placement in the Community

KENNETH TARDIFF, MD, MPH*

Introduction

There have been obstacles along the road of deinstitutionalization in terms of placing and keeping chronic psychiatric patients in the community. Some of these obstacles have been inadequate funding for aftercare services, community resistance and fear of mental patients. A major component of the latter obstacle is the belief that mental patients are dangerous in terms of violence or other criminal behavior. A number of studies have confirmed that discharged mental patients do have high rates of crimes against persons in the community[1-5] and do assault their therapists at a significant rate,[6-8] while others have cautioned that previous criminal history must be taken into account when considering the subsequent violent or criminal behavior of mental patients in the community.[9]

The inpatient unit occupies a place of practical importance in this issue, since it is there the decision to discharge a patient into the community is made; yet, there have been few efforts to determine the frequency of assaultive behavior among inpatients or the characteristics of assaultive patients associated with a better chance of community placement. Studies examining incident reports probably suffer from underreporting of assaultive behavior.[10-11] The author attempted to directly assess the frequency of dangerous behavior, as well as other problems, in a large survey of inpatients in 1977, where 6% of inpatients manifested behavior dangerous to others in the hospitals.[12] The opportunity to define assaultive behavior more precisely and to assess which assaultive patients were deemed appropriate for community placement presented itself as a second survey was conducted at the end of 1979. This paper presents the findings of that survey.

Methods

This paper is based on the most recent survey of all patients residing in two of the larger state hospitals on Long Island, NY. The surveyors were experienced staff, predominantly nurses of the hospitals, but they did not assess patients on wards where they worked. Surveyors participated in training workshops so as to familiarize them with the manual of operational definitions for items on the survey instrument. In completing an assessment of a patient, the surveyor interviewed the patient, staff working with the

*Dr. Tardiff is the Associate Dean for Student Affairs in the Departments of Psychiatry and Public Health of the Cornell University Medical College, New York, NY.

patient and reviewed the medical record. The instrument for the current survey, which can be obtained from the author, defined assault as physical assault toward other persons at least once in the three months preceding the survey. Thus, this study has focused on clearly defined assaultive acts and not on threats of assault or destruction of property. Unfortunately, assessment of the seriousness of each assaultive action was not possible. In addition, the current survey included an assessment of the likelihood of release into the community as opposed to the need for different levels of inpatient supervision.

It should be noted that the survey did not include patients in special units for the treatment of alcoholism or mental retardation and all patients under the age of 17 years. In addition, this analysis of the data excluded patients who had been in hospital for less than three months since the author was not interested in the acute phase of hospitalization which was covered in previous studies of assault at the time of or just prior to admission to hospitals.[13-14]

Diagnosis merits special attention as a variable in this study in two regards. First, the category "other non-psychotic disorders" is comprised mostly of personality disorders. Second, paranoid schizophrenia, paranoid states and manic episodes were grouped because of evidence suggesting that these categories are more closely related to each other than they are to other types of schizophrenia.[15] The low frequency of manic episodes and paranoid states (1%) further allays concern about this combination since any association in this category will reflect paranoid schizophrenia rather than the less frequent diagnostic categories combined with them.

Results

There were 5,030 patients residing in the two hospitals for over three months. As is seen in Table 1, most of these patients had been in the hospital for many years, and this was reflected in their older age distribution. Most of the patients were diagnosed as schizophrenic with a slightly greater proportion of non-paranoid schizophrenia among male patients. In addition, a substantial number of patients had psychotic organic brain syndromes. Most patients were white and the rest were either black or Puerto Rican. Three-fourths of the male patients and almost half of the female patients had never been married. For both sexes, approximately half of the patients were in hospitals on an involuntary basis.

As is seen in Table 2, there were 173 (7%) male patients and 186 (7%) female patients who were physically assaultive towards other persons in the hospitals at least once in the three months preceding the survey. Male and female patients were similar in terms of the overall frequency of assault as well as a pattern of higher rates of assaultive behavior in the younger age groups, with over one-fourth of patients in the youngest age group having manifested assaultive behavior.

Table 1
Characteristics of All Patients

Characteristic	Male (N=2328) Percent	Female (N=2702) Percent
Age		
17-24 years	8	3
25-34 years	7	4
35-44 years	13	7
45-64 years	22	17
65-74 years	28	27
75-102 years	22	42
Duration of Hospitalization		
3 months to 2 years	9	9
2 years to 10 years	18	16
10 years to 20 years	19	15
20 years to 30 years	16	18
30 years to 40 years	16	18
greater than 40 years	22	24
Primary Diagnosis (DSMII)		
Paranoid schizophrenia	28	34
Other schizophrenia	42	33
Depressions	2	6
Psychotic Organic Brain Syndromes	21	21
Mental Retardation	5	4
Other non-psychotic disorders	2	2
Legal Status		
Voluntary	53	49
Involuntary	47	51
Marital Status		
Never married	76	45
Married	12	25
Separated or divorced	9	12
Widowed	3	18
Race		
White	79	85
Non-white	21	15

Table 2
Rates of Assault in the Preceding Three Months by Age for Male and Female Inpatients

	Male		Female	
Age (years)	Number of Patients Assessed	Percent Assaultive in Age Group	Number of Patients Assessed	Percent Assaultive in Age Group
17-24	183	27	78	31
25-34	175	15	95	22
35-44	293	11	200	10
45-64	507	5	444	11
65+	1170	3	1885	4
All Ages	2328	7	2702	7
Statistics	$X^2 = 150.06$, df = 4, $p < .00005$		$X^2 = 142.31$, df = 1, $p < .00005$	

The surveyors placed each patient at one of four levels in terms of mental status and treatment needed. As is seen in Table 3, these ranged from level 1 which was the most restrictive and intense to level 4 which indicated that the patient was stable and appropriate for community placement. As expected, 7% of male and 4% of female patients with a history of at least one assaultive episode were still dangerous to others at the time of the survey and required a highly secure psychiatric environment. Likewise, patients with a history

Table 3
Current Mental Status and Level of Treatment Needed by History of Assault in Past Three Months

Mental Status and Level of Treatment Needed	Male		Female	
	Assault (N=173) Percent	No Assault (N=2155) Percent	Assault (N=186) Percent	No Assault (N=2516) Percent
Level 1 Currently dangerous to others so as to require a highly secure psychiatric environment	7	<1	4	<1
Level 2 Currently showing severe psychotic symptoms so as to require intensive psychiatric services	31	11	32	10
Level 3 Psychiatric symptoms stabilized but still requires 24 hours behavioral supervision and **not** appropriate for community placement	49	59	52	66
Level 4 Psychiatric symptoms stabilized and is appropriate for community placement	13	30	12	24
	100	100	100	100
Statistics	(X^2 = 156.80, df = 3, p < .00005)		(X^2 = 120.91 df = 3, p < .00005)	

of assault were three times more likely than non-assaultive patients to show severe psychotic symptomatology at the time of the survey and to require intensive psychiatric services on the inpatient unit. For most patients, although the proportion was greater for non-assaultive patients, psychiatric symptoms had stablized, but there was a continued need for inpatient treatment. Last, only 13% of male and 12% of female patients with a history of assault were deemed appropriate for community placement. Patients without a history of assault were twice as likely to be appropriate for community placement.

The rest of the analysis focused on the 359 patients with a history of assault and determined which assaultive patients were deemed appropriate for community placement and which needed various levels of inpatient supervision. The placement of assaultive patients in the four levels of supervision described in Table 3 was analyzed in relation to age, diagnosis, sex and race. Only age (X^2 = 43.95, df = 12, p < .00005) and diagnosis (X^2 = 31.95, df = 15, p = .0065) were related to the assignment of patients to levels of supervision. Those assaultive patients assigned to level 1, that is requiring a secure environment for current behavior dangerous to others were more likely under 34 years of age and to have a primary psychiatric diagnosis of mental retardation. Assaultive patients assigned to level 2, that is, as needing intensive supervision for severe psychotic symptoms, but not currently dangerous to others were more likely under 34 years of age and diagnosed as schizophrenics other than paranoid type. Assaultive patients assigned to level 3, who had stabilized in terms of symptoms, but who were not appropriate for community placement, were over 65 years of age and over-represented in the psychotic organic brain syndrome and other non-

psychotic disorder diagnostic categories. Assaultive patients assigned to level 4, that is, as appropriate for community placement were more likely in the 34-64 year age group and in the diagnostic categories of paranoid schizophrenia and depression.

Discussion

This study found that 7% of patients residing in State hospitals for three months or longer physically assaulted other persons at least once in the three months preceding the survey. This rate of assault may be surprising in view of the fact that these were chronic patients residing in the hospitals for years. Furthermore, some groups did have substantially greater rates of assaultive behavior. Before discussing them, the absence of any difference in the frequency of assaultive behavior among men and women should be mentioned. This does not agree with the author's previous study[14] of assaultive behavior just before or at the time of admission, where men were found to be more assaultive than women. One may speculate these previous findings are due to men being more likely than women to be hospitalized for assaultive behavior in the community. On the other hand, it may be that once admitted to a hospital, the social role differences between the sexes in terms of expression of outwardly directed violence no longer is important and that the age and clinical state of a person are more important than role expectations in terms of sex. Although the seriousness of assaultive behavior was not directly assessed, there were indications that women were less of a threat and were less likely to be viewed as currently dangerous to others and in need of a secure environment.

Age and primary psychiatric diagnosis were related to whether assaultive patients were deemed appropriate for the community or whether they needed continued hospitalization. Young assaultive patients continued to be dangerous to others and to need secure, intensive supervision and control. The increased risk of assault among young patients raises the issue of segregating these patients from the rest of the hospital population, possibly into psychiatric intensive care units which have been described in the literature.[16] Interestingly, patients in the oldest age category also were poor candidates for community placement, probably for different reasons, namely poor physical health and need for medical and nursing care.

Diagnosis is even more important as a factor in the prospects for community placement, since it reflects successes and failures in the treatment of psychiatric illness. Patients with primary diagnoses of mental retardation, schizophrenia other than the paranoid type and psychotic organic brain syndromes were more likely to be poor candidates for community placement and to require secure environments or at least intense inpatient treatment. Assaultive patients with psychotic organic brain syndromes had stabilized, but still needed continued hospitalization, which one may suspect is related to their medical and nursing needs.

Paranoid schizophrenics with a history of assaultive behavior were more likely than most other patients to be seen as no longer dangerous and appropriate for placement in the community. This is interesting in light of their greater likelihood of being assaultive around the time of admission to a hospital.[14] Is it possible that the delusional thinking characteristic of paranoid schizophrenia is conducive to assault in the community and hospitalization, but that once in a hospital, these patients respond to neuroleptic medications and are able to control themselves, unlike non-paranoid schizophrenics or patients with mental retardation or psychotic organic brain syndromes? However, once discharged, are paranoid schizophrenics prone to discontinue medications, resurgence of delusional thinking and subsequent increased likelihood of assaultive behavior? This raises the issue of whether there should be policy related to compulsory compliance with aftercare, use of depot neuroleptics or possibly not discharging paranoid schizophrenics with histories of assault. This hypothesis merits further study before one further contemplates such broad policy or legislation.

In conclusion, this survey has found that assaultive behavior is substantial among certain groups of chronic inpatients. The group of assaultive mental patients is not homogeneous, so that one must differentiate by age, diagnosis and other clinical characteristics those assaultive patients who pose a danger to others and those who may be able to live in the community with adequate aftercare services.

References

1. Rappeport, J. and Lassen, G.: Dangerousness — Arrest Rate Comparisons of Discharged Patients and the General Population. American Journal of Psychiatry 121:776-783, 1965.
2. Rappeport, J. and Lassen, G.: The Dangerousness of Female Patients: a Comparison of the Arrest Rate of Discharged Psychiatric Patients and the General Population. American Journal of Psychiatry 123:413-419, 1966.
3. Giovannoni, J. and Gurel, L.: Socially Disruptive Behavior of Ex-Mental Patients. Archives of General Psychiatry 17:146-153, 1967.
4. Zitrin, A.; Hardesty, A.; Burdock, E. and Drossman, A.: Crime and Violence Among Mental Patients. American Journal of Psychiatry 133:142-149, 1976.
5. Sosowsky, L.: Crime and Violence Among Mental Patients Reconsidered in View of the New Legal Relationship Between the State and the Mentally Ill. American Journal of Psychiatry 135:33-42, 1978.
6. Madden, D.J.; Lion, J.R. and Penna, M.W.: Assault on Psychiatrists by Patients. American Journal of Psychiatry 133:422-425, 1976.
7. Whitman, R.M.; Armao, B.B. and Dent, O.B.: Assault on the Therapist. American Journal of Psychiatry 133:426-431, 1976.
8. Tardiff, K. and Maurice, W.L.: The Care of Violent Patients by Psychiatrists: a Tale of Two Cities. Canadian Psychiatric Association Journal 22:83-86, 1977.
9. Steadman, H.; Cocozza, J. and Melich, M.: Explaining the Increased Arrest Rate Among Mental Patients: the Change of Climate in State Hospitals. American Journal of Psychiatry 135:816-820, 1978.
10. Kalogerokis, M.G.: The Assaultive Psychiatric Patient. Psychiatric Quarterly 45:372-381, 1971.
11. Evenson, R.C.; Altman, H. and Sletten, I.W., et al: Disturbing Behavior: a Study of Incident Reports. Psychiatric Quarterly 48:266-275, 1974.
12. Tardiff, K. and Deane, K.: The Psychological and Physical Status of Chronic Psychiatric Inpatients. Comprehensive Psychiatry 21:91-97, 1980.
13. Tardiff, K. and Sweillam, A.: Characteristics of Violent Patients Admitted to Public Hospitals. Bulletin of the American Academy of Psychiatry and the Law 7:11-17, 1979.

14. Tardiff, K. and Sweillam, A.: Assault, Suicide and Mental Illness. Archives of General Psychiatry 37:164-169, 1980.
15. Taylor, M. and Abrams, R.: Manic-Depressive Illness and Paranoid Schizophrenia: a Phenomenological, Family and Treatment-Response Study. Archives of General Psychiatry 31:640-642, 1974.
16. Crain, P. and Jordan, E.: The Psychiatric Intensive Care Unit — an Inpatient Treatment of Violent and Adult Patients. Bulletin of the American Academy of Psychiatry and the Law 7:190-198, 1979. □