Zero violence or zero seclusion. Which is more acceptable in our hospitals?

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Introduction

There is a clear and established link between serious mental illness and violence. Secure forensic mental health services provide care and treatment to patients with history of serious violence. The vast majority of patients in forensic services suffer from severe mental illness such as schizophrenia as well as high rates of co-morbid polysubstance abuse and maladaptive personality traits.

Mental health services are under significant pressure to reduce the use of seclusion and restrictive practices, whilst at the same time mandated to provide safe environments for patients and staff. A report published in December 2020 by the Mental Health Commission (MHC) noted that since 2008, the use of physical restraint has increased while the total number of episodes of seclusion has decreased, albeit increased average duration of seclusion. The Commission further noted that it strongly advocates for the use of de-escalation measures over restrictive practices. However, to date, the MHC has not mandated any reporting of physical violence within units, and therefore seclusions and restrictive practice rates are reported in isolation. Therefore, it is difficult to assess proportionality of any restrictive practices used in psychiatric wards. The Committee for the Prevention of Torture (CPT) of the Council of Europe have not recommended the ending of seclusion, rather they have recommended that seclusion is utilised for the shortest period possible to prevent violence (proportionality) and that it must be used in accordance with the law of that country.

We also note that the current very serious lack of admission beds in psychiatric services in Ireland, together with the very limited numbers of psychiatric ICU (PICU) beds, likely means that patients may be more unwell by the time they are admitted which could have an effect on firstly the proportion of admissions that are involuntary but secondly the rates of seclusion and restrictive practice, as patients are more unwell by the time they are admitted.

The aim of this study is to determine the number and characteristics of violent incidents, and other incidents, in a secure forensic hospital in Ireland.

Methods

This study was conducted at the Central Mental Hospital (CMH), Dublin, Ireland, which is the only secure forensic hospital in the Republic of Ireland. The male wards are organised into acute, medium and rehabilitation clusters of different security levels – high dependency, medium and low dependency, all on one site. There are also female and intellectual disability wards.

A retrospective review of all incidents in Central Mental Hospital, Dundrum over a 30-month period (March 2019 to August 2021) was conducted. Incidents were categorised into physical assaults and other incidents including sexual violence, security breaches and verbal threats. Diagnostic categories, demographic details were collated. Baseline measures of need for security at the time of admission (DUNDRUM-1) and the urgency of need for admission (DUNDRUM-2) were collated, as were measures of violence risk (HCR-20), therapeutic programme completion across a variety of domains including physical and mental health, substance use, offending behaviour and social and occupational functioning (DUNDRUM-3). Recovery across a variety of domains was measured (including rating insight, working alliance, hope and other domains) using DUNDRUM-4. Scores on all these measures were collated. Ethical approval was granted by the Research Ethics and Effective Committee of the Central Mental Hospital.

Results

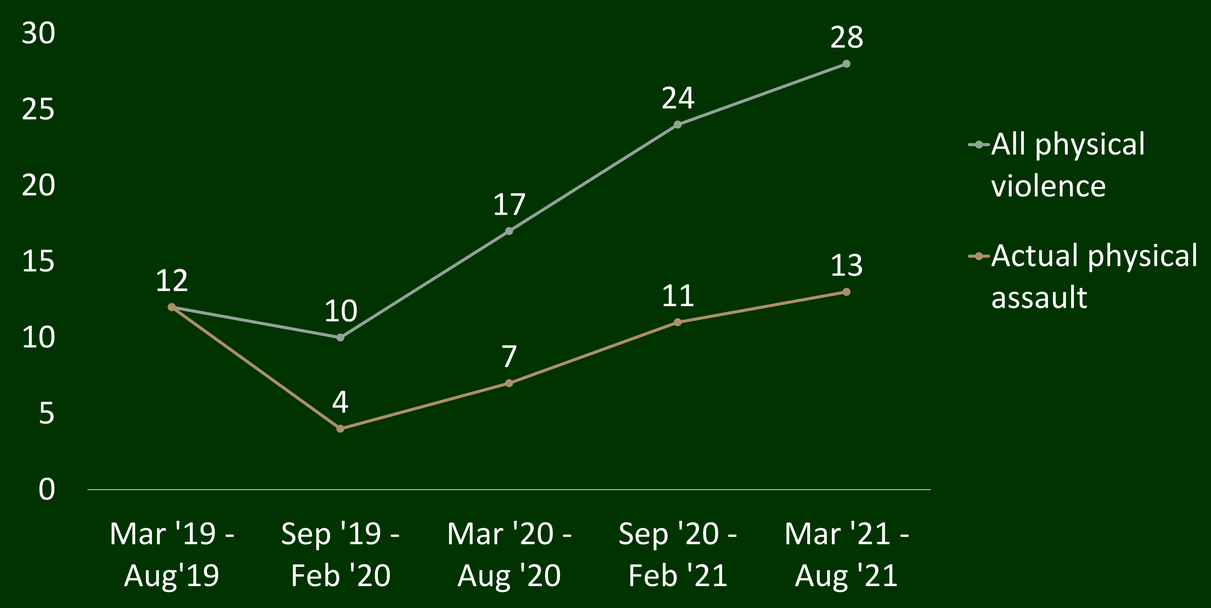
There were 320 incidents recorded between March 2019 and August 2021 (Table 1). The mean age of the patients was 46.1 years, SD 15.1. Most patients (71.3%) had schizophrenia or schizoaffective disorder.

Since March 2020, there has been an upward trend in the number of physical violence incidents perpetrated by patients. The number of incidents of actual physical assault also increased during the study period (Figure 1). The causes of this upward trend remain unclear, but may reflect a rise in acuity among patients within the CMH. The rise in physical assaults would indicate this is a real rise, as incident forms would be unlikely to have been previously missed for actual physical violence. 93.4% of the incidents involving physical violence were perpetrated by male patients. Female patients contributed to 30.0% of the self-harm incidents. A small group of patients were responsible for the majority of the incidents. Of the 91 incidents of physical violence, 47 (51.6%) involved an actual physical assault. Of all the cases that involved actual physical assault, 27 (57.4%) cases involved patients as victims and 20 (42.6%) cases were perpetrated against staff in the hospital. Victims of assaults were more likely to be males (n=43, 91.5%).

Table 1: Types of incident

Type of Incident	Frequency (n, %)
Physical assault, actual or attempted	91 (28.4%)
Security breach	79 (24.7%)
Physical health	64 (20.0%)
Verbal threat	44 (13.8%)
Sexual harassment	25 (7.8%)
Self-harm incident	10 (3.1%)
Others	7 (2.2%)
Total	320 (100.0%)

Figure 1: Frequency of physical violence every six months



Compared to patients whose incident was not physically violent, those patients whose incident involved attempted or actual physical assault had significantly higher scores on historical risk of violence (HCR-H) (ANOVA F=5.139, p=0.024), current risk of violence (HCR-C) (ANOVA F=24.951, p<0.001), future risk of violence (HCR-R) (ANOVA F=7.906, p=0.005) and dynamic risk of violence (HCR-dynamic) (ANOVA F=32.224, p<0.001).

Compared to patients whose incident was not physically violent, those who engaged in attempted or actual physical assault had worse scores on measures of therapeutic programme completion (DUNDRUM-3) (ANOVA F=41.181, p<0.001), worse scores on recovery (DUNDRUM-4) (ANOVA F=41.041, p<0.001) and higher baseline security needs (DUNDRUM-1) (ANOVA F=7.231, p=0.008) as well as higher baseline urgency of need for admission (DUNDRUM-2) (ANOVA F=6.159, p=0.014).

Discussion

Physical assaults and other violent incidents happen in mental health units; this must be acknowledged. This is the case for forensic psychiatry units as well as general adult community units and other psychiatric services. We found that patients with a history of serious violence and higher baseline security needs prior to admission were more likely to engage in violence whilst an in-patient. We also found that even among patients with a serious history of violence, better therapeutic programme completion and recovery across a wide variety of domains was associated with less violence during admission.

Reviews of rates of the use of restrictive practices rarely include data of physical violence against patients and staff in psychiatric units. Restrictive practices, must be used in accordance with the law, but are necessary at times to prevent serious harm to patients and staff in psychiatric hospitals. Any review of mental health legislation or the code of practice in relation to restrictive practice must reflect on the primary need for the safety of staff and patients in psychiatric hospital settings. Barriers to treatment and to admission for the most unwell patient group, e.g. insufficient admission bed numbers or difficulty in practical use of mental health legislation, may inadvertently have the effect of increasing rates of restrictive practices, as patients are likely to be more unwell by the time they are admitted to hospital.

References

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