

Violence Report

Section I : Executive Summary

This report is an analysis of the incident data provided by the DSH hospitals encompassing patient-on-patient violence, patient-on-staff assaults, and patient victim and patient aggressor injuries. In order to protect the privacy issues of DSH staff, no specific information about staff injuries were included in this report. Additionally, as the psychiatric programs did not utilize WaRMSS during the period covered by this report, violence in these programs will not be addressed in this report.

Acts of physical aggression or violence by patients in the DSH hospitals have decreased overall, as shown by:

1. a decrease in overall assaults by patients in DSH hospitals; this decrease is seen across virtually all legal commitments, and especially in the more numerous patient groups that comprise the bulk of our patient census (such as IST's, MDO's, and NGI's); *see Section II.1* ;
2. a decrease in the number/percentage of individual (unique) patients committing aggressive acts (*see Section II.2*);
3. a decrease in the number/percentage of individual (unique) patient victims of aggressive acts (*see Section II.3*);
4. a decrease in the most severe injuries suffered by both a) patient victims of the patient assaults and b) patient aggressor's in patient assaults (*see Section II.4*)

These findings document substantial improvement in several areas of violence, especially in the last 2 years across all DSH hospitals. These outcomes derive in large part from Executive Director leadership focusing on implementing violence reduction programs in their hospitals. Moving forward, DSH has identified areas for future action:

5. while patient on patient assaults have shown a substantial decline, patient assaults on staff do not appear to have declined as much as other areas measured; and
6. while other metrics of patient violence have shown decreases, the number of individual patients with 10 or more aggressive acts in a calendar year have remained constant, despite noted gains in other areas (*see section II 5*).
 - a. In fact, the data shows that a small group (numbering 116, or about 2% of Average Daily Census, or ADC) of repetitively violent patients (those who have 10 or more violent incidents for two years or more) account for about 35% of violent acts annually (*see section II 6*).

- b. The data also show that different patient groups have different rates of violence, with patient groups such as LPS, DJJ, IST's, and MDO's having higher rates of violence than other patient groups.

In summary, it is believed that the decrease in violence has occurred because of the implementation of planned, systematic new initiatives aimed specifically at violence by the DSH hospitals. These outcomes can also be viewed as showing that current programs to reduce violence have been successful and have resulted in reduced numbers of both patient-aggressors and patient-victims. Moving forward, there remains a group of patients with a much higher than expected number of aggressive acts, for whom standard treatment and current programs have not succeeded in reducing or managing violent acts. Further initiatives aimed at reducing violence in this group, such as enhanced treatment and enhanced security programs are being developed and implemented in various pilot programs, to investigate their potential effectiveness at making further reductions in aggression and violence. Recommendations to DSH leadership, based on this report, are as follows:

Recommendations:

1. DSH should adopt a slightly modified and updated method for reporting violence data that would better enable tracking and analysis of assaults and aggression/violence trends.¹

Specifically, the use of “assaults per 1000 patient days” would provide an accurate measure that could be used over time to track aggression/violence. This use of a rate (i.e., per 1000 patient days) would enable DSH to take into account changing population and census. Currently, the most commonly used method to report violence is aggregate monthly totals. This is not as precise a measure as a rate measure, as it a) is subject to variation simply due to the number of days in month, and b) does not take into account increases or decreases in patient census.

Along with a measure of rate, the use of an additional measure, “number of unique violent patients” would also provide additional capabilities to track violence, and better identify patients in need of further analysis, assessment, and treatment.

2. DSH should routinely use these reporting methods to regularly track, analyze and report aggression/violence data as well as evaluate program implementations designed to reduce violence.

Key leaders and stakeholders should identify regular intervals to receive and review reports on aggression/violence statistics. Examining these data at regular intervals would allow for a systematic review of data on an ongoing basis. This in turn would allow for the data to be more

¹These recommendations are consistent with Bowers, et. al., (2011), Inpatient violence and aggression: a literature review, Institute of Psychiatry, King's College, London.

meaningfully analyzed and for progress to be tracked. Intervals such as semi-annual or quarterly are commonly used analysis and reporting intervals. This would ensure that progress of initiatives to mitigate violence are regularly evaluated, and could allow for additional program resources to be allocated based on the progress of the intervention.

3. DSH should continue to strengthen current data collection and analysis efforts consistent with worldwide standards and the scientific literature.

The clinical and scientific literature offer valuable guidance that will help DSH to better leverage our clinical expertise and available database data (e.g., the scientific literature review by Bowers, et. al., (2011) referenced previously). The value of already having a reporting system and incident database to track aggression/violence cannot be overstated. Having a database currently containing over four years of data will enable even more advanced analyses to be undertaken in the future. In that vein, some of the most advanced analyses to potentially be undertaken will require the use of highly specialized skills and knowledge (i.e., time series analysis, forecasting). It is further recommended that DSH evaluate obtaining this highly specialized expertise through the most cost-effective means (i.e., such as contracting).

4. Consistent with Recommendation 2 and Recommendation 3, DSH should consider allocating more data management resources to enable widespread clinical use of its databases.

At present, although a large amount of data regarding aggression, violence, self-injury, and suicide attempts (to name just a fraction of the incident data stored in the WaRMSS database) is being collected, there is insufficient systematic use of this data to inform clinical practice or interventions. As data collection increases, the amount of clinical patient data that could be used to inform clinical practice will increase immensely. This will require the additional steps of aggregating and presenting the information back to hospital leadership as well as to clinicians, to better inform clinical practice and refine program development, program evaluation, quality assurance and performance improvement efforts. Along with this increase in information and communication between data analysts and end-users, extra steps will be required to maintain the highest level of quality and accuracy in reporting and communication. Additional resources will be required to analyze these data and to maximize their value to hospital and DSH leadership.