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Discharging the Violent Psychiatric Inpatient

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ABSTRACT: Since psychiatrists may be held legally accountable for their patients' violent acts against others, psychiatrists on inpatient wards are faced with the dilemma of deciding whether or not, and when, to discharge improved but still possibly dangerous patients. This paper presents a survey of an inner-city hospital's experience with violent patients admitted over a seven-month period and describes an interdisciplinary disposition committee, composed of a senior consulting psychiatrist and other mental health professionals, established by this hospital to help make these difficult decisions. The committee carefully evaluates all identified high-risk patients according to specific criteria before such patients are discharged. Two case studies illustrate this process of evaluation.

KEYWORDS: psychiatry, mental illness, discharging, dangerousness, violent inpatients, third-party liability

Recent clinical research has underscored the severe limitations of psychiatrists' ability to predict patients' dangerousness [*1*]. Nevertheless, psychiatrists may still be held legally accountable for their patients' violent acts against others [*2*]. This dilemma has placed enormous pressures on those psychiatrists on inpatient wards who have to make decisions on discharging improved but possibly dangerous patients. These decisions, difficult in themselves, are made even more problematic by three factors: the high rate of violence associated with patients hospitalized for psychiatric treatment [*3*]; the much shorter lengths of time that patients now spend in hospitals with the attendant necessity of making early discharge decisions; and, since the Tarasoff decision [*4*], the increased risks clinicians run of incurring third-party liability for the harm done to others by their patients.

The purpose of this paper is to present the experience of an acute-care psychiatric unit of an inner-city hospital in making these discharge decisions over a seven-month period. To facilitate and improve such decision-making, the hospital has established an interdisciplinary disposition committee. Composed of a senior consulting psychiatrist from outside the ward, the chief psychiatrist of the inpatient unit, the chief psychiatric resident, the psychiatric attendings, residents and other mental health professionals involved with the case, this committee carefully evaluates these identified as high-risk patients according to specific criteria before they are discharged. Before going into the committee's actual work, it is important to have some understanding of the dimensions and complexity of the problems with which the committee members are confronted.

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Increase of Violence Among Patients Admitted to Psychiatric Hospitals

In a 1-year study of psychiatric hospitalizations in 1 catchment area, Craig [*3*] found that approximately 11% of the patients had been assaultive before admission to the hospital. Rossi et al. [*5*], in a massive hospital chart review, found the percentages of patients admitted to the hospital who had been associated with prior attacks on persons to be 11.5, 12.5, 9.5, and 16 for the years 1979, 1980, 1981, and 1985, respectively. They also found a distinctly higher rate of readmissions for violent patients than for other patients. Binder and McNiel [*6*] examined the medical records of 300 patients admitted to the acute-care psychiatric ward of a university hospital. They found that 15% of these patients had assaulted someone within 2 weeks before their hospitalizations and that in 54% of these cases the victim was a family member.

In researching the percentage of violent patients admitted to their own short-term and locked-door psychiatric unit, the present authors found that the results were compatible with the studies cited above. Out of a total of 488 admissions from April through December 1985, we found that 55 patients (11.3%) had been violent to persons, 15 patients (3.1%) had been violent to property, and 22 patients (4.5%) had threatened violence (see Table 1). Of those 55 patients (11.3%) who had displayed violence toward others, 30 (55%) received a diagnosis of schizophrenia, 7 (13%) a diagnosis of adjustment disorder/personality disorder, and 9 (15%) a diagnosis of alcohol/substance abuse (see Table 2). The relatively high percentage of the violent-to-person patients diagnosed as schizophrenic corresponds to those reports in the literature on schizophrenic patients who, when they became violent, did so only during their acute psychotic periods as one aspect of a generalized loss of impulse control [*3, 7*]. The impressive number of violent-to-person patients diagnosed as adjustment disorder/personality disorder (7 patients or 13%) and as alcohol/substance abuse patients (9 patients or 15%) reflects a growing tendency to admit to psychiatric units a greater variety of patients believed to be dangerous. Recently, increasing pressures have led clinicians to admit psychi-

TABLE 1—*Total admissions to the psychiatric unit (488) from 28 April 1985 to 21 Dec. 1985.*

Categories of Violence	Number	Percentage
Violent to persons	55	11.3
Violent to property	15	3.1
Threatening violence to persons	22	4.5
Total	92	18.9 (of 488 admissions)

TABLE 2—*Diagnostic categories of the 55 violent-to-person patients from 28 April 1985 to 21 Dec. 1985.*

Diagnostic Categories	Number	Percentage
Schizophrenia	30	55
Depression (severe)	4	7
Alcohol/substance abuse	9	15
Adjustment disorder/personality disorder	7	13
Other:	5	9
seizure disorder (1)		
mental retardation (2)		
brief reactive psychosis (2)		

atrically those patients considered to be dangerous—including, as Appelbaum [*8*] points out, patients diagnosed as antisocial personality disorder who would not have been admitted for inpatient treatment in the past. Appelbaum believes that 2 legal trends have contributed to these pressures to hospitalize dangerous patients: a focus on the issue of dangerousness as a criterion for civil commitment; and the expanding risk to psychiatrists of third-party liability for harm done by their patients to victims. According to Appelbaum this increased third-party liability risk has been seen in recent cases in which the Tarasoff rationale seems to be combined with the reasoning in earlier hospital escape cases where psychiatrists were held liable for harm done to victims without the victim or victims necessarily being identified, on the principle that the possibility of violence toward someone should have been foreseen. Consequently, the clinician is pressured into admitting those patients perceived to be dangerous to the psychiatric unit, at least for a period of observation.

Increase of Violence Among Psychiatric Patients on the Ward

The large numbers of violent or disruptive patients now admitted to inpatient services has made the effect of these patients on inpatient wards a subject of growing concern. But, as the literature addressing this problem makes clear, the difficulties of documenting this effect are considerable. For example, the recent increase of reported assaults by patients against staff members is suggestive, but not accurate. As Lion et al. [*9*] point out, many such assaults still go unreported; they attribute the gross underreporting of these kinds of assaults to a variety of attitudes among staff members, attitudes ranging from "simply not bothering," to taking such assaults "as a matter of course," to the fear that such an assault either represents or will be viewed as "a performance failure."

In their study of these patient assaults in a large state hospital, Lion et al. [*9*] found that 72% of the assaults occurred in admission units, and of the patients involved in these assaults, 66% were acutely psychotic or manic, 20% were diagnosed as suffering from personality disorders or mental retardation, and the remaining 14% carried diagnoses of drug dependency, epilepsy, or organic brain syndrome. In another study of the rates of assault against staff and other patients, Tardiff [*10*] found that 7% of the patients residing in two state hospitals for at least three months had assaulted one or more persons within that period of time. And Fottrell [*11*] found that there were many incidents of petty, but not serious, violence committed by young schizophrenic patients on acute psychiatric wards. The different findings of these studies supports the assertion Reid et al. [*12*] make in a discussion of the seemingly confusing data in the literature on the subject of rates of assault in hospitals: they note that there are considerable differences in reported rates of assault between different hospitals and even between different units in the same hospital, the reasons for which are not entirely clear.

Another major concern raised by the increasing number of violent patients being hospitalized particularly when these patients are admitted to short-term treatment units, is their potential to drastically change the ward's therapeutic milieu [*13*]. Johansen [*14*] includes among the consequences of admitting patients with chronic character pathology on inpatient units the loss of milieu speciality that results from the need to devote considerable resources to containment procedures, increased staff regression caused by role diffusion, which in turn leads to reduced therapeutic effectiveness, and loss of cost-effectiveness owing to increased staff burnout.

In a study of violent acts committed by patients against either other patients or staff members which required written incident reports, the present authors were able to document a total of 28 such violent incidents during a one-year period. Of these, 24 reports concerned violence against other patients and 4 reports documented violence against staff members. The patients committing these assaults included 15 schizophrenic patients, 5 bipolar, manic-type patients, and 5 atypical or brief reactive psychosis patients (Table 3). Signifi-

TABLE 3—*Diagnostic categories of inpatients who committed violence against other patients or staff members during a one-year period.*

Diagnostic Categories	Number
Schizophrenia (mostly paranoid type)	15
Bipolar disorder, manic type	5
Atypical psychosis	3
Brief reactive psychosis	2
Seizure disorder	1
Delirium tremens	1
Adjustment disorder with depression	1
Total	28

cantly, there was only 1 report of violence committed by a patient diagnosed as adjustment disorder/personality disorder, a fact we attribute to the policy at this hospital of discharging these types of patients as soon as intensive treatment has brought about improvement in their Axis 1 diagnoses and they are not considered to be immediately dangerous to self or others.

In the event that the patient is not psychotic and his original Axis 1 diagnosis—for example, depression, suicidal behavior, anxiety, alcohol/substance intoxication—has been ameliorated, if the patient remains potentially dangerous to others or prone to act in a disruptive manner on the ward, the clinicians are faced with a dilemma and, according to Gutheil and Appelbaum [*15*], must weigh their responsibility to the individual patient against their responsibility to the ward population in general. In making the decision about discharging this kind of patient, those authors stress "the importance of assessing the patient's differential dangerousness on or off the ward." In a later communication, Appelbaum [*16*] argues that before discharging nonpsychotic but dangerous patients, the clinician should engage the hospital administration and its legal department in a thorough discussion of the case.

Increase of Dangerousness Among Discharged Patients

In the past, patients released from psychiatric hospitals were found to be no more dangerous or even less dangerous than the general population, but the situation has changed dramatically. In 1922, Ashley [*17*] followed 1000 paroled patients from Middletown State Homeopathic Hospital; he found that their yearly arrest rate was on an average 2.4 per thousand, and those arrests were not for any serious instances of violence. Similar findings revealing low arrest rates of released patients were recorded by other investigators, including Pollock [*18*] in 1938 and by Cohen and Freeman [*19*] in 1945. But by 1965, the published results of the important study by Rappaport and Lassen [*20*] on patients discharged from Maryland Psychiatric Hospitals revealed that these discharged patients were just as dangerous as the general population. One year later, the same authors [*21*] reported their findings in a study of discharged female patients which revealed that these patients had a higher rate of arrest for aggravated assault than did the population at large. In recent years other authors [*22–24*] have also found higher rates of criminal arrests among discharged psychiatric patients than among the general population. Several authors [*25–27*] have accounted for these recent findings by pointing out what seems to be the increased number of people currently being admitted to mental hospitals who have a prior criminal arrest history. Such patients create additional problems for the ward clinicians, for ultimately it becomes their responsibility to make the decision to discharge these kinds of patients from the hospital.

Psychiatrist's Third-Party Liability for Violence Committed by the Patient

In discharging these dangerous patients the clinician may be placing himself at risk for third-party liability if the patient once discharged goes out and harms another person. The *American Law Reports* (ALR) [*28*] specifies that the general standard of care expected of the physician, who is usually the one who makes these discharge decisions, is that he or she exercise adequate "care, skill, and knowledge" so as to avoid being found negligent and held liable for damages occurring as a result of an error in clinical judgment. The courts in California and New York, which have had numerous cases of negligent release, have pointed out the need of the public to accept certain facts about the treatment of mental disorders, including the facts that psychiatric treatment is not an exact science, that rehabilitative visits outside the hospital are often therapeutic, and that there are inherent risks in releasing patients which ultimately must be balanced against the needs of the patient to be given the opportunity to improve and return to society.

Appelbaum [*29*] points to another factor when he expresses his concern about the recent appellate decisions inspired by *Tarasoff* [*4*] which have resulted in "a standard that approaches strict liability" rather than a standard that evaluates therapists' liability for their patients' violent acts in terms of the presence or absence of clinician negligence. Appelbaum cites the Jablonski [*30*] and Davis [*2*] decisions as indicative of this trend. In contrast, Beck [*31*] fails to detect any single legal doctrine coming out of recent court decisions, though he does conclude that courts seem to hold that in the absence of a foreseeable victim, the clinician does not incur a duty to protect the victim. Beck stresses the fact that only eight cases dealing with discharging inpatients have raised the Tarasoff duty to protect the intended victim as a cause of action, and that only one of these cases, Davis [*2*], resulted in a psychiatrist being found negligent for failing to protect his patient's victim despite there having been no allegation that the psychiatrist had failed to render less than the usual professional care. The court did, however, conclude that the patient's mother, whom he killed by a shotgun blast during a struggle with her in which she had tried to prevent him refiring the weapon after he began firing in the house two months after he was discharged from the hospital, was a foreseeable victim. The court cited a single note in the patient's 1973 hospital record to indicate that he had threatened her over money to support his alcohol and drug habit.

In a review of existing case law involving discharging mental inpatients, Del Carmen [*32*] found that the courts have traditionally employed a variety of legal rationales to free government agencies or psychotherapists from liability. But when there is "abuse of discretion, gross negligence, or lack of due care; when the injury is foreseeable; and when a special relationship exists between the victim and the released patient," the courts have decided in favor of the plaintiffs. Del Carmen emphasizes, however, the serious difficulties involved in trying to apply these general guidelines and notes that, in any event, there is also considerable subjectivity in courtroom decisions. Because of this basic unpredictibility in the litigation process, he strongly recommends that considerable care be taken in decisions about releasing most patients.

Interdisciplinary Disposition Hearings

The interdisciplinary disposition hearing is a departmental instrument for systematically deliberating before deciding whether or not to discharge a high-risk dangerous patient. This same committee also meets to make determinations on discharging potentially suicidal patients or on referring psychotic patients, who may not necessarily be perceived as dangerous, to long-term care in a State hospital. The committee is chaired by a senior (physician) psychiatrist of the Department of Psychiatry from outside the ward who functions as the hospital's internal though independent consultant on the case. Other permanent members of the

committee are the chief of the psychiatric inpatient service, the chief psychiatric resident, and those mental health professionals from the ward's therapeutic team who are involved in the case, including the attending psychiatrist, psychiatric resident, nurse, and social worker. The committee meets whenever needed as determined by the chief of the service after a high-risk case is identified or whenever there is doubt about any case involving the question of violence.

Some particularly portentious signs that lead ward clinicians to identify a patient as a high-risk case include the following: (1) a history of extreme violent or threatening behavior resulting in injury to the victim preceding admission; (2) a history of the patient's violent behavior in the family or unwillingness of the family to have the patient return home or both; (3) a history of repeated rapid decompensations associated with violence in a noncompliant patient who also abuses alcohol or drugs; (4) a history of arrests, incarcerations, and involvements with the criminal justice system for repeated violence acts; (5) a history of repeated assaultive, disruptive or threatening behavior while on the ward; and (6) a history of unremitting psychosis with agitation, hostility, disorganization, paranoid delusions, and command hallucinations to harm self or others despite intensive treatment on the ward.

Once a patient has been identified as high risk, his or her case is formally presented by either the psychiatric resident or the attending psychiatrist with additional information about the patient being supplied by representatives of the different disciplines. This is followed by the senior psychiatric consultant interviewing the patient in the presence of the committee. The case is then discussed in great detail from the varying perspectives of the clinicians. If a consensus can not be achieved, the case is rescheduled for further consideration at a later date. Although all the members of the committee contribute to the discussion, it is the chief (psychiatrist) of the service who makes a preliminary decision while the senior psychiatric consultant retains the right of final decision. From May through December 1985, a total of 28 cases were reviewed by the committee; 10 of these patients were recommended for discharge to the community and 18 for transfer to a State hospital. The dispositions of the cases, most of whom were diagnosed as paranoid schizophrenics, are listed in Table 4 by diagnostic category.

Risk Management in the Decision-Making

Since the determination to release potentially dangerous inpatients is essentially an uncertain and often hazardous undertaking, a kind of risk-management approach needs to be taken. The present authors have been influenced by Kroll and MacKenzie [*33*] in their risk-management methodology in making such discharge decisions. Those authors divide their approach into three components-risk assessment (involving the identification of risk factors and estimating the probability of their occurring), risk evaluation as a sociopolitical process (involving ethical and social value judgments about matters such as psychiatric expertise and public policies), and risk reduction (involving the creation of a realistic program to identify and correct avoidable risk factors). Kroll and MacKenzie provide a decision table with a checklist for use in analyzing the risk factors involved releasing a violent patient.

Before the patient can seriously be considered for discharge, our interdisciplinary disposition committee must be satisfied that, by the specific criteria on their checklist, the patient's condition and situation has either improved or been resolved. The committee first compares each aspect of the mental status of the patient at the time of admission with the patient's current mental status. Then the committee systematically considers the following: history of violence, evidence of remission of symptoms, likelihood of compliance with follow-up treatment or taking medication or both, alcohol or drug dependence, available supportive network, psychodynamic considerations, and situational factors. Since it is unlikely that the patient's long-standing conflicts could have changed in the brief duration of the hospitalization, situational or environmental factors are extremely important to devise an acceptable

TABLE 4—*Interdisciplinary disposition hearings from 1 May 1985 to 12 Dec. 1985: diagnoses and dispositions.*

Diagnosis	Discharged[a]	Transferred to Bronx Psychiatric Center[b]
Paranoid schizophrenia	6	12
Chronic undifferentiated schizophrenia	1	0
Primary degenerative dementia	1	0
Substance abuse and antisocial personality	2	0
Schizoaffective disorder	0	5
Bipolar disorder	0	1
Totals	10	18

[a]Of these, 8 were either violent to person, violent to property, or threatened violence, and 2 were very confused and disorganized.

[b]Of these, 14 were either violent to person or violent to property, or threatened violence.

plan to reduce these external sources of stress. Any prediction of future violent behavior must certainly consider the likelihood of the patient interacting with particular environments, especially because the individual may be dangerous only in a particular situation.

Case A

Ms. A., a middle-aged, divorced, and socially isolated Caucasian woman, was brought to the hospital by the police after she threatened her landlady with a pair of scissors for the second time. The first time Ms. A threatened her landlady, whom she felt was harassing her, she had been arrested but not incarcerated; instead, she was scheduled to undergo a competency-to-stand trial examination at the court clinic. After the second incident, a relative called the police and had her taken to the hospital.

Ms. A had a long history of mental illness with multiple psychiatric hospitalizations. Although her record showed no pattern of violent behavior, she had never been compliant with either after-care treatment or taking medication, and after a short period of time she would decompensate after each discharge. Ms. A was diagnosed as a paranoid schizophrenic, and although she was suspicious and paranoid on admission, she significantly improved after taking oral antipsychotic medication.

The interdisciplinary disposition committee confronted, in Ms. A's case, the dilemma of whether or not to discharge her. Although she appeared to be compensated at the time the committee considered her case, they had to determine the likelihood of her remaining compensated, or of her becoming paranoid and potentially dangerous soon after being discharged. Had she been remanded to a prison forensic psychiatric unit for her competency evaluation, she would not have been released without a hearing before a judge, who would be immune from liability. But in a civil hospital there would be no guarantee of immunity from third-party liability if she decompensated and attacked someone after being discharged from the hospital. After consulting with the hospital's risk-management specialist, the committee met three times on this case and finally decided to recommend discharging her after she agreed to take intramuscular long-acting Prolixin Decanoate® injections, attend the Day Hospital, and have a relative look after her on the outside. With Ms. A's permission, this relative met with some of the members of the committee and was instructed about particular signs of decompensation to watch for such as suspiousness and verbalizations of being harassed. The relative agreed to assume responsibility not only to monitor any signs of Ms. A's

decompensation, but also to see that Ms. A kept her clinic appointments and to contact the clinic as needed.

Case B

Mr. B, a 39-year-old, unemployed, black, former heroin addict and more recent alcohol abuser was brought to the emergency room by the police after he was found wandering on the street in an acutely intoxicated state. In the emergency room, he repeatedly threatened to kill his ex-wife. Mr. B had a long history of assaultive behavior, mostly against women, and as a young man had served six years in prison on a manslaughter conviction. He had also been previously hospitalized for both alcohol and heroin detoxification. He agreed to have his ex-wife contacted and informed about his threatening remarks. He underwent the alcohol detoxification regimen and after five days denied having any more homicidal ideation.

The interdisciplinary disposition committee met twice, several days apart, on this case. It was concluded that he did not have an underlying psychotic disorder, but that he was clearly dependent on alcohol and had an antisocial personality disorder. The patient insisted that he would stay away from his ex-wife and agreed to return to an Alcohol Rehabilitation Center, where he had also once received individual counseling but which he had attended only sporadically in the past. He was given advice on how to apply for welfare assistance and other benefits. He was discharged from the hospital.

Conclusion

As these case studies illustrate, one of the crucial decisions that psychiatrists in hospitals are called upon to make is whether or not to discharge violent patients. Essentially this requires a determination as to whether or not the patient has sufficiently recovered and is probably no longer dangerous. The recent literature has underlined the inadequate definitions of dangerousness now available and has suggested both that psychiatrists are unable to predict and that they usually overpredict it over a long-term period. Several authors [*34–36*] have qualified these sweeping assertions on dangerousness by pointing to the more valid assessments of dangerousness that can be made at least to some degree for short-term situations. Monahan [*36*] refers to "a second generation of research and theory of violence prediction" which has begun to criticize the past prediction research as having been mostly limited to clinical predictions in long-term custodial institutions. Monahan emphasizes the need to develop other forms of predictive technologies such as basing predictions on actuarial methodologies and on the results of research in other settings such as short-term community settings. These research undertakings eventually could result in clinicians being better equipped to predict dangerousness with greater accuracy.

Unfortunately, we do not now possess advanced predictive capabilities. There are no well-controlled empirical studies on violent patients who have been discharged from short-term psychiatric hospitals. There is no standardized or reliable data base on which to base these kinds of predictions. Nevertheless, even though the limitations of the predictive value of clinical assessments are widely recognized [*37*], psychiatrists are required to make clinical assessments on when to discharge violent inpatients. Given this situation, the advantages of a disposition committee such as the one described above are substantial. Three factors make an interdisciplinary disposition committee such as the one described above beneficial to doctors, patients, and the general population: the presence of a senior consulting psychiatrist from outside the ward, preferably a consultant with some forensic science experience; the means of obtaining consultations with the risk-management specialists of the hospital when the case warrants such a consultation; and the participation of staff members from various disciplines and at various levels of expertise. Our experience with this committee argues that it not only makes good clinical sense, but it also makes good legal sense.

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