

Marie Cugini Schur, Ph.D.
Forensic Mental Health
Conference
March 2015

Enhanced
Treatment Unit:
A Successful
Intervention for
Violent
Inpatients

Introduction

- The Enhanced Treatment Unit (ETU) is a pilot program designed to address violence due to mental illness
- Goal is to increase safety in the facility as well as assist these patients in their recovery

2

Outline

- ETU Nuts and Bolts
- Admission and Discharge
- Treatment
- Outcomes
- Strengths and Challenges
- Limitations
- Future Directions

3

4

Mission

- Protect staff and patients from harm
- Return patients to mainstream treatment with supports in place
- Assist the patients in their recovery
- Prevent future aggression

ETU Guidelines and Policy Manual, 9/1/14

5

Development

- Extensive manual
- Approved and supported by various levels of administration
- ETU staff were trained
 - 2 weeks of training (staff were also vetted)
 - Focused on Motivational Interviewing, clinical skills, and safety training
- ETU opened December 2011
- Frequent evaluative processes

6

ETU "Nuts and Bolts"

- Pilot program to address aggression influenced by severe mental illness
- Unit opened December 2011
- Staff:
 - Higher staff to patient ratios
 - AM/PM – 7 nursing staff; NOC – 4 nursing staff
 - One full clinical team
 - DPS on unit 24 hours a day (2 per shift)

7

ETU "Nuts and Bolts"

- 🔑 Patients:
 - ⊗ 12 patients at one time
 - ⊗ Has served 103 patients (9 of these twice, 2 three times)
- 🔑 Layout of unit
 - ⊗ Cameras
 - ⊗ Patients in front hall; Four restraint rooms in back
 - ⊗ Private courtyard
 - ⊗ DPS Station next to Nursing Station

8

ETU "Nuts and Bolts"

- 🔑 Training
 - ⊗ All volunteer staff
 - ⊗ Booster trainings/off-sites
 - ⊗ Floats receive one-day training
 - ⊗ DPS are trained on clinical basics

ETU Staffing

- Full clinical treatment team, with one psychiatrist, psychologist, social worker, rehabilitation therapist, and unit supervisor
- Nursing staff allocation: 7 staff for AM and PM shift, and 4 staff for NOC (overnight) shift
- 2 Police Officers on the unit at all times
 - Sergeant is also often there during AM shift

9

10

Admission Criteria

- Behaviors primarily driven by **severe mental illness pathology** (formerly referred to as Axis I conditions):
- Recurrent aggressive behaviors originating primarily from severe mental illness that have been **unresponsive to mainstream therapeutic interventions**:
- A **serious assaultive act** that results in serious injury or a significant threat of assault
- A **reasonable prospective to change** with a relatively-brief intervention

ETU Guidelines and Policy Manual, 9/1/14

11

Admission Tracks

1. Stabilization of Aggression (most typical)
2. Diagnostic Clarification
 - Only somewhat complex cases are accepted
 - Once diagnosis is clarified, patient returns to home unit
 - Admission criteria are a bit loosened
 - Only need some evidence that violence may be related to severe mental illness
 - Psychopathic traits are acceptable

12

Typical Reasons for Denial

1. Aggression not due to severe mental illness
 - e.g., secondary to psychopathy, borderline personality disorder
2. Standard interventions have not been attempted on the home unit
 - e.g., no consultation, Clozapine attempt, behavioral intervention
3. Patient is not aggressive enough
 - e.g., he has a HAS Level 3 and can leave the unit unsupervised; patient is simply a "nuisance"

13

Typical Reasons for Denial, con't

4. "Real" issue is not aggression
 - e.g., danger to self
5. Patient is too chronic to benefit from a short-term intervention
 - e.g., patient needs long-term dementia care

14

Admissions Rates

- Approximately 70% acceptance rate
 - Rate was lower in the past (50%); Majority of those referring better understand the criteria
 - There is an appeal process to Medical Director and Clinical Administrator
 - Administration can place someone on the ETU who does not meet criteria due to hospital need (~10% of admittances)

15

Admission Process

1. Home unit Treatment Team refers
2. Program Director approves referral
3. ETU Treatment Team reviews the referral/patient data
4. If accepted, patient is moved when a bed is available (other patients may be moved to allow an admission; dependent on dangerousness)

16

ETU Interventions

- Aggressive medication regime
 - When legally appropriate, required that incoming patients have involuntary medication order
 - Increased use of Clozapine
 - Consultation actively sought (statewide Psychopharmacology Resource Network)
 - Remove medications for diagnostic clarification

17

ETU Interventions, con't

- All patients are required to have individual therapy, unless it is unsafe to do so
- Group Treatment is highly encouraged
 - Ex: Aggression Reduction, Cognitive Therapy for Psychotic Symptoms
 - Group participation typically increases on the ETU
- Behavioral Plan – reinforcement for positive behaviors
- Assessment

18

ETU Interventions, con't

- Milieu Treatment – pleasant, clean, structured environment
 - Balance safety and therapy
 - Appropriate behaviors modeled
- Unit culture – staff work to maintain a can-do attitude, excellence is expected, ascribe to a specialist mentality

19

Discharging from the ETU

- Goal: Patient length of stay < 120 days
- Reviewed frequently; determined by consensus of ETU Treatment Team
- Discharged to receiving Program
 - Referring Program must accept patient back
 - Program Director determines unit placement
 - Sometimes, original unit is too toxic
- Other outcomes include discharged to jail (as competent), prison (Salinas Valley), or a conservator

20

Discharge Criteria

- Clinical progress
 - Significant reduction in symptoms, assaults
- Completion of the referral question
 - e.g., the diagnosis is clarified
- Maximum benefit is reached
- Determination that patient is inappropriate for treatment on the ETU
- To make an ETU bed available for a more acute patient

ETU Guidelines and Policy Manual, 9/1/14

21

Transition Process

- Transition process begins at admission
- Typical elements of a transition include:
 - Visits to the receiving unit
 - Transfer meeting between two teams; historical & treatment information presented
 - Motivational meetings with patient
 - Discipline-to-discipline consultation
 - Specialized trainings to home unit (e.g., PKU, Psychopathy, etc.)

22

Follow-Up

- ETU staff available for consultation
- Monitor that receiving units are utilizing treatment recommendations
- Evaluative measures
 - Violence rates (incidents and restraint hours)
 - Psychiatric symptoms
 - Quality of Life
- Follow-up interview with patients (6 months after)

23

...well, does the ETU work?

24

Patient Age & Race

Variable	ETU	DSH-A
Age	36.9 (SD = 9.4)	42.1 (SD = 12.0)
Race		
Caucasian	41.1%	37.6%
Black	28.9%	29.3%
Hispanic	26.7%	26.2%
Asian-American	3.3%	3.1%

25

Patient Commitment Code

Variable	ETU	DSH-A
Commitment Code		
PC 2962	45.6%	35.8%
PC 2972	16.7%	15.7%
PC 1370	20%	17.3%
PC 2684	5.6%	18.4%
PC 1026	10%	11.4%

*Note: Numbers do not add to 100%, various irregular commitments fill the remaining percentage

26

	ETU	DSH-A
Schizophrenia (all types)	41.1%	50.9%
Schizoaffective Disorder	44.4%	23.3%
Bipolar Disorder (I & II)	7.8%	9.6%
Delusional Disorder	2.2%	0.6%
Polysubstance Dependence	47.8%	36.5%
Mental Retardation	8.9%	2.2%
Borderline Intellectual Functioning	10%	7.7%
Antisocial Personality Disorder	50%	29.2%
Borderline Personality Disorder	3.3%	1.9%
Personality Disorder NOS	1.9%	0.6%

27

Patient Characteristics Summary

- ETU patients are more likely to be an Mentally Disordered Offender (PC 2962), less likely to be an inmate from corrections (PC 2684)
- ETU patients are younger
- More severe disorders (Schizoaffective)
- More complex presentation (co-morbid Personality Disorder, Mental Retardation, substance abuse)

28

Preliminary Analysis

- Average Census = 12
- Length of stay = 113 days (*SD* = 87.1; *Mdn* = 97.0 days)
 - 120 days is the limit
 - Can be extended with Administration approval
- Range for length of stay = 8 to 629 days
 - One highly-dangerous individual placed there for approx. 2 years

29

Outcome Measures

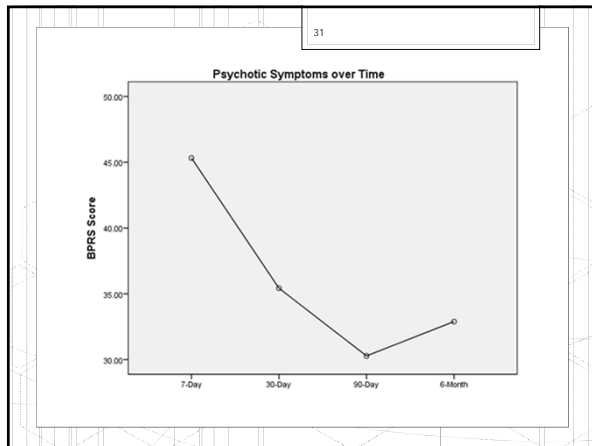
- Psychosis = Brief Psychotic Rating Scale (Overall & Gorham, 1962)
- Mania = Young Mania Rating Scale (Young et al., 1996)
- Quality of Life = World Health Organization's Quality of Life – Brief (WHO, 1996)
- Aggression = Frequency of aggression to staff or peers that resulted in a Special Incident Report
- One-to-one hours = Number of hours patients were in room seclusion, wrist restraints, or full bed restraints due to behavior

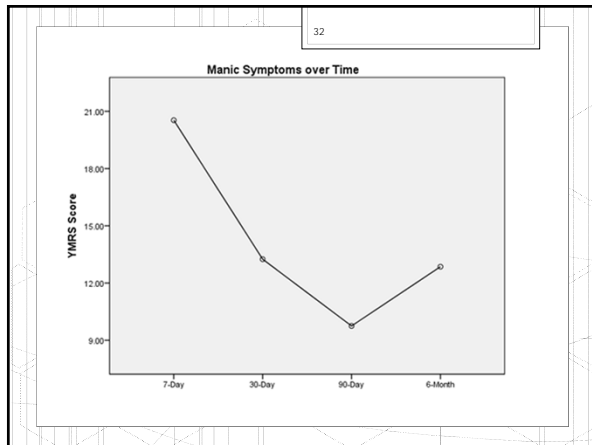
30

ETU and Psychiatric Symptoms

- Psychosis and mania reduced from ETU intake to 6-month follow-up

	<i>M</i>	<i>SD</i>
Psychosis		
Intake (7 days)	45.32	11.09
6-Month Follow-up	32.89	14.19
$F(3, 81) = 10.835, p < .001$		
Mania		
Intake (7 days)	20.54	9.13
6-Month Follow-up	12.86	10.94
$F(3, 81) = 12.905, p < .001$		





33

ETU and Quality of Life

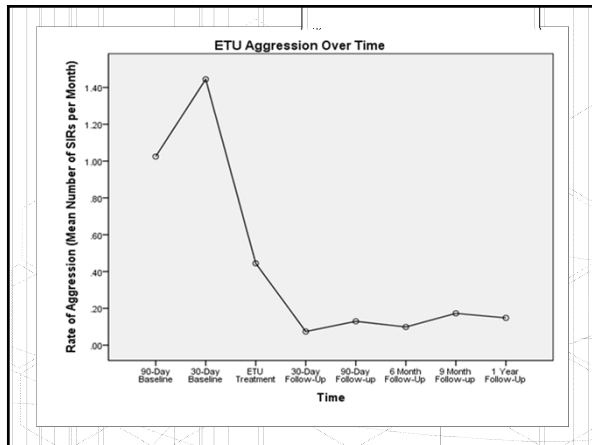
- Quality of life did not improve
- $t(24) = 1.663, p = ns$
- Similar means at intake (57 out of 100) and 90-day follow-up (64 out of 100)
- Speculatively, patients may not be able to achieve a good deal of life satisfaction while being involuntarily committed

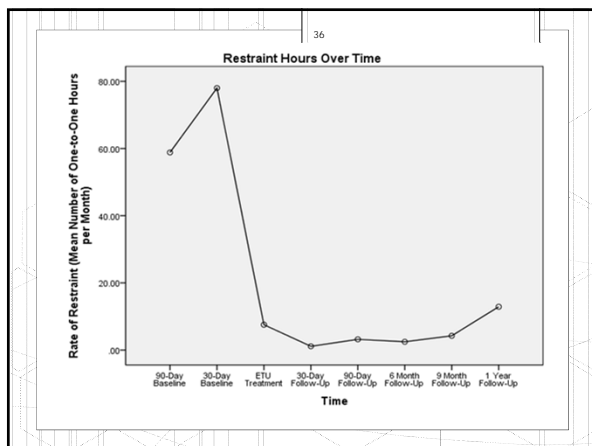
ETU and Aggression

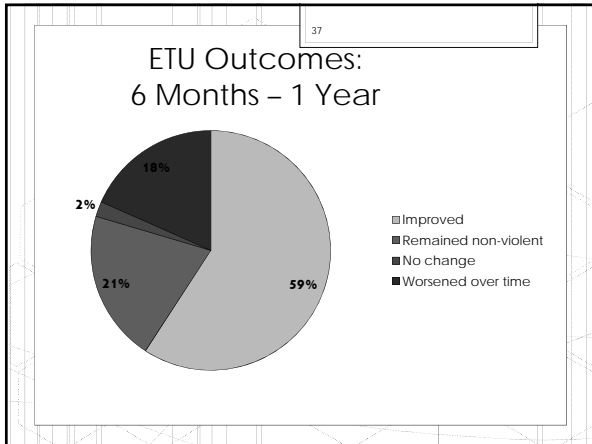
- Aggression and one-to-one hours reduced from baseline to 1 year follow-up

	<i>M</i>	<i>SD</i>
Aggression		
90-day baseline	1.03	1.41
1-year follow-up	0.15	0.38
$F(2.160, 56.153) = 8.856, p < .001, \eta_p^2 = .254$		
One-to-one hours		
90-day baseline	58.8	139.44
1-year follow-up	12.8	29.3
$F(1.155, 28.865) = 4.867, p < .05, \eta_p^2 = .163$		

34







- 38
- ### Maintaining the Change
- From baseline to 6-Month follow-up:
 - 59% are less aggressive
 - 21% had zero incidents upon admission, and remained at zero incidents during follow-up
 - Inappropriate referral
 - Admitted for threat of violence
 - 2% show no improvement
 - 18% *increase* their aggression

- ### Why do we think the ETU works?
- Structure & milieu of the unit
 - Clozapine, medication practices
 - Increased one-to-one attention, interaction
 - Excellent staff (carefully selected)
 - Increase in personal and psychological space (reduced crowding)
 - Comprehensive program

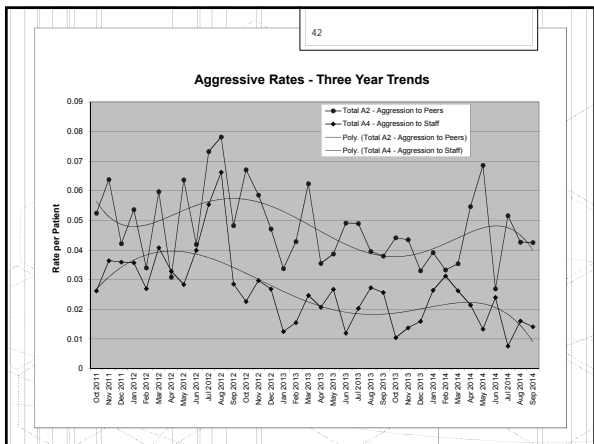
Why do some "fail" or get worse on the ETU?

- Salient factors:
 - Medication changes/ETU medications not maintained
 - Home unit does not use behavioral interventions
 - ETU recommendations not able to be followed (resources are key)
 - Chronic conditions - Personality Disorders, Mental Retardation
 - Comorbid conditions – cognitive challenges, personality disorders
 - Illness is simply refractory

40

What about hospital-wide aggression?

- Of the top 50 most aggressive patients, 40% of them were treated on ETU

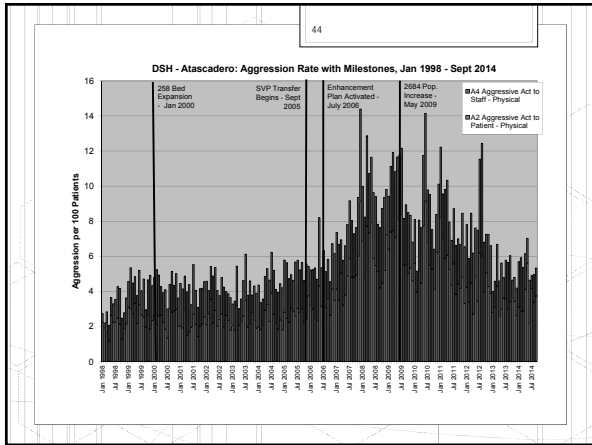


43

...can we take credit??

- In a word, no
- Aggression at other hospitals also decreased
- Violence rates are multi-factorial
- Without an experimental design, we don't know how much - if any - of the decrease the ETU is responsible for
- We only know that those admitted to the ETU have improved





Program Challenges

- In the past, many referrals that were inappropriate and extended transfers
- Transition back to home unit sometimes unsuccessful due to resources/other factors
 - Sometimes, units do not want the patients back
- Role confusion & "too many bosses"

45

46

Program Challenges, con't

- Assessment completion
 - Resources, time
- Staffing
 - Burnout
 - Conflict/splitting
 - Turnover and vacancies
 - Monitoring, mentoring, off-sites, reassignment
- Drift from policies, manual, intent
 - E.g., admission criteria interpreted too strictly, length of stay too long

Institutional Challenges

- 7301/MDO revocation/AB 109
- Unit for those who do not meet criteria but are dangerous?

47

Institutional Challenges, con't

- AB 1340
 - Plan to develop an Enhanced Treatment Program that will accept all dangerous patients

49

Limitations

- Fairly small sample size
- Evaluation:
 - Cannot determine exact mechanism of action
 - No comparison group
 - Next report: create two imperfect groups
 - Patients aren't returned to home unit (unequal comparisons)
- Currently, the ETU is still a pilot program and results should be considered as preliminary

50

Future Directions

- Continue to collect aggression data
- Continue to explore new directions in treatment
 - Additional consultation
- Address burnout
- Increase census?
 - Increase program cost savings

51

Conclusions

- Program has many strengths. Many of these are not novel and elemental to patient success (investment, face-to-face time)
- Several challenges, which require a good deal of organization and oversight
- ETU is a successful program for the amelioration of violence due in part to mental illness
