Risk Management Challenges in Behavioral Health

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Goals

- Increase knowledge of behavioral health risks faced when evaluating and treating patients with serious mental illness or behavioral problems.
- Identify and define the major risks
- Identify who is at risk
- Review practices for managing behavioral health risk
What is Risk?

Definition:

- Exposure to the chance of injury or loss; a hazard or dangerous chance.
- In healthcare we are concerned about injury and/or loss to individuals as well as to our healthcare institutions.
Risks for psychiatric patients

- Suicide
- Violence against them
- Loss of autonomy
- Medication Side effects
- Boundary Violations
- Restraints and Seclusion
Risks for providers and the public

- Damage to property
- Bodily Harm/Death
- Emotional Harm
- Loss of accreditation
- Loss of licensure
Major Mental Illnesses are Brain Disorders

- Schizophrenia
- Major Depression
- Bipolar Disorder
- Anxiety Disorders and Panic
- Obsessive Compulsive Disorder
Schizophrenia is characterized by disorganized thinking

- **Positive Symptoms:**
  - Confusion about what is real or imaginary
  - Belief in clairvoyance
  - Paranoia
  - Hallucinations
  - Heightened or dulled perceptions
  - Odd thinking and speaking processes

- **Negative symptoms**
  - Passivity
  - Interacting in a mechanical way
  - Flat emotions
  - Decrease in facial expressions
  - Monotone speech
  - Lack of spontaneity
  - Difficulty in abstract thinking
Major Depression

- Characterized by pervasive hopelessness, sad or anxious mood
- Persists for at least two weeks
- Symptoms can include:
  - Sleep disturbance
  - Appetite disturbance
  - Difficulty concentrating
  - Fatigue or low energy
  - Guilt, feelings of worthlessness
  - Loss of interest in usual activities
Bipolar Disorder

- Manifests itself with mood swings
- Manic/hypomanic phase
  - Increased energy
  - Increased impulsivity or risk taking
  - Decreased sleep
  - May be euphoric or extremely irritable
  - Grandiose ideas of their abilities
  - Increased productivity
  - Racing thoughts
- Depressive Phase similar to major depression
Obsessive Compulsive Disorder

- Characterized by repetitive intrusive thoughts
- Compulsive behaviors in response to the thoughts
- Thoughts and/or behaviors interfere with functioning
  - Excessive hand washing
  - Counting
  - Rituals
Anxiety and Panic

- Debilitating Worry that is in excess to the situation
- Interferes with daily functioning
- Panic is acute onset with physical symptoms
  - Increased heart rate
  - Tingling or numbness in the extremities
  - Attacks usually last 20-30 minutes
Case #1

- 57 y/o divorced WM.
- History of recurrent major depression w/o psychosis
- Admit to day program due to worsening depression
- Symptoms include poor sleep, decreased appetite, feeling hopeless. Has passive suicidal ideation. He has low energy, and poor concentration
- Recently took a “package early retirement” from job as an engineer.
- Lives alone although adult daughter planning to move in with him shortly
When we think about risks in mental health suicide tops the list.

Most common reason for malpractice lawsuits against psychiatrists

Estimated that 50-80% of psychiatrists will have at least one patient commit suicide while under their care.
According to the CDC:

- There are over 40,000 suicides/year in the U.S.
- 2.2 million people plan suicide
- 8.3 million have thoughts of suicide
- 1 million attempt suicide
- 10th leading cause of death in this country
- 2nd leading cause of death in individuals aged 18-34
Predicting Suicide

- Unfortunately, mental health professionals are not good at predicting suicide.

- New research is promising:
  - Suicide Implicit Association Task (IAT) is a tool that is currently being studied. It examines reaction times to “life” and “death” words and is administered on a computer.
  - Specific Genetic markers have been identified but studies currently need replication before having a role in clinical practice.
  - Post-mortem examinations are giving some clues into biomarkers that may be used to help predict suicide.
Suicide Assessment

- Why do it if we cannot make predictions?
- This is still very important because it helps us understand how we might intervene to address the source of a patient’s suicidality.
- Also an important part of the documentation in a patient’s chart to explain the clinician’s understanding of the patient’s frame of mind and to justify actions he/she may consider.
Basic Suicide Assessment 5-Step Evaluation (B-SAFE)

1) Identify Predisposing Risk Factors
2) Seek Protective Factors
3) Conduct a specific suicide inquiry
4) Determine intervention and safety needs
5) Document assessments and treatment plan
Risk Factors (historic)

- History of mental illness (particularly bipolar disorder, major depression, borderline personality disorder, schizophrenia and PTSD)
- Family history of suicide
- History of childhood abuse
- Loss of parent in childhood
- History of self harm or previous attempts
- Substance abuse
- Chronic pain/poor physical health
- Social isolation
Risk Factors (social and demographic)

- Male 3:1 female
- White, Native American
- Age: 18-29 more frequent attempts; 45-54 highest rate of completed suicide
- Protestant > Catholics and Jews
- Divorced or single
- Lower socioeconomic/education
- Access to firearms (51% of suicides by firearms)
Potentially Protective Factors

- Resiliency in past crises
- Family responsibilities and a sense of obligation to them
- Religious or spiritual beliefs
- Capacity for reality testing
- Positive relationships
- Frustration tolerance
Deciding on Intervention

- Hospitalize or other level of care
- If hospitalize then determine voluntary or involuntary
- If hospitalize then decide about 1:1 observation by staff
- If not hospitalizing then review safety plan.
- May have contact with family or significant others
- Want to ensure that there is no access to firearms.
Evaluating Suicide Plan or Intent

- Assess level of hopelessness
- Ask specifically about a plan or acts in furtherance of a plan (e.g. bought a rope for hanging, has a firearm etc.)
- Ask if they have rehearsed their plan
- Ask if they have researched suicide online
- Ask what has stopped them thus far in following through with the plan
- Find out if they have ever attempted suicide
- Ask about family history of suicide
- Ask about history of self harm
Documentation

- It is essential that all of the preceding steps are documented in the chart.
- It is essential that clinicians document their reasoning and give examples when relevant.
- In terms of protecting from medico-legal risk, this is the best defense.
- Unfortunately, with clinicians feeling time pressure, this is where they can fall short. Make sure that your medical records are not only set up for billing but for meaningful documentation.
Substances and Suicide

- Alcohol found in approximately 33% of people who complete suicide
- 23% have antidepressants in their system at the time of suicide
- 20.8% test positive for opiates
Violence and Mental Illness

- Majority of people with serious mental illness are no more likely to be violent than anyone else.
- Only 3-5% of violent acts can be attributed to individuals living with serious mental illness.
- Patients with severe mental illness are over 10 times more likely to be victims of violent crime than the general population.
- SUBSTANCE ABUSE in addition to a diagnosis of a major mental illness greatly increases the risk of violence.
- Bad News: Mental Health workers are 4 times as likely to be victims of occupational violence than others.
Case #2

- 59 y/o DWF with history of bipolar disorder
- Admitted to an inpatient unit due to mania with psychotic features.
  - Grandiose, bringing homeless people into her house.
  - Has belief that she can “save” everyone and make the world a better place
  - Extremely irritable, impulsive. Throwing her tray of food when she didn’t get her way
  - Not sleeping, pressured speech, belligerent, provocative
We are not good at predicting whether a patient may be violent but there are precautions that we can take.

Important to ensure that interactions with psychiatric patients are conducted in a place that is calm and free of too many distractions.

Make sure that clinicians/staff have a means of exiting room safely.

Do a violence assessment.

Make sure your institution has a safety plan.
Physical Signs of Imminent Violence  (Berg, Bell, and Tupin, 2000)

- Chanting
- Clenched Jaw
- Flared Nostrils
- Flushed face
- Clenched or Gripping hands
- Darting Eye Movements
- Increased proximity of patient to Clinician
- Inability of Patient to Comply with reasonable Limit setting
2006: Portland Police shot and killed a man with schizophrenia after a confrontation.

Public outrage led to Portland police requiring their officers complete 40 hours of specialized training.

2012: Justice Department study showed “a pattern of unnecessary force during interactions with people who have or are perceived to have mental illness.”

This time Portland had 100 officers sign up for added training to handle complex calls.

Good News: between 2008 and 2014, there was a 65% decrease in force by officers.
C.I.T (Crisis Intervention Team Training)

- Developed about 3 decades ago in Memphis
- Teaches officers ways to defuse potentially violent encounters.
- Sometimes best approach is to disengage, not continue engagement with identified person.
- About 2700 police departments are using some form of this training.
A number of ways in which psychiatric patients can lose their autonomy.

1) NMI-Notice of Mental Illness (AKA Hospital Hold)
2) Seclusion
3) Restraints
4) Deemed Incompetent by a court
Hospital Holds - Notice of Mental Illness (NMI)

HOSPITAL HOLD CRITERIA

- A physician, in consultation with another physician or qualified mental health provider, has determined:
  
  - (1) the patient is a danger to self or others; **AND**
  - (2) the patient is in need of emergency care or treatment for a **mental illness** **AND**
  - (3) the patient is not willing to participate in treatment

- **Patient must meet all criteria in order to place the patient on a Hospital Hold.**
- **Voluntary patients should not be placed on a Hospital Hold**
Hospital Holds (cont.)

- The purpose of a hospital hold is to take a person who is involuntary and believed to be mentally ill into custody with the intent to initiate the civil commitment process.

- If the patient is a danger to themselves or others, but does not have a mental illness, he/she may meet criteria for a restraint or seclusion.

- Consider whether a public safety hold is appropriate if the patient is intoxicated or under the influence of controlled substances.

- Patients who have been placed on a hospital hold and attempt to leave or who present an immediate danger to themselves, staff or others may be placed in restraint or seclusion as behaviors indicate.
Treatment of patient on a hold

- Treatment is offered but cannot be forced on a patient unless their behavior poses threat to self or others.

- Example: Patient is hearing voices, shouting at the wall but not making threats (cannot forcibly medicate).

- Patient is hearing voices, shouting at staff, threatening safety of others (may restrain, which may include chemical restraints)

- Forcibly medicating patients held on a commitment requires a 2nd opinion by another psychiatrist who is not involved in patient’s care except in emergency situations.
Case #3

- 27 y/o woman with schizophrenia
- Reclusive, lives in a group home
- Despite medication continues to have some auditory hallucinations that comment about her.
- Has been having right upper quadrant pain
- Stones are seen on ultrasound
- Medical team recommends cholecystectomy
- Getting consent
Can mentally ill give consent?

- Must first evaluate capacity
- If they have capacity then they can make the medical decision.
- If it is determined that they lack capacity then there is a surrogate decision maker who makes the decision.
Capacity vs. Competency
Capacity

- Functional Assessment pertaining to a particular decision

- Determination can vary because person can have the capacity to make certain decisions but not others.

- Requires four decisional abilities:
  - Understanding relevant information
  - Appreciation of the information’s application to one’s personal situation
  - Rational Reasoning
  - Ability to communicate a clear and consistent choice
Competency

- It is a legal standard
- Determined by a judge not a physician
- Input from a medical or psychiatric professional is often requested
- Restricts autonomy
- Associated with a loss of most legal rights
  - Exceptions: sterilization, ECT, psychosurgery, abortion or withholding of life sustaining treatment 125.320; 127.540 statute
Psychiatry in Hospital Emergency Departments

- 2 million people seek treatment annually in the US for Behavioral Health Care problems in hospital emergency departments at a cost of about $4 billion.
- ED staff often feel burdened by behavioral health patients.
- 6 to 12% of all US ED visits are related to psychiatric complaints.
- Often hospital ED’s are overcrowded and are not staffed adequately to deal with mentally ill.

Strategies for Expediting Psych Admits by J.D. McCourt, MD, Emergency Physicians Monthly February 14, 2011
Boarding in USA ER’s

- Studies showing average psychiatric patient in medical emergency departments boards for an average of between 8 and 34 (!) hours
- 2012 Harvard study: Psych patients spend an average of 11.5 hours per visit in ED; those waiting for inpatient beds average 15-hour stay
- 2012 CHA Study: After decision made for psychiatric admission, average adult waits over ten hours in California EDs until transferred
- In Portland ED’s, it is not unusual for patients to wait >100 hours for a psychiatric bed
Boarding is a costly practice, both financially and medically.

Average cost to an ED to board a psychiatric patient estimated at \$2,264.

Psychiatric symptoms of these patients often escalate during boarding in the ED.

Nicks B, Manthey D. Emerg Med Int. 2012
Alameda Model PES

- Averages 1200-1500 very high acuity psychiatric patients/month, approximately 90% in involuntary detention
- Focus is on collaborative, non-coercive care involving therapeutic alliance when possible
- Presently averaging 0.5% of patients placed in seclusions and restraints – comparable USA PES programs average 8-24% of patients in seclusions and restraints
Alameda Model – John George PES

- EMT - protocol for medical clearance and safe transport
- EMT transports to PES or ED
- Any patient over 65 goes first to nearest ED for medical clearance
- 35% patients come from 11 other local EDs
- 35 recliners
- Were able to reduce the local EDs boarding time from 10.5 hours to 1 hour and 20 minutes
- John George PES discharges 75% of the patients
2014 Alameda Model PES Study

- Published in the Western Journal of Emergency Medicine
- [http://scholarship.org/uc/item/01s9h6wp](http://scholarship.org/uc/item/01s9h6wp)
- Psych patient boarding times in area ED were only one hour and 48 min – compared to CA average of ten hours and 03 min
- Approximately 76% of the patients were discharged from the PES avoiding unnecessary hospitalization
A UNIQUE COLLABORATION
As...


