CNA

The Mental Health Crisis

Managing Risk in Emergency, Aging Services and Primary Care Settings

Introduction

The 1960s and 1970s witnessed a major change in behavioral health service delivery, as the emphasis shifted from institutionalization to outpatient treatment, a potentially promising and progressive development. Unfortunately, the subsequent decades-long shortfall in federal and state funding for clinics and other community-based resources has left the existing mental health (MH) network significantly under-resourced and struggling to meet the demands of a burgeoning patient population.[1] (See "Prevalence of Mental Illness Within the General Population" at right.)

The ongoing national MH crisis is characterized by too few inpatient beds and overtaxed outpatient facilities. In fact, under the present delivery system, it is estimated that more than half a million individuals with serious mental illness do not receive the care they need.[2] As a result of these systemic flaws, a new population has emerged of high risk MH patients, who are …

- **Uninsured or underinsured** for a variety of services.
- **Frequently noncompliant,** due to chronic disorders that are either untreated or sporadically managed on an episodic basis.
- **Homeless or with limited residential options** due to longstanding substance abuse and/or debilitating and untreated conditions.

Prevalence of Mental Illness Within the General Population

- **Every year in the U.S., an estimated 43.8 million adults experience some form of mental illness.** One in 100 (2.4 million) adults live with schizophrenia, 2.6 percent (6.1 million) with bipolar disorder, 6.9 percent (16 million) with major depression and 18.1 percent (42 million) with anxiety disorder.
- **Young adults 18-25 years of age have the highest prevalence,** with 25.8 percent experiencing some form of mental illness.
- **By 2020, mental illness and substance abuse disorders will probably surpass physical diseases** as the major cause of disability worldwide.
- **Every year, about 45,000 Americans commit suicide,** which amounts to approximately one death every 12 minutes.
- **Suicide is the second leading cause of death** among Americans between the ages of 10 and 34.

Sources: National Alliance on Mental Illness (NAMI), the Substance Abuse and Mental Health Services Administration (SAMHSA) and the National Institute of Mental Health.

It is estimated that **more than half a million** individuals with serious mental illness **do not receive** the **care** they need.

1 See Raphelson, S. "How the Loss of U.S. Psychiatric Hospitals Led to a Mental Health Crisis." National Public Radio, November 30, 2017.
2 Szabo, L. "Cost of Not Caring: Nowhere to Go." *USA Today*, May 12, 2014.

This CNA special resource examines liability exposures associated with treating the substantial population of chronic MH patients. It focuses on hospital emergency rooms, aging services organizations and primary care practice sites, which comprise the basic care continuum for these high risk patients. (See chart below.)

Along with practical strategies to improve delivery and continuity of care, this resource offers risk management recommendations addressing a broad range of behavioral health-related safety issues and liability exposures, including many that appear in the sidebar at right. Also included is a listing of industry resources designed to help providers and organizations inform themselves about and respond to the multiple challenges associated with MH and substance abuse treatment.

Cyclical Pattern of Care for High Risk Mental Health Patients

Emergency Department

- **The patient presents in acute distress,** e.g., alcohol intoxication, drug overdose, psychotic state, suicidal ideation.
- **The patient's condition is stabilized,** and the patient is either hospitalized or prepared for discharge.
- **The patient has limited-to-no housing options** at time of discharge.

Aging Services Organization

- **The patient is admitted to a facility** for long-term shelter and continued treatment.
- **The patient's condition improves** and the patient is discharged back to the community.
- **Alternatively, the patient remains indefinitely in the facility** due to lack of available housing.

Primary Care Practice or Clinic

- **The patient returns to the community** and relies on a primary care provider for ongoing care.
- **The primary care provider continues treating the patient** unless and until the patient has an acute episode requiring emergency care.

Common Liability Exposures for Chronic Mental Health Patients

Emergency Departments

- Failure to monitor.
- Medication mismanagement.
- Untreated violence and aggression.
- Suicide.
- Elopement.
- Premature discharge.
- Violations for illegal "patient dumping."
- Security incidents, e.g., inappropriate use of force or stun gun.

Aging Services Settings

- Aggression directed against staff or other residents.
- Failure to monitor high risk MH residents for harmful behavior.
- Failure to provide a safe environment by commingling violence-prone residents with the frail elderly.
- Failure to prevent suicide or self-harm.
- Overdose due to smuggling in drugs and/or hoarding medications.
- Wandering/elopement.
- Failure to transfer residents with acute MH emergencies to a tertiary care setting.

Primary Care Clinics

- Inadequate risk screening and assessment.
- Failure to recognize MH symptoms and refer to a specialist.
- Medication mismanagement, including prescription drug interactions.
- Uncoordinated handoffs.
- Patient noncompliance.
- Illicit drug-seeking.
- Failure to warn others of potential harm.
- Failure to follow up.

High Risk Patients in Emergency Settings

In the 1975 landmark decision *O'Connor v. Donaldson*, 422 U.S. 563 (1975), the U.S. Supreme Court determined that an individual who does not pose a danger to self or others and may live without state supervision has the right to be released from a state mental facility. This decision reinforced the trend toward "de-institutionalization." Studies reveal that there are now fewer than 50,000 inpatient beds at specialized psychiatric facilities nationwide.[3]

This paradigm shift in the delivery of behavioral health services has created additional burdens for hospitals, especially within their emergency departments (EDs), as they confront a growing population of high risk MH patients in need of acute care. (See "High Risk Mental Health Patients in ED/Inpatient Settings: By the Numbers" at right.)

As the number of uninsured and untreated MH patients continues to rise, many EDs have learned that they are ill-equipped to respond to such pressing diagnoses as delirium, dementia, adjustment reactions, threats of self-harm, and alcohol- and drug-related disorders. Consequently, some patients slip through the cracks, creating exposure to allegations such as failure to monitor, medication mismanagement, untreated violence and aggression, and premature discharge, among others.

Given the current environment, many EDs serve as holding areas for individuals in acute mental distress while they await inpatient admission, transfer to short-term rehabilitation settings or aging services facilities, or discharged back to the community. While there are no simple solutions to this problem, some EDs are embracing a collaborative care environment, in order to enhance MH patient management, reduce overcrowding and provide meaningful therapeutic services to those in need. The bottom line is that effective treatment of MH disorders and medical comorbidities requires a timely, multidisciplinary and comprehensive approach.

High Risk Mental Health Patients in ED/Inpatient Settings: By the Numbers

- **Every year, 5.7 million patients present to EDs with a primary diagnosis of mental disorder,** according to an annual survey of hospital ambulatory medical care trends.*
- **Almost a quarter of all stays at community hospitals for patients age 18 and older involve behavioral health issues,** including schizophrenia, depression, bipolar disorder and addiction.**
- **Approximately 13 percent of discharged mental health patients are readmitted to the hospital within 30 days,** as are 10 percent of discharged substance abuse patients.***
- **More than half of hospital spending for mental health treatment occurs in community hospitals,** and over three-quarters of hospital spending for substance abuse treatment occurs in the inpatient or outpatient departments of community hospitals.****

Sources: *National Hospital Ambulatory Medical Care Survey: 2015 Emergency Department Summary Tables, Table 11. **Data on Behavioral Health in the United States. American Psychological Association. *** Kamal, R. "What Are the Current Costs and Outcomes Related to Mental Health and Substance Abuse Disorders?" Kaiser Family Foundation, July 31, 2017. **** Piper, K. "Hospitalizations for Mental Health and Substance Abuse Disorders: Costs, Length of Stay, Patient Mix, and Payor Mix." ***Piper Report***, June 25, 2011.

The bottom line is that effective **treatment of MH disorders** and medical comorbidities **requires** a **timely, multidisciplinary** and **comprehensive approach**.

3 "Care of the Psychiatric Patient in the Emergency Department: A Review of the Literature." American College of Emergency Physicians®, October 2014.

Creating a Risk Management Framework for EDs

The following suggestions, which can be adapted as necessary, are designed to help EDs and providers evaluate their policies in regard to treating chronic MH patients and managing associated risks:

Form a strategic team to identify strengths and limitations in meeting MH needs in the ED setting. The team should include representatives from administrative, support and clinical areas, including medical-surgical, critical care, psychiatry, social services, security, quality improvement and risk management.

Review MH patient outcome data, current policies, and available provider tools and resources. In addition to establishing a knowledge base for the team, such a review is essential to identifying and eliminating roadblocks to sound care. For additional guidance on conducting a strategic analysis of MH-related issues, see ECRI Institute PSO's "2018 Deep Dive™: Meeting Patients' Behavioral Health Needs in Acute Care."

Collaborate with community health liaisons in developing a patient outreach program, encompassing state and local support services, referral networks and outpatient treatment options. Liaisons engage with high risk, high need patients and their caregivers with the goal of enhancing continuity, reducing inpatient stays, and minimizing use of the ED as an expensive and often unsuitable backstop for MH system gaps and inadequacies.

Participate in a local ED Enhancement Project, whereby community MH centers, addiction treatment programs, other EDs and law enforcement agencies identify high-frequency ED utilizers and collaborate to link them to community support services.

Develop standard treatment protocols and tools for use when no psychiatrist is available for consultation in the ED. Effective tools – such as psychiatric medical clearance checklists and protocols for treating agitated patients – can significantly reduce the length of ED stays by helping providers interpret findings and initiate immediate care.

Hire a mental health specialist. If resources permit, consider appointing an MH specialist to help providers identify clinically significant findings, establish treatment regimens, prescribe appropriate medications and initiate post-discharge follow-up appointments.

Adopt clinical care pathways. Use of evidence-based guidelines can help on-site healthcare providers respond more efficaciously and consistently to higher risk situations, including the following:

- Intensive care admissions.
- Electroconvulsive therapy.
- Treatment of active schizophrenia/early psychosis.
- Anxiety and depression management.
- Bipolar affective disorder management.
- Suicide precautions.
- Dual-diagnosis complications.

Train the hospital rapid response team (RRT) in MH emergencies. To reduce the toll of crises on the ED staff, a growing number of hospitals are cross-training their RRTs to bring clinical expertise to the bedside of patients who exhibit active psychosis, symptoms of substance abuse or withdrawal, uncontrollable anxiety and/or anger, or other signs of a significant mental disturbance or potentially disruptive behavior. In addition to stabilizing patients, documented RRT intervention may help prevent claims asserting failure to respond to aggressive behavior or threats of violence.

Conduct a ligature risk assessment in the ED setting, in order to reduce the risk of patient suicide and self-harm, as required of organizations accredited by The Joint Commission.

Coordinate with state or regional telepsychiatry networks for prompt consultations when a psychiatrist is unavailable on site. Such remote evaluations can both hasten delivery of needed treatment and shorten ED stays. See "Increasing Access to Mental Healthcare via Telehealth," a white paper from *Becker's Hospital Review*, for a case study of how technology can improve delivery of behavioral health services in the ED setting.

Use of **evidence-based guidelines** can **help** on-site healthcare **providers respond more efficaciously** and **consistently** to higher risk situations.

Interventions to Minimize Clinical Risks in EDs

Interventions	Present Yes/No	Comments
Utilize ED observation units to help increase efficiency, decrease hospital admissions and enhance care coordination.		
Properly staff observation units with specially trained medical professionals, and secure the environment for agitated and actively psychotic patients who may present a threat to themselves or others.		
Convert a small number of inpatient beds to psychiatric intensive care to accommodate patients who present in an acute psychiatric episode and improve the flow of patient admissions from the ED.		
Train ED staff to assess and manage acute MH emergencies, emphasizing the need for frequent assessment of at-risk patients.		
Emphasize to staff that they must *never* leave high risk patients unattended, even momentarily, and remind them that many suicide attempts occur in bathrooms.		
Use trained personnel as observers or sitters, rather than family members or volunteers.		
Comprehensively document patient screening for MH emergencies as required under the Emergency Medical Treatment and Labor Act (EMTALA), and consult legal counsel regarding obligations to screen and stabilize patients undergoing a mental health crisis.		
Institute effective safety procedures, including 1:1 monitoring when appropriate, as well as body and belongings searches for drugs, weapons and other contraband. Implement these measures consistently and document them in the patient healthcare information record.		
Increase the number of safety and security rounds in the ED when MH patients are undergoing treatment there.		
Remove potentially hazardous items – including shoelaces and belts, electrical appliances, razor blades, sharps containers, tubing and cords, sheets, mattress protectors, glass mirrors, plastic trash can liners, etc. – from treatment bays or rooms, and ensure that windows are secured and no weight-supporting fixtures or rods are present. For more information on environmental assessment, see Behavioral Health Design Guide and the VA Mental Health Environment of Care Checklist.		
Limit the dosage and/or number of prescribed pills to reduce the likelihood of an accidental or intentional drug overdose.		
Document all discussion of suicide risk among physicians, staff, patients and family.		
Note any threats directed by the patient toward another, and inform that individual of the danger in accordance with statutory requirements.		

Interventions	Present Yes/No	Comments
Document the clinical reasoning for the decision to discharge or transfer a patient. Include supporting information and measures taken to connect the patient with community resources and housing options.		
Never discharge patients who have articulated a plan to harm themselves or others. Take action to retain such patients, consistent with state regulations.		
Note in the patient healthcare information record that family members and primary healthcare providers have been apprised of decisions regarding discharge or transfer, and state whether they agree.		
Refer substance abuse patients to community-based counseling, treatment and behavioral therapy services, as well as local addiction crisis services that offer emergency access to the anti-overdose drug naloxone, as permitted by state statutes.		
Create written post-discharge summaries for the patient and family, including appointments with outpatient providers, referrals to MH clinics or substance abuse programs, and crisis management instructions.		
Develop a network of trained volunteers within the hospital to provide assistance and information to individuals with serious MH illness and their families regarding community resources.		
Draft stringent, legally compliant policies addressing patient privacy, including third-party access to MH and substance abuse treatment records.		

Create written **post-discharge summaries** for the patient and family, **including appointments** with outpatient providers, **referrals** to MH clinics or substance abuse programs, and **crisis management instructions**.

Primary Mental Health Diagnoses in Aging Services Settings

In recent years, skilled nursing and assisted living facilities have witnessed an increase in the number of younger individuals admitted with primary-diagnosis MH disorders. (See "Primary Mental Health Diagnoses in Aging Services: By the Numbers" below.) Aging services providers are trained to treat stable MH diagnoses, but typically have less experience providing care to younger residents admitted with a serious mental illness and/or addiction issues.[4]

In fact, resident advocates warn that a convergence of adverse factors (see "Why High Risk Mental Health Admissions Are Rising in Aging Services Facilities" at right) is creating a "perfect storm" of risk for those facilities whose staff members lack the requisite training and experience to safely meet the needs of mentally ill residents.[5] Aging services administrators must be cognizant of the situation and adopt effective, well-documented methods to promote the safe care and recovery of this resident population.

Primary Mental Health Diagnoses in Aging Services: By the Numbers

- **Nationwide, the proportion of younger (i.e., under 65) residents in senior communities has increased significantly,** from 12.9 percent in 2005 to 17.4 percent in 2015.*
- **In California, the under-65 nursing home resident population grew by nearly 40 percent** in the two decades from 1994 to 2014.**
- **Between 2000 and 2016, the number of nursing home residents diagnosed with serious mental illness rose significantly** in various states: for example, from 4.5 to 9.3 percent in Pennsylvania, from 6.5 to 11.8 percent in New York, from 4.9 to 13.4 percent in Texas and from 8.9 to 15.0 percent in California.***

Sources: * "Study: Ohio Nursing Homes Skew Younger" and "Lack of Care Choices Results in Many Young People Relying on Nursing Homes for Their Medical Care." ** "Shifting Population in California Nursing Homes Creates 'Dangerous Mix'". *** "Severely Mentally Ill Residents: A 'Perfect Storm' Creates an SNF Wave."

Why High Risk Mental Health Admissions Are Rising in Aging Services Facilities

1. **The swelling number of aging baby boomers** coping with chronic addictions, mental illness and homelessness augments the need for long-term beds.
2. **Declining census rates in aging services facilities,** creating financial incentives to fill bed vacancies with younger, mentally ill patients. (Under Medicaid rules, the federal government will help pay for residents' care as long as the facility's mentally ill population stays under 50 percent, encouraging states to mix the two populations. See "Mentally Ill Endanger Nursing Home Patients," from NBCnews.com.)
3. **State waivers of the Pre-admission Screening and Resident Review (PASRR)** – a federally mandated mental health prescreening of individuals seeking admission to a Medicaid-certified aging services facility – effectively permit direct admission of residents from hospitals or short-term rehabilitation units to aging services facilities without evaluation of their mental health status.
4. **The lack of behavioral healthcare requirements in the aging services regulatory framework** makes it easier for facilities to admit primary-diagnosis mental health residents without rigid care expectations or concern over potential survey deficiencies.
5. **Alternative revenue streams, such as the Money Follows the Person Rebalancing Demonstration Grant, which is currently in effect in 29 states, circumvent state Medicaid restrictions** on where MH patients can seek long-term care for their conditions.
6. **Insufficient alternative sites for residential mental health** due to widespread de-institutionalization and continuing closure of specialized inpatient MH settings.

4 For the purpose of this resource, "serious mental illness" refers to the primary diagnoses of schizophrenia and bipolar disorder, two highly disabling MH conditions that are frequently associated with younger residents. The Minimum Data Set assessment tool's broader definition of "mental illness" comprises four diagnoses: schizophrenia, bipolar disorder, depression and anxiety.

5 Barbera, E. "Severely Mentally Ill Residents: A 'Perfect Storm' Creates an SNF Wave." *McKnight's Long-Term Care News*, January 15, 2019.

Creating a Risk Management Framework for Aging Services Settings

As the aging services resident profile changes, organizations should reassess the benefits and risks of commingling younger and older residents. The following initiatives, executed by qualified staff, can help organizations develop a comprehensive strategy in this area:

Conduct a facility assessment. Few aging services organizations were designed to care for younger residents with MH disorders, who may require secure environments, one-on-one supervision and/or specialized behavioral therapy. Prior to accepting residents with MH disorders, administrators should assess the facility and implement necessary environmental and policy modifications – such as secured units, suicide prevention measures, restrictions on medications and hazardous materials, and/or resident segregation – to protect residents and mitigate liability exposure. See the Behavioral Health Design Guide to identify and address risks relating to environment of care.

Establish reasonable admission criteria. Admission policies should realistically reflect the scope of available services and the range of MH diagnoses the facility can safely manage and treat. As the Minimum Data Set assessment lacks clinical measures to differentiate the severity of mental illness, a psychiatrist or psychologist should be consulted during the assessment process. Such a specialist can perform a thorough diagnostic review and help ensure that the organization is capable of housing and caring for prospective residents.

Avoid discriminatory actions. Aging services organizations that refuse admission to residents based on MH or addiction status risk running afoul of the Americans with Disabilities Act (ADA). According to one study, individuals with severe behavioral issues – including bipolar disorder, drug/alcohol addiction and especially schizophrenia – are statistically less likely to be admitted to high quality nursing homes, as rated by the Centers for Medicare & Medicaid Services (CMS) 5-Star Quality Rating System. Administrators should consult legal counsel when drafting admission criteria and ensure that the protocol for refusals is consistent with applicable laws and is uniformly applied.

Evaluate staffing needs and competencies. Successfully managing residents with MH disorders requires a sufficient number of trained employees who understand the emotional and physical needs of these individuals. Skilled nursing facilities also must educate new hires and existing staff in pharmacological therapy, non-pharmacological interventions, de-escalation techniques and communication strategies, among other subjects. The greater the number and gravity of MH disorders among residents, the wider the range of necessary staff skills and competencies.

Understand the guidelines for psychotropic medications and gradual dose reduction (GDR). Continued CMS scrutiny of psychotropic medication utilization has resulted in confusion regarding proper prescribing practices for residents with chronic MH disorders. By establishing thresholds for psychotropic drug use and developing a process to review diagnosis, dosage and alternatives to drug therapy, organizations can help ensure that these medications are neither overused nor unnecessarily restricted. For guidance with implementing GDR initiatives, including regulatory compliance concerns, see Mathew, R., Butler, B. and Hobbs, D. "An Electronic Template to Improve Psychotropic Medication Review and Gradual Dose-Reduction Documentation." *Federal Practitioner*, October 2016.

Develop a written policy regarding medication-assisted treatment (MAT) for residents with substance abuse issues who have completed opioid detoxification and are receiving addiction treatment drugs such as methadone, buprenorphine or naltrexone. The policy statement should ...

- **Assign accountability for policy compliance and review** to one individual in the organization.
- **Refer to current standards and/or guidelines for MAT** and comply with federal registration requirements, if applicable. (See 21 CFR 1306.07.) For additional resources, including clinical guidelines for MAT and related tools, visit the Substance Abuse and Mental Health Services Administration (SAMHSA) site.
- **Draft legally compliant protocols for use of MAT drugs,** including parameters for eligibility, as well as restrictions, limitations and exclusions.
- **Create a "chain-of-custody" record,** documenting the signatures of all individuals who handle MAT drugs, if the drugs are supplied by outpatient treatment programs.
- **Create a medical order policy,** either requiring that the medical director sign the order or, alternatively, permitting an attending physician to write a standing order.
- **Outline a clinical protocol,** including assessment of the resident and documentation of medical contraindications, such as difficulty breathing, chest pain, lightheadedness, hallucinations and/or confusion.
- **Establish documentation requirements,** including transcription of the order and notation of resident assessment, medical clearance and consent to treatment in the resident healthcare information record.

House violent and psychotic residents in secured units under the supervision of staff trained in MH care, whenever possible. These units help increase security by separating higher risk individuals from vulnerable elderly residents. If such segregation is impossible, staff can mitigate risk through the following interventions, among others:

- **Assign rooms near the central nursing station for residents with poor impulse control and judgment** who may pose a threat to other residents.
- **Restrict "open door" policies,** which permit visitors to move freely in and out of rooms, for high risk residents.
- **Monitor deliveries to high risk residents,** in order to intercept possible exchanges of drugs or other contraband.
- **Evaluate suicide risk frequently** and implement appropriate precautions, keeping in mind that resident acuity often varies significantly over the course of treatment.
- **If necessary, secure a written physician order for physical restraint use,** performing and documenting assessments on an hourly basis while the restraints are in place and noting residents' response to their use.
- **Routinely examine residential living spaces** to identify and eliminate potential stressors, such as temperature extremes, high-contrast or flickering lighting, and loud noises.

Customize resident care plans to control negative behaviors in high risk MH residents. Ask family members to identify past behaviors or life experiences that may have contributed to combative episodes and develop a realistic plan for successful management, containment and prevention. (See "Care Planning for Combative Residents" at right.)

Evaluate suicide risk frequently and **implement** appropriate **precautions,** keeping in mind that resident **acuity often varies** significantly over the course of treatment.

Care Planning for Combative Residents

- **Assess residents upon admission to identify past incidents of aggression and violence,** utilizing a standard tool such as the Brøset Violence Checklist.
- **Identify known and potential triggers for negative behaviors,** including ...
  - Withdrawal symptoms.
  - Financial concerns and other sources of anxiety.
  - New onset illness.
  - Medication changes, side effects and interactions.
  - Environmental stressors.
- **Evaluate combative and aggressive behaviors on an ongoing basis** and incorporate findings into daily care. For a sample template, click here.
- **Modify the living environment to reduce contributing factors,** focusing on roommate compatibility, personality traits, cultural background, issues with sharing, eating and recreational preferences, need for rest and privacy, etc.
- **Draft a resident-specific response protocol** to control the frequency, intensity and duration of the combative behavior. Include these safeguards, among others:
  - Approach the resident from the front, never the back.
  - Keep one's arms at one's sides.
  - Remain at a safe distance from the resident.
  - Refrain from touching the resident when aggressive signs and behaviors are escalating.
  - Speak in a relaxed tone, while maintaining eye contact.
- **Assign a minimum two-person team to contain belligerent residents** and remove them to a safe, quiet location.
- **Conduct a thorough debriefing after violent occurrences,** including post-incident documentation and open discussion of staff reactions and lessons learned.

Interventions to Minimize Clinical Risks in Aging Services Settings

Interventions	Present Yes/No	Comments
Set realistic admission criteria and quotas for high risk residents.		
Assign a social worker or nurse to conduct an in-person assessment of residents before admission, in order to determine anxiety level and potential for aggression.		
Screen high risk residents for MH conditions and substance abuse, using the established screening tools listed on page 14.		
Comprehensively document the admission process for high risk residents with MH conditions to avoid potential ADA violations, paying special attention to the following issues: • **Is aging services placement appropriate,** according to treating professionals? • **Can placement be reasonably accommodated,** in view of the resources available and the needs of other residents? • **Does the individual oppose admission** or express a desire to be in a less restrictive setting?		
Consult with psychologists and psychiatrists early in the admission and intake process, and consistently thereafter.		
Allocate sufficient time and resources to educate all direct care staff about managing potentially violent encounters, including how to de-escalate a crisis situation.		
Teach critical management skills to staff, such as how to assist residents with tasks they find unmanageable, negotiate with them about daily activities and routines, and identify triggers for agitated or violent behavior.		
Establish certain "absolute conditions" triggering transfer of residents with acute psychoses or dependencies to inpatient treatment facilities, including severe respiratory depression, active withdrawal states, suicidal thoughts and life-threatening behaviors.		
I**n a central nursing station, post contact information for local hospitals, EDs and/or psychiatric facilities that have agreed to accept transfers from the facility,** in order to avoid unnecessary delays in stabilizing and treating acute conditions.		
Set firm but realistic goals when drafting care plans for difficult and noncompliant residents, and meet with family members to review organizational policy on managing violent episodes.		
Educate friends and family members of individuals living with mental illness by offering programs such as NAMI's Family-to-Family course, which helps participants improve coping and problem-solving skills via discussion and interactive exercises.		

Interventions	Present Yes/No	Comments
Teach staff to recognize signs of drug-seeking and secret drug-taking, including repeated claims that medications lack effectiveness, sudden personality changes and development of side effects, such as drowsiness, constipation and/or confusion.		
Adopt safeguards against medication hoarding, including: • Mandatory oral cavity checks for controlled and other coveted substances. • Disposal of discontinued medications. • Use of sublingual or liquid drug forms. • Routine inspections of resident rooms and belongings.		
In writing, prohibit the selling or trading of hoarded medications to other residents and explain to residents and family that such actions will have consequences, including, but not limited to, eviction.		
Designate a recreational area for younger residents, and offer therapeutic activities and programs designed to maintain or restore their ability to live independently.		

Chronic Mental Health Patients in Primary Care Settings

When patients with high risk MH disorders stabilize, either in short-term rehabilitation settings or following longer stays in aging services organizations, they are usually discharged back to their communities. Such patients typically rely on primary care providers in office practice or clinic settings to serve as their gatekeeper to continued behavioral health services and treatment. The trend toward increased primary care utilization by MH patients places significant demands on providers. (See "Mental Health Patients in Primary Care: By the Numbers" at right.)

In fact, two-thirds of primary care physicians report being unable to help their patients obtain adequate outpatient mental health resources, due to lack of insurance, inadequate coverage, health plan impediments and/or shortage of available specialists, among other factors.[6] As more patients look to primary care sites for behavioral health treatment, providers are revising practice models to offer easier access and more comprehensive care.

Mental Health Patients in Primary Care: By the Numbers

- **Four-fifths of individuals with a behavioral health disorder will visit a primary care provider** over the course of a year.
- **Half of all behavioral health disorders are treated in primary care,** and 48 percent of appointments involving use of psychotropic agents are scheduled with a non-psychiatric primary care provider.
- **Two-thirds of individuals with a behavioral health disorder get no behavioral health treatment,** and between 30 and 50 percent of primary care patients referred to an outpatient behavioral health clinic miss the first appointment.

Source: "Benefits of Integration of Behavioral Health," Patient-Centered Primary Care Collaborative, 2019.

6 See "Benefits of Integration of Behavioral Health," from the Patient-Centered Primary Care Collaborative. In response to such access disparities, the Affordable Care Act classifies MH services as one of the 10 essential health benefits that health plans must provide. In addition, the Mental Health Parity and Addiction Equity Act restricts insurers from imposing more stringent benefit limitations on MH services than on medical/surgical services.

Creating a Risk Management Framework for Primary Care Settings

The following interventions can significantly improve delivery of MH services in primary care settings, including physician offices and outpatient clinics:

Enhance staff training. Effective intervention begins with educating staff to detect the signs and symptoms of MH disorders. The following online educational resources are oriented to staff members in primary care-based settings:

- "Core Competencies for Behavioral Health Providers Working in Primary Care." Eugene S. Farley, Jr. Health Policy Center, 2015.
- "Primary Care Providers." Resources for providers from the SAMHSA-HRSA Center for Integrated Health Solutions.

"Co-locate" MH professionals in community-based clinic settings, when resources permit. Integrative care models encourage psychiatrists and other licensed MH practitioners to share workspace with primary care providers. Known as "co-location" or "bidirectional integration," this approach is designed to improve MH services by facilitating collaboration and permitting face-to-face handoffs between primary care physicians and behavioral health specialists. For guidance on implementing a co-location model of care, see "Evolving Models of Behavioral Health Integration in Primary Care," scrolling down to page 22.

Adopt universal screening. Integrated care calls for uniform and systematic screening of patients in pediatric and primary care settings, in order to identify and address MH issues earlier. Universal screening helps identify at-risk patients across a specified population and indicates those in need of further medical evaluation. The following list of screening and assessment tools is a starting point, focusing on different types of presenting symptoms:

- CAGE (i.e., Cut down, Annoyed, Guilty and Eye-opener) Substance Abuse Screening Tool for both alcohol and drug use.
- GAD-7 (General Anxiety Disorder-7), which measures severity of anxiety.
- Patient Health Questionnaire (PHQ-2 and PHQ-9) for depression.
- Primary Care Post-traumatic Stress Disorder Screen.
- UNCOPE (i.e., Used, Neglected, Cut down, Objected, Preoccupied, Emotional) Screening Instrument for Substance Abuse.

Utilize disease management principles. The concept of disease management has long played a role in improving outcomes and efficiency of care delivery for patients with cancer, cardiac disease and other chronic physical illnesses. The use of evidence-based treatment guidelines and clinical protocols can also help reduce errors, improve treatment consistency and control costs for depression, anxiety, substance abuse, attention-deficit hyperactivity disorder and other common MH conditions. The following organizations offer evidence-based MH care pathways and related clinical tools:

- Effective Child Therapy: Evidence-based Mental Health Treatment for Children and Adolescents.
- SAMHSA's National Registry of Evidence-based Programs and Practices (NREPP).

Conduct an environmental hazards analysis aimed at mitigating violent episodes. Key safety measures include attention to lighting, installation of alarm systems and panic buttons, and adoption of effective locking procedures, all of which can protect residents and staff from hostile and aggressive behavior.

Develop emergency protocols. All staff members should be trained in responding to crisis situations, summoning emergency assistance, and reporting incidents both internally and to law enforcement.

Integrated care calls for **uniform** and **systematic screening of patients** in pediatric and primary care settings.

Interventions to Minimize Clinical Risks in Primary Care Settings

Interventions	Present Yes/No	Comments
Keep credentials up-to-date regarding baseline competencies for diagnosing, treating and managing mild-to-moderate psychological conditions in various patient populations, including adults, adolescents, children, pregnant patients, chronic pain patients and substance abusers. Regularly document all skills proficiency courses taken.		
Utilize evidence-based care pathways and algorithms when diagnosing and treating bipolar disorder, clinical depression, anxiety, attention-deficit hyperactivity disorder, and other common mental and emotional conditions.		
Comprehensively document patient diagnoses and supporting clinical evidence.		
Obtain informed consent in writing prior to initiating treatment or changing medications.		
Adopt MH-specific policies and procedures in such areas as laboratory testing, medication management and follow-up visits.		
Draft a protocol for managing difficult and demanding patients, including handling prescription requests for opioids and other controlled substances.		
Interact respectfully with aggressive patients, remembering to speak calmly, maintain appropriate distance and use their name frequently to establish rapport.		
Use tested conflict-management techniques to defuse confrontations, such as acknowledging feelings of fright or helplessness.		
Draft a protocol for managing suicidal ideation in MH patients, including when to transfer patients to a higher level of care.		
Consider co-managing patients with an MH specialist when appropriate, such as when prescribing unfamiliar or multiple psychotropic drugs.		
Consult with MH specialists when indicated, e.g., when questions arise concerning treatment, patient response or professional competencies.		
Draft a protocol for conducting and documenting "curbside consultations" with MH specialists, whether these discussions take place in person, by telephone or online.		
Generate a treatment plan for MH patients and share it with other physicians and medical assistants within the primary care practice.		
Record all referrals in the patient healthcare information record, noting reports sent and follow-up actions taken.		
Draft a protocol addressing how to respond to requests for records, subpoenas and court orders seeking treatment information protected by *42 CFR Part 2*, which is the federal regulation governing confidentiality of patient records involving substance use. (See the Subpoena Response Toolkit from the American Health Lawyers Association; access requires membership.)		

Managing Violent Situations: Safety Tips for Providers in All Settings

Mental health (MH) emergencies are a relatively common occurrence in all healthcare settings. They can be frightening and overwhelming for staff as well as other patients or residents. Successful management of threatening outbursts requires a collaborative team approach, supported by evidence-based response protocols and ongoing crisis intervention training. The following techniques can help ensure that staff and patients/residents remain safe and calm during volatile moments:

Promote safety awareness. To help enhance readiness and minimize risks, organizations should review and update the facility emergency plan on a routine basis and ensure that staff members understand its components, including the following:

- **Appropriate response times** to potentially violent situations.
- **Proper interventions** for every stage of aggressive behavior.
- **Emergency protocols** for handling firearm, bomb or hostage threats.
- **Provision of medical attention** to those in need.
- **Post-incident procedures,** including staff debriefing sessions.
- **Use of role-playing** as a training method for crisis situations.

Train staff to handle patient/resident aggression. Serious mental illness may be associated with mood and behavioral changes, as well as outbursts of a verbal or physical nature, which may involve threats of self-harm or injury to others. All personnel – including management, physicians, clinical staff, volunteers, and contracted workers and service providers – should receive specialized training in managing patients/residents with psychiatric conditions or comorbidities. Training should address such topics as anticipating and preventing violence, counseling angry individuals, de-escalating conflict, safely restraining out-of-control individuals, responding to assault on self or others, and documenting assessment findings and interventions.

The following general techniques can help defuse a potentially explosive situation:

- **Protect others from injury** by removing agitated patients/residents from shared or public spaces.
- **Talk in a calm and respectful fashion,** despite abusive language or other provocations.
- **Listen carefully and sympathetically** and acknowledge the individual's feelings.
- **Give patients/residents choices,** so they have a sense of control.
- **Be firm and direct in manner,** but not angry or irritated.

Adopt a triage scale. An effective assessment tool that classifies volatile patients/residents by risk severity can expedite evaluation and suggest the appropriate level of intervention at the onset of a crisis. One commonly used resource is the Mental Health Triage Tool, which can be used in ambulatory, outpatient and residential settings.

Certify staff members in MH first aid, including awareness of the signs and symptoms of a mental health crisis and knowledge of how to respond properly.

Utilize crisis intervention teams. While patients/residents with chronic mental illness sometimes wander or otherwise behave impulsively, those with both mental illness and substance abuse issues may exhibit a more directed form of aggression, especially when intoxicated or in withdrawal. Crisis intervention teams play a key role in preventing violence in such circumstances. See "Practice Guidelines: Core Elements for Responding to Mental Health Crises," from SAMHSA.

Provide a secure, weapons-free environment. High risk patients/residents should be routinely checked for potentially dangerous items both on their persons and in their rooms, and visitors should be closely monitored to ensure that weapons and drugs do not fall into their hands. Patient/resident and staff safety also requires ongoing attention to basic staffing and workplace practices, such as maintaining proper staff/patient or staff/resident ratios (especially during off-peak hours), preventing employees from becoming isolated from co-workers, and transporting impaired or potentially violent patients/residents in a secure and approved manner.

Communicate with local law enforcement regarding incidents, emergency plans, response procedures, changes in facility layout or patient/resident populations, and other safety and security issues.

Conclusion

MH-related risks are a source of concern for every type of healthcare setting, from hospital EDs and aging services facilities to community clinics and office practices. By integrating physical and mental diagnostic and care needs, and responding to the special needs and issues of mentally ill patients/residents, healthcare organizations and providers can improve outcomes while reducing their degree of liability exposure. In addition, by getting involved in local and national efforts to address the MH crisis, leaders can help strengthen their communities, reduce the overuse of ED capacity and acute care beds by individuals with behavioral and addictive disorders, and provide a measure of hope to those trapped in a cycle of chronic mental illness and inadequate care.

Quick Links

General Resources

- Bland, D., Lambert, K. and Raney, L. "Resource Document on Risk Management and Liability Issues in Integrated Care Models." *American Journal of Psychiatry*, 2014 data supplement.
- "Integrating Behavioral Health Across the Continuum of Care." American Hospital Association (AHA) and Health Research & Educational Trust, February 2014.
- "Mental Health By the Numbers." National Alliance on Mental Illness (NAMI), 2019.
- National Mental Health Organizations, a listing from the AHA, 2019.
- Quality Initiatives and Resources, a listing from the National Association for Behavioral Healthcare, 2018.
- "What Is Integrated Behavioral Health Care (IBHC)?" Agency for Healthcare Research and Quality.

ED-related Resources

- "7 Steps to Expand the Behavioral Health Capabilities of Your Workforce: A Guide to Help Move You Forward." AHA, 2016.
- "Alleviating ED Boarding of Psychiatric Patients." *Quick Safety*, a publication of The Joint Commission, December 2015, issue 19.
- "The Transformation of Behavioral Health Care Begins in the ED." A white paper from Vituity, 2018.
- Zeller, S. "Dedicated Psychiatric Emergency Services Reduce the Need for Inpatient Hospitalizations," *CEP America*, posted April 30, 2015.

Aging Services-related Resources

- Bern-Klug, M., et. al. "Nursing Home Residents' Legal Access to Onsite Professional Psychosocial Care: Federal and State Regulations Do Not Meet Minimum Professional Social Work Standards." *The Gerontologist*, August 2018, volume 58:4, pages e260-e272.
- Frankel, M. et al. "Tips and Techniques for Supporting Residents with Mental Illness: A Guide for Staff in Housing for Older Adults." Jewish Community Housing for the Elderly and Jewish Family & Children's Service, 2012.
- Kaldy, J. "When Mental Illness and Aging Make Nursing Homes Necessary: What Next?" *Caring for the Ages*, May 1, 2018, volume 19:5.
- "Securing Stable Housing." NAMI, 2019.

Primary Care-related Resources

- "Addressing Mental Health Concerns in Primary Care: A Clinician's Toolkit." American Academy of Pediatrics, 2010. (Available for purchase.)
- Gelber, S. and Dougherty, R. "Disease Management for Chronic Behavioral Health and Substance Use Disorders." Center for Health Care Strategies, Inc., February, 2005.
- Klein, S. and Hostetter, M. "In Focus: Integrating Behavioral Health and Primary Care." Commonwealth Fund, August 28, 2014.
- Oken, R. "Liability Risks Associated with Mental Health Care Can Be Managed." *AAP News*, December 29, 2016.
- "Promoting Chronic Disease Management: A Guide for Behavioral Health Care Teams." Healthier Washington Practice Transformation Support Hub, 2018.

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