Case Studies on Behavioral Health Risks in the Non-Psychiatric Setting: Violence, Suicide and Firearms

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Background

- Crisis at a community hospital/mental health clinic
- National crises both in and out of healthcare setting involving violence
- Recent gun/violence prevention initiatives since Newtown
- Psychiatric patients in acute settings (ED/ inpatient), clinics, other areas
- Challenging population, more frequency
  - Staff, environment not equipped

Objectives

- Explain the importance of
  - appropriately and adequately assessing risk of danger to self or others, and
  - warning identified third parties of impending harm

  to reduce the risk of psychiatric patients in the acute care setting.
- Identify strategies acute care organizations can take to address the risk of psychiatric patients, such as
  - environmental safety changes,
  - improving risk assessment,
  - ensuring appropriate mental health consultation, and
  - training staff

  to ensure the safety of themselves and others.

Objectives

- Summarize the legal implications in the care of psychiatric patients, including the duty to warn and the ownership or possession of firearms by patients with psychiatric conditions.

Suicide

2013 national statistics

- **41,419** suicides in the US
  - **112** per day
  - One every **12 minutes**
- 2nd leading cause of death ages 15-34
- 3rd leading cause of death ages 10
- 3rd leading cause of death white, non-Hispanic men 45-64

Suicide

2008-9 statistics

- **8.3 million** in US reported having suicidal thoughts
- **1 million** in US reported making a suicide attempt
- Females – more likely than males to report suicidal thoughts
- Males – **80%** more likely to have had a suicide plan and/or attempted suicide

Suicide

Impact on healthcare 2011

- Deaths from suicide – **38,364**
  - Costs - **$154 million**
- Suicide attempts with admission – **316,572**
  - Costs - **$3.159 billion**
- Suicide attempts with ED visit and discharge – 134,202
  - Costs - **$464 million**

- Total suicidal events in hospitals – **489,1138**
- Total costs - **$4,137,000,000.**

Suicide

- **58%** of those who engage in suicidal behavior never seek healthcare services
- Much higher number with suicidal thoughts/ behaviors are treated in outpatient settings or not at all…

Impact of psych pts in ED

- Effect of deinstitutionalization:
  - Prior to Lanterman Petris Short (LPS) Act in 1967 # of state hospital patients – **18,831**
  - 5 years after LPS –Roughly **7,000** patients

- Effect of managed care: Total # psychiatric beds in CA
  - 1995 – **9,400**
  - 2007 – **6,500**

- 2010 – **60%** cut for community mental health programs

- Going into emergency departments - EMTALA

Impact of psych pts in ED

Survey of 123 ED directors from 42 CA counties

- Time for psych evals (time referral placed to completed eval)
  - **5.97 hours**
- Avg. wait time for psych pts in ED (decision to admit to placement)
  - **10.05 hours**
- Avg. wait time for pediatric patients in ED (as above)
  - **12.97 hours**

Comparison – avg. wait time non-psych patients – **7.10 hours**

Case studies

- Case 1
- Case 2
- Case 3

Risk management implications from case studies

Standard of care

Standard of care is set by facility/departmental policies – if do not fulfill obligations in policy, you have not met standard of care

Departmental or facility-wide policies/practices for at-risk patients

- Violence
- Suicide
- Elopement

Third parties

Duty of care extends to identifiable foreseeable third parties.

- Must take appropriate action if a situation of foreseeable harm occurs.
- Duty to warn and related issues discussed in more detail later in program.

Screening for risk potential

Must have appropriate screening for risk of danger to self or others.

- Suicide assessment – difficult to “predict”; current tools not validated
- Failure to screen as a “reasonable healthcare professional in the same or similar circumstances” fails to meet the standard of care
- Even if meet policy, policy must meet above standard

Other risk management considerations from this population

ED triage nursing – staff competency, security

- Considerations/actions for personal safety when dealing with potentially violent patients
- Effective communication strategies to assess and interview patients at risk for/with psychiatric conditions
- Identification of common medical/physical conditions that may present as psychiatric behaviors (medication-induced dementia, etc.)
- triage staff/triage areas
  - equipped with some sort of emergency assistance notification system tied to security assistance
  - Environmental hazards in triage area minimized

Psychiatric consultations

Protocol for situations/presentations that require psychiatric consultation

Designated person to perform psychiatric assessments

- Psychiatrist – (live or telemedicine)
- Regional mental health professional
- Mid-level professionals (MSW, PNP, etc.)
- Psychiatric unit nurses

Safe Rooms/Areas

Reference:

International Association for Healthcare Security and Safety. Security Design Guidelines for Healthcare Facilities. Accessible at http://www.iahss.org

- Located away from department exits
- In close proximity to dedicated rest rooms with plumbing and fixtures that mitigate the potential for patients to cause harm to themselves or others
- Video surveillance incorporated with audio capability to monitor patient activity remotely, with cameras enclosed in tamper-proof housing
- Access in and out of the room or suite of rooms, if used, is controlled

Safe Rooms/Areas

- Doors are equipped with tamper-proof hardware and an observation window with window coverings managed from outside the room
- Walls, ceiling, and doors are hardened to prevent penetration
- All removable objects and/or medical equipment are protected behind locked cabinetry, gates, impact-resistant laminate, or other hardened material
- Safety measures are incorporated that mitigate the potential for patients to cause harm to themselves or others
- Televisions, if used, are mounted behind protective glazing
- Patient restraint storage is maintained in close proximity

Policy/practice for use of safe rooms/areas

- Removing or securing medical equipment or other unsafe items prior to use, if such equipment is housed in the safe room
- Staffing/monitoring of patients kept in that area
- If there is not a specialized safe room for at-risk patients, policy/practice to place patients at risk in observable areas

Competency training of the non-triage ED staff

Suicidal behaviors

- Behavioral cues/statements indicative of suicidal thoughts, plans and behaviors for patients not previously assessed to be at risk of suicide
- Behavioral cues/statements of patients indicating increasing suicidality

Potential aggression

- Signs of increasing agitation
- De-escalation techniques
- How to get assistance in deepening crisis
- Appropriate use of restraints when necessary

Sitters, security

- Use of PCTs/sitters/1:1 – not nurses, no nursing judgment
- Specific training for sitters
  - How to interact with patient
  - What behaviors to watch for
- Security staff member stationed in the ED at all times
- If a security staff member is not stationed in ED, one available immediately, including in triage, if needed
- Security personnel take part in aggression/violence prevention training

Boarding patients

Process/plan for holding behavioral health patients for extended periods of time in the ED while awaiting transfer/disposition

- A physician/provider to remain responsible for medical oversight of the patient for the duration of the stay
- The physical environment is appropriate to the needs of the patient
- An assurance that the patient's needs are addressed through appropriate physician/provider orders (which may include medications)
- An assurance that any necessary staff observation levels as appropriate to the condition are continued

Other settings – med/surg acute care

Difference between acute psychiatric suicidal patients and general hospital suicidal patients

- Psychiatric patients
  - Young males, psychiatric diagnosis
  - Admitted with recent sx attempt or ideation
  - History of mental illness, substance abuse, previous attempts
- General hospital unit suicidal patients
  - Older, males
  - No history of psych or sx behavior
  - Pain, depression, physical distress
  - Often new onset chronic disease and/or recent major life stressor

Other settings – med/surg acute care

- Other settings (Ambulatory/acute medical inpatient) –
  - Safe environment (triage, intake areas safe)
  - Staff training (physical safety distance, verbal intervention techniques)
  - Emergency plan
  - Security access/911
  - Suicide/ICU psychosis on inpatient units

Legal Issues Relating to Treating Dangerous Patients

The Duty to Warn

Balancing public safety with patient confidentiality

Defined: the responsibility of a counselor or therapist to breach confidentiality if a client or other identifiable person is in *clear* or *imminent* danger.

- Warning of the *threat* of violence
- Warning of the *risk* of violence

Statistics compiled in a 2008 study showed that 75% of psychologists are misinformed about the legal duties that arise when treating potentially dangerous clients

Origins of the Duty to Warn

California, 1976: “the right to confidentiality ends when public peril begins”

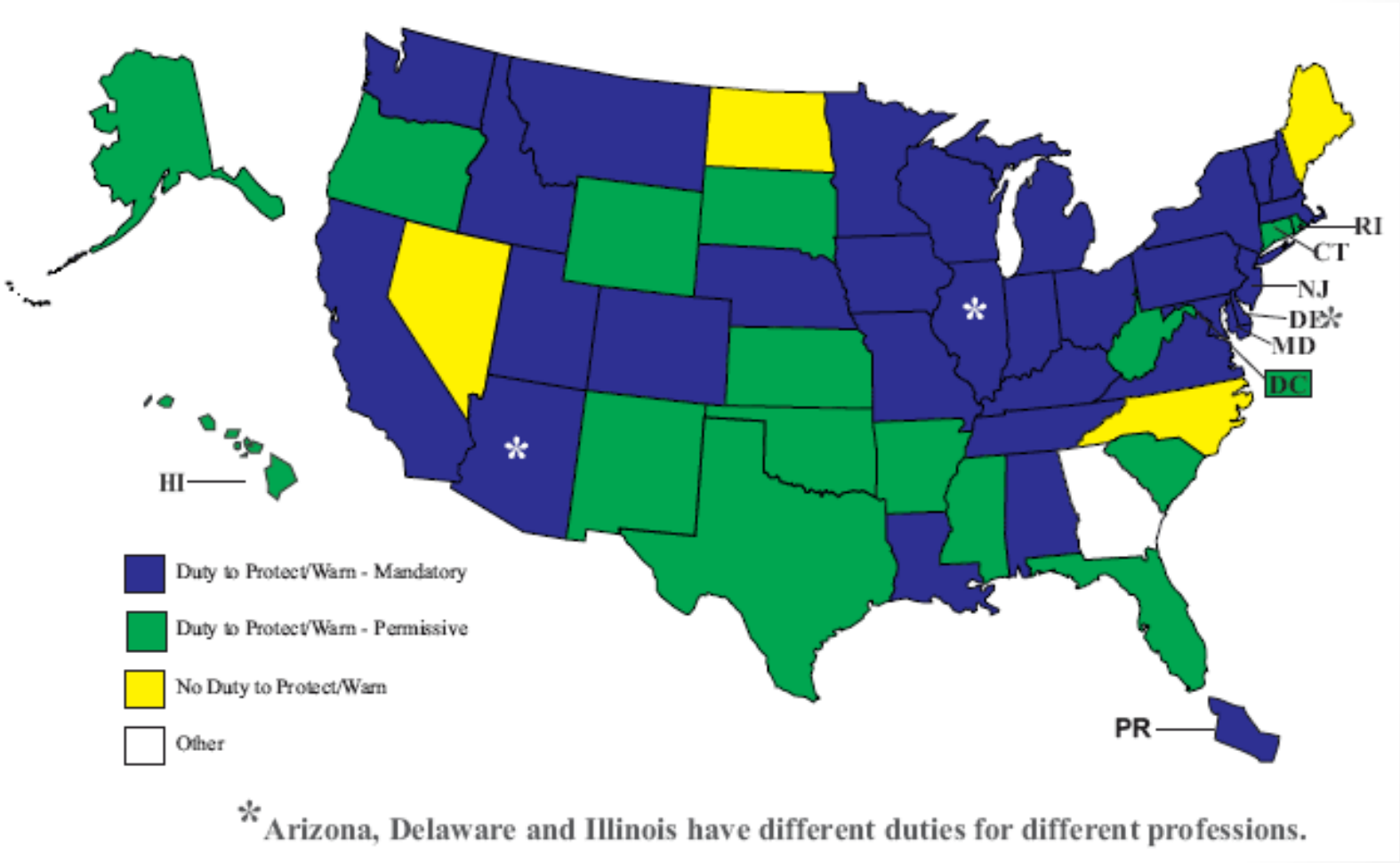
- *Tarasoff v. Regents of the University of California* (1976): set an affirmative duty to warn a potential victim of intended harm or others likely to apprise the victim of danger, notify the police, or take whatever other steps are reasonably necessary under the circumstances
- The duty to a potential victim was based on the special relationship between doctor and patient

The Duty to Warn

The 1986 California Immunity Statute was enacted in light of the *Tarasoff* requirements, granting therapists immunity from potential future liability if they made reasonable attempts to warn a potential victim and notify the police.

The statute made reference to "a duty to warn and protect," causing much confusion as to what was actually required for immunity.

The Duty to Warn, State Breakdown



Interpreting Tarasoff: Cal. Civ. Code § 43.92

In 2013, the California Duty to Warn became the Duty to *Protect*

This revision recognized that warning a victim may not be a protective course of action.

- The 2013 statute unambiguously changed the duty to warn to a **duty to protect**
- All references to a therapist's duty to warn were removed from the immunity statute

When a therapist believes that warning the victim will exacerbate the patient's risk, or where warning may not be feasible, they can take alternative protective actions to satisfy the duty to protect and avoid liability.

Understanding the 2013 Revision

In California, there is no mandatory duty to warn

The Duty to Protect is satisfied if the therapist chooses to warn, but can also be satisfied through other protective actions.

- Encourages, but does not mandate warning
- Other options include hospitalization of the patient, medication management, and other therapeutic interventions

In practice, the Duty to Protect is actually more helpful to therapists, because in order to be found liable, their alternative protective actions have to be proven negligent.

Case Examples

Example: Warning May Exacerbate a Dangerous Scenario

A patient entered the hospital after saying she wanted to kill her father. The father was being released from prison after completing his sentence for killing the patient's mother. He recently threatened the daughter because he wanted the mother's monetary inheritance, which went to the daughter when the mother was killed. However, hospital physicians believed there was also a risk that the father would kill the daughter if apprised of her threat.

After one day on the inpatient unit, the daughter calmed down and credibly said she was simply angry, and would not carry out any violent acts against her father.

Case example continued

Before the 2013 revision, the only option was to warn the father of his daughter's threat. If she was released from the hospital and killed her father, there would be automatic liability for the hospital physicians for their failure to warn.

Now, the duty to protect can be satisfied if the daughter is kept in the hospital for further evaluation and assessment of her potential dangerous propensities. It can also be satisfied through medication management to alleviate the risk of acting on her threat to kill her father.

Similar examples include warning the perpetrator in an abusive relationship of a threat by the victim, or warning feuding parties in a custody dispute of fleeting threats by one against the other.

Immediacy Requirement

The law requires therapists to “immediately report” the identity of a threatening patient.

In October 2013, this was amended to require that protective actions be taken within 24 hours.

The Elliot Rogers Shootings

Uncertainty in the case of vague or lack of readily identifiable victims

Gun Violence Restraining Order

On September 30, Governor Jerry Brown signed California AB 1014, a new law that allows family members and law enforcement officers to seek a **Gun Violence Restraining Order (GVRO)** against people who pose a threat to themselves or others.

> **“California can create a mechanism that would allow those closest to a troubled individual to act when there are warning signs that that person is at risk for violence.”**

GVRO

If a judge determines someone to be a risk and issues a GVRO, that order will:

- Temporarily prohibit that person from purchasing or possessing firearms or ammunition
- Allow law enforcement to temporarily remove any firearms or ammunition already in that person's possession
- Include procedures to allow the person have his or her guns and ammunition returned

Other States on the Duty to Warn/ Protect

Nebraska: permits a jury to consider whether the therapist knew or should have known of a patient's *dangerous propensity*, absent identification of an identifiable victim. *Lipari v. Sears, Roebuck & Co*

Delaware*:* duty to warn when a patient's dangerous propensities presents an unreasonable risk of harm to the public at large

Arkansas: Requires a mental health services provider to warn a law enforcement officer of a credible threat by a patient [HB 1746, 2013]

New York's Mandatory Duty to Warn

NY Mental Hygiene Law § 9.46: requires mental health professionals to report a threat of *serious* and *imminent* danger to the patient or a third person

Reasons for disclosure must be documented in the clinical record

Good faith disclosures are protected from both civil and criminal liability

In the Hospital Setting

After the Newton and Aurora shootings, the DHHS emphasized that HIPAA is not intended to hamper a provider's ability to disclose necessary information about a patient to law enforcement, family members, or other potentially at risk persons where disclosure may reasonably prevent or minimize an imminent danger to the health or safety of a patient or the individual

- US Department of Health & Human Services. Message to Our Nation's Health Care Providers. January 15, 2013.

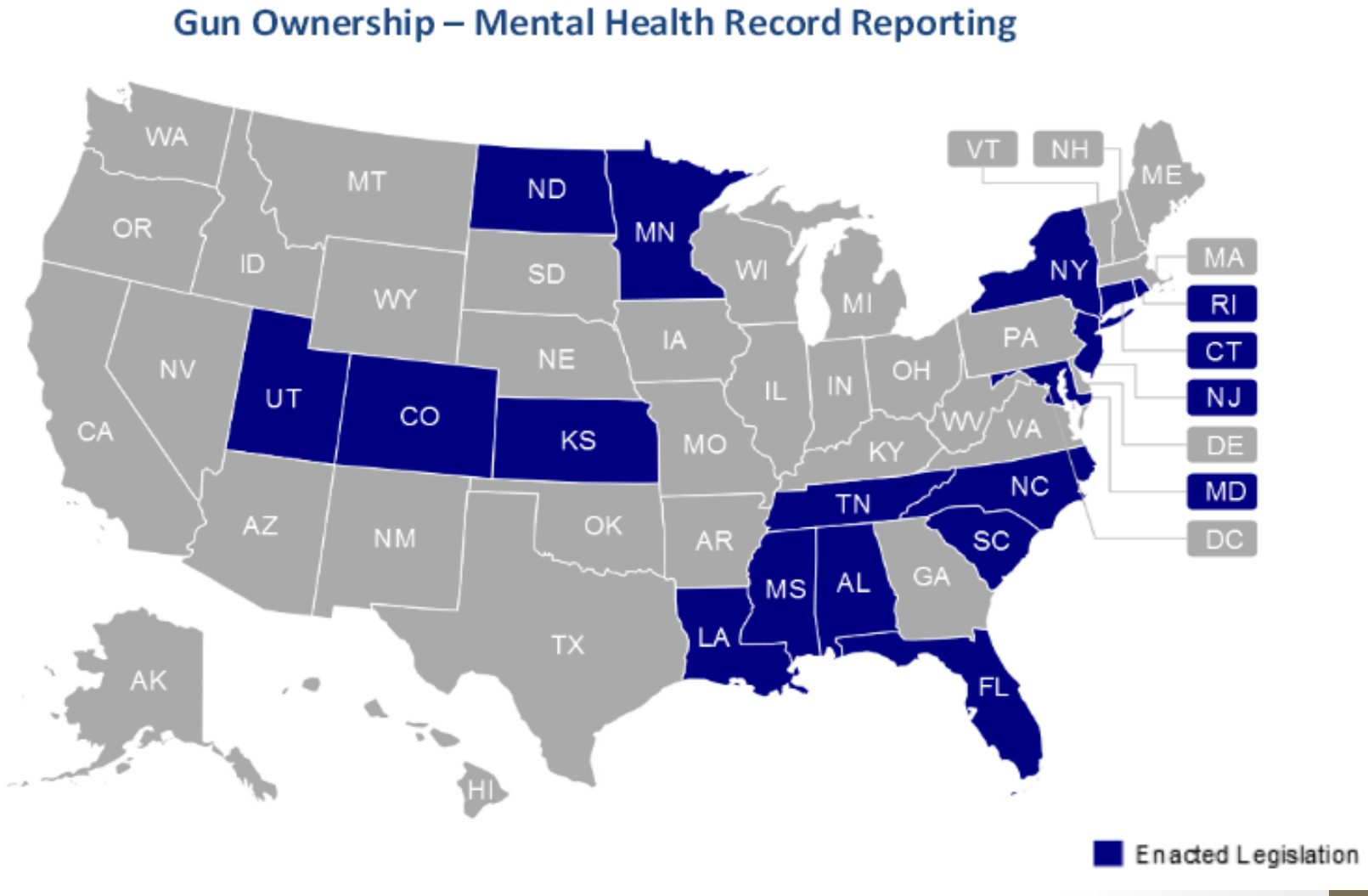
In the Hospital Setting

Some states limit reporting requirements to specific mental health providers; others use “health care provider”

California’s Duty to Warn applies to all “psychotherapists” as defined in Cal. Evid. Code § 1010, including

- Licensed psychologists
- Clinical social workers engaged in psychotherapy
- School psychologists with requisite credentials
- Marriage/family therapists
- Licensed physicians/surgeons certified in psychiatry
- Assistants/interns/trainees under the supervision of psychotherapists
- Registered nurses with a master’s degree in psychiatric-mental health nursing

Mental Illness & Violence Prevention: Firearms



Mental Illness & Violence Prevention: Firearms

Hospital killing in Delaware County shows safety gap in mental health

BREAKING: Armed Doctor Stops PA Hospital Killer; Faces Loss of Job, License to Practice Medicine

By Robert Farago on July 24, 2014

New York's SAFE Act

The Secure Ammunition and Firearms Enforcement Act (2013): broadened the clinician's duty to warn and increased requirements to report mental health records for the purpose of limiting firearms purchases

- Requires MHPs to report patients who are likely to engage in conduct that will cause serious harm to themselves or others.
- The report will be used to crosscheck the individual's name against a comprehensive gun registration database. If they possess a gun, the license will be suspended and law enforcement will be authorized to remove the person's firearm or the individual may be prevented from obtaining one in the future

Other Recent Legislation

Tennessee: requires mental health providers to report any patient who makes an actual threat of bodily harm against a reasonably identifiable victim to local law enforcement, who must then report to NICS [SB 789]

Connecticut: requires reporting of mental health information for gun permits [SB 1160]

Colorado: requires background checks for purchases and transfers of firearms [HB 1229]

Florida: persons involuntarily admitted to a mental health facility may be prohibited from purchasing a firearm

Today's presentation brushed the surface of these two major issues in healthcare litigation. For more in-depth information on any of the topics discussed today, please contact me at any time.

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