Helping Mentally Ill Victims of Violent Crime

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Overview: mass murders — only one-fourth committed by people with severe mental illness (SMI); 30% to 40% of major mass shootings attributed to people with SMI; poor target for intervention because rare and heterogeneous events (not characterized by similar risk factors); other violent acts — psychiatric assessments reveal mental health issues in 1 of 6 people charged with murder; only 5% of perpetrators have Axis I disorders when those with addiction and comorbidities excluded; media — in major studies, 5% to 10% of violence related to SMI; however, media fosters stigma by repeatedly linking MI with violence; this may cause patients with MI to avoid treatment and promote discrimination against them

Violent victimization: clinicians should ask patients whether they have been victims of crime; patients with SMI frequently exploited and victimized by crime; patients with MI 2 to 140 times more likely to be victims of crimes than people without MI; in United States and other western countries, people with MI 5 times as likely to be murdered and 25 times as likely to be victims of sex crimes; 20% to 75% report being victims of crime within past year; patients with SMI usually accurate historians about crimes

Consequences: rate of posttraumatic stress disorder similar or higher among people with MI compared with members of general population; violent victimization increases risk for suicide; standard interventions effective (eg, eye-movement desensitization and reprocessing, trauma-focused cognitive behavioral therapy) but not always offered

People who engage in violence: risk of perpetrating violence higher in people who have lived with MI and experienced violent victimization; among people with MI, comorbid addiction and recent violent victimization account for most of risk of engaging in violence

Involuntary outpatient commitment: in study of patients discharged from inpatient care, associated with 50% reduction in rate of violent victimization within 1 yr of discharge; limited tool for protecting patients from violence

Management: clinician should ask about trauma, empathize, and offer treatment for trauma and advocacy services; best practices for asking about victimization not known; more research needed on prevention and ways to help law enforcement personnel investigate crimes against people with MI; violence against people with MI provides opportunity for clinicians to partner with law enforcement; prosecutors and judges want to understand how to improve handling of such cases in court; those who support and advocate for victims also eager to partner with clinicians

Prevention: might include teaching situational awareness or self-defense; best way to prevent violence against people with MI unknown; grants available to fund services for people with MI who have experienced violent crime; grants tied to research outcomes

Summary: recent legislation addresses coercive treatment but does not emphasize providing services for people with MI; providing mental health services unlikely to significantly decrease violence in community; additional resources available at www.audio-digest.org/editorial/victimization

Questions and Answers

Human trafficking: Federal Bureau of Investigation active in this area; victims of human trafficking have severe mental health issues; online training available to help health-care professionals identify and care for victims of trafficking

Suggested Readings


Educational Objectives

The goals of this program are to improve management of psychiatric emergencies. After hearing and assimilating this program, the clinician will be better able to:

1. Characterize the relationship between violence and severe mental illness.
2. Describe the objectives of efforts by emergency departments to prevent suicide.
3. Explain the differences between a safety plan and a safety contract for a patient at risk for suicide.
4. Address gaps in communication affecting patients with mental illness and their families.
5. Advise a mentally ill patient who wishes to prepare a psychiatric advance directive.

Faculty Disclosure

In adherence to ACCME Standards for Commercial Support, Audio Digest requires all faculty and members of the planning committee to disclose relevant financial relationships within the past 12 months that might create any personal conflicts of interest. Any identified conflicts were resolved to ensure that this educational activity promotes quality in health care and not a proprietary business or commercial interest. For this program, members of the faculty and planning committee reported nothing to disclose.
Emergency Tools and Resources for Preventing Suicide
Adam Chu, MPH, Senior Project Associate, Suicide Prevention and Resource Center, Education Development Center, Waltham, MA

Suicide Prevention Resource Center (SPRC): part of Education Development Center (EDC); nonprofit, federally funded center dedicated to promoting national strategy for suicide prevention; SPRC supports emergency departments (EDs) and behavioral health-care organizations

Suicide: tenth leading cause of death overall and second leading cause of death in persons 15 to 24 yr of age; suicides and attempted suicides may be prevented when clinicians in EDs practice screening and brief interventions; one-fourth of people who die by suicide seen in ED within 4 wk of death, but most seen for another reason; care provided to patients at risk for suicide may not reflect latest research or connect them with necessary services; 44% of patients at risk have previously attempted suicide; risk for attempted suicide highest during first 30 days after discharge; most patients do not receive outpatient treatment within that time frame, suggesting that continuity of care could be improved

Suicide prevention: national strategy revised in 2012 to include use of standardized protocols based on risk profiles within EDs; SPRC tasked with developing resources to address this objective; SPRC created consensus-based guidelines for suicide prevention in EDs; guidelines — cover screening, assessment, brief interventions, and discharge planning; briefly address documentation, working with intoxicated patients, telepsychiatry, and legal issues

Major recommendations: consensus and evidence indicate that standard protocol should be adopted for risk assessment; protocol includes exchanging information with family members; safety measures depend on patient’s level of risk and circumstances and should balance safety with providing least restrictive care (respecting patient’s autonomy); level of risk may change acutely, so patient may need to be reassessed before discharge from ED

Key interventions recommended by consensus panel: must be clinically useful, facilitate continuity of care, be feasible within ED, and center on patient; must be feasible for clinicians who do not specialize in mental health; designed to be delivered in bundles rather than individually

Brief patient interventions: visit to ED may be only opportunity to educate patient and family about preventing suicide; documents and resources should not replace one-on-one communication

Safety plan: includes list of possible coping strategies that patient may use in future; should be written in patient’s own words and consist of actions patient capable of performing; patient and clinician should collaborate in formulating plan (should address lethal means, involve collaterals, and be reviewed and revised regularly); every patient at risk for suicide should leave ED with safety plan; plan vs contract — collaborative safety plan differs from safety contract; no evidence supports efficacy of such contracts, which may foster false sense of security; however, literature supports collaborative safety plans, which may be facilitated by nonmental health specialists; addressing lethal means — over half of suicides in United States involve firearms; clinician should arrange for and confirm removal of firearms; SPRC offers free course covering lethal means and how to conduct these conversations

Rapid referral: patients need immediate access to outpatient services; ED should establish partnerships or formal agreements with outpatient providers to ensure availability of appointments and transfer of necessary information; safety plan most effective when outpatient provider aware of and participating in plan created at point of care

Caring contacts: recommended intervention supported by highest level of evidence requires that patients at risk for suicide have personal contact during transitions in care; requirement aims to foster feeling of connectedness in patient, which should facilitate adherence to transition or discharge plan; crisis services may facilitate outpatient follow-up and ensure smooth transition

Free online training: created by EDC in response to increasing rate of suicide at acute-care facilities; training addresses risk assessment, lethal means, and suicide attempts

Feedback on consensus-based guidelines: users have relied on guidelines to develop policies at organizational level, improve clinical care, conduct training, and influence policy at level of state

Next steps: zerosuicide.sprc.org offers comprehensive approach to suicide prevention in behavioral health-care systems; studies on “zero-suicide” model recently funded by National Institute of Mental Health; Joint Commission issued sentinel alert on detecting and treating suicidal ideation

Questions and Answers

Universal screening: not proven superior to selective screening, but not harmful; regardless of approach used, screening tools should be applied consistently

Screening pediatric patients: guidelines not yet created; research ongoing

High-risk patients: until recently, suicide prevention primarily focused on community facilities; crisis infrastructure still under development and may vary by location

Suggested Readings


Psychiatric Advance Directives

Phyllis Foxworth, BS, Advocacy Vice President, Depression and Bipolar Support Alliance, Chicago, IL

Depression and Bipolar Support Alliance (DBSA): peer-directed organization for people with mood disorders; majority of board of directors and staff members identify with diagnosis of mood disorder; DBSA supports group meetings, education, and research

Whole health: mood disorders chronic conditions with comorbidities that demand management of whole health of individual; patient-centered care focuses on collaborative relationship with patient, understanding outcomes that interest patient, and shared decision making

Communication: Health Insurance Portability and Accountability Act protects rights of patients; communication with families sometimes challenging for clinicians when patient unable to communicate or does not wish to relate to loved ones; in some circumstances, patient cannot articulate desired outcomes or collaborate with clinician to discuss treatment

Case example 1: Susan married to Judy but lived in state that did not recognize same-sex marriage; Susan developed wellness and recovery action plan in collaborative effort that included Judy; Susan had bipolar disorder, lived productive professional life, and in long-term relationship with Judy; Susan concerned about whether her treatment plan likely to be followed in case of psychiatric emergency

Case example 2: Joyce concerned about her son Scott; Scott had psychiatric emergency in adolescence but then stabilized; however, during freshman year in college (several hundred miles from home), Scott had another psychiatric emergency;
family did not learn of event for several days; family eventually learned where Scott hospitalized, but because of regulations supporting rights of patients, treatment facility could not confirm or deny his admission; at time of admission, Scott unable to complete HIPAA form granting facility permission to communicate with family

Survey: conducted by speaker to explore experiences of patients presenting to emergency department (ED) with agitation; participants in survey self-selected; information also sought from peers and family members; 50% of respondents stated that ED did not inform them of right to refuse treatment; 49% stated they did not consent to administration of medication; 32% claimed they had no opportunity to provide medical history to ED; only 20% of families believed ED kept them informed of status of family member being treated; survey reveals lack of communication

Psychiatric advance directive (PAD): offers patient voice in his or her treatment and ensures that care addresses concerns of patient; providers want to have collaborative relationship with patient and to provide best quality of care; families want to be supportive

Content of advance directive: legal document allows patient to direct care when he or she incapacitated; treatment — elements of advance directive may include which medications and dosages work best for patient, which medications patient does not want, and preferences regarding specific treatment facilities; agent — advance directive may appoint agent; agent may be directed to make decisions about medical treatment or to pay bills, handle child care, or assume other major responsibilities while patient incapacitated (eg, spouse of Susan in Case 1 may serve as her agent); retrieving advance directive — patient may keep electronic copy (labeled as PAD) on keychain; agent should also retain copy; in Case 2, Joyce presented PAD to treatment facility; document informed facility that parents agents, giving them authority over treatment and right to be advised; presentation of advance directive immediately changed situation and allowed parents to support patient; advance directive may be stored in medical record; some states have registries of PADS

Legal status: 50% of states have statutes supporting PADS; most other states specify that agent may be appointed; New Jersey mandates that state maintain registry database of PADS

Advantages: using advance directive could reduce frequency of admissions to ED; in DBSA survey, most participants returned to ED; randomized trial studied 469 patients with severe mental illness; one group attended facilitated session where received instructions on how to complete PAD; control group provided with documents and resources only; 61% of patients in facilitated group and 3% of controls completed advance directive; psychiatrists who reviewed these advance directives found them consistent with standards for treatment in community; many patients specified preferred medications and treatment facilities but none refused treatment; in follow-up evaluation at 1 mo, patients in facilitated group who completed advance directive more engaged in treatment, and often went on to develop wellness plan and garner outside support and clinical treatment; study suggests that having PAD might reduce rate of returns to ED

Peer specialists: EDs may consider including peer specialists on staff; peer specialists trained and certified and have lived experience of mood disorder, substance use disorder, or other mental health condition; peer specialist supports patient while navigating medical, legal, housing, or social services system

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Estimated time to complete the educational process:
- Review Educational Objectives on page 1: 5 minutes
- Take pretest: 10 minutes
- Listen to audio program: 60 minutes
- Review written summary and suggested readings: 35 minutes
- Take posttest: 10 minutes

Suggested Readings

1. Which of the following statements about violence and severe mental illness (SMI) is most accurate?
(A) Most mass murders are committed by people with SMI
(B) The media fosters stigma surrounding SMI by linking it with violence
(C) Standard interventions such as cognitive behavioral therapy are not usually effective for treating patients with SMI who are victims of violence
(D) Patients with SMI are poor historians with respect to violent crimes committed against them

2. In a study of patients recently discharged from inpatient care for psychiatric illness, which of the following factors was associated with protection against violence during the following year?
(A) Treatment for substance use disorders
(B) Classes on situational awareness and self-defense
(C) Residence in a state that provides services for people with mental illness who are victims of crime
(D) Involuntary outpatient commitment

3. Major changes made in 2012 to the guidelines for suicide prevention focus primarily on:
(A) Expanding the use of telespsychiatry
(B) Targeting the high rate of suicide among 15- to 24-yr-olds
(C) Establishing standard protocols based on risk profiles for use in emergency departments (EDs)
(D) Staffing EDs with mental health specialists

4. All the following are recommended as safety measures for use by emergency departments to prevent suicide, EXCEPT:
(A) Respecting the autonomy of the patient
(B) Involving collaterals
(C) Formulating a safety contract
(D) Addressing lethal means

5. According to a consensus panel, interventions performed within emergency departments (EDs) to prevent suicide should involve all the following factors, EXCEPT:
(A) Continuity of care
(B) Clinical utility
(C) Feasibility within an ED
(D) Delivery of individual interventions rather than bundled interventions

6. The Depression and Bipolar Support Alliance is directed by:
(A) Peer groups
(B) State governments
(C) The Health Insurance Portability and Accountability Act
(D) Professional psychiatric groups

7. In a survey conducted by Foxworth et al that explored the experiences of patients presenting to an emergency department (ED) because of agitation, which of the following was most frequently reported by respondents?
(A) Lack of access to an ED
(B) Medication administered without consent
(C) Participant given no opportunity to provide his or her medical history to ED personnel
(D) Family not informed of status of family member being treated

8. Which of the following is a true statement about psychiatric advance directives?
(A) Is not a legal document
(B) May be included as part of the medical record
(C) Is valid only in states that offer registries of such directives
(D) Must appoint an agent

9. Which of the following results was the major finding of a randomized controlled trial that assessed the utility of facilitated sessions that teach mentally ill patients how to complete a psychiatric advance directive?
(A) Most patients in the facilitated group completed the advance directive
(B) Advance directives were not always consistent with standards for treatment in the community
(C) 3% of patients used their directives to refuse any treatment
(D) Having an advance directive reduced the likelihood that the patient needed to return to the emergency department

10. Which of the following is the role of a peer specialist in an emergency department?
(A) Screen for substance use disorders
(B) Enforce protections provided by the Health Insurance Portability and Accountability Act
(C) Serve as agent within an advance directive
(D) Support patients with mental illness as they navigate the medical system

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