

# Minority Report to the DMH Mental Health Task Force on Staff and Client Safety

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The DMH Task Force on Staff and Client Safety had a formidable mandate: “to develop potential *mechanisms* to improve current practices, policies and processes (emphasis added)”. We were also asked to consider recommendations in relation to their feasibility and recovery-orientation.

I am writing this report because: 1) as a long-time evaluator of state funded services, I am familiar with some practical “mechanisms” to improve safety which did not make it into the final report as recommendations, and 2) I did not play a role in the deliberations or writing of this report. (I stepped away from active committee work because of an unfortunate dynamic I experienced internal to the committee.)

That being said, I neither endorse nor dissent from the majority report, though there are categories of recommendations that I overall endorse. I was certainly struck by the amount of written and reported testimony and evidence that the mental health system is under-resourced, with several consequences that affect consumer care and staff safety:

- unskilled staff
- inexperienced staff
- insufficient staff training
- not enough staff

Thus, I support those recommendations that will lead to a skilled, experienced and appropriately compensated front-line staff. In addition, I specifically endorse recommendation 6 on providing staff with the technology to rapidly summon assistance as needed. I also support in a general fashion collaborative information sharing, but in a way that does not condition the receipt of services on the client’s providing embarrassing information about themselves. **Here are my own recommendations:**

**Recommendation 1:** *That provider staff be trained to engage clients in “Shared Decision Making (SDM)”, which has been defined as “an interactive process in which physicians [providers] and patients [clients] simultaneously participate in all phases of the decision-making process and together negotiate a treatment to implement.*

**Recommendation 2:** *Staff should make every attempt to involve the client in decision making around risk (according to the principles of SDM); and if the client is not involved, meet with the client after that to discuss what has happened, and how to involve the client in the future.*

Recent studies, including CQI's Massachusetts focused studies, have found that while the majority of people with mental illness want to participate in treatment decision-making and are able to do so, a large majority of them are not actively involved.

High quality treatment decisions, which according to the literature reflect client preferences and the most up to date medical information, is the aim of a SDM approach. **Research demonstrates that when decisions reflect patient preferences, there is increased service satisfaction, improved treatment adherence, and decreased symptom burden.** As clients become more active in decisions about their treatment, they also share more responsibility for the consequences of those decisions. Active involvement in treatment decision making may lead to improved self-esteem and self-management skills

The gains in adherence are greatest with preference-sensitive care, such as psychiatric medications, where the evidence for the superiority of one medication over another does not allow clear differentiation; in this situation, the highest quality choice depends on how individuals value the risks, benefits and side effects of treatments. **As noted by Leucht et al "[s]ide effects are extremely important in choice of drug, because the efficacy of a medication can be interpreted only in the context of its adverse effect profile."**

With effective decision supports mechanisms, clients will be prepared to actively participate in making treatment decisions with providers. One common type of decision support is the client "decision aid," which provides concrete information about a health condition and the potential outcomes of different treatment options, and helps the client to clarify his or her personal values.<sup>1</sup> Other types of decision supports include client self-advocacy trainings, question-formulation preparation, and assistance with the development of printed provider meeting agendas.<sup>2</sup> Dr. Pat Deegan's web-based "CommonGround" has been effectively used in many venues (<http://www.patdeegan.com/commonground/about>).

### References for Recommendations 1 & 2

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- Hamann J, Cohen R, Leucht S, et al (2005), . Do patients with schizophrenia wish to be involved in decisions about their medical treatment? *American Journal of Psychiatry* 162:2383-2384
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<sup>1</sup> The Substance Abuse and Mental Health Services Administration ("SAMHSA") has a Consumer/Survivor Initiative Website devoted to SDM, including SDM Webinars, communication tools, tips and briefs for mental health clients and providers. SAMHSA is also supporting the development of an "interactive, web-based decision aid focusing on a decision relevant to antipsychotic medications." Like all decision supports, decision aids are designed to complement, not replace, the advice of providers.

<sup>2</sup> Decision supports can be delivered via printed materials; via in-person or web-based presentations; or through interactive experiences such as audio-guided workbooks, electronic shared spaces such as Google groups, and personal coaching or mentoring. Decision supports that are interactive not only have great potential to engage clients, but also to empower them to manage and take control of their illness.

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Swanson, KA., Bastani, R., Rubenstein, LV., Meredith, LS., & Ford, DE. (2007). Effect of Mental Health Care and Shared Decision Making on Patient Satisfaction in a Community Sample of Patients with Depression. *Medical Care Research and Review, 64*(4), 416-430.

### **Recommendation 3: DMH should establish clear PACT discharge criteria.**

Program for Assertive Community Treatment (PACT), an evidenced based practice, is an intensive team-based and holistic approach leads to reduced hospitalizations and increased housing tenure. PACT is more likely than CBFS to address safety issues because the team includes clinical staff and has more intensive contact with the client.

Unfortunately, many are of the belief that PACT is by definition "time-unlimited" service, regardless of a client's progress. However, the initial PACT standards were developed before recovery was accepted as a conceptual framework. In addition time unlimited ACT services are not only expensive, but they also restrict the ability of teams to take on new clients. Thus, the "time-unlimited" approach is contraindicated as it reduces the potential for new DMH clients who may be dangerous to be admitted into a PACT team (versus CBFS) As stated by noted research Robert Rosenheck et al (2010):

An original principle of ACT was that services would be offered on a time-unlimited basis ... and the Dartmouth ACT fidelity scale ... lists long term service delivery as a core fidelity indicator. This principle was initially stimulated by findings from an early publication on ACT ... which found that even after 14 months of treatment, participants who no longer received the full, high intensity service experienced deterioration in their clinical status and increased rates of re-hospitalization. ***However, the assumption that services should be provided on a time-unlimited basis was not intended to imply that they should be provided at the same level of intensity on a time-unlimited basis. Prolonged service delivery at such high intensity could inadvertently increase costs and limit some patients' access by committing limited staff resources to clients who could transition to a less intensive level of services without loss of benefit. [emphasis added]***

In addition, the literature indicates that some clients who are PACT clients are able to move safely on to less intensive services, often with no effect on hospitalizations. It has been difficult to identify which groups of clients would best benefit from discharge, but the PACT program described in Rosenheck et al, using the below criteria, generated successful transitions to lower intensity services; that is, when the client is:

- clinically stable,
- not abusing addictive substances

- not relying on extensive inpatient or emergency services,
- capable of maintaining themselves in a community living situation,
- independently participating in necessary treatments.

### References for Recommendation 3

- Hackman, A, Stowell, K. (2009). Transitioning Clients from Assertive Community Treatment to Traditional Mental Health Services. *Community Mental Health Journal* . 45:1-5
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- Rosenheck, RA & Dennis, D. (2001). Time limited assertive community treatment for homeless persons with severe mental illness. *Archives of General Psychiatry*. 58(11), 1073-1080.
- Rosenheck, RA, Neale, MS, Mohamed, S. [javascript:AL\\_get\(this, 'jour', 'Psychiatr Rehabil J.'\)](#): (2010). Transition to low intensity case management in a VA Assertive Community Treatment model program. *Psychiatric Rehab. J*. Spring;33(4):288-96.
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**Recommendation 4:** *The state should establish at least nine (9) Peer Run Respite, which are designed to stabilize 3-4 clients at a time who would otherwise be hospitalized,*

Although I understand the positive motivations behind Recommendations #3 (increase beds) and #10 (direct admissions to the state hospital), they are not consistent with a recovery oriented and feasible approach. Peer run respites are “... non-medical alternative programs [that] offer a comfortable, non-judgmental environment in which one might be able to process stresses as well as explore new options. The hope is that these interactions will result in fresh, short-term solutions and a wider array of options for handling future crises.” (<http://www.power2u.org/peer-run-crisis-alternatives.html>). People who enter into a peer run respite are generally not considered dangerous to others but otherwise would end up in a hospital, taking up space from people with higher safety needs. Research increasingly is providing evidence on the cost-effectiveness of PRR (<http://www.power2u.org/evidence-for-peer-run-crisis.html>). Consistent results in quasi-experimental and experimental studies demonstrate a significant impact on community and social integration and fewer hospitalization days. For more information, contact noted psychiatrist Dan Fisher, MD, PhD, at the National Empowerment Center in Lawrence (800-769-3728).