



**Mental Health Risk Retention Group, Inc.**

*A Liability Insurance Company Owned by its Policyholders*

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West Yavapai Guidance Clinic (WYGC)

1998 Negley Awards

For Excellence In Risk Management

Avoiding Liability for Suicide

As an intensely private and personal act, suicide is not always preventable; however, the behavioral health provider has a professional and ethical duty to take every reasonable measure to detect the presence of suicide ideation, to prevent the patient from acting upon suicidal impulses, and to provide a rational and reasonable basis for action or inaction on behalf of the patient.

#### APPLICATION SUMMARY

During the past four years, West Yavapai Guidance Clinic (WYGC) has developed a formal Risk Management Program which focuses on collection and reporting of data, staff training and empowerment, risk assessment and management, targeted clinical protocols, facility design, and administrative procedures. This program was precipitated by a client suicide and a malpractice suit. These efforts appear to have been effective in improving the detection and management of suicide and building a foundation for legal protection in the event of litigation.

#### AGENCY/COMMUNITY SUMMARY

Yavapai County, Arizona, is the second-fastest growing rural area in the United States. Arizona's large and rapidly

growing elderly population has a suicide rate that is one of the highest in the nation, in a state that consistently ranks in the top five U.S. states in adult suicide. These well-established mortality rates and a series of cluster suicides among the teenage population in the early 1980s have caused WYGC to be uniquely interested in the prevention and treatment of

suicide. WYGC is the primary, behavioral health provider for publicly-funded services to the geographically dispersed

and rapidly growing communities of northwestern Arizona. The agency provides comprehensive outpatient services to a base population of 85,000 and inpatient services to a base population of 130,000. The agency serves approximately 4,000 clients annually with a staff of 180 with an annual operating budget of just less than seven million dollars.

## RISK EXPOSURE

Because WYGC provides comprehensive services in a growing area with historically high rates of suicide, risk and

liability are crucial considerations. The following services represent the greatest program exposure to suicidal ideation and behaviors and the resulting exposure to liability for suicide:

The only 24-hour mobile crisis intervention service approximately 50% of referrals are based on danger to self or others;

A Level I Adult (high intensity, short stay, crisis stabilization) 19-bed acute psychiatric unit. Responsibilities include crisis stabilization for suicidal risk and evaluation for civil commitment for court-ordered treatment;

A Level I Child four-bed acute psychiatric unit. This unit routinely provides crisis stabilization for suicidal risk;

The sole provider of screening, evaluation and treatment services under civil commitment statutes (danger to self, others and/or gravely disabled);

Community support programs, case management and psychiatric services for approximately 450 persons with serious mental illness (SMI); and

A 24-hour active outpatient unit serving high-intensity, multi-problem individuals and families.

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## RISK MANAGEMENT PROGRAM: BACKGROUND

Several pivotal events served as the catalyst for development of the WYGC Risk Management Program.

1. Epidemiological data relating to high adult suicide rates over time within the populations served.

2. The completed suicide by hanging of a patient in the WYGC Psychiatric Health Facility shortly after its opening in 1989.
3. Increases in suicide as a presenting problem within the crisis and acute care components (Attachment A).
4. A protracted malpractice lawsuit filed against the agency in 1992, successfully defended in 1995 (Attachment B).
5. Being named jointly in a lawsuit filed against a local hospital emergency room regarding a multiple victim murder/suicide (WYGC was subsequently dropped as a defendant in the suit).

## RISK MANAGEMENT PROGRAM: DESCRIPTION

### **Summary & Philosophy**

WYGC's Risk Management Program is based upon the following principles: empowerment and heightened awareness of all staff streamlined, proactive reporting of potential risk exposure detailed clinical and administrative documentation a formal review process as part of a Total Quality Management (TQM) Program (Attachment C).

### **Key Elements**

- 1) The Risk Management Committee

This interdisciplinary committee serves under the agency's Quality Assurance program. It reviews incident data, identifies areas of risk, monitors selected risk areas, and makes recommendations for focus and change (Attachment D).

- 2) Collection, Analysis and Dissemination of Data

In addition to meeting external reporting requirements, WYGC's Critical Incident data is collected routinely and reported to staff, agency Board of Directors and the managed care company for state-supported services. The Key Performance Measures and detailed breakdown of incident data (Attachments E and F) are the

primary tools for tracking critical incidents and reporting potential risk and liability.

### 3) Clinical Policies and Procedures

WYGC's policies give special attention to danger to self in the following ways:

- Routine danger-to-self assessment and documentation at all outpatient psychiatric visits.
  
- Clinical protocols and procedures for all service areas including crisis intervention, on-call, inpatient, intake and assessment.
  
- Routine, documented risk assessment for all client enrollments.
  
- A three-tier supervisory system for on-call staff [by policy, all danger to self episodes are reviewed by a senior clinician and, as needed, by a staff psychiatrist] (Attachment G).

### 4) Prompt Intervention and Retrospective Review

#### *Administrative Review*

All patient mortalities, including suicides, are given immediate management and clinical review to assure attention to Quality of Care considerations, accurate and timely external reporting, maximum preparation in the event of external inquiry (legal, media, survivors) and avoidance of litigation. At a minimum, the following actions are taken:

1. The assignment of a staff liaison to surviving family members.
2. The sequestering and sealing of all the client records.
3. Determination of the need for legal consultation and notification of malpractice carrier.

#### 4. Preparation of press releases and assignment of a media liaison.

##### *Peer Review*

A peer review of cases is held through a formal committee process, with emphasis on quality of care against accepted clinical standards and procedures. In addition, all client mortalities are reviewed by the Managed Care Organization and the State Division of Behavioral Health which oversees care to publicly-funded clients.

##### *Direct System Intervention (post-suicide)*

WYGC offers intervention and expert consultation following suicides in the school system. Experience from a cluster of adolescent suicides during the early 1980s proves that the agency benefits from a risk management perspective by interceding proactively in community suicides where appropriate to avoid “copycat” suicides (Attachment H).

#### 5) Staff Orientation and Training

a) Indoctrination of all new employees on incident reporting and risk management including detection, reporting and management of suicidal risk for staff at all levels of the organization (Attachment I).

b) The inclusion of Risk Management topics in the weekly staff newsletter, including specific analyses of cases identified in Mental Health Law Review and potential implications for WYGC (Attachment J).

#### 6) Prospective Design and Oversight of Facilities and Equipment

WYGC has worked extensively in retrofitting and designing inpatient and residential facilities to minimize danger to self, especially in its acute care setting. Because of staff sensitivity (resulting from the aforementioned completed suicide in 1989), details relating to equipment and architectural features exceed licensing and code requirements. These efforts have focused on: elimination of architectural features that could be used as hanging devices such as sprinklers, shower detail, heating and cooling grates, ceiling structures; staff visibility of at-risk clients; the control of potentially life-threatening equipment (e.g., cords, sharps, belts, contraband); and window design that allows for both maximum light and maximum safety (Attachment K).

## 7) Clinical Care Standards and Protocols

a) Specific Standards of Practice for crisis intervention services and diagnostic groups focus on danger to self, standardized risk assessment, documentation, and escalating supervisory consultation and oversight (Attachment L).

b) Inpatient and outpatient protocols that emphasize assessment for risk, appropriate level of care placement, documentation, and pre-discharge assessment and treatment planning.

c) Leadership role in the development of a Risk Assessment tool formally adopted and used by behavioral health providers across Northern Arizona for client enrollment and assessment (Attachment M).

## PROGRAM EVALUATION AND OUTCOME

- Architectural details, second-level review criteria, suicide risk management as part of Best Practice Standards, and staff orientation focusing on risk management can all be directly attributed to the incorporation of risk management in the Total Quality Management (TQM) Program.
- The attached data relating to suicides across northern Arizona indicate that the population served by WYGC has had the lowest suicide rate (1997) of all reporting units with a steady decline of suicides during the reporting period (1992-1997). Although this cannot be attributed directly or exclusively to the risk management program, it is a positive indicator of effective patient management within a catchment area that continues to experience a high rate of suicide overall (Attachment N).
- There have been no complaints or lawsuits filed against WYGC concerning the management of suicide since the program was implemented.
- Staff evaluation and satisfaction data consistently indicate a high degree of satisfaction with the Risk Management training being provided (Attachment O).
- When formally tracked as a Quality Assurance indicator, 98% of all psychiatry notes documented SI/HI

[Suicide Ideation/Homicide Ideation] assessment (Attachment P).

- Overall, the numbers of critical incidents have remained constant suggesting a stabilization of client mortality. The number of incidents (critical and non-critical) have increased, due to improved staff awareness and reporting. WYGC encourages staff reporting in order to ensure a constant flow of data for review (refer again to Attachment E).

## REPLICATION

This model can be readily adapted and replicated to other settings and behavioral healthcare providers. It is best integrated into an existing comprehensive Total Quality Management Program and relies upon a high degree of managerial commitment. Costs of the program are primarily in staff time required for training and committee work. There are no significant direct costs. Elements of this program have been provided to members of the Arizona Association of Mental Health, Drug and Alcohol Treatment programs at its last two statewide training conferences (Attachment Q).