"Are you kidding?": Effects of funding cutbacks in the mental health field on patient care and potential liability issues

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Mental health funding cuts and associated reductions in training have exercised a starkly negative effect upon psychiatric patient care in recent years, as reflected in research conducted in the United States and abroad. This article conveys and discusses an illustrative case example with additional reference to appellate and institutional advocacy approaches to the problem.

KEY WORDS: *Emergency psychiatry, institutional staffing, mental health funding, correctional psychiatry.*

Many reporting on or working in the field of mental health have noted the direct or indirect effects that cuts in mental health funding have imposed on clinicians at all levels during the last two decades and especially during the last decade. Such effects have included decreased staffing,

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coerced early retirement of senior staff, decreased hiring of new staff, decreased training programs, and so on, all of which necessarily result in the closing of some units and reduced bed availability on the units that remain. According to a recent editorial in the *Boston Globe* ("Murder," 2011):

> Deinstitutionalization of the mentally ill proceeded with a fervor in the 1970s. In 1970, the state maintained 12,500 beds in secure state mental institutions. By 1980, that number dropped to 2,200. Now only 626 beds are available in a handful of secure units. And that number could fall by another 100 based on Governor Patrick's latest budget proposal, which includes a $21 million cut to the Department of Mental Health.

Needless to say, while the number of available beds and appropriately trained caretakers has been reduced, the number of persons needing mental health care in various settings has not. As their conditions inevitably deteriorate without the structure and care provided by psychiatric facilities, many of these individuals, either seeking help independently or guided towards seeking help by the medical system or the criminal justice system, end up turning towards these increasingly overwhelmed hospital facilities via emergency rooms and shelters. The stress on the diminishing available treatment centers and appropriately trained staff has been widely noted and commented on, not only across the United States, but also in studies from various countries.

Reviewing the inevitable consequences of such funding cutbacks on practitioners working in the service areas covered by private insurance, HMOs, or even the public sector, psychiatrists Appelbaum and Gutheil (2007) identified "an added inducement to mental health professionals and administrators to abandon understaffed public and publically supported facilities. Those who remain may feel that their hands are tied in trying to provide appropriate care" (p. 266).

In the United Kingdom, Nolan and Smojkis (2003) have cited various studies to the effect that "28% of the nurses in

the NHS [National Health Service] were suffering from minor mental health problems, generally identified as anxiety and depression," that "mental health problems were significantly correlated with increasing workload, understaffing, job insecurity and perpetual organizational changes" while "violence against health care staff has been found to have negative mental health consequences" (p. 375), and that, overall, psychiatric workplace violence is generally associated with "overcrowded wards, budget cuts and poor working and patient environments rather than with patient psychopathology" (p. 377).

An online report from the University of Chicago Law School (n.d.) also relates compromises in the support given psychiatric caretakers and facilities to the deteriorating condition of mentally ill patients:

> Persons with serious mental illness routinely become disengaged from community care because providers are not funded in a manner which permits them to provide the level and types of services needed to insure continuity of care. The results are predictable: rehospitalization, homelessness, excessive reliance on nursing homes for persons with mental illnesses and even involvement in the criminal justice system.

Increased pressures on the usual pathway for rehospitalizations, i.e., emergency rooms, have been described in a number of reports. One such report, predicting the inevitable negative sequelae of cuts in funding and reduced available facilities for the mentally ill population, which is increasing not only in numbers but also in acuity of symptoms, recently appeared in the *Arizona Daily Star*:

> The cuts are unprecedented in Arizona and in the long term could impact taxpayers and health-care providers by putting more pressure on jails and emergency rooms.... "When you reduce benefits like this to people who are seriously mentally ill ... there's a potential ripple effect in the whole community" (Innes, 2010).

Negative effects of such "pressures" on emergency rooms are further described in an online press release from the

National Alliance on Mental Illness (2004):

> A recent upsurge in people with mental illness seeking treatment in emergency departments is taking a significant toll on patient care and hospital resources nationwide.... Six in 10 emergency physicians surveyed report that the increase in psychiatric patients is routinely affecting access to emergency care for all patients, causing longer wait times, fueling patient frustration, limiting the availability of hospital staff and decreasing the number of available emergency department beds. Two-thirds (67 percent) of emergency physicians attribute the recent escalation of psychiatric patients to state health care budget cutbacks and the decreasing number of psychiatric beds.... "Emergency department overcrowding is a growing and severe problem in the United States," said Dr. J. Brian Hancock, President of ACEP [the American College of Emergency Physicians]. "As dedicated as emergency physicians and nurses are to caring for patients, we are reaching a breaking point where they may not have the resources or the surge capacity to respond effectively."

The sources cited above are only a few of many decrying the escalating damage to the care of mentally ill patients resulting from financial cutbacks. Among mental health professionals at any level, the conversation inevitably progresses toward specific detriments to mental health care, whether involving cuts in material or in the salary, number or training of staff. When discussing these increasing deficiencies, the staff evinces significant disappointment, anxiety, and cynicism regarding the quality of care and safety that can be maintained in the psychiatric setting. The following is an illustrative incident.

Case example

The setting

A resident in his final years of training at a hospital in the Midwest was serving as an on-call psychiatrist (OCP), covering the psychiatric inpatient units as well as the rest of the medical units and the so-called psychiatric prison unit at night. He had become accustomed to hearing expressions of concern by the dedicated psychiatric inpatient staff, whom

he had come to know well, regarding the results of economic cutbacks, including decreased staffing and training, increasing sense of helplessness, decreasing motivation, and sinking morale, as the staff wrestled with gaps in the coverage, care, and safety of their locked psychiatric units.

Nevertheless, the remaining staff continued to attempt to maintain an atmosphere of professionalism when subduing or at times restraining acutely disruptive and disorganized psychotic patients—procedures that required clear leadership by the more experienced staff and reasonably well-organized coordination of the restraint process by the less experienced staff. Their attempts at maintaining adequate professional leadership and coordination were evident even when gaps in staffing required calls to other units for added support personnel.

Such professionalism, especially leadership of a well-trained and coordinated team, becomes even more necessary in dealing with the challenges presented by a prison unit. This kind of unit houses individuals with not only emotional, psychiatric, or severe personality disorders, but also a history of expressing their problems with impulsive but focused, rather than disorganized, violence. Such violent behavioral expression had begun to be demonstrated by one patient on the prison unit during the night covered by the OCP.

The incident

The OCP received a phone call around 2:00 a.m. A female voice, sounding urgent and upset, stated that she was a medical intern newly assigned to the prison unit as their on-call internist and that there was a male inmate-patient becoming "somewhat agitated." She needed advice from a psychiatrist about what to do to calm him. She had given the inmate a small dose of the antipsychotic medication Haldol, but so far it appeared to have had no effect on his agitation. The OCP asked why the intern had not contacted the psychiatrist who presumably would have been covering the

unit full-time and would be more familiar with its forensic patients. The intern explained that she was not aware of any psychiatrist specializing in forensic patients assigned to the unit on a full-time basis. That position had reportedly been converted to a partial coverage position due to budget cutbacks. The OCP advised her to wait another 30 minutes to allow the medication to take effect. She did so and phoned again, urgently asking the OCP to please come to the unit. The patient had become even more agitated and was "beginning to pick up the chair in his room and slam it against the large windows there." A banging sound could be heard in the background.

The OCP hurried to the prison unit. Proceeding through various locked barriers, he noticed the uncanny disparity between the agitated activity and emotions displayed by the intern, standing and waving from behind the windows of the nurses' station, and the strikingly calm, smiling presence of the senior guard sitting within view of the intern, just across from the nurses' station. The guard, who appeared entirely uninvolved, did not offer assistance to the intern or the OCP (this passive, detached attitude of the senior guard, like the absence of the forensic psychiatrist, was entirely unlike the experience the OCP remembered from his previous visit to the unit two years earlier). The intern ushered the OCP into the station, thanking him repeatedly for coming to the unit, and presented him with a slim medical chart of the agitated patient/inmate.

Again the OCP was impressed with the contrast between this extremely slim chart (containing a minimal history and follow-up progress notes) and the charts he had reviewed two years before, containing at least a full history, physicals, labs and, depending on the patient's length of stay, detailed progress notes. Clearly, this patient had received significantly less psychiatric attention than those the OCP had consulted on two years ago. This chart revealed diagnoses that included ADHD. The medications

included Prozac, Wellbutrin, Neurontin, and Ativan. Adderall, a stimulant, and Clonazepam, an anxiolytic medication, had just been discontinued.

Asked where the patient was, the senior guard, with a broad grin and a slight chuckle, answered sarcastically, "Just follow the banging." When the OCP did so, he noted three or four young, fit, uniformed male guards standing at a doorway observing the male patient's activity inside the room. Some of the men were just staring blankly while others appeared to be smiling. Once more, the OCP was struck that none of these guards, unlike those present during his previous visit to the unit, were trying to calm, soothe, or reason with the patient. Instead, they appeared to be trying to remain as distant from the patient as possible.

The patient

The patient appeared to be approximately 30 years of age and was barefoot and wearing only long pants. Overweight and muscular, he was covered with perspiration, and horizontal scars on his arms. The patient was informed that the OCP was a psychiatrist who had been called to see him by his intern, who was concerned that he was so upset.

Putting down the metal chair he had been holding, the patient-inmate angrily retorted that he had been asking for his Adderall all day but was being refused it. In fact, he reported, the guards had teased him by offering him M&Ms as pills when he requested the Adderall. He insisted that he needed to get it now at a dose of 40 mg. According to the medical chart this medication had been discontinued, and no reason was noted for this discontinuation. The OCP responded that it was approximately 3:00 a.m. and that a stimulant medication at that hour might make the patient feel even less calm and unable to sleep. The OCP suggested to the patient that he could receive some sedating medications, which would calm him down and help him sleep. The patient replied that he didn't want to get any more Haldol. He said, "Haldol puts me in a coma; it also makes

my neck go like this." (He twisted his head to the side and upward.) "I hate that stuff. What I need is the Adderall." The OCP repeated his concerns about increased agitation and sleeplessness. The patient responded, "Well then, I can see that you are not going to help me." He then turned around, picked up the metal chair and headed towards the window.

The OCP told the guards the patient needed to be placed in restraints. Nobody moved. As the patient began to bang the chair against the window, the OCP loudly repeated the request for restraints and emphasized that it needed to be done immediately; other units should be notified, if necessary, to assist in the restraint procedure in order to protect the patient. Again, no guard moved. Finally, one guard said with a chuckle, "Yeah, but who's going to protect us?" Exasperated, the OCP asked whether this unit had any experience in using restraints.

One guard, again adopting a humorous and sarcastic tone, answered, "We have restraints but they're metal ones." Another guard clarified, "He means handcuffs." The OCP returned to the senior guard and informed him that (as was now easy to hear) the patient was breaking through the large window in his room, perhaps intending to exit through the window. He reported that the guards in the room appeared unable or unwilling to place the patient in restraints and equally unwilling or unable to do anything to inhibit or block the patient from leaving. The remark about handcuffs implied that they had not been trained in an actual restraint process.

The senior guard smiled and said sarcastically, "That's a good point. Make sure you mention it when you write your report." The OCP, at this point feeling an even stronger concern about the lack of assistance available on the unit, informed the guard that he needed to obtain help from the other units to get the patient into four-point restraints before

he broke through the window (a standard procedure utilized by locked units in such a crisis situation). A nurse suggested calling campus security; another staff worker, possibly a mental health worker, suggested calling the state police. Clearly, no staff member on the unit was sufficiently well informed on how to proceed appropriately during such a crisis.

One of the guards then ushered the OCP behind the barred door near the nurses' station and locked the door. When the OCP asked why he was doing this, the guard said that he was trying to keep the OCP safe. The OCP responded that he didn't need to be kept safe, that the patient was not attempting to attack anyone, but rather to get out through the window. The patient needed to be stopped and rendered safe. The OCP could not assist with this if he were locked behind the barred door. The guard reopened the door and the OCP proceeded back to the patient's room.

On arrival, the OCP found the guards inside the room looking out the window, reporting that the patient was out on the ledge and that he was cutting himself. The OCP observed that none of the guards was near the patient (who was cutting his left upper arm with a piece of glass) or even attempting to talk to him. The OCP asked where the patient had obtained something with which to cut himself. One of the guards said that the patient had broken a light bulb. None of the guards had attempted to prevent him from doing so. Noting once again that none of the guards could be relied on to attempt to restrain the patient in any fashion, the OCP, acutely aware of the urgent need to deal with this situation quickly, decided to try to lure the patient back into the room.

The OCP called to the patient, telling him he could have any medication he wanted to feel better but would have to come in to get it. The guards all repeated this to the patient. He responded that he wanted 40 mg of Adderall. The OCP

informed the patient that the nurses had no Adderall on the unit but that he could have an equivalent amount of Ritalin (a related stimulant) now, if he was able to come into the room to get it. He responded that he had to be sure the OCP had the medicine for him before he would come in. The OCP ran to the other end of the unit to the nurse's station, obtained the medication, showed it to the patient and urged him to come in. The guards, still remaining distant from the patient, also began calling to him, telling him that the doctor had the medicine for him and he needed to come in.

The OCP noted that the inner windowsill was covered with sharp pieces of broken glass and a significant amount of blood. He asked for someone to wipe the ledge free of glass and blood to prevent the patient from slipping and cutting himself on the glass. Again, none of the guards made any move to assist. The OCP grabbed a towel from the floor and wiped the blood and glass off the ledge. As he was doing so, noticing that the patient's blood was dripping fairly rapidly from his arm onto the OCP's hand, he became very concerned about the patient's blood loss. The OCP told the patient that he needed to come in quickly because he was losing a lot of blood. The patient replied that this was all right because he had received four units transfused before he had arrived on the unit. The OCP told him that he had already lost at least one unit on the window ledge; that his face was increasingly pale; and that he could faint and fall off the ledge and wouldn't be able to get the medicine he wanted so badly. After a brief hesitation the significantly weakened patient, finally assisted by the guards, climbed down from the ledge into the room. At this point the patient was given the Ritalin. The OCP asked the guards to bring the patient to a clean room and to put pressure on his bleeding wounds, which they attempted to do by wrapping towels around his arms. Soon afterwards, the patient became calmer and discussed with the OCP subsequent treatment, patient rights, and the need for him to accept other medications to help him remain calm. The OCP brought the

additional medications, agreed to by the patient, to the patient's new room and gave them to him as the guards helped him change out of his bloody pants and clean the blood off his body. Extra sedation was also negotiated and accepted by the patient to increase his psychiatric stability in order to transfer him to a medical hospital to deal with his wounds. The transfer was accomplished without further problematic behavior.

Discussion

Although the state's public health department sent the OCP an official letter of appreciation praising his actions in averting a potentially tragic sequence of events, the letter made no mention of a plan to address the specific factors that led to the practical compromises in patient care and safety documented above, concerns the OCP had conveyed directly to the administrators of the hospital. In fact, during the last days of his rotation at this hospital, the OCP subsequently had an unexpected opportunity to speak briefly and informally with the senior security guard from the unit. When asked whether his department had subsequently addressed the concerns he had expressed to him that night, the guard responded with his familiar smile, calm demeanor, and sarcasm: "Are you kidding?"

In reviewing the prison unit crisis described above from the viewpoint of compromised patient care, a number of factors noted raise concern. These include the reported decrease in the quantity (and inevitably the quality) of psychiatric attention and time being spent on the inmates of that unit. The change in medications is also problematic. It could have reflected an attempt to replace a stimulant medication with the potentially less addicting antidepressant Wellbutrin and to replace the longer acting anxiolytic, Clonazepam, with the much shorter acting anxiolytic medication Ativan. However, the chart contained no accompanying history or

notes explaining how or why this decision was made and no instructions clarifying how the uninformed staff should address the patient's potential reaction to the sudden alteration in the medications on which he might have become dependent. The absence of such information and instructions regarding these medication changes left any covering psychiatrist, interns or nursing staff changing shift unaware of the potential emotional and behavioral sequelae of such changes and unprepared to deal with them.

Other problematic factors in this incident include the abdication of leadership, involvement or even assistance by the senior guard; the related absence of professional attitude or active assistance by the younger guards (perhaps masking or working in conjunction with a lack of preparation and training); the patient's report that he had been teased by the guards with offers of M&Ms when asking for medications; the inappropriate presence of breakable glass windows reinforced only by fine wire; the presence of heavy metal furniture unsecured to any surface in the patient's room; and, finally, the apparent total absence of any plan as to how the unit should respond to a patient undergoing an intense physical and psychological crisis.

Is this truly a problem of funding at its core? It is likely that each of the factors mentioned above was a direct or indirect result of economically driven reductions in personnel, training programs, and material. The OCP observed not only the deficits of inadequate training, inexperienced personnel, and improper furniture and equipment, but also the apparent effect of such deficits on the reduced and insufficiently trained staff that were left to deal with potentially dangerous or violent crises.

Ongoing staff cutbacks and shortages can lead to bitter complaints, resentful attitudes, and passive-aggressive stances by psychiatric unit staff members. In the case described, these factors in turn may have been essential

components of the negative outlook of clinical staff, the unprofessional relationship between the guards and the patient, the abdication of leadership by the senior guard, and the guards' altogether inadequate participation in preventing the potentially lethal progression of the patient's escalation.

The results of increasing financial pressures, both direct and indirect, on staffing and thereby on the mentally ill patient or inmate, may be becoming more dramatically evident within the prison system, in part due to the significantly greater likelihood of impulsively violent behavior present within that system. Nevertheless, although many psychiatric patients treated within the mental health system may never express their symptoms through physical violence, experienced mental health professionals know well that the possibility of physical violence by a seriously disturbed, especially psychotic, mental health patient should never be underestimated.

Tragic events resulting from financially driven alterations in the operation of mental health care facilities have been occurring more frequently, at times involving sequelae dealt within the legal system, as illustrated in the two cases presented below.

According to a recent Tennessee Court of Appeals case (*Brister v. HCA Health Services of Tennessee*, 2011):

> On January 11, 2009, McCall Brister ("Plaintiff"), a twenty year old woman, was involuntarily committed to Skyline Medical Center ("Skyline") for emergency psychiatric diagnosis, evaluation, and treatment. While at Skyline, Plaintiff alleges she was sexually assaulted by a male patient.

On January 8, 2010, Plaintiff filed suit against Skyline; paragraph twelve (12) of her complaint alleges that:

> The Defendant, HTI Memorial Hospital Corporation, negligently and carelessly:

(a) failed to adequately supervise, monitor and protect McCall Brister;

(b) failed to adequately supervise, monitor and control the individual who sexually assaulted her;

(c) accepted residents for care when the facility lacked the necessary resources to care for those individuals and protect other residents;

(d) places a male residents [sic] who by the nature of their admission have a history and unpredictable and potentially violent and assaultive behavior in the same are with McCall Brister, a twenty (20) year old vulnerable woman unable to defend herself;

(e) placed McCall Brister in a room remote from the nurses station such that it was unsupervised; and

(f) failed to provide sufficient numbers of adequately trained staff at Skyline Medical Center.

The Court of Appeals ultimately concluded that "we find that the claims related to 'understaffing' sound in principles of ordinary negligence" (*Brister*, 2011).

Even more striking is a case involving patient violence and the death of a staff member having occurred more recently at a mental health facility in Massachusetts. As expressed in January, 2011. by Bernard Carey, Executive Director of the Massachusetts Association for Mental Health as lead author of a letter to the Commissioner of the Massachusetts Department of Mental Health:

In the wake of the horrific tragedy involving the murder of a residential staff person at North Suffolk Mental Health, we are requesting that the Department of Mental Health appoint an independent third party to conduct an objective and comprehensive review of the publicly funded community based mental health system. Residential services do not exist in a vacuum. In the context of this tragedy, the review should include but not be limited to an examination of: the impact of budget reductions on community services ... reviewing staff training and safety provisions; and, public accountability and oversight provisions. It is our belief that

the review examines *all of the systemic issues* [italics added] raised by this tragedy" (NAMI Massachusetts, 2011).

Whether demonstrated by the current dramatic example or by the extensive literature on the subject, any further financial cutbacks resulting in reductions in the quality and quantity of staffing, training programs, and so on, will inevitably produce decreases in staff morale, cooperative support and the safety of both patients and staff. Such changes inevitably result in increased stress and further staff departures, endangering the maintenance of an effective and safe treatment milieu. This cycle of negative sequelae can contribute significantly to pressures on and compromises in professional judgment among staff working at all levels, expressed verbally, behaviorally or otherwise, whether within psychiatric facilities, public health facilities or in any similar system.

As funding for mental health care continues to decline and clinicians face cuts in staffing and training programs, with increasing pressures on and threats to the safety and judgment of the remaining staff, all of those who work in patient service areas, including psychiatric prison units, may eventually find themselves expressing the same despairing and helpless perspective captured by that embattled, weary and detached senior security guard in his response to the OCP's query about remedial measures: "Are you kidding?"

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