PATIENT SAFETY AND PSYCHIATRY

RECOMMENDATIONS TO THE BOARD OF TRUSTEES

OF THE AMERICAN PSYCHIATRIC ASSOCIATION

from the

APA TASK FORCE ON PATIENT SAFETY

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The American Psychiatric Association Task Force on Patient Safety
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I. Introduction

At least 44,000 Americans die each year as a result of medical errors, and the number may be as high as 98,000. Even when the lower estimate is used, the number of deaths due to medical errors is greater than the number attributable to the eighth leading cause of death. Total national costs of errors are estimated to be between $17 and $29 billion, half of which are health care costs.

These are the figures, featured in the Institute of Medicine report, "To Err Is Human," that have galvanized the American health care industry and the public to increase patient safety by attending to the reduction of medical errors.

Medical errors in psychiatry had received relatively little attention until an investigative series in the *Hartford Courant* reported that between 1988 and 1998, 142 deaths nationwide occurred during seclusion and restraint in psychiatric facilities. That report was greeted by psychiatry with the same skepticism and assertions of inevitability that had characterized the reaction of other medical specialties to initial reports of medical error. The degree to which seclusion and restraint deaths should be thought of as preventable events, and therefore as errors, remains controversial. But additional studies indicate that adverse events associated with medication administration are an important source of medical errors, which means that psychiatry must join the rest of medicine to address patient safety as a crucial issue.

It is also clear that improving patient safety involves a profound change in clinical culture. The traditional focus on the role of individual professionals as the source of error must shift to an examination of flawed systems of care that make it possible for errors to occur. Specifically, the principles of error reduction are the following:

> Errors are as much a product of the design of systems as of individual behavior. Errors can be prevented if it is assumed they can be. Error prevention involves learning from the experience of other medical specialties; other psychiatric and mental health professionals; and other industries that involve the application of potentially dangerous technology to human well-being. Error prevention in the clinical situation involves scrutiny and feedback from others. Privacy and confidentiality of practice may be misused to diminish opportunities to improve patient safety. Sharing clinical practices is a way of increasing safety. Thus, the culture of safety is a group responsibility implemented through individuals.
>
> Examples for consideration follow.

A. Preventable Adverse Medication Event

A 62-year-old homeless man was found collapsed in the gutter near the Westin Hotel in downtown Metropolis. In the emergency room he smelled of alcohol, woke up agitated, and after a physical examination was immediately put on an alcohol-withdrawal protocol consisting of intravenous vitamins and hydration, as well as Tranxene, a long-acting benzodiazepine. The standard dose of Tranxene is 15-30 mgm p.o. prn for agitation from alcohol withdrawal. The intern on the substance abuse service wrote 30 mgm p.o.q6h (every six hours) rather than prn, and the medication was continued for a week before the order was questioned. The patient remained drowsy and uncommunicative until the medication was finally reduced. When he awoke he

moaned with pain on any movement. X-rays revealed bilateral fractures of his femurs, leading to the conclusion that he had been struck by a car while he was intoxicated.

B. Seclusion and Restraint

Dr. H, the clinical director on a psychiatric inpatient service, was a firm believer that de-escalation programs to prevent the use of seclusion could be effective. But he also felt strongly that manic patients could benefit from the limit setting offered by judicious use of seclusion and, occasionally, restraints, particularly for manic patients who also suffered from character disorders. Mary G. was a frail, anorexic college student admitted in a manic state who was manipulative and sexually provocative with other patients and with staff. Dr. H wrote orders that included seclusion with restraints prn as a prominent feature of her treatment plan. When Mary was secluded it seemed to enrage her and increase her agitation rather than calming her down. Dr. H defended his judgment and insisted that seclusion should be continued, quoting several of his own papers on the subject. During the third episode of seclusion Mary died after a half-hour of frenzy, fighting her restraints. When the case was reviewed, a more complete family history revealed that as a young teenager Mary had been raped repeatedly by her father and an older brother. There was evidence from an earlier hospitalization that she identified seclusion as a repetition of those experiences.

C. Suicide

A 32-year-old research psychologist explained to his chief that he had to take some time off to oversee home repairs following roof damage after a recent storm. His manner was calm, although he seemed somewhat more worried and preoccupied than usual. He disappeared two days later, and after another week his body was discovered in a public park half a mile from his home. An autopsy revealed that he had died of an overdose of medication. Reviewing recent events, his chief discovered that the other members of the research team had recognized the psychologist's depression and administered a rating scale showing that he was possibly suicidal. When shown his scores the psychologist said, "If this were anyone but me, I would say he was deeply depressed. But I am really not depressed. In fact I am just fine." The members of the team considered insisting that he be evaluated and committed but could not bring themselves to do so because of his professional status and confidentiality concerns. It also came to light that several years before he had suffered from depressive somatic delusions, which had been concealed by those around him.

D. Change in Clinical Culture

In November 1994 a single catastrophic death and a second permanent, debilitating injury at the Dana-Farber Cancer Institute sent the staff and public reeling. Betsy Lehman, a 39-year-old Boston Globe health reporter and mother of two, succumbed to a chemotherapeutic overdose. She was undergoing an advanced breast cancer drug protocol as part of a Harvard research study. Another patient, 52-year-old Maureen Bateman was seriously injured as a result of the same unintentional mistreatment.

What is perhaps the most chilling aspect of the story is that the error was detected eight weeks later by a data manager. If it had not been a research protocol, it is possible that no one would have noticed the four-fold larger dosage of cyclophosphamide administered for four days straight to each patient instead of quartered across the days. Betsy Lehman died from heart failure the day before she was due to be discharged, three weeks after she received the fatal high doses; Maureen Bateman also suffered from cardiac toxicities, but she died in 1997 from her cancer.[1]

These events resulted in twenty-eight front-page Globe stories in the first three months after the story broke.[2] Sixteen out of eighteen nurses were pursued for five years by the Massachusetts Board of Registration in Nursing and received probationary action, and one left the nursing profession after this, her first job.[3]

Today thirteen of the nurses remain at the hospital—an extraordinary example of support by the hospital administration. In response to this tragedy, the Dana-Farber has partnered with the Joint Commission on Accreditation of Healthcare Organizations and the National Patient Safety Foundation, among others, to make an example of their mistake and dramatize their commitment to continuous self-improvement. In remodeling their system they have developed a $1.7 million computerized physician-order entry system that has served as a model for twelve other institutions, which adopted similar systems after Lehman's death. Moreover, the Dana-Farber leadership has appointed a vice-president of patient safety. The CEOs at the Dana-Farber and later at the Brigham and Women's Hospital, now the site of Dana-Farber inpatient beds, became strong and consistent advocates for their nurses in the conflict with the Board of Registration in Nursing.[4] In this way it was possible to mitigate the distress among the staff and promote a pattern of communication and cooperation in creating a universally safer culture. Because of these measures, error reporting and successful preventive measures have increased significantly.[5]

Note: **Throughout the remainder of this report, the Task Force uses the term "preventable adverse event(s)" as the optimal interest area instead of "medical error."** The Task Force recognizes that, given the limits of medical practice and technology, there may not always exist an alternative to a course of action taken; hence, not all adverse events are preventable and therefore they are not medical errors.

Section II of this report provides broad recommendations for the American Psychiatric Association to engage psychiatrists in a national effort to improve patient safety in psychiatric care. Section III offers a second level of specific recommendations for those in a position to act. Sections IV through IX briefly describe the process and deliberations of the Task Force that led to its conclusions and recommendations.

Will the APA Board of Trustees endorse the following?

II. Task Force Recommendations:

A. The APA Board of Trustees reaffirms its commitment to safe patient care as a fundamental element of the Association's advocacy for patients and for the clinical culture of psychiatry. (See recommendations for implementation on page 7.)

B. The APA Board of Trustees designates patient safety a major programmatic priority as a contribution to quality patient care that is largely devoid of organizational or professional self-interest. (See recommendations for implementation on page 7.)

C. The APA Board of Trustees directs the focus of initial patient safety activities to four priority areas that are especially relevant to psychiatric practice: change in clinical culture to focus on patient safety, adverse medication events, use of seclusion and restraint, and suicides in inpatient/residential settings. (See recommendations for implementation on page 8.)

D. The APA Board of Trustees and the Assembly encourage the District Branches and state associations to commit to the improvement of patient safety within the psychiatric practices of their members by offering educational programs and activities at the local and regional level. (See recommendations for implementation on page 12.)

E. The APA Board of Trustees encourages individual psychiatrists to commit to the delivery of safe care and to participate in educational, organizational, and institutional activities intended to improve patient safety in their various practice settings. (See recommendations for implementation on page 13.)

F. The APA Board of Trustees encourages the leadership of AADPRT, and directors of medical student and psychiatric residency training, to adopt patient safety as a major focus of training, including curriculum development in the four areas of change in clinical culture, adverse medication events, restraints and seclusion, and suicide. (See recommendations for implementation on page 13.)

G. The Board of Trustees fosters APA's leadership and collaboration in the many aspects of patient safety with other health care providers, professions, patients/families, organizations, institutions, systems, and other stakeholders. (See recommendations for implementation on page 14.)

H. The APA Board of Trustees fosters internal collaboration among APA components and divisions with the goal of improving patient safety. (See recommendations for implementation on page 15.)

I. The APA Board of Trustees establishes a Committee on Patient Safety within the Council on Quality Care with a charge, membership, and funding as suggested on page 15. (Note: No new funds are required in 2003 or 2004.)

J. The APA Board of Trustees encourages the Medical Director to dedicate a portion of existing resources and staff to promote and advance patient safety in the near-term and sustain its momentum as an enduring program into the future. (See recommendations for implementation on page 16.)

III. Recommendations for Implementation of A – J

For each major recommendation, the Task Force offers a second level of specific recommendations for consideration by those in a position to act, e.g., APA leaders, District Branch leaders, individual psychiatrists, training directors, APA components and staff. While Recommendation C specifically addresses preventable adverse medication events, suicide, and seclusion and restraint, all recommendations are intended to address the need for change in clinical culture in the interest of patient safety.

A. The APA Board of Trustees reaffirms its commitment to safe patient care as a fundamental element of the Association's advocacy for patients and for the clinical culture of psychiatry.

Recommendation for implementation:

1. Include patient safety as a major focal point of the APA's first strategic priority, *Advocacy for Patients*. No treatment activity is complete without attention to patient safety.

B. The APA Board of Trustees designates patient safety a major programmatic priority as a contribution to quality patient care that is largely devoid of organizational or professional self-interest.

Recommendations for implementation:

1. Showcase a national commitment to engage APA members in improving patient safety with a major address and subsequent workshops at the 2003 Annual Meeting. Stimulate articles in *Psychiatric News* about patient safety and the commitment of APA to this new priority.

2. Foster patient safety programs at the APA Annual Meeting, Institute on Psychiatric Services, and other educational settings, including interactive programs offered via the Internet.

3. Develop a program and timetable of publications on patient safety for submission to the *American Journal of Psychiatry, Psychiatric Services,* and *Psychiatric News.* This program should include development of a periodic patient safety electronic letter as an educational resource with articles that focus on best practices, model programs, new developments, and practice dilemmas. Encourage submission of similar pieces to other mental health and medical journals.

4. Develop a national list serve for discussion and exchange of information about best practices and results concerning patient safety in the field of psychiatry.

C. The APA Board of Trustees directs the focus of initial patient safety activities to four priority areas that are especially relevant to psychiatric practice: change in clinical culture to focus on patient safety, adverse medication events, use of seclusion and restraint, and suicides in inpatient/residential settings.

Recommendations for implementation:

APA Leadership—In addition to related recommendations B, G, H, I, and J:

Adverse Medication Events

1. Promote effective strategies to prevent adverse medication events, such as use of available clinical decision support systems and computerized physician order entry programs. If those are not practicable, programs can pursue computerized clinical evaluation/monitoring systems that provide clinicians and the facility with alerts and data concerning such matters as patients' allergies, dangerous drug interactions, and mistaken drug dosages.

2. Encourage all psychiatric programs to develop a system to report, analyze, and learn from preventable adverse medication events.

3. Define issues and promote development of information technology solutions for data collection and analysis for psychiatric programs, facilities, and systems.

4. Encourage psychiatric programs to share and publish research and trends in their experience with the prevention of adverse medication events to capture and promulgate best practices.

5. Partner with other national organizations, such as NASMHPD, NAPHS, and NPSF, to promote best practices in preventing adverse medication events in psychiatric settings.

Seclusion and Restraint

6. Encourage psychiatrists to support programmatic efforts intended to minimize the use of restraints and seclusion and to ensure that, when such interventions are necessary based on clinical judgment, they are administered safely by trained personnel.

7. Encourage psychiatric programs, facilities, and systems to track restraint and seclusion rates and to share research findings and clinical experience about best practices.

8. Encourage psychiatric programs to follow up instances of use of restraint and seclusion with a debriefing.

Suicide

9. Continue to develop suicide assessment/intervention guidelines.

10. Promote exchange of research, experiences, and best practices concerning suicide assessment and intervention among psychiatric organizations, JCAHO, the Center for Medicare and Medicaid Services, and psychiatric programs through publications, educational programs, and communications.

11. At the APA's Annual Meetings, encourage the presentation of programs about suicide assessment/intervention in all settings, inpatient, outpatient, residential.

12. Through the proposed committee and staff efforts, identify and disseminate improved suicide assessment and reassessment protocols.

13. Encourage national and state regulatory and accrediting agencies to establish valid, protected registries of suicides and to make available reliable, meaningful data on these incidents. Information should be collected from medical/surgical and psychiatric inpatient, outpatient, long-term nursing care, behavioral health/residential, and private practice settings.

14. Promote opportunities and funding for research about intervention in suicide, including assessment and reassessment of suicide risk, factors relevant to high-risk minority, pediatric, and adolescent populations, and the effects of suicide on families and providers.

District Branches—In addition to related recommendation D:

Adverse Medication Events

15. Encourage identification and sharing of best practices to prevent adverse medication events among local psychiatric programs and psychiatrists, including those with ambulatory patients.

16. Urge psychiatrists to ensure psychiatry's inclusion in development of local CPOE systems.

Seclusion and Restraint

17. Encourage leaders of local psychiatric programs to track restraint and seclusion rates and to share research, clinical trends, and best practices.

18. Promote and disseminate educational programs on minimal and safe use of restraints and seclusion relevant to local District Branch membership.

19. Provide a mechanism (meeting, newsletter column, list serve) for members to share best practices for minimization and safe use of restraints and seclusion.

20. Work with local licensure boards to facilitate the expectation that best practices will be incorporated into reviews for licensure/certification of facilities.

Suicide

21. Work at the state level with agencies and associations to share best practices and data about suicide.

22. Establish a support group or activities for individual APA members (including MITs) who have lost a patient to suicide.

Individual Psychiatrists—In addition to related recommendation E:

Adverse Medication Events

23. Learn about common prescribing errors that lead to preventable adverse medication events.

24. In inpatient and residential settings, pursue use of available computerized order entry systems or medication evaluation/monitoring programs.

25. Learn about and use PDAs, algorithms, quick reference guides to treatment, and other technical aids for safer prescribing and avoidance of adverse drug events.

26. In outpatient settings, make sure a patient can read back the prescription just written.

27. If a clinical leader in an inpatient or residential program, encourage the program to map process flow of medications to review for reduction of potential adverse medication events.

Seclusion and Restraint

28. Support programmatic efforts to minimize the use of restraints and seclusion and to ensure that, when such interventions are necessary based on clinical judgment, they are administered safely by trained personnel. Seek information about best practices.

Suicide

29. Seek information about assessment/intervention/postvention guidelines for suicidal patients.

30. Evaluate all patients for suicide potential. Use risk reduction and improved, standardized assessment and treatment protocols. Establish a monitoring strategy.

31. Reevaluate high-risk patients (e.g., depressed, psychotic, substance abusing) for suicide risk periodically during hospitalization and at transition points in the continuum of care.

32. Obtain information from family and friends of patients, if appropriate and possible, when assessing suicide risk. Educate family members or friends about signals and how to respond. Provide family members with cognitive aids.

33. Improve communication about suicide risk of patients among office/hospital/residential staff.

34. Commit to providing adequate documentation regarding assessments and reassessments, as well as near misses and self-injury events.

Training Directors—In addition to related recommendation F:

Adverse Medication Events

35. Incorporate best practice development and implementation in training programs.

36. Emphasize medication order "rules," like using computerized order entry or medication evaluation/monitoring programs where available, using PDAs, algorithms, quick reference guides, and other technical aids.

37. Teach trainees to ask patients to read back prescriptions they have just written.

38. Challenge trainees' assumptions that others are double-checking medications and prescriptions.

Seclusion and Restraint

39. Emphasize training for careful prescribing of modern pharmacological interventions that have proven antiaggressive features, such as atypical antipsychotics, as an approach to prevention of the need for seclusion and restraint.

40. Involve psychiatric residents in a multidisciplinary model for training, e.g., de-escalation of violent behavior, safe application of seclusion and restraint.

Suicide

41. Give high priority to development and teaching of a curriculum on suicide risk, assessment, and reduction. Include a multidisciplinary exchange about these issues.

42. Encourage use of assessment/intervention protocols and guidelines; use simulations and role-playing approaches to help desensitize.

43. Ensure adequate documentation and proper supervision/consultation.

44. Ensure that formal and informal support is available for residents and fellows who have lost a patient to suicide.

45. Teach residents to seek information from family or friends, if appropriate and possible, when assessing suicide risk. Teach them to educate family members or friends about suicide signals and how to respond.

D. The APA Board of Trustees and the Assembly encourage the District Branches and state associations to commit to the improvement of patient safety within the psychiatric practices of their members by offering educational programs and activities at the local and regional level.

Recommendations for implementation:

1. Establish a Patient Safety Committee.

2. Make patient safety activities a central feature of programming for the District Branch meetings. The District Branches should take responsibility for ensuring that eligible activities carry CME credit. Local programs could include the following:

- Meetings on patient safety for the entire membership.
- CME course on the technology (and technical aspects) of patient safety in each of the four areas of emphasis and perhaps others.
- Demonstrations or support for the introduction and use of technological aids—PDAs, software for clinical care, etc.
- Support for groups of hospital staffs of all disciplines to share best practices and strategies for changing institutional practices and culture. This is also an opportunity to develop a partnership with local consumer/family member groups.
- Initiation of groups of solo practitioners meeting regularly to discuss patient safety aspects of their cases, within the boundaries of peer review protections, or with paid expert consultants in psychopharmacology, psychotherapy, forensic psychiatry, child and adolescent psychiatry, etc.
- Train groups of practitioners to examine adverse events as a service to local institutions—psychiatric hospitals, nursing homes, and residential facilities.

3. Develop a recognition program focusing on patient safety contributions of individual members.

4. Promote healthcare leaders, whether psychiatrists, administrators, and other medical or clinical staff chiefs, in the institutions and community who have demonstrated their commitment to safety improvements for psychiatric patients.

5. Form alliances to participate with state medical societies, hospital associations, state regulatory agencies, consumer and advocacy groups, and other professional societies to advance patient safety.

6. Encourage use of a national list serve for psychiatrists concerning patient safety.

7. Establish an opportunity for members to anonymously report on patient safety issues to establish databases and to allow anonymous, generalized comparisons.

E. The APA Board of Trustees encourages individual psychiatrists to commit to the delivery of safe care and to participate in educational, organizational, and institutional activities intended to improve patient safety in their various practice settings.

Recommendations for implementation:

1. Educate oneself about the principles and practices of patient safety as applied to the practice of psychiatry.

2. Become a local patient safety champion. Assume a leadership role in preventing, examining, and eliminating adverse medical events across the continuum of care. Each psychiatrist can work within the parameters of his or her own practice setting.

3. Exert leadership in establishing a nonthreatening, confidential atmosphere in work places that will encourage psychiatric staff and others to report actual or potential adverse medical events in a timely manner.

4. Psychiatrists who work in psychiatric facilities or general medical facilities with psychiatric departments can provide leadership by supporting a single comprehensive adverse medical event reporting program that:

- Receives and analyzes confidential reports to identify system-based causes of adverse or potentially adverse events; and
- Recommends and disseminates prevention strategies for adverse medical events.

5. Be active in a healthcare organization's patient safety, risk management, and performance improvement processes for the purpose of a) assessing safety evaluation/monitoring systems in terms of relevance to psychiatric practice, b) implementing adverse medical event prevention strategies, and c) reviewing occurrences of adverse medical events and developing corrective actions.

6. If in solo practice, commit to sharing clinical practices with other practitioners to have the benefit of professional comments and experience. Work with the District Branch or state association to implement an appropriate group for solo practitioners.

7. Engage in dialogue with patients and families about patient safety issues.

F. The APA Board of Trustees encourages the leadership of AADPRT, and directors of medical student and psychiatric residency training, to adopt patient safety as a major focus of training, including curriculum development in the four areas of change in clinical culture, adverse medication events, restraints and seclusion, and suicide.

Recommendations for implementation:

1. Share best practices and curricula concerning patient safety with directors of other training programs within the training institution, as well as directors of other psychiatric training programs outside the institution. Develop and use performance improvement and patient safety issues in curricula for residents and fellows in psychiatry.

2. Encourage institutional leadership, faculty, and physicians, when interacting with residents and fellows, to model and affirm a commitment to reporting and remedying adverse patient safety events using a systems approach.

3. Be aware of institutional lessons learned concerning patient safety; participate on patient safety/quality committees. Encourage residents and fellows to participate in hospital medical staff committees involved in performance improvement and patient safety activities.

4. Incorporate into the training program adverse medical event reporting, root cause analysis, and the ongoing sharing of lessons learned about patient safety.

5. Encourage faculty to model disclosure of adverse medical events to patients and families.

6. Encourage development and use of questions concerning patient safety on the PRITE exam.

G. The Board of Trustees fosters APA's leadership and collaboration in the many aspects of patient safety with other health care providers, professions, patients/families, organizations, institutions, systems, and other stakeholders.

Recommendations for implementation:

1. Encourage the American Board of Psychiatry and Neurology to include patient safety issues in examinations.

2. As an organization, collaborate with allies to advocate for and support federal legislative and regulatory initiatives that provide disclosure protections for reporting of actual and potential adverse medical events. Seek allies to advance tort reform concerning patient safety. Some potential allies are the AMA, CMSS, AACAP, JCAHO, and NQF.

3. Work with hospital associations, professional organizations, consumer organizations and other advocacy groups, and accrediting, licensing, and regulatory bodies to define elements of patient safety for incorporation into behavioral health programs and standards.

4. Look for opportunities for collaboration with malpractice insurers to identify and attend to areas where risk management, quality improvement, and patient safety intersect.

5. Collaborate with the National Patient Safety Foundation, the Partnership for Patient Safety, the VA Center for Patient Safety, and other national patient safety organizations to identify best practices and encourage opportunities for research in patient safety for psychiatric patients.

6. Encourage healthcare facility leaders to recognize and use psychiatry's special talents and training. Involve psychiatrists in the facility's patient safety program to work with care providers involved in adverse medical events, to help get issues on the table, and to help reduce the untoward impact on personnel after an adverse event. Seek input from psychiatrists regarding the development of policy and

practices in patient safety, especially concerning disclosure and a nonpunitive approach.

H. The APA Board of Trustees fosters internal collaboration among APA components and divisions in order to improve patient safety.

Recommendations for implementation:

1. Advocate for funding and opportunities for patient safety research in inpatient, outpatient, and consultation-liaison psychiatry, especially in areas of preventable adverse medication events, reduced and safe use of seclusion and restraint, and suicide interventions. Encourage APIRE to give attention to patient safety research funding and opportunities in its newsletter.

2. Encourage the APA Council on Psychiatry and the Law to review statutes and tort reform relative to confidentiality and protection from liability when reporting patient safety events. Request a proposal for short and long-term approaches for advancing tort reform.

3. Urge the APA Division of Government Relations to work with coalitions and alliances to advocate for legislative and regulatory initiatives that provide disclosure and liability protections for reporting adverse patient safety events.

4. Support the APA educational leadership in directing attention to patient safety programs and issues in collaboration with training directors, ABPN directors, and others.

5. Incorporate patient safety concepts into the APA practice guideline design.

I. The APA Board of Trustees should establish a Committee on Patient Safety within the Council on Quality Care with a charge, membership, and funding as suggested below.

The six-member committee is charged to:

1. Stimulate, shape, and oversee development of APA efforts in the area of patient safety, implementing many of the recommendations on these pages.

2. Advise staff who are planning or executing activities.

3. Prepare and seek approval of APA policies and position statements on patient safety.

4. Collaborate with and support efforts of the APA components to prepare relevant policies and position statements concerning areas that have significant bearing on patient safety (e.g., approaches to legal, legislative, or regulatory reform to ensure protections for disclosure of adverse medical events).

5. Serve as the Association's spokespersons to promote patient safety to the District Branches and other organizations with interests in patient safety (e.g., AACDP, NPSF); serve as advisors to APA representatives to other organizations regarding

patient safety issues (e.g. APA representative to the JCAHO professional and technical advisory committee).

6. Serve as the Association's reviewers of material disseminated for comment by national patient safety groups (e.g., the NQF).

7. Prepare/solicit, review, and ensure appropriateness of patient safety articles for APA publication or placement on the APA website.

8. Prepare or encourage preparation by others of proposals for patient safety education programs to be submitted to the program committees of APA meetings; advise District Branches and state associations on opportunities for programming and speakers.

No funding is requested for 2003 or 2004 because the residual from the initial grant will allow for one face-to-face meeting, several conference calls, and time-sensitive mailings each year; the remaining amount would allow for travel to a limited number of strategically important meetings on patient safety.

The Board could approve the Committee for a three-year tenure and reevaluate its effectiveness and the need to continue at the end of that term.

J. The APA Board of Trustees encourages the Medical Director to dedicate a portion of existing resources and staff to promote and advance patient safety in the near-term and sustain its momentum as an enduring program into the future.

The staff effort will:

1. Work with the proposed APA Committee on Patient Safety to build, coordinate, and implement the Board's actions concerning patient safety in psychiatric practice.

2. Collect and disseminate information about patient safety in psychiatric practice concerning:

- Best practices, e.g., programs designed to prevent and reduce use of seclusion and restraints, suicide, and adverse medication events
- Models to achieve cultural change within the profession concerning attitudes, practices, protocols
- Models of clinical leadership in patient safety
- Models for policy change
- Sources of GME and CME level training programs—live, printed, electronic
- Models for root cause analysis, addressing "why" an adverse event occurred, and failure mode and effects analysis, addressing the "what if" of an adverse event that occurs very rarely
- Commercial or hospital-specific computer programs for public and private psychiatric facilities (examples of adverse event reporting systems, clinical decision support systems, hospital evaluation/monitoring systems)
- Principles for purchase and safe use of computerized order entry programs
- PDA software that promotes safe prescribing and medication use (e.g., E-pocrates)
- Model programs that promote disclosure of adverse events and near misses

3. Set up an APA patient safety web page to disseminate policies, program resources, informative articles, guidelines adopted by other organizations/agencies, newly adopted national priorities or standards, relevant FDA announcements, etc.

4. Coordinate development of, or collaboratively write, information pieces for publication or posting on an APA patient safety web page or in a periodic electronic patient safety letter to the membership.

5. Encourage submission of proposals for presentations that focus on patient safety and psychiatry at the APA's annual meetings.

6. Support committee members in their advocacy and educational efforts by organizing educational packets, preparing PowerPoint presentations, identifying speakers, etc.

7. Where appropriate, represent the office and Association at meetings with other organizations that address the actions taken by the APA Board of Trustees relevant to patient safety.

8. Identify methods to evaluate effectiveness of the program, seeking feedback from members, District Branches, and components.

9. Work with the proposed Committee on Patient Safety to seek additional funding to sustain patient safety activities in future years.

IV. Why Patient Safety in the Specialty Society?

Anesthesiology was the first medical discipline to advance internal safety standards. At the turn of the 20th century, there was an international controversy over the precise dosing and delivery of chloroform. Gordon Levy's experiments with adrenaline and light chloroform in 1911 revealed an association between chloroform and fatal ventricular fibrillation. For the next fifty years anesthesiologists witnessed a disproportionate number of patient deaths despite a growing body of knowledge in the field. Faulty technology and a yet imperfect understanding of drug effects and interactions seemed to be at root. As international research began to accrue in the area, it became evident that inconsistent and poor data were inadequate to explain widely divergent mortality rates.

By the late 1970s a crisis in medical liability insurance spurred the American Society of Anesthesiologists to form the ASA Committee on Patient Safety and Risk Management. With the early adoption of patient safety standards by Harvard Medical School and its Risk Management Foundation in 1984, the ASA followed suit, compelling its membership to do the same. Meanwhile, within a handful of years, the pulse oximeter and capnograph became ubiquitous in operating rooms nationwide. In 1985, the Anesthesia Patient Safety Foundation was launched. With its momentum and influence, it has served as a model for cutting-edge, cost-effective patient safety and clinical culture research, design and simulation.

V. Why Psychiatry?

Psychiatrists, like other medical professionals, are concerned about patient welfare. Incumbent upon them as providers of care is the responsibility to do the right thing, for the right person, at the right time, in the right manner. While diagnostic opinions and therapeutic approaches vary, doing the very best for patients, preserving their trust by regarding "first, do no harm" as a cornerstone of practice is fundamental. That essential value has quickened the patient safety movement across the country.

As cases of patient death and injury have increasingly come to light over the past decade, efforts to safeguard patients against avoidable, adverse events have drawn unprecedented attention in health care. The particular focus has been on hospital care. While this area has been a perpetual concern, sustained investigation and physician acknowledgement of the breadth of the issue has quickened a national will to change.[6] As evidence, a comparison of the first and second Institute of Medicine Reports, *To Err Is Human in* 1999 and *Crossing the Quality Chasm* in 2001,[7] demonstrates the increasing level of concern and proliferation of strategic imperatives.

As the last ten years of research and programmatic change can attest, much institution-level coordination and interoffice collaboration have paved the way for change. The Institute of Medicine, Agency for Healthcare Research and Quality, Surgeon General, Veterans Health Administration, Joint Commission for Accreditation of Healthcare Organizations, medical societies, HMOs, and hospitals have begun to formalize programs to address system-wide clinical culture, and professional vulnerabilities to preventable adverse medical events. In response, patient safety as a function of risk management has grown significantly within institutional quality assurance and improvement activities. Where highly publicized medical calamities have given rise to calls for greater accountability, such cases also have yielded opportunities to restore patient confidence and trust in medicine. Voluntary reporting mechanisms and a responsive institutional culture are among the crucibles for change.

VI. Where Does Patient Safety Intersect with the APA?

As the Dana-Farber story illustrates, when an institution stands behind its staff and is willing to take a hard look at its practice, even at the risk of exposing itself to internal and external criticism

and harm to its reputation, preventable adverse medical events are reduced. Psychiatrists have argued that the nature of their work, especially as delivered in private practice, does not lend itself to reporting and analysis. Psychiatrists tend to be relatively isolated in their practice and rely on a strong commitment to confidentiality to do their work. In contrast, the most compelling lesson in patient safety is that sharing information about practice is essential if preventable adverse medical events are to be reduced.

Within a universe of potential and actual adverse events, there are incidents capable of causing serious, disabling harm and patient death in psychiatry. In Medicare-funded health care organizations, they are known as "sentinel events" and are reportable to the JCAHO and often to the appropriate state regulatory body as well. From January 1995 to January 2002, JCAHO attributed its largest number of sentinel events to suicide (258/1541).[8] Of the total sentinel events reported, 75% resulted in patient deaths—25% of which were inpatient deaths.[9] The majority occurred in general hospitals, followed by psychiatric hospitals, psychiatric units in general hospitals, behavioral health facilities, and, sixth most frequently, in emergency departments.[10]

In the fall of 2001, in the light of the IOM reports and new initiatives by the Agency for Healthcare Research and Quality, the APA leadership recognized its potential for service to the mental health community, as well as inpatient, ambulatory, and private care sectors with regard to patient safety. A preliminary report issued by the NQF concentrated on twenty-seven serious "never events" as well as recommending desirable reporting structures at the state and national levels. The call for reporting stimulated further interest as well as some caution within the APA. Aided by a grant from a pharmaceutical company, the Association sought to define an array of safety concerns with regard to psychiatric patients.

VII. The APA Task Force on Patient Safety

Acknowledging the national attention being directed to patient safety, in October of 2001 the Board of Trustees chose to bring psychiatry into the national discussion of the issue and established a patient safety project. Supported by a $25,000 grant from AstraZeneca, APA's Department of Quality Improvement and Psychiatric Services proposed and APA President Richard Harding appointed a group of prominent psychiatrists to an APA Task Force on Patient Safety with the following stated goal:

> *The desired outcome of this project is an improvement in patient safety and a reduction in preventable adverse events in three domains of psychiatric practice, addressed in the context of the systems in which care is delivered, and achieved in collaboration with other major players in those systems of care*.

The Task Force comprised five members. Co-Chairs Al Herzog, M.D., Vice-President of Medical affairs at Hartford Hospital, and Miles Shore, M.D., on the faculty at Harvard's Kennedy School of Government and Harvard Medical School, led the group. Rhonda Robinson Beale, M.D., Blue Cross Blue Shield of Michigan; Susan Padrino, M.D., Resident, Internal Medicine & Psychiatry at Duke University and APA Member in Training Trustee; and Albert Vogel, M.D., Associate Dean for Clinical Affairs, University of New Mexico School of Medicine, and APA Trustee, broadened the range of membership representation.

Actively involved in the planning process and its year-long activities were Claudia Hart, Director, and Nina Rogers, Executive Assistant, Department of Quality Improvement and Psychiatric Services at the APA; Sara Charles, M.D., Chair, APA Council on Quality Care; and Lloyd Sederer, M.D., then Director, APA Division of Clinical Services. Michelle Freshman, M.P.H., M.S.N., A.R.N.P., B.C., was appointed special consultant to the Task Force.

By February 2002 the newly assembled Task Force met at APA headquarters in Washington, D.C., to focus on a handful of topics in psychiatry that had already begun to stir public scrutiny and the institutional will to change.

A. Initial Task Force Goals

1. Review and summarize applicable patient safety literature
2. Identify three domains of preventable adverse events in psychiatric practice
3. Define the elements of the identified preventable adverse events
4. Identify areas where opportunities exist for improvement
5. Identify potential collaborators to achieve these goals
6. Convene a small invitational conference on psychiatry and patient safety
7. Summarize conference discussion
8. Provide final recommendations, maintain meaningful activities and leadership

B. Consensus Opinions from Task Force Members

1. Terminology—The Task Force adopted the term "preventable adverse events" as the optimal interest area instead of "medical error" to be more inclusive of a variety of incidents and to specify incidents that otherwise could have been avoided. The Task Force recognizes that given the limits of medical practice and technology there may not always exist an alternative to the course of action taken.

2. Applicability—In most instances, recommendations are intended to pertain to inpatient and outpatient settings, although much of the research and programming to date has been in the inpatient arena.

3. Clinical Culture Change—Many physicians believe they should never make a mistake or at least never expose a mistake. Most physicians train and perform in an atmosphere that supports silence when an adverse event or "near miss" occurs. Many physicians also recognize that errors in healthcare are more likely to result from failures in complex and interdependent medical, administrative, and communication processes rather than individual culpability. In the light of this, susceptible environments that nearly or actually result in patient harm or death require system-wide redress, calling into question the basic notions of institutional culture regarding reporting and remediation. Culture change challenges this institutionally learned behavior.

4. Data Collection—Larger institutions are more likely to benefit from integrated data collection and analysis functions. The Task Force believes that smaller entities—individuals and group practices—would experience a similar advantage by comparing and contrasting events on a group or regional basis. The APA would want to facilitate data collection, analysis, and interventions.

VIII. Topic Selection

The APA Task Force considered all twenty-seven of the events deemed to be egregious lapses in patient safety by the NQF[11] and found six that were particularly relevant to psychiatry:

1. patient death or serious disability associated with patient elopement for more than four hours
2. patient death or serious disability associated with a medication error

3. patient death or serious disability associated with the use of restraints or bedrails while being cared for in a healthcare facility
4. sexual assault on a patient within or on the grounds of a healthcare facility
5. death or significant injury of a patient or staff member resulting from a physical assault
6. patient suicide or attempted suicide resulting in a serious disability while being cared for in a healthcare facility.

In addition, the Task Force reviewed data collected by the JCAHO concerning reported "sentinel events." Furthermore, members consulted with Alan Levenson, M.D., a recognized expert in professional liability issues relevant to psychiatry, and reviewed publications and announcements from the Agency for Healthcare Research and Quality, the Institute for Safe Medication Practice, the National Patient Safety Foundation, the Leapfrog Group, APA components, and others. Drawing from the above list as well as other sources, the Task Force carefully examined seven areas of adverse events: suicide, restraints and seclusion, adverse medication events, boundary violations, elopement or disappearance from a facility, physical assault, and incorrect or missed diagnosis.

In May 2002, the Task Force met in Philadelphia to report back on topic assignments. By consensus, Task Force members tried to determine which areas of psychiatric practice had presented the highest level of concern with regard to patient safety so as to yield the most fruitful discussions and program initiatives. Ultimately, weighing current knowledge and potential impact, the group selected suicide; preventable adverse medication events; and restraints and seclusion.

A second grant from AstraZeneca in 2002 supported an invitational meeting in July 2002. The Task Force convened the conference, Patient Safety and Psychiatry, in Chantilly, Va., with approximately 20 invited field experts. Participants shared error reduction technology research, medication delivery system designs, successful statewide programming that minimizes unnecessary restraint and seclusion, the Veteran Health Administration's organization-wide logging and analysis of untoward events, and the Anesthesia Patient Safety Foundation's twenty-year triumph in setting nationwide standards in patient safety. Many others weighed in with perspectives from managed care, risk management, psychiatric hospital administration and practice, psychiatric training, and patient advocacy. The conference offered a rare opportunity to discuss the relevance and applicability of a patient safety paradigm in psychiatry.

With the aim of extracting recommendations for the APA and its membership within the chosen topic areas, each presenter helped the group recognize and recommend necessary steps to create institutional patient safeguards in psychiatry.

Invited attendees included:

David W.Bates, M.D., Chief, General Medical Division, Brigham and Women's Hospital
Jack Bonner III, M.D., Medical Director, Behavioral Health Services, Marshall I. Pickens Hospital
James B. Conway, Senior Vice President and Chief Operating Officer, Dana-Farber Cancer Institute
John W. Goethe, M.D., Director, Burlingame Center for Psychiatric Research and Education, Hartford Hospital/Institute of Living
Martin J. Hatlie, J.D., President, Partnership for Patient Safety
Kevin A. Huckshorn, R.N., M.S.N., C.A.P., Director, Technical Assistance, National Association of State Mental Health Program Directors
Nalini V. Juthani, M.D., Professor and Director, Psychiatric Education, Bronx-Lebanon Hospital Center and Albert Einstein College of Medicine
Steven J. Karp, D.O., Chief Psychiatric Officer, Department of Public Welfare for the Commonwealth of Pennsylvania

Caryl Z. Lee, R.N., M.S.N., Program Manager, National Center for Patient Safety, U.S. Department of Veteran Affairs
Kathleen McCann, R.N., D.N.Sc., Director of Clinical Services, National Association of Psychiatric Health Systems
Jacqueline M. Melonas, R.N., M.S., J.D., Vice President, Risk Management, Professional Risk Management Services
Robert M. Pearce, M.D., private practice psychiatrist
Terry C. Pellmar, Ph.D., Director, Board of Neuroscience and Behavioral Health, Institute of Medicine
Ellison "Jeep" Pierce, Jr., M.D., Executive Director, Anesthesia Patient Safety Foundation
Paul Quinnett, Ph.D., Executive Director, QPR Institute
Phil Sheridan, M.S.W., Manager, Referral Unit, Psychiatric Facility
Susan Sheridan, M.B.A., M.I.M., Advocate with the Perspective of the Patient's Family
Kasey K. Thompson, Pharm.D., Director, Center on Patient Safety, American Society of Health-System Pharmacists
Robert A. Wise, M.D., Vice-President, Division of Research—Standards, Joint Commission on Accreditation of Health Care Organizations

IX. Rationale for the Topics Recommended to the APA Board of Trustees

Considerable research and discussion, as well as guideline and policy formulation, has emerged nationally in the area of preventable adverse medication events. Seclusion and restraint and suicide in psychiatry have not benefited from similar momentum to date. As a result, research and programming in these areas are scarce. Yet, the gravity of these events and the demonstrated potential for dramatic improvement are no less compelling.

A. Preventable Adverse Medication Events

Statistics on preventable adverse medication events range from alarming to shocking. Anywhere from 7,000 to 44,000 to 98,000 deaths are estimated per year, with upwards of 750,000 to a million patients suffering from otherwise preventable injuries.[12, 13, 14] As greater numbers of drug-related injury and death were formally uncovered in the medical community,[15] several concerned groups made concerted efforts to transform this source of embarrassment and remorse into action. What became the banner cause in a nationwide campaign for patient safety remains pivotal.

David Bates, M.D., Chief of the Division of General Medicine at Brigham and Women's Hospital, has been fighting for system improvement from the early days of the growing patient safety movement. He defines a medication error as one related to the "processes of ordering, transcribing, dispensing, administering, or monitoring medications, irrespective of their outcome, which brings to bear close call events as well as injurious errors."[16]

Since the subject appeals to many, in many different settings, he has presented widely on this subject. One strategy he uses to dramatize the difference between *what is seen* and *what is heard* is the comparison between reported and documented errors (through chart review)—a process of grueling investigative work that yields volumes of otherwise unspoken medication-related injury. He has tried to address this process, among other analyses of system failures, with technological time savers. As an extensively published researcher on the subject, he recently shared some pertinent findings at the conference on patient safety and psychiatry in July and brought to light several key lessons learned in psychiatry.[17]

Dr. Bates noted that psychiatry suffers from system weaknesses similar to those in the rest of medicine. Several notorious examples of adverse preventable medication events were observed in an inpatient psychiatric facility in the Northeast. In particular, Bates's colleagues found excessive use of

antipsychotics (which was acknowledged as a common concern from other studies) and polypharmacy leading to confusion in diagnosing organic versus pharmacological cognitive impairment. In addition, research investigators uncovered failures to achieve ictal threshold with ECT because of competing medications in the body, as well as the dispensing of lethal amounts of drugs to potentially suicidal patients. The error rate was 7%, and nearly a third of these were preventable.[18]

According to Dr. Bates, in a recent nursing home study about half of the errors were considered preventable; moreover, 72% of the serious ones were.[19] In fact, in many instances a patient had been started on a psychoactive drug and suffered progressive debilitation for lack of adequate monitoring. In another inpatient psychiatric unit on a large southwestern medical campus, the rate of admissions was especially high due to adverse drug events, attributable to abrupt discontinuation and other forms of noncompliance.[20]

Much of the focus on reduction of preventable adverse medication events has been on rooting out the potential for common mistakes: wrong patient, wrong drug, wrong dose, wrong amount, wrong route of administration. In fact, hospitals have adopted conventions in writing prescriptions, such as requiring decimal and unit descriptions, demanding legibility, alerting clinicians to look-alike-sound-alike drugs, and repeating-back verbal orders. Automated dispensing devices have followed the generation of unit-dose dispensing.[21] However, the real beacon in the industry comes from computer-based tools such as computerized physician order entry.

Computerized input of patient data and orders has been slowly gaining ground in the U.S., particularly in hospital settings, as a strategy to mitigate preventable adverse medication events. The Leapfrog Group, a consortium of purchasers of health plans that give high priority to quality care, has set CPOE as a standard for members to encourage or require. In fact, this is one of three strategies that it anticipates will have the greatest impact upon health care safety. The organization states that nearly one million serious medication incidents occur annually in the U.S. and that nearly half of them may be preventable.[22]

CPOE systems require major financial investment, but costs need not prohibit system-wide efforts to reduce preventable adverse medication events.

John W. Goethe, M.D., Director of the Burlingame Center for Psychiatric Research and Education, Hartford Hospital/Institute for Living, shared information about another type of program. He made a case for a 20-year-old, PC-based, non-CPOE, home-grown clinical support system developed on a scale to meet his outpatient practice needs. Through his role as Director of Quality Management for the entire operation in psychiatry and med/surg, he expanded the program after collaboratively developing practice guidelines for the patient population being served. His group has built a flow chart of diagnostic reasoning to prompt logical action steps. If a confirmatory diagnosis requires a lab test or if a medication requires blood level monitoring, the clinician is alerted. When an action step is not taken, or involves an override of a guideline, the clinician is asked to account for his or her decision and is compared to peers in real time. Dr. Goethe has lately been involved in a review of the national CPOE systems currently available. He admits his system is not specifically focused on capturing every preventable adverse medication event because it is not connected to the pharmacies outside of the setting. However, it can track event data retrospectively and anticipate problems when drug choices fall out of the decision support rubric. At the July 2002 meeting, Dr. Goethe said,

> I think there are things you can and should do and the PC solution may be the easiest. It actually moves us toward the sophisticated CPOE because it gets clinicians to the keyboard. I think you can require that there be typed orders…and that orders come from a "pick list"…the practitioners are enthusiastic about it because it saves them so much time…and the point of typing it in is you then have a database.[23]

The popularized use of hand-held devices in the field would seem to offer potential for reducing multiple types of preventable adverse events related to prescription writing. One advantage is that medication look-up, ordering, data transfer, and management can be guided, streamlined, and made more cost-effective. Wireless aids are capable of downloading and uploading web-based resources; tapping clinical decision support features for potential drug warnings as well as price and coding information; and producing legible scripts for ready printing and archiving. At least one product is on the market that drives orders to a patient's own pharmacy or health care facility.[24] Moreover, point-of-care data interfaces with computer and billing records with an automatic charge capture. Decision support and Internet access also are provided.

Clearly the trend is toward automation, streamlining data entry and supporting clinical reasoning. Psychiatry can benefit from the steep wave of momentum dedicated to this area already.

B. Restraint and Seclusion

The JCAHO, the NQF, and the Psychiatrists Purchasing Group, Inc. all viewed seclusion and restraint as a significant safety risk. Task Force members reviewed the public controversy over the last four years regarding inappropriate and/or unsafe use of seclusion and restraint for psychiatric patients and determined that there have been encouraging trends in its reduced application worth modeling more broadly.

The issue was highlighted by a series of articles published in the *Hartford Courant*[25] in 1999 attributing 142 deaths in 50 states in ten years to seclusion and restraint; one-third of those who died were suffocated and a quarter were under age 17.[26,27] One of the *Courant's* articles noted that the Harvard Center for Risk Analysis estimated that 50-150 deaths occur annually as a result of seclusion and restraint and most go unreported.[28] NAMI produced a documentary in 1999 called "Cries of Anguish" that dramatized five deaths, including a nine-year-old boy, in a group of thirty-nine restrained or secluded patients in 19 states.[29]

The resulting debate had an impact on JCAHO standards and HCFA/CMS regulations. Although changes have been made in many treatment programs to ensure appropriate policies and staff training, the public continues to suspect that dangerous seclusion and restraint practices are widely used in psychiatry.

Some best practices have emerged since the highly publicized events mentioned above, and some large programs, such as the program of the Commonwealth of Pennsylvania, have established policies to drastically reduce the use of seclusion and restraint in its public hospitals with encouraging results. Steven J. Karp, D.O., Chief Psychiatric Officer, Department of Pubic Welfare and Medical Director of the Office of Mental Health for the Commonwealth of Pennsylvania, has been in charge of Pennsylvania's progressive restraint and seclusion policy implementation. Kevin A. Huckshorn, R.N., M.S.N., C.A.P., Director of the Office of Technical Assistance, National Association of State Mental Health Program Directors, has extensive experience in the field. Dr. Huckshorn has seen a program arise from the ground up and take root with care and commitment in a Florida psychiatric hospital. Huckshorn and Karp presented details of their programs at the conference on patient safety and psychiatry.

Clinical culture is the issue. Since restraint and seclusion involve many levels of staff, all have to believe in this minimization approach and need the assurance that physical safety will be optimized despite the restricted use of force with patients. That is considered the first hurdle. Every institution in the Pennsylvania state hospital system had to approach this hurdle differently, but all placed an emphasis on risk assessment training. Dr. Karp oversees nine hospitals, including two forensic units. Since 1992, the use of restraints *in all settings* decreased from more than 13,000 hours

per calendar year (5,000 patients) to 6.25 hours for the month of March 2002 (approximately 2,500 patients).[30] He described the effort as setting a bar and putting in place the supports at all levels to hit that mark—through values, leadership, and treatment.[31] He observed that data sharing among institutions, as a form of constructive competition, motivated staff to keep their incidents down. One more lesson learned was that the rate of "as needed" prescriptions did not increase in Pennsylvania as their restraint and seclusion events decreased.

The APA is in a pivotal position to advocate for minimized use of seclusion and restraint. Moreover, the use of modern, atypical antipsychotics has offered opportunity for improved management. Pennsylvania's program was awarded the Innovations in Government Award in 2000.[31]

C. Suicide

Suicide is the eighth leading cause of death in United States; there is a suicide every 17 minutes.[32] Each day 86 of the 1,500 who attempt suicide die trying.[33] Thirty thousand Americans succumb annually to suicide.[34] Twenty-one percent of high school students seriously considered ending their lives in 1997; eight percent made an attempt.[35] Yet, there still exists the stigma associated with having a diagnosis of mental illness, substance abuse, or suicidal ideation; fears of societal prejudice and discrimination make patient identification and diagnosis equally challenging.[36]

Perhaps as much a result of these perceived and real barriers, minority and youth populations commit a disproportionate share of the suicides. Suicide among American Indians/Alaskan Natives is 1.5–2 times the rate of all other ethnic groups.[37] While they experience a lower rate of firearm- related deaths, American Indian/Alaskan Native males age 15–24 comprise 64% of suicide cases, four times the rate of other youth.[38, 39] Suicide rates among youth under 20 has been increasing at alarming rates. Among African American youth, suicide was the third leading cause of death for 15–19 year-olds in 1995, double the rate of fifteen years earlier.[40, 41] For youth identified as homosexual, attempted suicides are 2–6 times as likely, and completed suicides among this population make up a third of the all self-inflicted deaths.[42]

In January 1996, the JCAHO classified suicide as a sentinel event under its voluntary reporting guidelines. On the heels of this decision, the concepts of root cause analysis and failure mode and effects analysis were introduced in order to search for likely factors contributing to suicide in the sphere of care. JCAHO developed a companion database in order to track trend events and design network-wide improvements.[43]

Of the hospital-based suicides reported to JCAHO between 1996 and 2001, analysis identified environmental and practice deficiencies such as non-breakaway bars, rods, or safety rails and inadequate security; incomplete or inadequate suicide assessment methods; incomplete reassessment; incomplete orientation and training of staff or inadequate staffing levels; incomplete or infrequent patient observations; incomplete communication among caregivers or unavailable information; and inadequate care planning.[44]

Paul Quinnett, Ph.D., Executive Director, QPR Institute, a speaker at the APA patient safety conference, made a convincing case by drilling into some of the above issues. He emphasized that suicide is dependent on the relationship between the clinician and the patient. All that follows reflects upon the integrity of this bond; suicide intervention, likewise, is possible within this context. Because in this condition the progression to death involves a patient's will, there is inherently a window of opportunity. But no doubt this is an art. While a previous history of mental illness is correlated to suicide in over 90% of the cases,[45] the literature does not support a general population screening as specific in identifying potential suicide victims.

Periods of vulnerability are of particular concern. Dr. Quinnett especially stressed adequate, timely assessment and *reassessment*, appropriate training, communication among the disciplines—whether hunches or history— and clinician alerts to statistically and professionally known vulnerabilities to suicide. Examples of the latter include a patient's transition from an inpatient psychiatric facility to home; a patient with known suicidal risk factors being within several weeks of a visit with his or her primary care physician; a patient experiencing stressful life transitions like the death of loved one; or a patient self-medicating with alcohol or drugs. Moreover, access to the means for self-harm and the expression of concern by a patient's family are imperative signs for intervention.

Without specific attribution, Dr. Douglas Jacobs, Chair of the Work Group to Develop an APA Practice Guideline on Treatment of Patients with Suicidal Behaviors, shared with the Task Force evidence that he has collected from various sources. His data indicate that 50% of individuals who complete suicide are in psychiatric treatment at the time: 10% are inpatients, and 5–10% are post-hospital discharge; 50% are not in treatment. In an analysis of records of 100 patients who committed suicide in a hospital, Dr. Jacobs and his colleague found that 77% denied suicidal intent in their last communication with staff. This emphasizes the need for improved assessment and reassessment protocols.

While there is growing attention to suicide as an event that can be reduced, organizational and training strategies to support this work are essential. Clearly the APA has a role to play in setting the national message, working with its network of District Branch leaders, and influencing clinical education across medical and psychiatric training programs.

X. Conclusion

No call for sweeping change in the way people do things clinically, administratively, and technologically will be heeded without a demonstrated change in clinical culture, reinforced by a nonpunitive environment that is supportive of lessons learned. Psychiatry has the opportunity to leverage many proven strategies in this direction as well as make a mark targeting concerns that have already registered among psychiatrists and the public at large. Culture change involves leadership, compelling stories, broad participation in the process of all those involved, training, and evaluation. Making a difference in adverse medication events, seclusion and restraint, and suicide is within the APA's reach.

Notes

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Acronyms

AACAP	American Academy of Child and Adolescent Psychiatry
AACDP	American Association of Chairs of Departments of Psychiatry
AADPRT	American Association of Directors of Psychiatric Residency Training
ABPN	American Board of Psychiatry and Neurology
AMA	American Medical Association
APA	American Psychiatric Association
APIRE	American Psychiatric Institute for Research and Education
ASA	American Society of Anesthesiologists
CME	Continuing Medical Education
CMS	Centers for Medicare and Medicaid Services
CMSS	Council of Medical Specialty Societies
CPOE	Computerized Physician Order Entry
ECT	Electroconvulsive Therapy
FDA	Food and Drug Administration
FMEA	Failure Mode and Effects Analysis
GME	Graduate Medical Education
HCFA	Health Care Financing Administration
HMO	Health Maintenance Organization
IOL	Institute of Living

IOM	Institute of Medicine
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
MIT	Member in Training (APA)
NAMI	National Alliance for the Mentally Ill
NAPHS	National Association of Psychiatric Health Systems
NASMHPD	National Association of State Mental Health Program Directors
NPSF	National Patient Safety Foundation
NQF	National Quality Forum
PCP	Primary Care Physician
PDA	Personal Digital Assistant
PRITE	Psychiatry Resident In-Training Examination
QPR	Question Persuade Refer
RCA	Root Cause Analysis
VA	Veterans Administration
VISN	Veterans Integrated Service Network