

Responding to Symptoms of Mental Illness in Primary Care Clinic Settings

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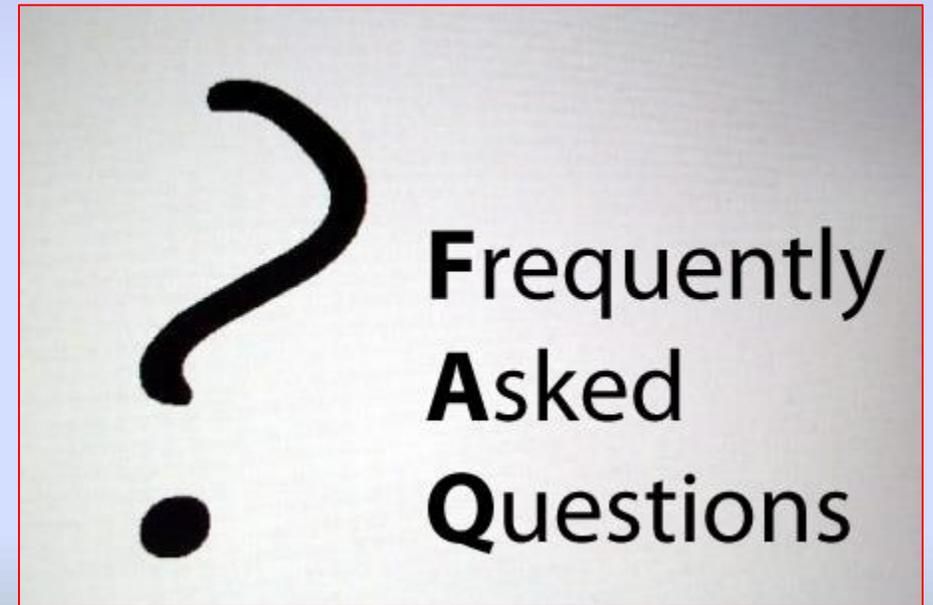
WHAT | WHEN YOU | WHAT
TODO | DON'T KNOW | TODO

What *kinds* of behaviors/conduct
cause problems here at Heartland?

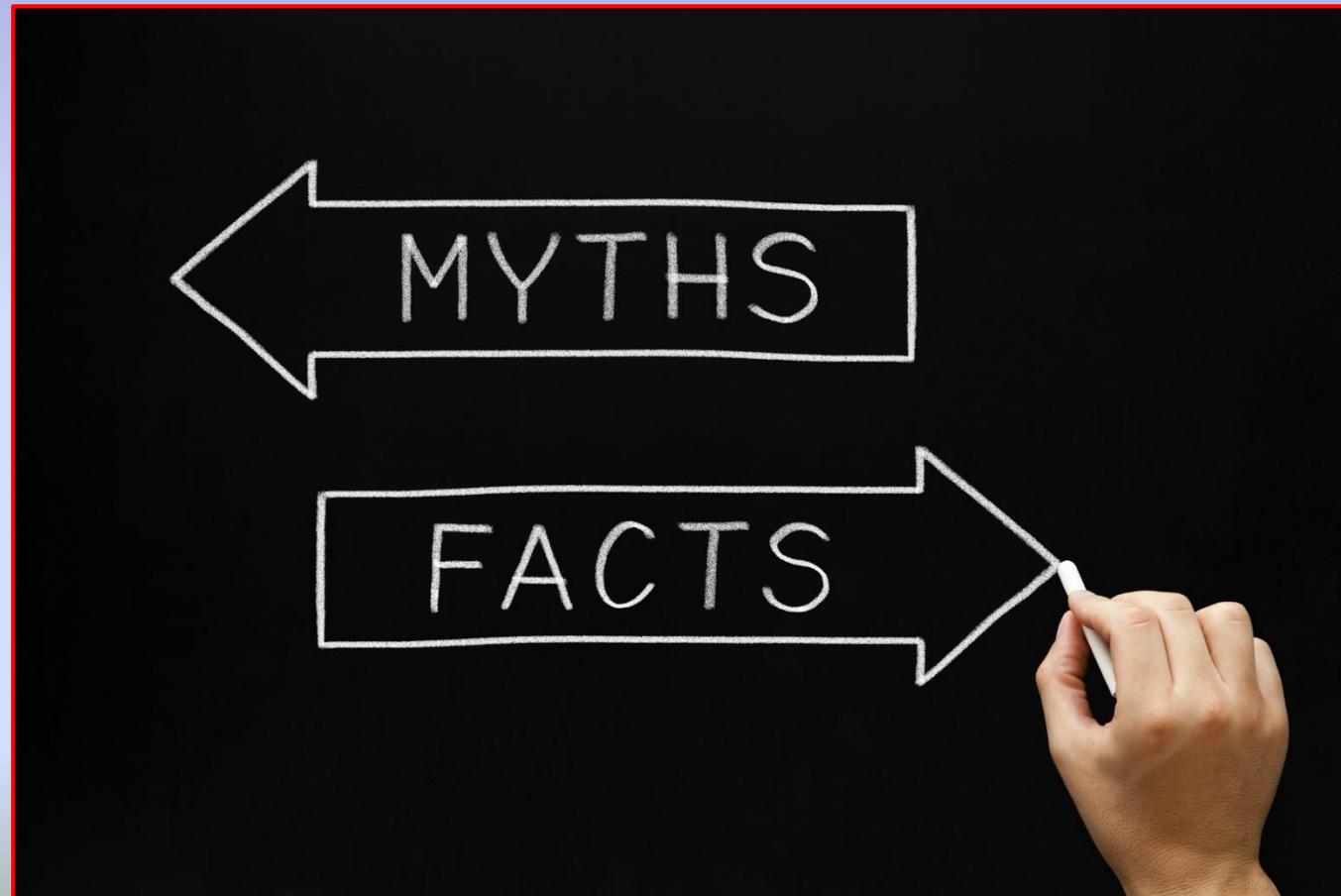
problematic

- Are they likely to become violent?
- Why don't they just stay on their medication?
- Why can't they understand that **EVERYBODY** has to wait their turn?
- I shouldn't agree with their paranoia or delusions, should I?
- What if I can't understand what they are talking about?
- Why can't they follow simple directions?
- What if they scare me or I feel threatened by them?
- Other questions?

Common FAQs about people with mental illness in clinic settings



Mental illness and violence; separating truth and fiction



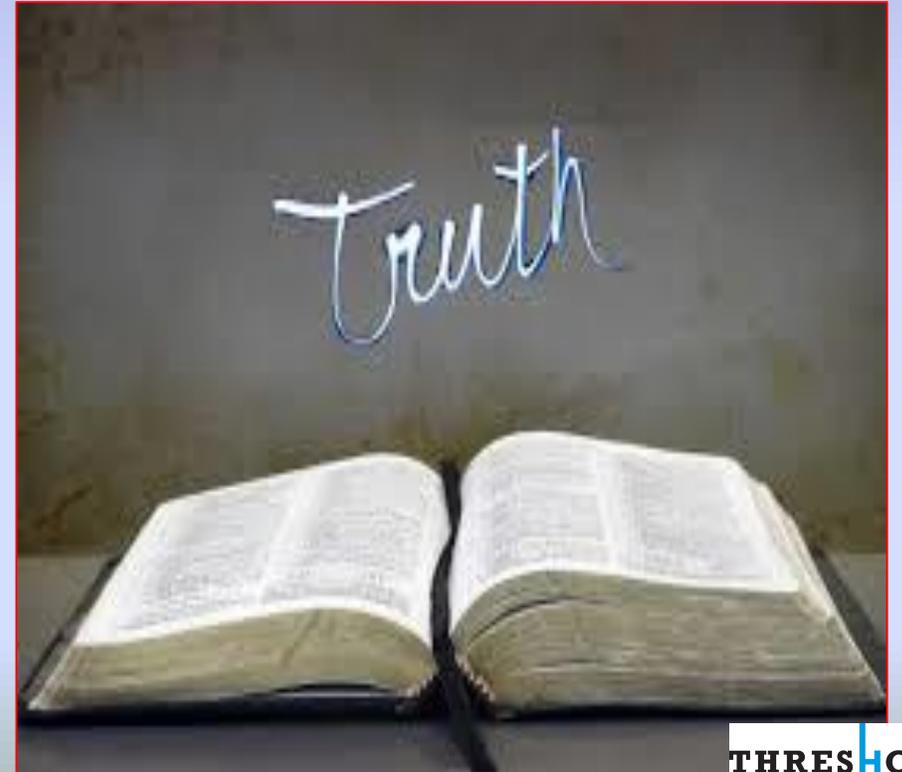
- Psychiatric illnesses with the associated feature of *psychoticism* (a break from reality) have a higher correlation with violent crime (10-12%)
- Mental illnesses that may have psychosis as a core feature
 - Schizophrenia
 - Schizoaffective Disorder
 - Bipolar Disorder
 - Psychotic Depression
 - Delusional Disorder
 - Severe personality disorder

Mental illness and aggression



Mental illness and aggression

- Persons with mental illnesses are **11 times** more likely to be the *victim* of violent crime rather than the *perpetrator*
- People with a history of trauma and post traumatic stress may be more susceptible to violent behaviors
- Substance abuse is a major determinant of violence and this is true whether it **occurs in the context of a concurrent mental illness or not.**



- Variables that elevate the risk of violent behavior in persons with mental illnesses
 1. History of perpetrating violence
 2. Past violent victimization
 3. Violence in surrounding environment (exposure)
 4. Substance abuse
- Variables considered to be protective factors regarding violence (i.e., deterrents)
 1. Prosocial family or other support
 2. Connection to treatment program or team
 3. Relatively stable housing
 4. Lower levels of impulsivity
 5. Minimal or no substance use

Violence and mental illness



- Stigma and marginalization
- Powerlessness and despair
- Deficits in social capital, i.e., social isolation and lack of connection to others
- Agitation and psychoticism
- Pervasive paranoia and persecutory beliefs
- Traumatic Brain Injury (TBI)
- Absence/unavailability of treatment or treatment non-adherence
- Threat/control override delusions (T/CO s)- delusions with anger, control or paranoid content
- Violent command hallucinations

Other risk factors for violence in people with MI



Important facts to remember

- Risk factors are just that: they merely *elevate* the possibility of violence; they don't incite, induce or ensure it.
- Print and other media tend to sensationalize stories about persons with mental illness and violence while neglecting to report on the overwhelming majority of people with mental illnesses who lead productive lives and never become violent.
- What have you heard, thought or believed about persons with mental illness and violence? What have been your experiences?



Exercise

- Form groups of three
- One of you will provide specific directions, by public transportation or car, from your neighborhood to this location, to a second person in your group.
- The third person will sit close to the ear of the person listening to directions and, using the rolled up sheet of colored paper, whisper the phrases from the script, directly into the person's ear.
- The goal is to stay in character as much as possible.
- I will tell you when to switch



What was that like?

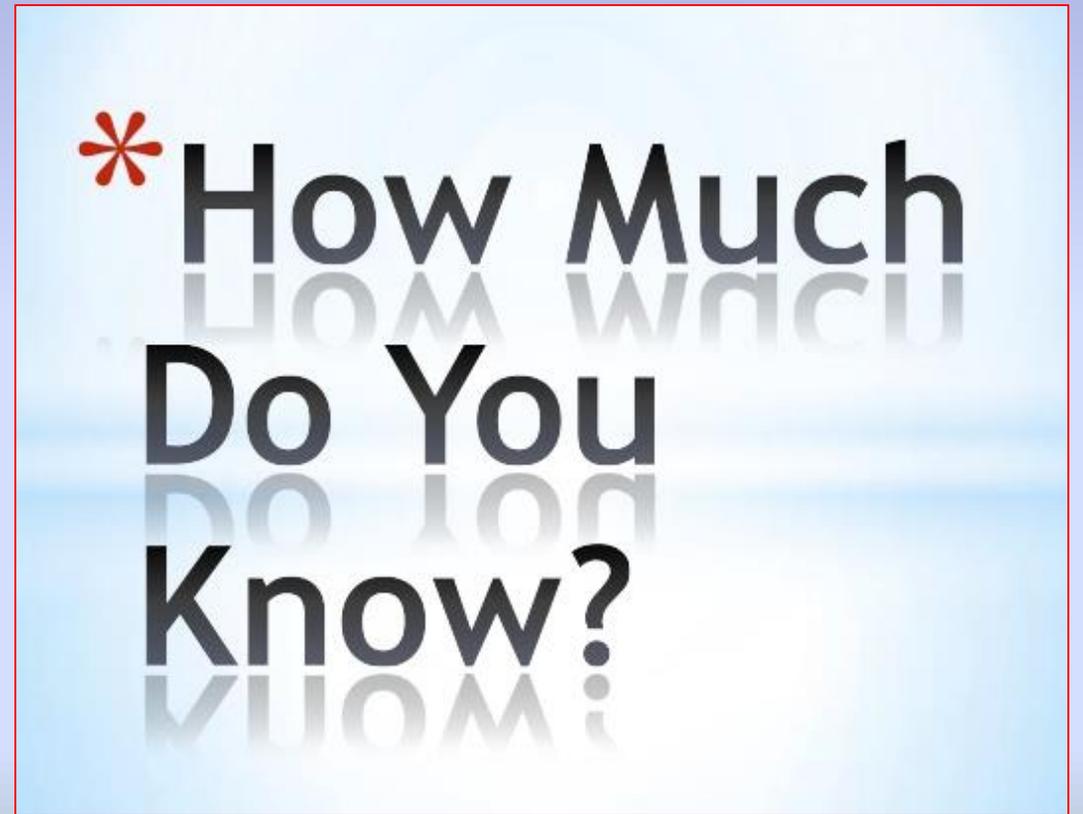
**tell me
about it**

...a wide range of diagnosable psychiatric illnesses that impair a person's ability to *think, feel, and behave* in a manner that allows optimum functioning in day-to-day life...

Mental health and mental illness occur along a continuum influenced by

- Biology and genetics
- Environment and circumstances
- Temperament/personality

What *is* mental illness?



- 1 in 5 people in the U.S. will be diagnosed with a major mental illness at some point in their lifetime
- 1 in 4 Americans have a 1st degree relative with a major mental illness
- Schizophrenia : .3-.7% worldwide
- Bipolar Disorder: 2-3%
- Major Depression: 10-25%
- Anxiety Disorders: 5-6%
- Substance Use Disorders: 10%
- Co-occurring trauma or PTSD, 50-90%

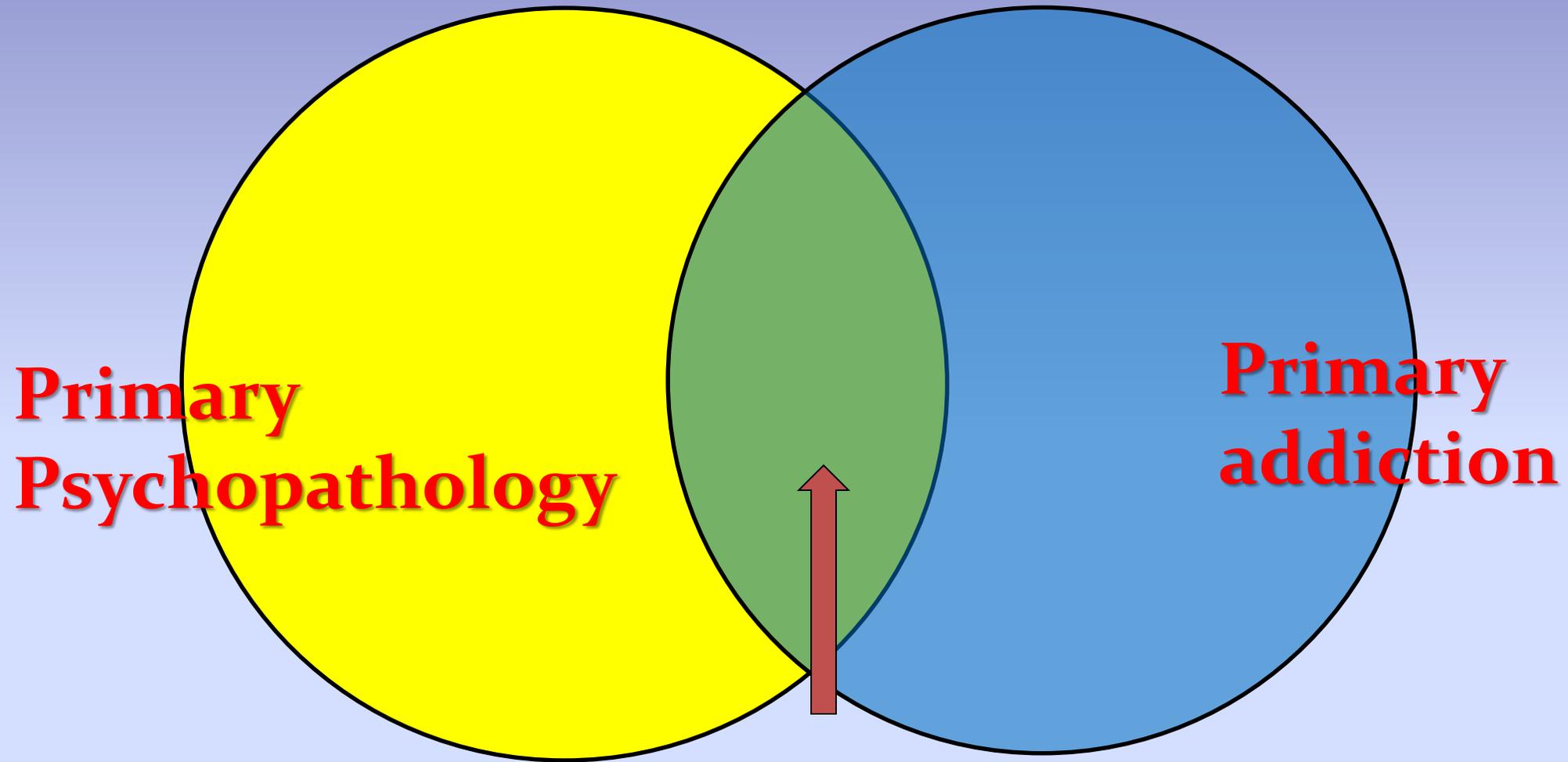
Prevalence of Psychiatric Disorders

Prevalence

&

Incidence

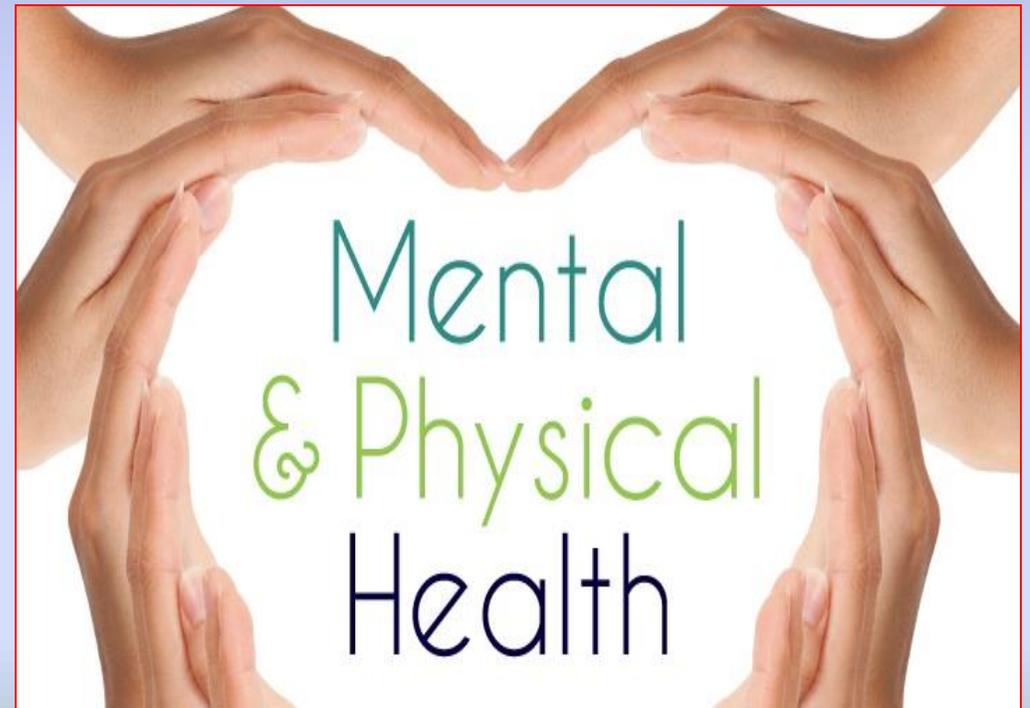
Mental Illness and Substance Use



Co-occurring Disorders

- Hepatitis B: 23.4% -(5% in general population)
 - Hepatitis C: 19.6% -(2% in general population)
 - Chronic pain syndromes
 - Tuberculosis
 - Cancers (esp. GI, liver and renal)
 - Issues related to poor diet and sedentary lifestyle
 - HIV: 3.1% - (0.5% in general population)
 - Diabetes: 10-15%
 - Morbid obesity: 25-50%
 - Hypertension: 15-18%
 - Tobacco-related diseases: 50-80% (lung cancer, COPD, asthma)
- ...and the many health problems associated with chronic substance use

Health problems in persons with severe mental illness



- Persons with severe mental illnesses often do not connect to medical services:
 - Absent or fragmented resources create problems negotiating system(s) of care
 - ‘Diagnostic and treatment overshadowing’ complicate accurate assessment
 - Generalized suspicion/distrust of medical providers
 - Perceived disrespect and discrimination on the part of medical providers
 - Lack of communication and coordination between providers
 - Poor adherence with treatment

Mental illness and Medical issues



Problems with psychiatric diagnosis

- Psychiatric diagnosis is **NOT** a science.
- There are many symptoms that overlap between diagnoses.
- Substance use complicates diagnosis and psychiatric illness complicates substance use
- Psychiatric illnesses vary in intensity and presentation.
- Mistrust, paranoia and lack of rapport with caregivers prevents honest communication.
- Diagnoses are wrong nearly as often as they are right.
- Diagnoses oversimplify and fail to communicate the reality of living with mental illness(es)



- “...the body's reaction to a change that requires a physical, mental or emotional adjustment or response.”
- Mental illnesses create a higher vulnerability and sensitivity to stress leading to a worsening of symptoms and potential relapses.
- Chaos and confusion owing to poverty and marginalization exacerbate existing stressors
- Visits to the doctor or clinic are commonly stressful activities for most people.

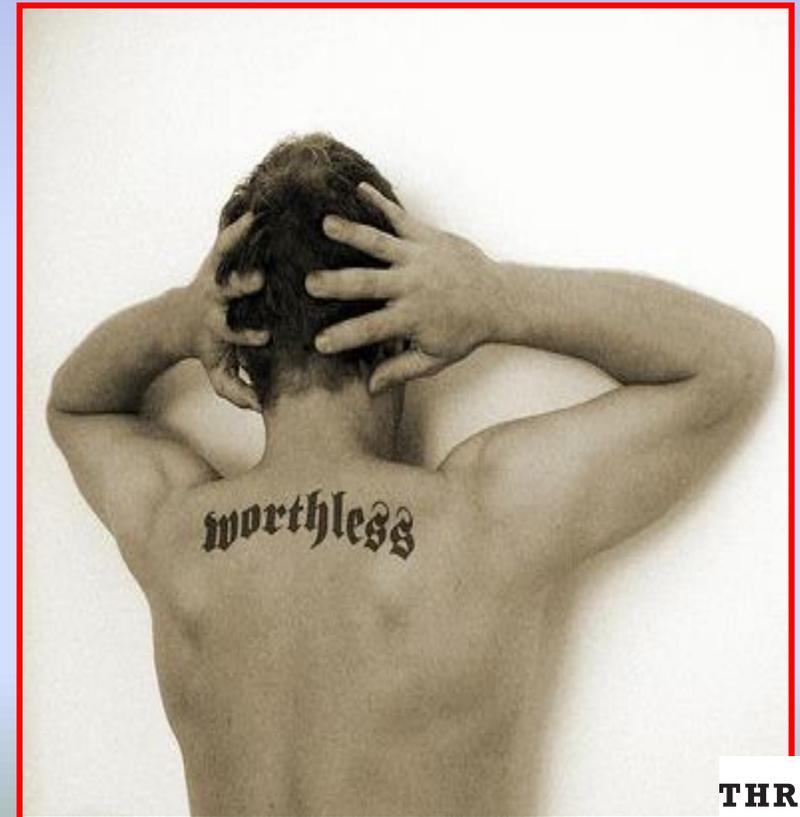
A word about stress...



- Individuals with serious and persistent mental illnesses (SPMI) often experience information processing biases; i.e. difficulty reading other people's emotions and body language accurately. There is a tendency to attribute negative intentions to strangers and to misinterpret verbal and non-verbal cues exacerbated by confusion, paranoia, other psychotic symptoms, panic or anxiety

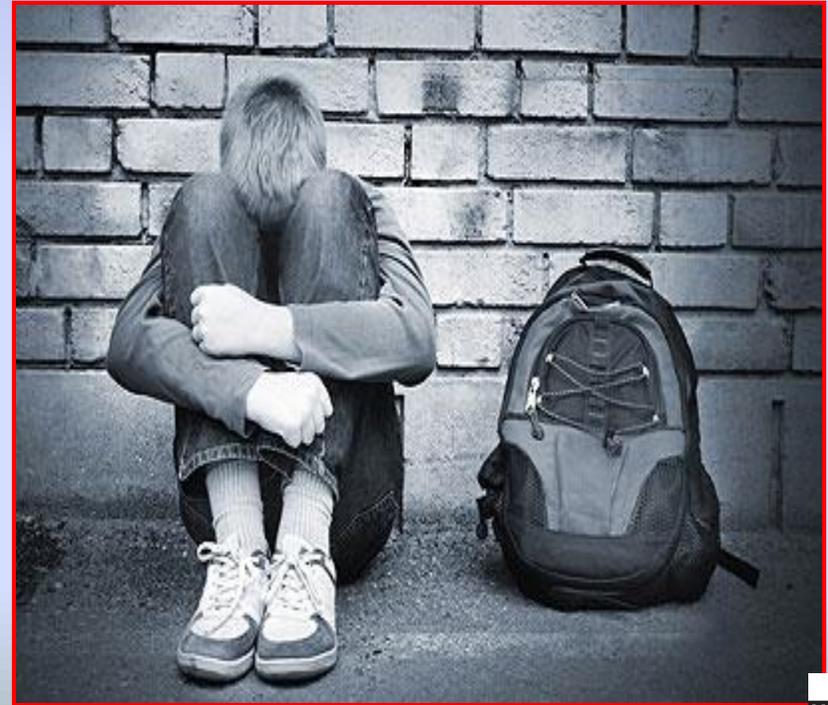
So... *“You will have to wait to see a doctor”* may be interpreted as *“You are unimportant and worthless”*

The experience of mental illness



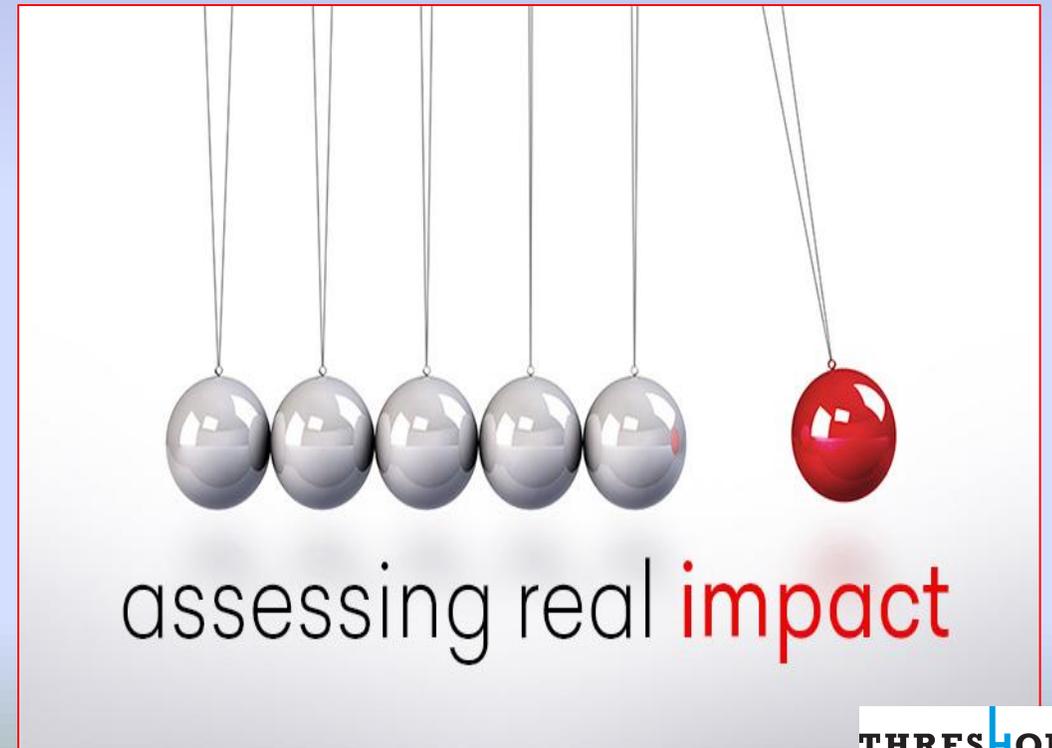
- Powerlessness
- Hopelessness and despair
- Feelings of invisibility and worthlessness
- Stigma
- Marginalization
- Suicidal feelings
- Loss of personal control
- Isolation
- Loneliness
- Not being listened to or understood
- Cumulative effects of poverty, homelessness, trauma, illness
- Unresponsive systems of care

People with mental illnesses often experience...



- Positive and/or negative symptoms of schizophrenia
- Anxiety and/or panic
- Cognitive deficits
 - Poor executive functioning
 - Trouble focusing
 - Limited “working memory”
- Impulse dyscontrol
- Deficits in social judgment
- Emotional dysregulation
- Problems with sensory gating, defensiveness and overstimulation
- Lack of distress tolerance
- Side effects of medications

People with SMI may also be impacted by....



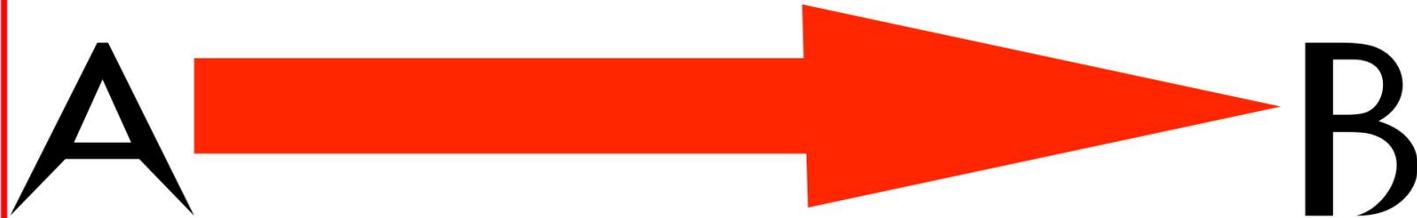
- Patient walks away and doesn't receive necessary medical treatment. Physical/mental health deteriorate
- Patient's feelings of being devalued and discounted are reinforced.
- Patient continues to be disruptive, compromising the comfort/safety of other patients and staff.
- Patient fails to obtain any subsequent treatment seriously jeopardizing physical and emotional quality of life.
- Behavior escalation; patient becomes physically aggressive.

Conflict and poor communication with patients may lead to...



There is usually a verbal precipitant to a physical outburst and a progressive development to a person's arousal or agitation over time

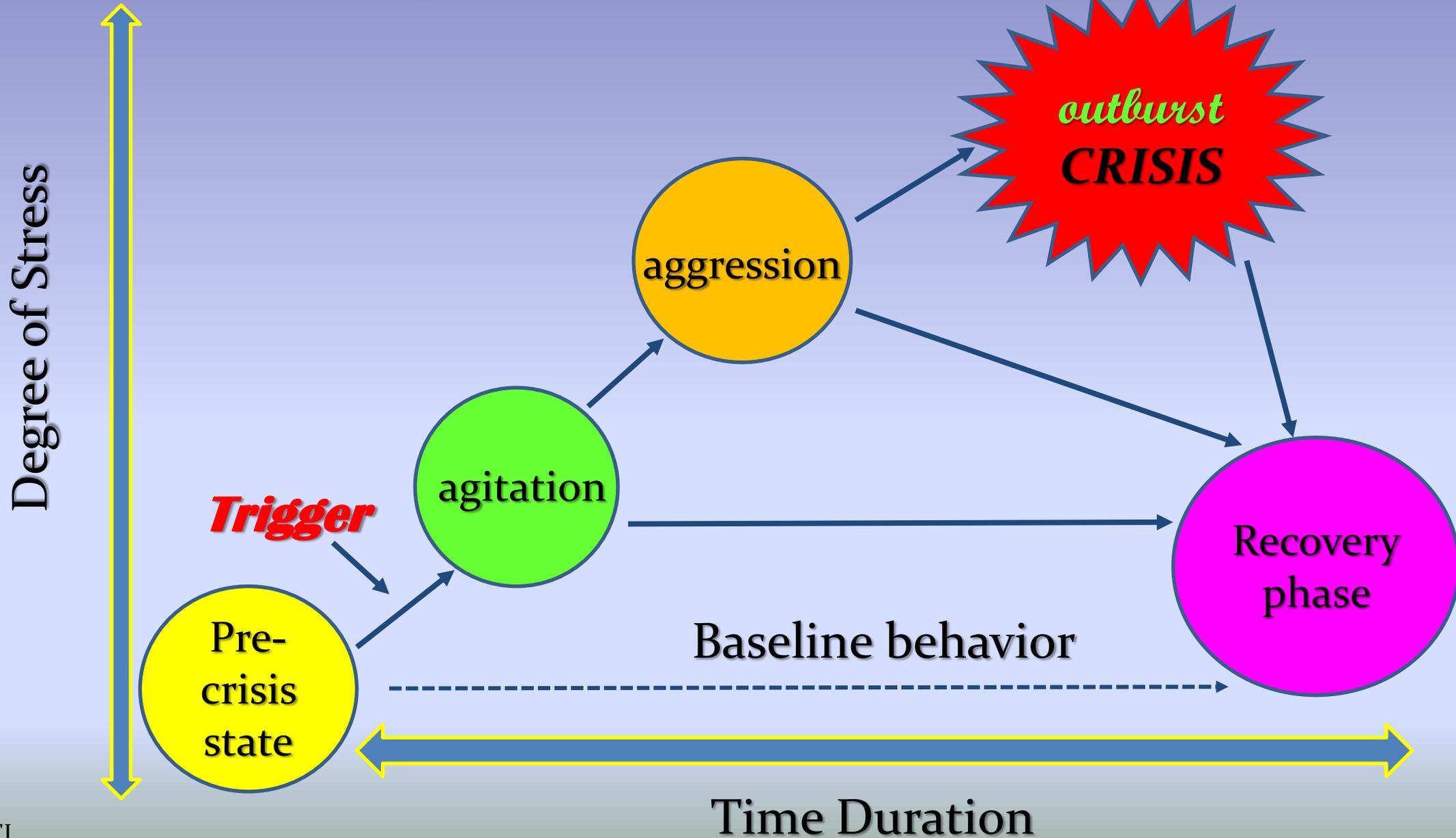
Progression



A way to understand this...



Stage model of Crisis Development



- What am *I* feeling right now?
 - Anger?
 - Frustration?
 - Fear?
 - Worry?
- What may the *member* be feeling right now?
 - Frustration?
 - Powerlessness?
 - Fear?
- How may the *environment* be affecting their experience?
- How do I *effectively and therapeutically* respond?

Things to
consider before
intervening

consider
this

Any physical or observable signs that are a marked deviation from baseline (customary)

- Tenseness of muscles
- Rigid posture
- Muttering
- Clenching of fists and teeth
- Facial grimaces or angry affect
- Statements of fear of losing control
- Unresponsiveness

Behaviors to look for in the agitation phase



Other?

Appropriate responses to agitation

- Maintain vigilance and observational assessment
- Demonstrate *empathy*
 - Ask interested, respectful questions
 - Repeat, rephrase, or summarize to gain clarity
 - Normalize and validate person's feelings
 - Solicit member's input; ask member to identify solutions and coping strategies
- Attend to physical space; keep appropriate distance, hands in sight, voice calm

Just Listen

Agitation and distress elevates

- Person becomes verbally abusive and/or loud
- Speech becomes more pressured
- Pacing, angry gesturing
- Referencing prior violence
- Making a mess, scattering clothes or objects
- Making general threats of violence or aggression
- Possibly exhibiting increased response to internal stimuli

Behaviors to Look for in the Aggression Phase



Appropriate Responses to Escalating Behaviors

- ***Maintain safe distance***
- Create safe space if possible (eliminate distraction, remove other people)
- Respectfully set limits and redirect, providing choices
- Keep an eye on exits
- Solicit input from member re: problem solving and helpful coping skills
- Keep cell phone handy
- ***Where possible, leave if requested to***
- Be prepared to call for help (911)



The Supportive Stance

- Be aware of potential exits and room layout
- Try to keep 2 ½-3 feet between yourself and the agitated individual
- Stand at an angle rather than face-to-face to appear less challenging or confrontational
- Angled stance allows for quicker movement if necessary
- Keep hands visible
- Maintain consistent, well-modulated, respectful but firm tone of voice
- Stay calm

STANCE



Loss of control intensifies

- Becomes physically menacing to you and/or others
- Clear behavioral dyscontrol—extreme gestures, choppy physical movements
- Makes overtly threatening gestures
- Throws objects down, bangs, kicks walls or furniture, damages property
- Articulates specific threats, curses, screams
- Punches self or pulls own hair

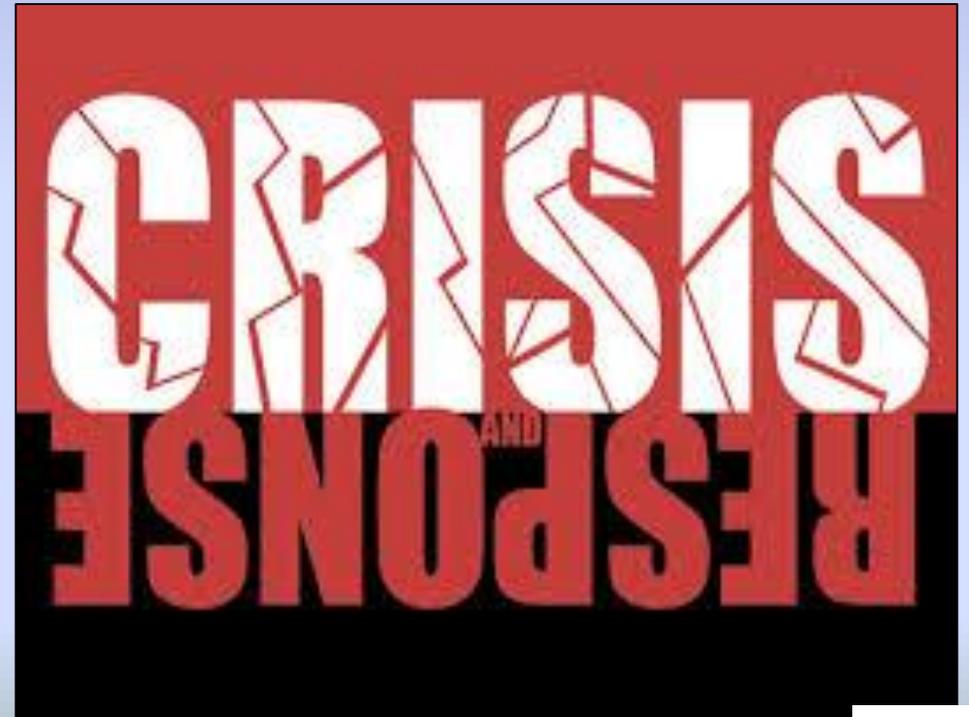
Behaviors to Look for in the Crisis Phase



Make ***SAFETY*** the priority

- Seek help (other staff or 911)
- Maintain calm posture and voice
- Provide additional space
- Keep area clear of other people
- Avoid direct eye contact
- Allow member to leave if so desired
- Allow member to “save face” if possible
- Maintain visual awareness of surroundings
- Don't threaten, direct, over-promise
- Don't try to be a hero

Appropriate Responses to Crisis



- Arguing with or countering
- Confronting or challenging
- Condescending or patronizing ('there, there')
- Dismissing or trivializing concerns
- Losing one's own composure
- Talking over someone
- Exhibiting impatience or disdain
- Standing too close
- Demonstrating excessive fear or paralysis
- ***Thinking this is a 'teachable moment'***
- Perception of disrespect

What does ***NOT*** support de-escalation

YOU'RE NOT HELPING!

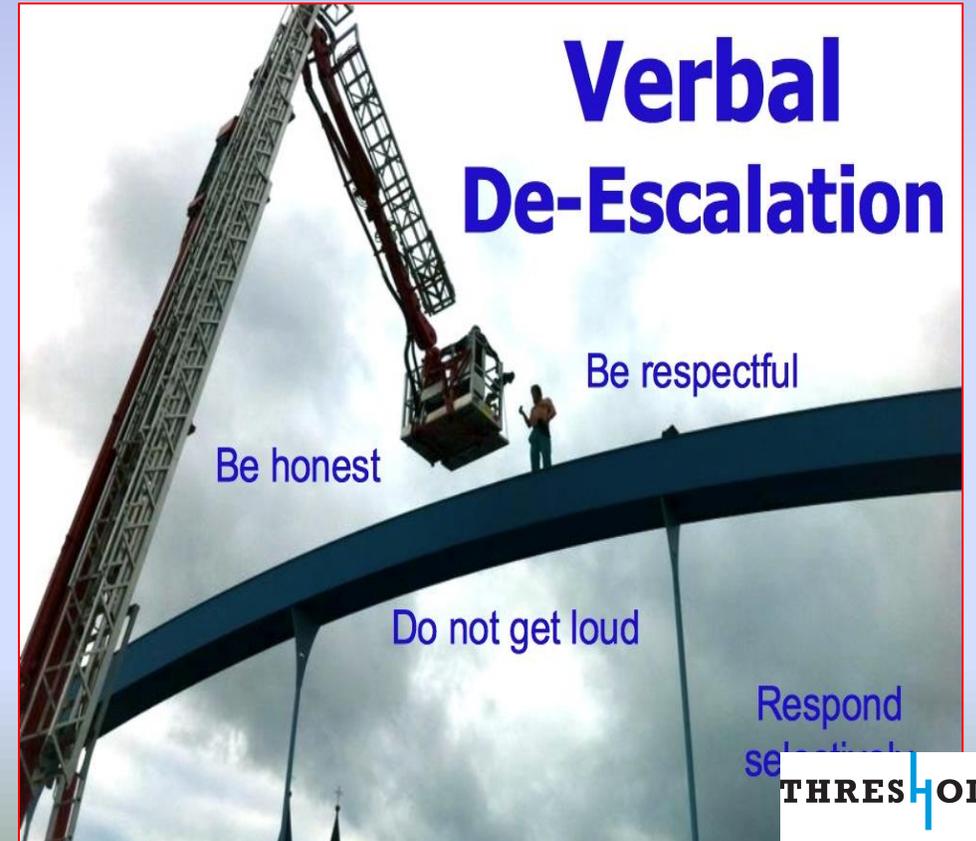
Tips for De-escalation

- Remember that what you say is not that important. Primary goal is to calmly lower level of arousal to baseline.
- Do not get loud or try to yell over a screaming person. Wait until he/she takes a breath; then talk.
- Speak calmly at an average volume.
- Respond selectively; answer all informational questions no matter how rudely asked. DO NOT answer abusive questions
- Explain limits and choices in an firm, but always respectful tone. Provide options where possible in which both alternatives are safe ones
- Empathize with and validate feelings, not behavior
- Do not interpret feelings in an analytic way.



Tips for De-escalation

- Do not argue or try to convince.
- Where possible, tap into the client's cognitive mode; ask people to order, number or rate something-it provides distance from emotions
- Provide information on the potential consequences of the current behavior without judgment, threats or anger.
- Represent external controls as institutional rather than personal.
- Trust your instincts. If you assess that de-escalation is not working, **STOP!** You will know within 2 or 3 minutes if it's working. Tell the person to leave, escort him/her to the door, call for help or leave, yourself, and call the police.



...and ***NEVER, EVER*** tell an angry person to
'just calm down'



Staff:

- Check in with each other periodically
- Discuss seeking additional help, if needed (EAP) or other resources
- Revisit discussion about incident
- Create a plan for the future

Member:

- Re-establish therapeutic bond
- Reassure member (if appropriate) that they will still receive treatment at the clinic
- Explore with them what happened (after they have returned to baseline)
 - What were the triggers?
 - What were they thinking and feeling?
 - What was going on in their body?
 - How do they feel about the consequences?
- Help them develop plans for recognizing strong feelings and developing skills to manage them

Post-Incident Follow Up



As a group, please consider the following vignettes

- Have a member of the group read it out loud
- Think about the following:
 - What are you thinking/feeling in the moment?
 - What might the patient be thinking/feeling in the moment?
 - What would you do first?
 - At what stage of crisis development would you place the patient?
 - What **specific** responses/actions might you take to deescalate the situation?
 - What kind of follow-up is warranted, if any?
 - Other comments/thoughts?

Practice



A patient walks into the clinic looking disheveled and smelling of alcohol. He is 90 minutes early for his regularly scheduled appointment. For a while, he sits quietly but at some point, he walks over to the reception desk and starts asking you personal questions and making suggestive comments: “how old are you?” “are you married?” “you are a fine looking woman” “I could treat you real right” How do you respond?



A patient has been coming to the clinic for several months. He is a large man and generally appears hostile and angry, muttering under his breath and whispering to voices. He is always accompanied by his Bridge worker who seems to be able to calm him when he gets agitated but the worker has been called away on an emergency. His pacing is becoming more frantic, he's getting louder and more agitated and other patients are beginning to look alarmed. He strides to the reception desk and demands that the "mf" doctor better see him next. What do you say/do?

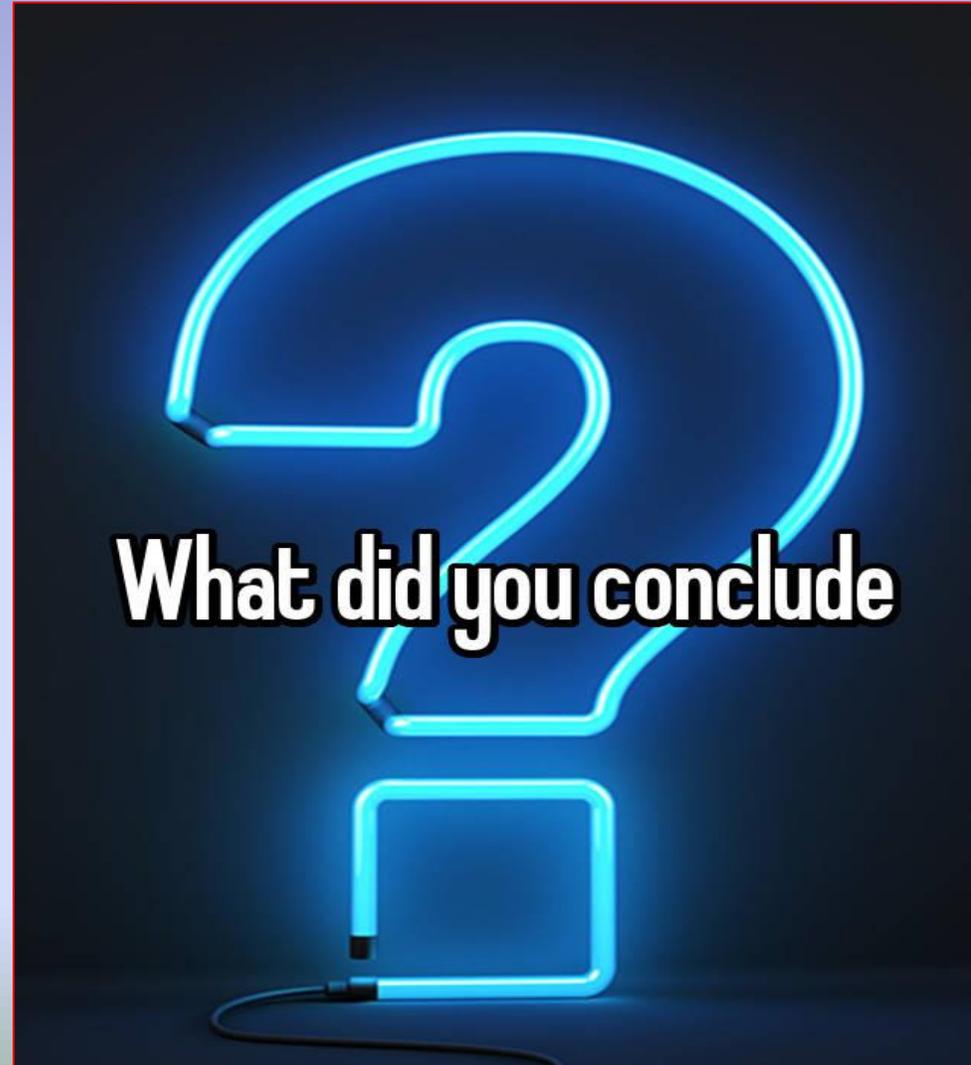
"So, what do you do?"

A female patient arrives at the clinic for her appointment. She is always quiet but this time, she does not respond when you ask her a question and sits, hugging herself and rocking with a glassy-eyed stare. She is whispering under her breath and appears very frightened. Another patient brushes by her and accidentally touches her arm. She becomes extremely agitated and upset, flailing her arms, moaning loudly and covering her eyes with her hands. She begins sobbing uncontrollably. Other patients begin to approach her to see if they can help. What do you do?



What Do You
Think?

Let's discuss...



- Try to demonstrate empathy and acceptance.
- Listen with respect, acknowledge the issue and validate feelings and experiences.
- Make efforts to *gently* redirect the individual to the task at hand.
- Inquire about personal comfort, i.e. “Would you prefer someplace quieter?” “What can we do to help you?” “How do you feel about answering some questions?”
- Check your tone of voice, volume and body language.
- Pay attention to verbal and non-verbal cues from the patient and adjust your responses accordingly.
- If necessary, excuse yourself and ask for help from someone else.
- Avoid direct eye contact with a person exhibiting paranoia. If possible, stand abreast of him/her as if facing a hostile world together.

No matter what the cause of the behavior...



Other useful tips

- When dealing with someone who is angry or agitated, listening respectfully conveys understanding. Avoid asking questions or re-directing immediately.
- When responding to someone who seems to be actively hallucinating, speak calmly and gently inquire what might help them feel safer and more comfortable.
- When dealing with someone who appears to be experiencing anxiety or panic, offer a quieter space, instruct them to relax their breathing and normalize their experience.
- In any situation where extreme emotions or discomfort are present, reassure the person that you are aware of their distress, and are willing to be helpful.
- **(1)** Listen to understand, **(2)** validate and normalize feelings **(3)** collaborate towards a solution

A red rectangular box with white, hand-drawn text that reads "How can we help you?". The text is written in a casual, slightly irregular font, with the words "How can we" on the top line and "help you?" on the bottom line.

Questions,
comments or
thoughts?



"Don't judge people.



You never know what kind of battle
they are fighting."

THRESHOLDS

HOME | HEALTH | HOPE

