General Hospital Psychiatry

Pacific Northwest Regional Hospital Medicine CME Conference
September 19, 2024 – 8-10 am session

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Disclosures

- No financial conflicts of interest
- This talk will discuss **off-label** use of medications
- Today's discussion of NMI (psychiatric holds) is **specific to Oregon**
- **NOT legal advice**
  - No part of this lecture constitutes legal advice
  - I am only sharing my personal understanding and comfort levels around certain medico-legal issues in peer-to-peer discussion
  - Consult your own attorney and/or hospital attorney as needed
  - I'm speaking for myself, not for OHSU

Request from the planning committee

- Types of holds
  - When to file an NMI *vs*. Medical Hold
  - Liability to providers when initiating holds
- “Go to” first line medications
  - First line approach for managing behaviors in setting of encephalopathy

Notice of Mental Illness (NMI)

- Each US state has process for involuntary psychiatric treatment
- Oregon: “Notice of Mental Illness” is first step in involuntary commitment
  - “Psych hold” – “two physician hold” – “2-doctor hold” – “hospital hold”
- Along the lines of:
  - “I can’t safely discharge this person to outpatient psychiatric care”
  - “But they aren’t agreeing to inpatient psychiatric care”

NMI – statutory considerations

- (ORS 426.005) “Person with mental illness” means a person who, because of a mental disorder, is one or more of the following:
  - Dangerous to self or others
  - Unable to provide for basic personal needs that are necessary to avoid serious physical harm in the near future, and is not receiving such care as is necessary to avoid such harm
- The unwritten part – connect acute mental illness with acute danger
  - Patient with “Truman Show” delusion hugging strangers downtown, scalp lac, return visit to ED for infection, still delusional
  - Patient found unresponsive in squalid conditions, hadn’t filled meds x2 months, previously stable when taking meds

NMI – commentary

- Qualifying mental illnesses ≠ everything in the *DSM*
  - Schizophrenia, schizoaffective disorder, bipolar disorder, very severe cases of major depression, occasionally eating or personality disorders
  - NOT delirium, dementia, anxiety; generally NOT substances or TBI
- Thresholds – generally a very high bar
  - Dangerous to self or others – must be imminent risk
    - Example: Did police presence interrupt an episode which is likely to continue if the patient is released? vs has the moment passed?
  - Unable to provide basic personal needs
    - Getting one meal most days, sleeping under a bridge = providing basic needs
    - Repeated admissions for DKA/HHS = probably providing basic needs
    - Unresponsive in tent during routine outreach worker visit = not providing basic needs

Eligible hospitals

- Only some hospitals can initiate an NMI
  - Must be approved as a “Holding Hospital” under Oregon Health Authority
  - Work with your local staff to determine whether you are a holding hospital (see Oregon Administrative Rules 309-033-0530, 309-033-0700, and other rules from Chapter 309, Division 33 related to “persons in custody”)
- If you are not a Holding Hospital your hospital may still be able to initiate an emergency hold (not NMI) under “Transport Hold” rules
  - Can be used to transport patient to a Holding Hospital
  - Work with your local staff to determine eligibility (OAR 309-033-0230 and other rules from 309-033)

When to file NMI – putting it together

- You are at an eligible holding hospital under OHA
- And the patient has a severe mental illness, and either:
  - They are *(imminently!)* dangerous to self or others, or:
  - They are *(profoundly!)* unable to provide their basic needs
- And the person needs high acuity treatment
  - “I can’t safely discharge this person to outpatient psychiatric care”
  - “But they aren’t agreeing to inpatient psychiatric care”

…then you are ready to file an NMI!!

What next?

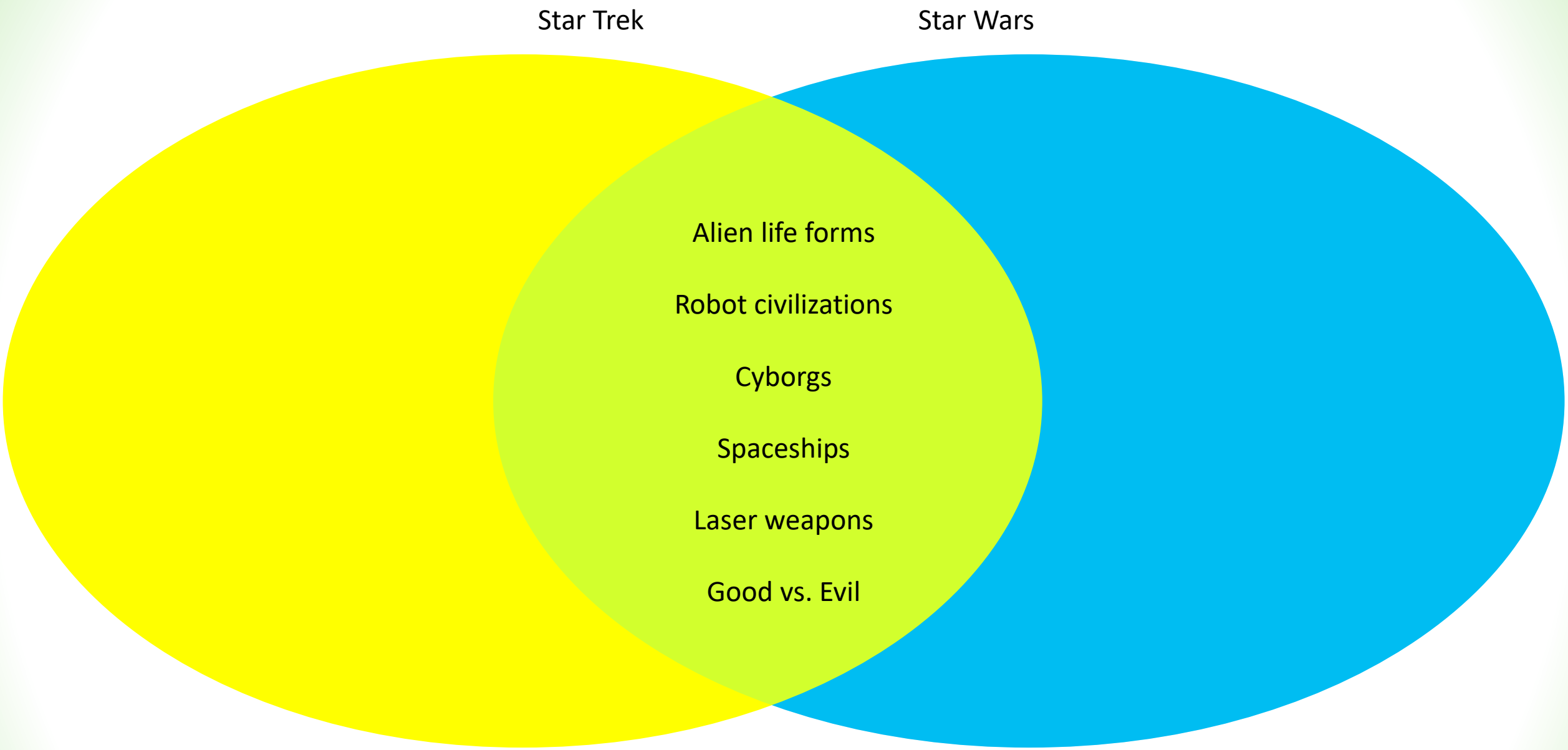
- Complete hold paperwork
  - Holding Hospitals often have their own internal version of the form and internal process
- Refer patient
  - Refer patient to inpatient psychiatric unit once medically clear
- County will investigate the hold, by judicial day #3 will make a recommendation:
  - “No Hearing” – civil commitment will not be pursued
  - “Hearing” – will pursue civil commitment hearing, judge decides outcome

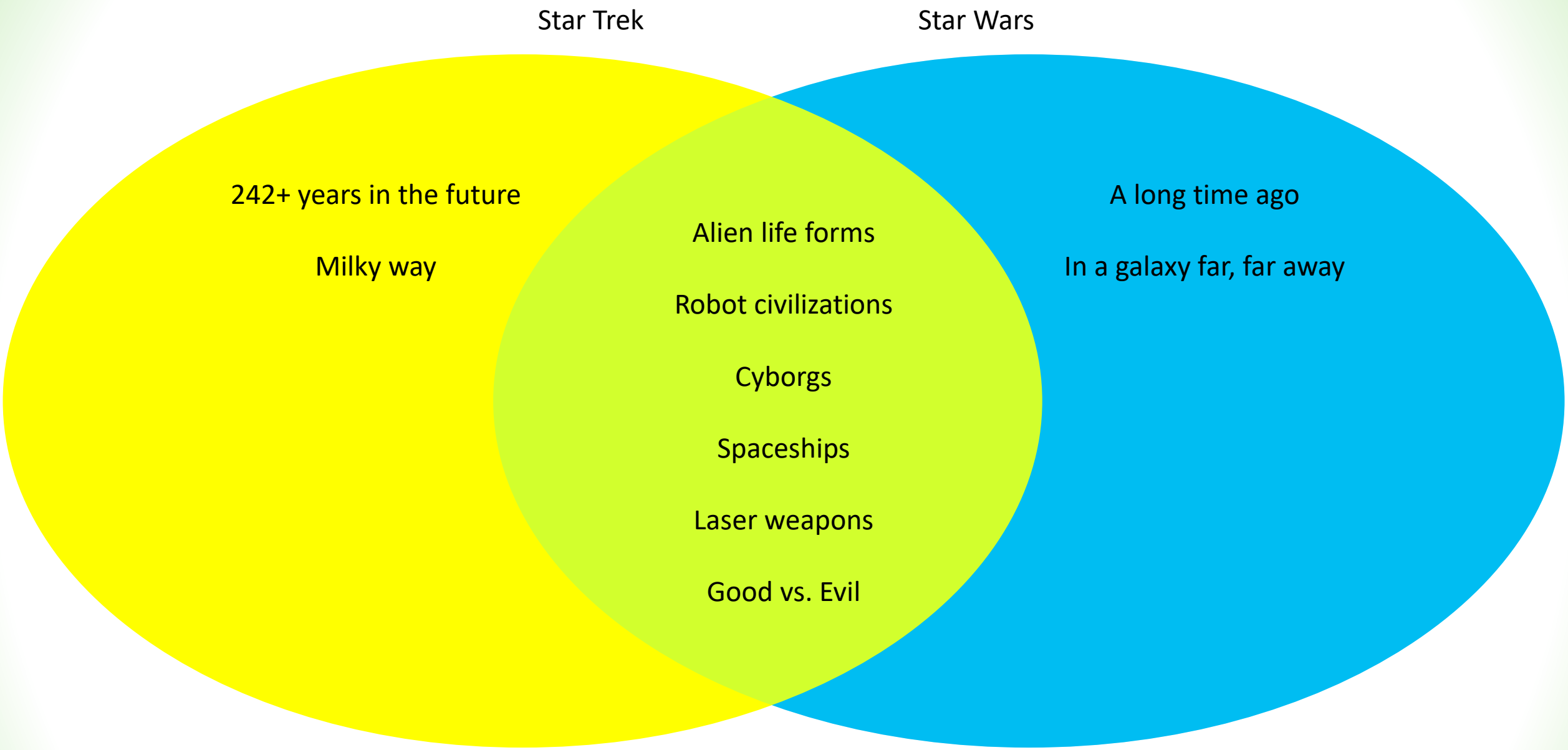
Liability in NMI's – the only easy issue

Statute (ORS 426.335)

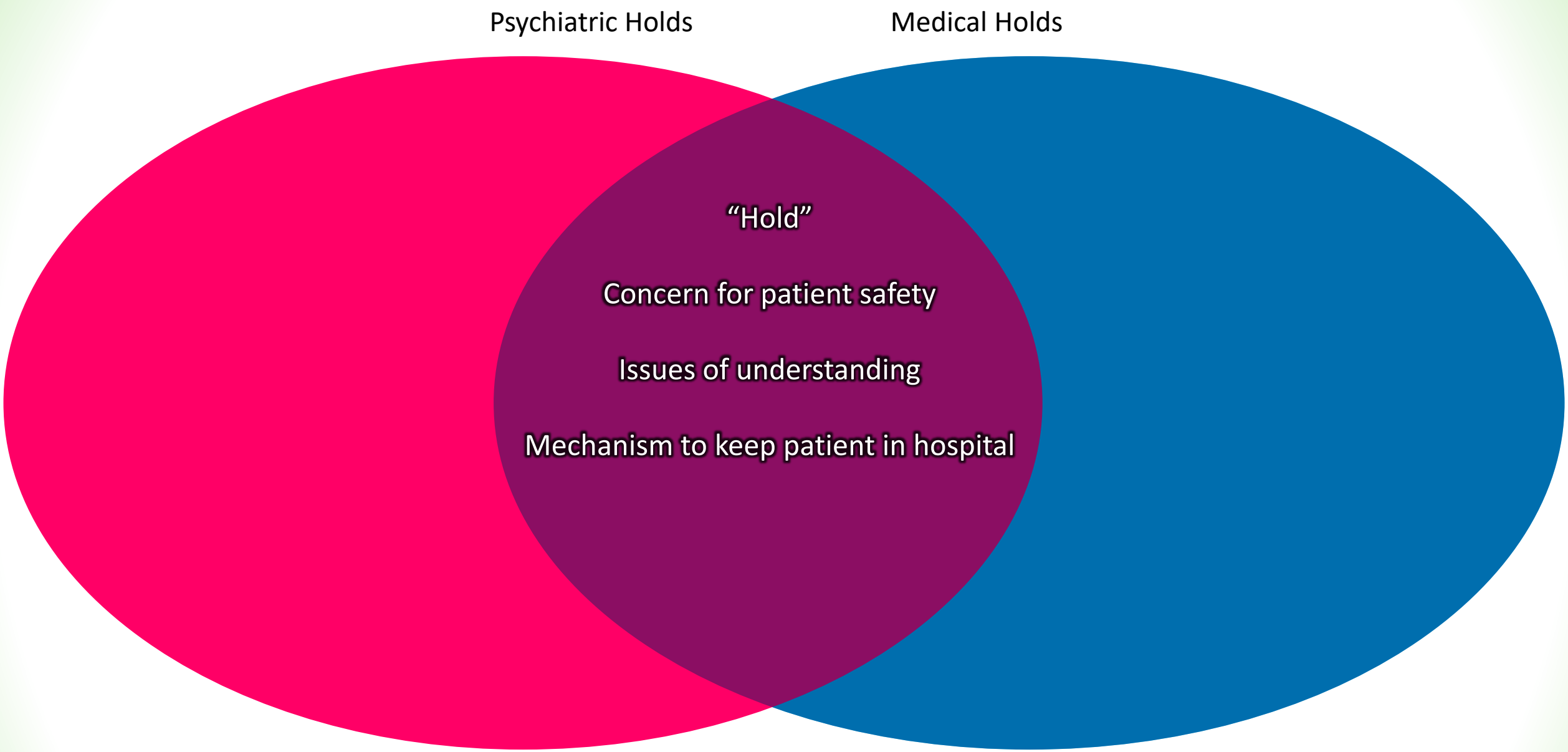
- "(1) The following individuals may not in any way be held criminally or civilly liable for the initiation of commitment procedures… provided the individual acts in good faith, on probable cause and without malice…
- "(g) Any independent practitioner associated with the hospital or institution where the person alleged to have a mental illness is a patient."

Consult your own/hospital attorney,
in my practice I feel comfortable that liability is limited!

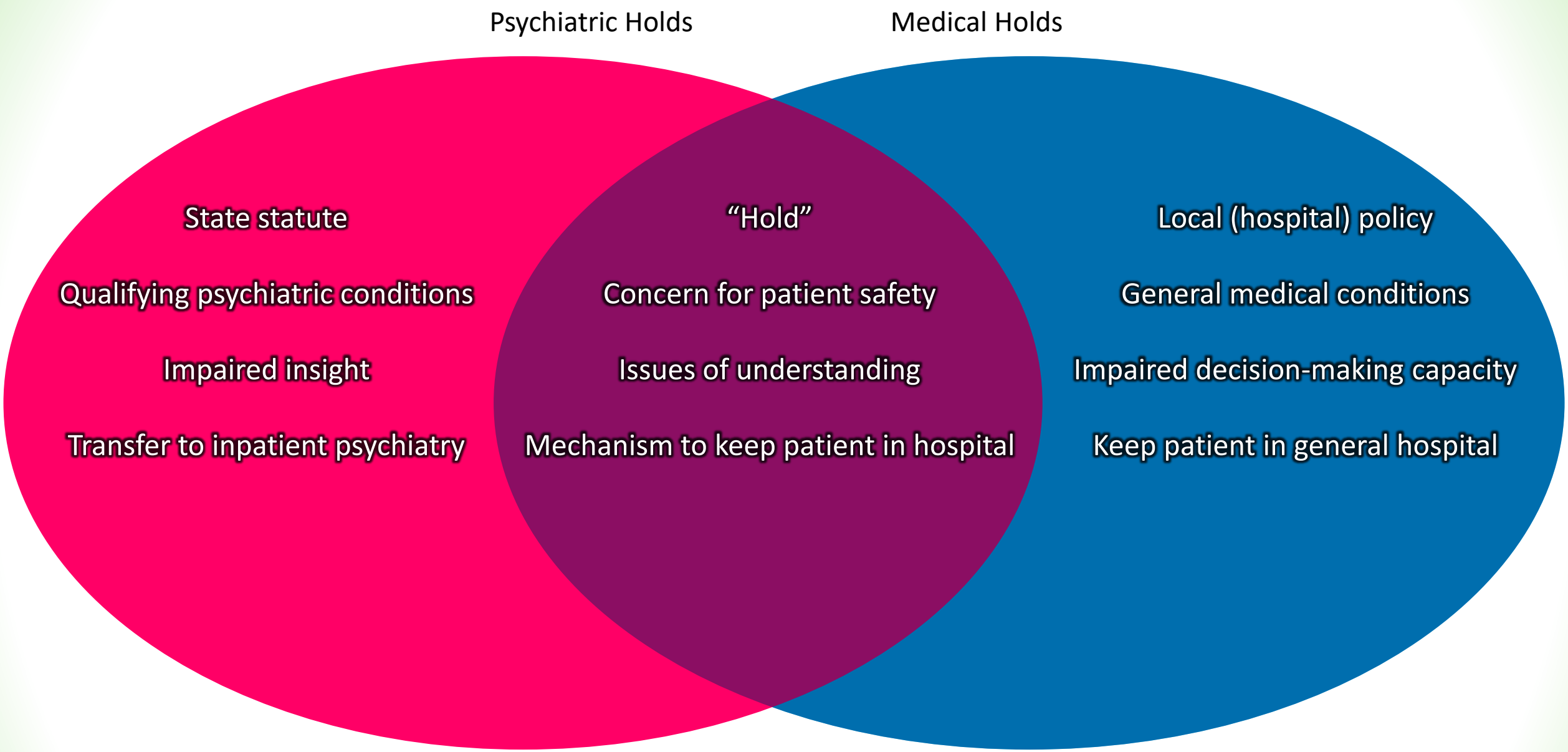

Star Trek
Star Wars
Alien life forms
Robot civilizations
Cyborgs
Spaceships
Laser weapons
Good vs. Evil



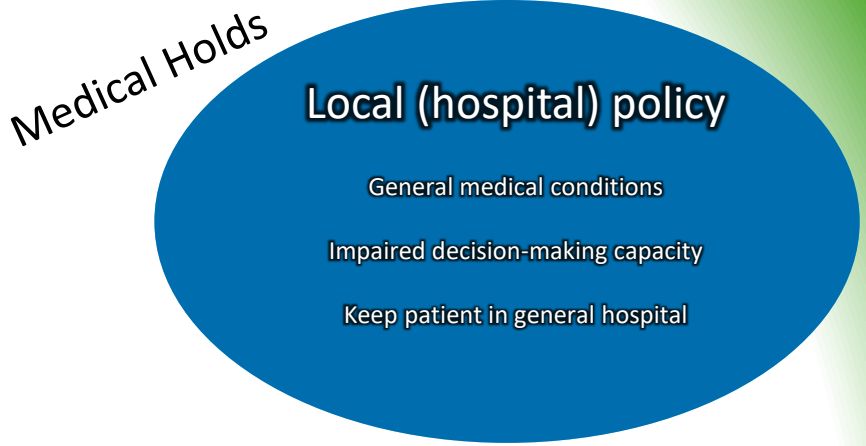
Star Trek and Star Wars are unrelated fandoms;
neither exists in the other's world; don't let the similarities distract you!



Similar terms and concepts, but Psychiatric Holds and Medical Holds are unrelated; they are unaware of each other; don't let the similarities distract you!

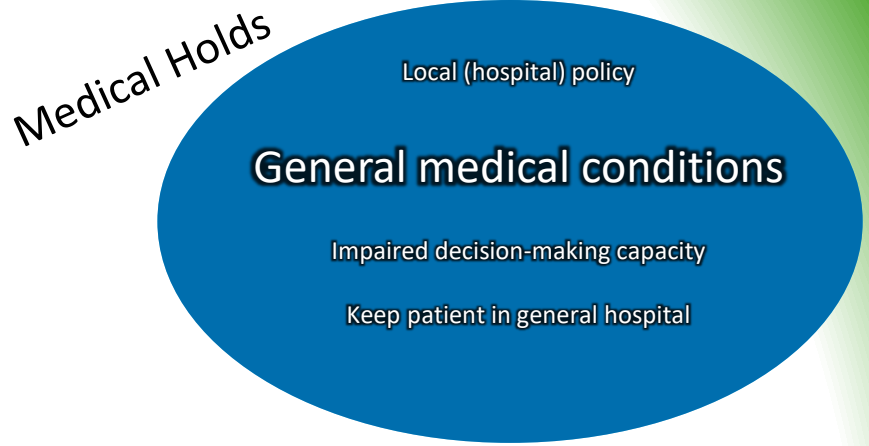

Psychiatric Holds
Medical Holds
State statute
Qualifying psychiatric conditions
Impaired insight
Transfer to inpatient psychiatry
“Hold”
Concern for patient safety
Issues of understanding
Mechanism to keep patient in hospital
Local (hospital) policy
General medical conditions
Impaired decision-making capacity
Keep patient in general hospital

Local (hospital) policy



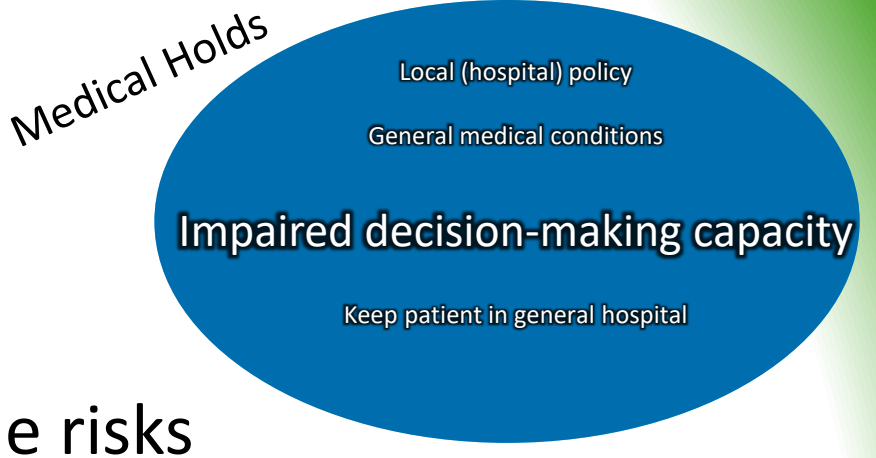
- Medical holds are local policy
  - No statute authorizes holding a **general medical** patient against their will
  - Hospitals may choose to adopt “medical hold” or “incapacity hold”
- OHSU’s “Emergency 72 Hour Medical Hold” policy (simplified):
  - Patient lacks capacity to … leave against medical advice…
  - Patient does not have an active mental illness…
  - Patient is asking or demanding to leave …
  - The discharge would mean terminating needed treatment.
- Medical hold at OHSU:
  - Time limited, opportunity for patient to regain capacity
  - Repeated capacity assessments required
  - Automatic consult to SW to identify surrogate decision maker

General medical condition



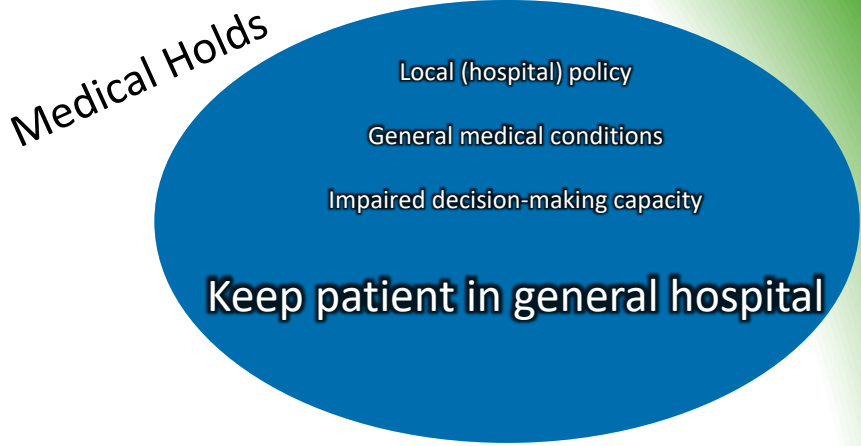
- Medical holds are a work-around
  - No legal mechanism to detain an incapacitated, medically ill patient
  - But discharge is seriously dangerous
- Limited to (NON-psychiatric) medical conditions
  - Since dementia, TBI, delirium, substance intoxication do not qualify for NMI, likely okay to use medical hold

Impaired capacity



- Reasonable people of sound mind can take some risks
- Being released from the hospital with a serious condition could raise concern for medical negligence
- Balance parentalism vs autonomy by assessing medical decision-making capacity

Keep patient in general hospital



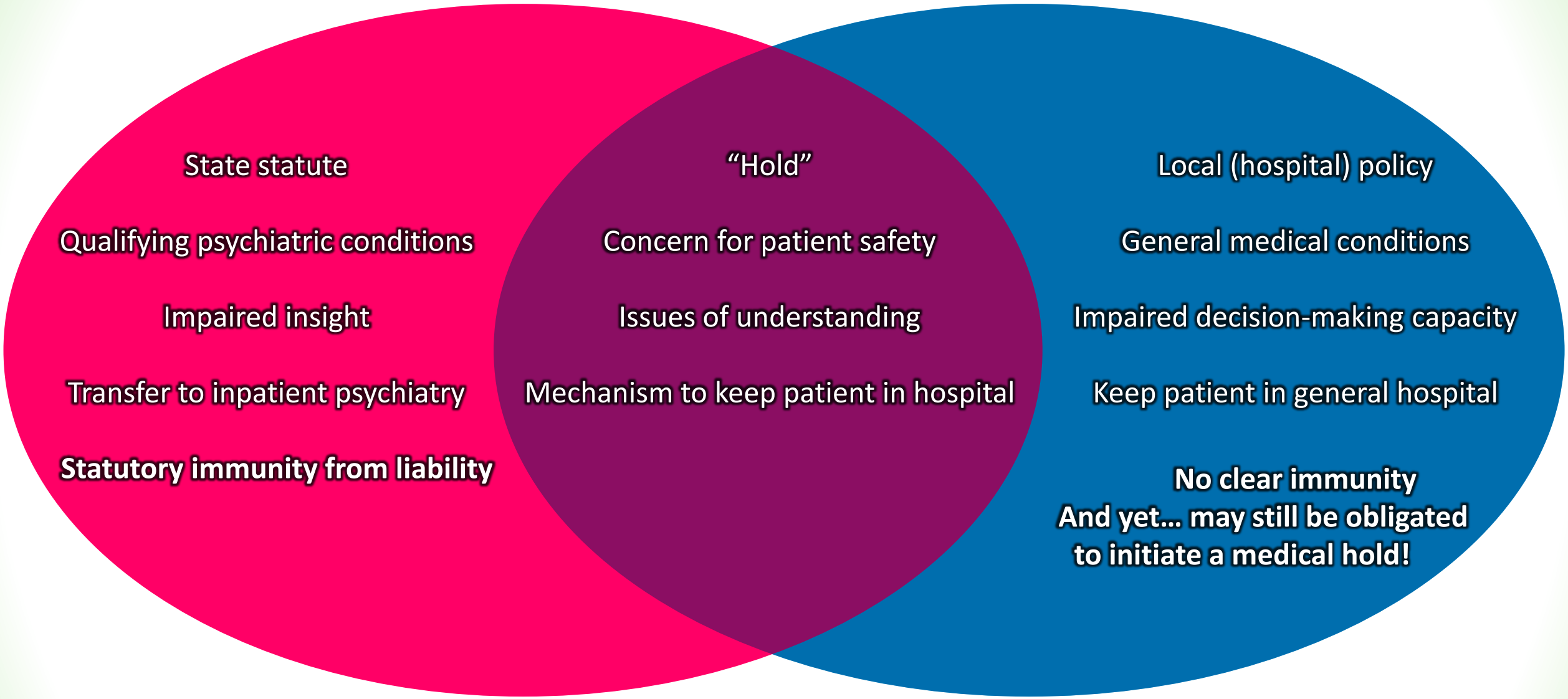
- To the extent allowed by policy, a medical hold authorizes you to keep patient in hospital
  - Doesn't mean you have legal authorization to detain person
  - Just means you're not violating your employer's policies
- Generally does not authorize further treatment

Example vignette

- Example case:
  - Mr. X is a 70-year-old male with history of alcohol use, chronic pain on ibuprofen, and untreated GERD, who presented for fatigue and found to have Hb 6.1 with concern for GI blood loss
  - He becomes frustrated with the wait time in the ED and prepares to leave
  - Falls on his way out from his ED room, combative with people helping him up, still insists on leaving

Example vignette

- Example case:
  - Mr. X is a 70-year-old male with severe anemia who insists on discharge
- Response
  - Provider concerned that discharge is seriously unsafe
  - Evaluate for medical decision-making capacity (re: choice to discharge)
    - If capacitated → discharge
    - If incapacitated → medical hold
  - Decide what treatments are urgent (e.g., transfusion, EGD)
    - Separate decision-making capacity assessments (for each decision)
    - Identify and involve surrogate decision-makers as needed
    - Ethics committee/surrogate decision-maker committee if needed


Psychiatric Holds
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State statute
Qualifying psychiatric conditions
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Transfer to inpatient psychiatry
Statutory immunity from liability
"Hold"
Concern for patient safety
Issues of understanding
Mechanism to keep patient in hospital
Local (hospital) policy
General medical conditions
Impaired decision-making capacity
Keep patient in general hospital
No clear immunity
And yet… may still be obligated
to initiate a medical hold!

Liability in medical holds – the hardest issue

- Allowing impaired patients to leave against advice
  - Risk of adverse events
  - Providers/hospitals may be liable for foreseeable harm
- Detaining medical patients under *psychiatric* holds is no good
  - Protected from liability for NMIs if acting in good faith
  - Known misuse of NMI for non-psychiatric patients ≠ good faith

Liability in medical holds – the hardest issue

- Medical holds
  - Liability trade-off:
    - Liabilities for letting patient AMA: medical negligence, abandonment, wrongful death
    - Liabilities for holding patient in hospital: false imprisonment, (?battery)
  - Damages for torts reflect degree of injury
    - Loss of earnings, pain and suffering, medical expenses; what damages do you expect…
      - If you let the patient AMA? If you hold the patient against their stated preferences?
    - How will bad outcomes be viewed in court?
      - Does my documentation reflect the risks of AMA discharge?
      - Did I document the impaired decision-making? (justify not honoring the stated decisions)
      - Did they have a good recovery as the result of my care while on medical hold?
      - Will independent expert witnesses say that medical hold saved patient from worse injury?

NOT LEGAL ADVICE
(this slide or any other slide of the talk)
Consult your own attorney and/or hospital attorney

Implementing medical holds

- If your hospital does not have a formal policy, consider working with hospital counsel to develop medical hold policy
- Sample policy available – “Medical Incapacity Without Mental Illness: A Legal and Ethical Dilemma for Physicians” *J Health Law and Life Sci 18(1)*:3-26

Request from the planning committee

- Types of holds
  - When to file an NMI *vs*. Medical Hold
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- “Go to” first line medications
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Medications

- Haloperidol
  - 5 mg PO/IM/IV Q4H PRN agitation, NTE 20 mg/24 hr in naive patients
  - Decades of experience, generally well tolerated
  - Not sedating = good for hypoactive delirium
- Olanzapine
  - 5 mg PO/IM Q4H PRN agitation, NTE 30 mg/24 hr in naive patients
  - Mild/mod sedating = helpful in hyperactive delirium
  - Well tolerated aside from metabolic syndrome
  - No IV
- Risperidone
  - 2 mg PO Q4H PRN agitation, NTE 6 mg/24 hr in naive patients

The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

Haloperidol for the Treatment of Delirium in ICU Patients

N.C. Andersen-Ranberg, L.M. Poulsen, A. Perner, J. Wetterslev, S. Estrup, J. Hästbacka, M. Morgan, G. Citerio, J. Caballero, T. Lange, M.-B.N. Kjær, B.H. Ebdrup, J. Engstrøm, M.H. Olsen, M. Oxenbøll Collet, C.B. Mortensen, S.-O. Weber, A.S. Andreasen, M.H. Bestle, B. Uslu, H. Scharling Pedersen, L. Gramstrup Nielsen, H.C. Toft Boesen, J.V. Jensen, L. Nebrich, K. La Cour, J. Laigaard, C. Haurum, M.W. Olesen, C. Overgaard-Steensen, B. Westergaard, B.A. Brand, G. Kingo Vesterlund, P. Thornberg Kyhnauv, V.S. Mikkelsen, S. Hyttel-Sørensen, I. de Haas, S.R. Aagaard, L.O. Nielsen, A.S. Eriksen, B.S. Rasmussen, H. Brix, T. Hildebrandt, M. Schønemann-Lund, H. Fjeldsøe-Nielsen, A.-M. Kuivalainen, and O. Mathiesen, for the AID-ICU Trial Group*

ABSTRACT

BACKGROUND

Haloperidol is frequently used to treat delirium in patients in the intensive care unit (ICU), but evidence of its effect is limited.

The authors' full names, academic degrees, and affiliations are listed in the Appendix. Dr. Andersen-Ranberg can be

Abstract Written Before Breaking the Randomization Code

BACKGROUND

Haloperidol is frequently used to treat delirium in intensive care unit (ICU) patients, but the evidence is uncertain.

METHODS

In this multicenter, placebo-controlled, blinded trial we randomly assigned adult, acutely admitted ICU patients with delirium to intravenous haloperidol (2.5 mg x 3 daily plus 2.5 mg as needed to total maximum daily dose of 20 mg) or placebo. The intervention was delivered in ICU if the patient had delirium. The primary outcome was number of days alive and out of hospital at 90 days.

RESULTS

We enrolled 1000 patients of whom 987 (98.7%) were included in the analyses, 501 patients assigned to group A and 486 to group B. Primary outcome data were available for 963 patients (97.6%). At 90-days, mean days alive and out of hospital was 35.8 days (95% confidence interval (CI) 32.9 to 38.6) in group A and 32.9 days (95% CI 29.9 to 35.8) in group B with an adjusted mean difference of -2.9 days (95% CI, -7.0 to 1.2, P=0.22). Mortality at 90 days was 36.3% in group A and 43.3% in group B (adjusted absolute difference -6.9 percentage points (95% CI -0.6 to -13.0). A serious adverse reaction occurred in 11 patients in group A and 9 patients in group B.

CONCLUSIONS

In ICU patients with delirium, assignment to A vs. B did not lead to statistically significant more days alive and out hospital at 90 days, but those assigned to A had lower 90-day mortality.

ABSTRACT

BACKGROUND

Haloperidol is frequently used to treat delirium in patients in the intensive care unit (ICU), but evidence of its effect is limited.

METHODS

In this multicenter, blinded, placebo-controlled trial, we randomly assigned adult patients with delirium who had been admitted to the ICU for an acute condition to receive intravenous haloperidol (2.5 mg 3 times daily plus 2.5 mg as needed up to a total maximum daily dose of 20 mg) or placebo. Haloperidol or placebo was administered in the ICU for as long as delirium continued and as needed for recurrences. The primary outcome was the number of days alive and out of the hospital at 90 days after randomization.

RESULTS

A total of 1000 patients underwent randomization; 510 were assigned to the haloperidol group and 490 to the placebo group. Among these patients, 987 (98.7%) were included in the final analyses (501 in the haloperidol group and 486 in the placebo group). Primary outcome data were available for 963 patients (97.6%). At 90 days, the mean number of days alive and out of the hospital was 35.8 (95% confidence interval [CI], 32.9 to 38.6) in the haloperidol group and 32.9 (95% CI, 29.9 to 35.8) in the placebo group, with an adjusted mean difference of 2.9 days (95% CI, –1.2 to 7.0) (P=0.22). Mortality at 90 days was 36.3% in the haloperidol group and 43.3% in the placebo group (adjusted absolute difference, –6.9 percentage points [95% CI, –13.0 to –0.6]). Serious adverse reactions occurred in 11 patients in the haloperidol group and in 9 patients in the placebo group.

CONCLUSIONS

Among patients in the ICU with delirium, treatment with haloperidol did not lead to a significantly greater number of days alive and out of the hospital at 90 days than placebo. (Funded by Innovation Fund Denmark and others; AID-ICU ClinicalTrials .gov number, NCT03392376; EudraCT number, 2017-003829-15.)

https://www.nejm.org/doi/suppl/10.1056/NEJMoa2211868/suppl_file/nejmoa2211868_appendix.pdf

- Secondary analysis:
  - “While there was a high probability of benefit *[from haloperidol]* on mortality, there was also a high probability of increased hospital length of stay. The most likely explanation is that treatment with haloperidol increased survival among sicker patients, leading to a longer hospital length of stay in this group…” (Andersen-Ranberg 2023 *Intensive Care Med*)
- Even though the first paper was considered a nail in the coffin for haloperidol in 2022, the reanalysis has received very little attention…
  - Some articles published in 2024 only cite the original analysis ☹
  - Mortensen 2024 *Intensive Care Med* –
    - Better 1-year mortality in group randomized to haloperidol

Medications

- Go-to medications:
  - **Haloperidol** 5 mg IM/IV Q4H PRN agitation, NTE 20 mg/24 hr in naive patients
  - **Olanzapine** 5 mg IM Q4H PRN agitation, NTE 30 mg/24 hr in naive patients
  - **Risperidone** 2 mg PO Q4H PRN agitation, NTE 6 mg/24 hr in naive patients
- (One) Strategy
  - Day #1 – order PRNs only
  - Until stable: Start/increase scheduled dose by 20-50% of prior day's PRN
  - Once improving: if no PRNs x1-3 days reduce scheduled dose by 10-20%

Medications

- Other pearls:
  - Acute dystonia = emergency – 2 mg IM/IV benztropine, repeat up to Q5-min x2 PRN, consider rapid response
  - Old, young, or other comorbidities – lower doses than prior slide
  - Some patient both tolerate *and* require much higher doses
  - D/C benzos, opioids, anticholinergics, other deliriogens
  - Do-not-disturb order 10 pm – 6 am (as soon as medically safe)
  - Treat underlying etiologies – multiple etiologies is the rule, single etiology is exception
  - Ambulation as tolerated

The end!

- Thank you
- Questions