Evaluation of Involuntary Psychiatric Holds Among Elderly Patients from 2009-2010

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Research Report

Evaluation of Involuntary Psychiatric Holds Among Elderly Patients from 2009-2010

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Abstract:

Introduction: Providing thorough assessment of elderly patients (65 years old or greater) in the acute hospital setting often challenges most experienced health care professionals. This is compounded when patients are not consciously seeking medical attention but have been brought in by various law enforcement or EMS as labeled “gravely disabled”, “danger to self”, or “danger to others.” Our investigative aim was to evaluate the usage of involuntary psychiatric hold (5150) among the elderly patient population at a large, urban hospital. Placement of these holds is variable depending on the enforcing party and only later evaluated for validity by a psychiatrist or psychologist.

Methods: A retrospective review of medical records was done between May 2009-April 2010 at Arrowhead Regional Medical Center in Colton, CA. The study was submitted and approved by an institutional review board prior to commencement. The inclusion criteria for this study were patients with age greater than 65 and 5150 placed prior to arrival or in the emergency department. The primary outcome was to compare the patients’ admitting diagnosis with their discharge diagnosis.

Results: One third of patients were found to have a valid psychiatric issue that required them to be placed in a geriatric psychiatric facility. The remainder of patients investigated had the 5150 hold released and were therefore discharged to family members, a skilled nursing facility, or homeless shelter. One third were treated for a medical condition other than psychiatric during their course of stay, and approximately one fourth were placed on antipsychotic medications.

Conclusion: The vast majority of 5150 holds placed on elderly patients are inappropriately administered and ordered. The resources utilized on 5150 elderly patients unfairly burden our healthcare system and a more revised system is recommended for better placement and usage of the involuntary holds.

Key Words:

Psychiatric hold, 5150 hold, elderly patient, elderly depression
Introduction

Arrowhead Regional Medical Center (ARMC) is a 456-bed tertiary care center with a free standing inpatient Behavioral Health Unit on site. ARMC is not equipped to provide elderly psychiatric care and therefore these patients are admitted to general medicine wards. The aim of this study is to further properly stratify patients placed on this hold and review admission diagnosis and discharge diagnosis.

Originally described in Section 5150 of California Welfare and Institutions Code, the policy went into full effect as part of the Lanterman-Petris-Short Act (LPS) in 1972. In essence the LPS Act was designed to provide persons with mental disorders with prompt appropriate evaluation regarding their detainment at a facility deemed to be capable of this assessment. The terms Danger to Self, Danger to Others and Gravely Disabled are thus applied to these behaviors. However the interpretations of these terms by the enforcing party may be variable and often do not strictly follow the definitions. Evaluation by a psychiatrist or psychologist must be made within the timeframe of the detention to evaluate for correct fulfillment of the criteria and either release the hold or assist in the treatment plan.

Through a retrospective chart review, this study aimed to evaluate if elder patient admitted for a irreversible cognitive or psychiatric process had a reversible component of organic etiology. By comparing patient’s admission and discharge diagnosis, trends documented could change how health professionals evaluate elderly and promote a greater awareness when placing a 72 hour detention on these patients.

Methods

The study was approved by the Institutional Review Board at ARMC. A retrospective chart review was conducted of all patients older than 65 years of age who were evaluated by psychiatric consult from June 2009- May 2010. These records were then evaluated to determine which patients were placed on a legal psychiatric hold, also known as a 5150. Medical records were obtained from the behavioral health unit. Chart review evaluated who placed the hold and whether it was danger to self or danger to others. Also the length of stay, co-morbidities, medications prescribed, admission diagnosis, discharge diagnosis and disposition upon discharge was obtained. The discharge was further placed in categories of home, versus skilled nursing facility, versus geriatric psychiatric facility, versus street or shelter, versus boarding care or assisted living. Our primary out come was to compare admission diagnosis with discharge diagnosis as to help determine the necessity or validity of the hold that was placed. The secondary outcome was to determine or prove the burden that is placed on the system and to make an argument that supports that a change needs to be made in the system.
Results

The total sample size of patients meeting the inclusion criteria was 135 patients; 10 of which were repeat patients. The patient’s ages ranged from 65-95 years old. Nearly 51% (69 patients) were male and 49% (66 patients) were female.

The results concerning the relationship between the three types of admitting 5150 hold are presented in Figure 1. The admission holds were comprised of 55.9% (80 patients) danger to self, 32.2% (46 patients) dangers to others, and 44.8% (64 patients) gravely disabled.

The majority of the patients were placed on a 5150 hold by the police department 79.7% (114 patients), 12.6% (18 patients) by the emergency department, and 7.7% (11 patients) by a miscellaneous category which included psychiatrist or crisis team. Additionally, of these patients, the majority, 71.3% (102 patients), were admitted in Arrowhead Regional Medical Center with an average length of stay of 5.9 days.

Demonstration of significant overlap of diagnoses
One third of the patients (44 patients) were transferred to geriatric-psychiatry unit or a behavior health unit, and 20% (27 patients) were placed in a skilled nursing facility. Only 5.2% (7 patients) required anti-depressant medication yet 32.6% (44 patients) were treated with medical intervention e.g. antibiotics and 20.7% (28 patients) required antipsychotic medication.

Upon final discharge 2.8% (4 patients) left against medical advice, 15.4% (22 patients) were discharged to a skilled nursing facility, 5.6% (8 patients) went to a boarding care or assisted living. 34.3% (49 patients) were discharged to a psychiatry facility while 33.6% (48 patients) returned home, 2.1% (3 patients) went to a shelter, and 1.4% (2 patients) died at ARMC.

There were only 15 patients discharged with the diagnosis of gravely disabled. The self-harm category includes 3 self-neglect, 6 suicidal ideations, and 1 suicidal attempt. The majority of the dementia diagnosis was diagnosed with dementia, 3 Alzheimer’s disease, 1 Lewy Body Dementia, and 4 Parkinson’s disease. The Psychiatric disorders included acute psychosis, adjustment disorder, bipolar disorder, delirium, psychosis.
schizoaffective, and schizophrenia. The majority of the medical conditions were hypertension and urinary tract infections.

**Discussion**

Our study aimed to answer the question: Does this mean elderly patients on psychiatric holds need to be admitted to a hospital? There is definitely a need to have a system in place for the geriatric population that requires in patient psychiatric care, to provide a safe environment where they can receive the counseling and medications needed for them to function in society.

A 2008 study by Cohen-Mansfield illustrated that there is a mismatch between the perceived and actual needs of community dwelling older adults in “domains of health and function”. Particularly, another study by Cummings et al in 2009 stated that assessing needs in 75 adults with severe mental illness age 55 years old or greater showed that up to 51% of patients with needs regarding sight and hearing are not receiving the right type of support.

Our review showed that neither gender nor age played any role in the placement of a hold. The majority of the holds were either dangers to self or gravely disabled. Only 7.4% of patients were actually discharged with the diagnosis of gravely disabled compared with 44.8% admitted with the same diagnosis. The review highlighted that the majority of hold were placed by the police department. Many elderly people are brought to the emergency department because the burden has been unfairly shifted to our police and fire departments. This in turn places a growing strain in the emergency department and that burden is then passed on to the general medicine wards. Given this data, educating and providing better resources such as a 24-7 case manager to the police department may decrease the amount of admission holds.

In terms of medical intervention, an unanticipated aspect of the review showed only 5.2% of patients requiring anti-depressant medication yet 15.8% of patients were discharged with the diagnosis of depression or history of suicidal ideations or attempts. Depression increases the risk of dementia and can lead to poorer outcomes. In 2006, Kohn and Epstein-Lubow showed depression strongly predicts mortality at both 5 years and 10 years. The most serious outcome discussed is suicide; elderly have the highest rate of suicide: at 60 years old 30% and at 70 years old greater than 50% in comparison to 25 years old approximately 5%. Considering the reported prevalence of depression, there may be under-diagnosis as well as under-treatment of depression in our community exacerbating the deteriorating mental health of elder patients. In 2002, Kales and Valenstein reported the prevalence of depression in elderly ranging from 3% up to 45% depending on an outpatient, inpatient, or nursing home setting while 70% to 90% go undiagnosed. Additionally, Kales and Valenstein report only 11% receive adequate treatment with medication. The majority of the patients placed on legal holds do not
require psychiatric care and therefore sit in a bed on the medical ward while the hospital social workers find their family and get them home.

The average cost of stay in the county facility is $1,000-$2,000 dollars per day. If there was a better system in place that could avoid the patients being admitted to the hospital and then getting these people back to their families as early as possible would be the ideal goal. For patients that are found to have no financial resources, there length of stay can be as long as 3 months while Medicare or state aid is applied for and granted. If we were to find a way to revise the system it may cut down on the treatments evoked upon this population.

The final outcomes showed 33.6% of patients returned home; this is encouraging data in two ways. First, this proves a reversible aspect to the patient’s cognitive or psychiatric status. Secondly, returning home is most often the preferred placement of the patient, as discussed by Cohen-Mansfield and Frank in 2008. Fried et al in 2004 also emphasized the need for screening and the risk assessment in elderly patients, given their complexity of issues that affect their ability to live independently. These studies along with our review ultimately suggest a need in communities for these services to prevent reversible declines in the elderly that result in unnecessary hold placements.
Figure 2. Correlation between admitting diagnosis and final disposition

Table 1. Final discharge diagnosis showing the percent and number of patients of total of 202 discharge diagnoses for 135 patients

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Percent</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gravely Disabled</td>
<td>7.42%</td>
<td>15</td>
</tr>
<tr>
<td>Suicidal Ideation</td>
<td>4.95%</td>
<td>10</td>
</tr>
<tr>
<td>Dementia</td>
<td>19.30%</td>
<td>39</td>
</tr>
<tr>
<td>Depression</td>
<td>10.89%</td>
<td>22</td>
</tr>
<tr>
<td>Psychiatric Disorder</td>
<td>25.74%</td>
<td>52</td>
</tr>
<tr>
<td>Medical Condition</td>
<td>24.75%</td>
<td>50</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>6.93%</td>
<td>14</td>
</tr>
</tbody>
</table>
Conclusion

In summary, our review’s results showed a discrepancy between admitting and discharge diagnosis. A system involving increased resources to the police department and case managers specific to elder social services is needed to improve the financial and time burden these involuntary holds have on our hospital.

References