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Held Hostage: The Case of a Difficult Patient, Hospital Discharge, and an Extreme Risk Protection Order

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Introduction

Patients with a diagnosis or traits of antisocial personality disorder are often treated within the medical hospital. While there is little evidence for how to treat this population pharmacologically or therapeutically (Cochrane, 2020), there is also a lack of data and training on how to manage this population when violence, real or threatened, occurs.

- In general, when patients are admitted medically there is some level of personality decompensation. Patients find themselves having to rely on others for their needs, often yielding dependent and more regressive personality. (Kaplan)
- The severity of reaction to discharge depends on several factors including:
  - patient's personality
  - severity of the illness
  - relationship between physician and patient
  - the situation the patient must enter following discharge from the hospital
- Threats of violence against medical staff is an unfortunate reality for many clinicians today. These threats may indicate frustration and poor coping skills and/or an underlying disorder (ex: psychosis, antisocial personality disorder, learning disability, etc).

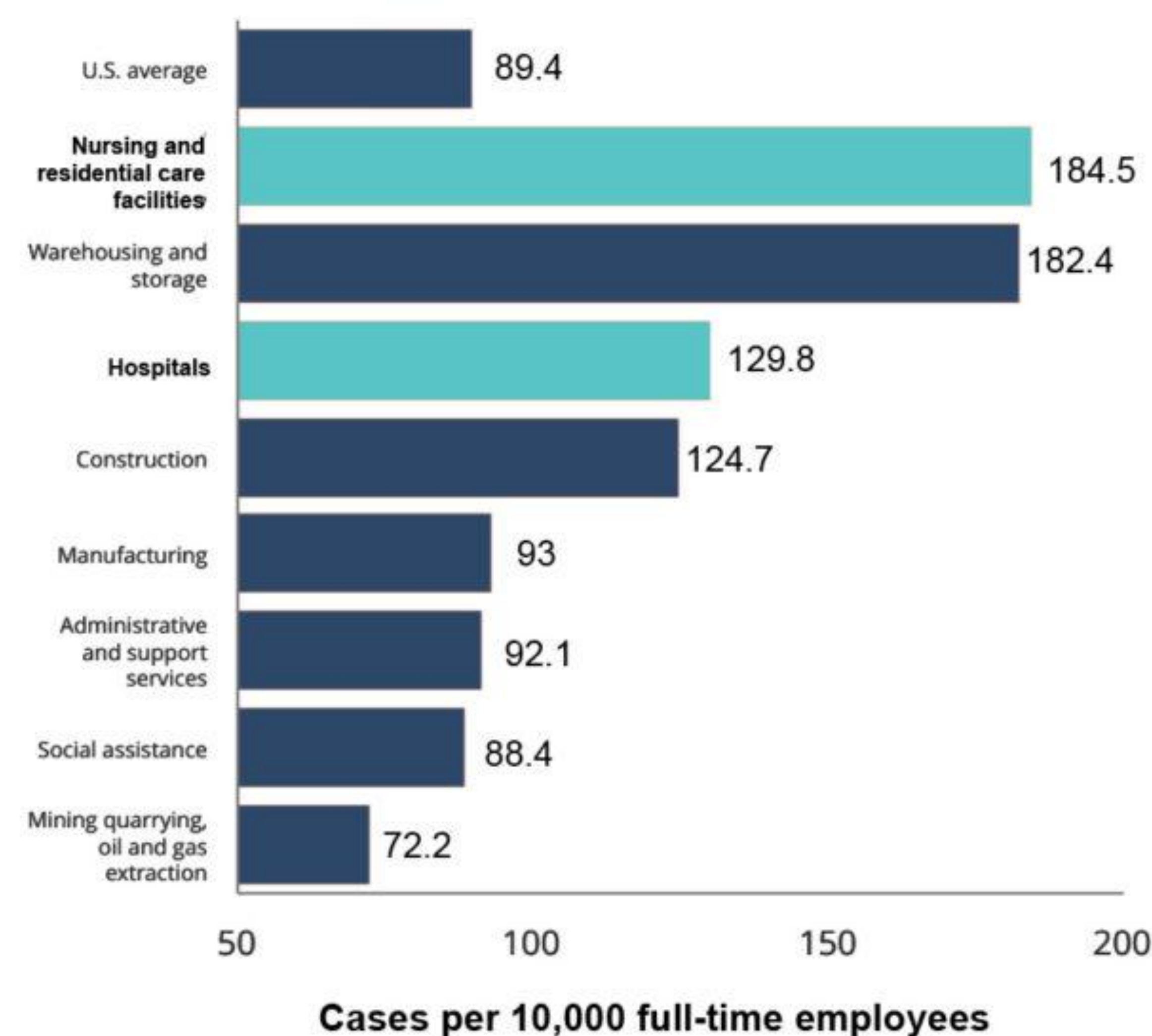

Figure 1. **Spok. (2020, January 17). Workplace Violence in Healthcare. https://www.spok.com/blog/workplace-violence-in-healthcare-what-does-the-data-say/**

Case Summary

28yo man with HIV (non-adherent with HAART treatment), bipolar disorder, and ADHD, who presented to the ED for chest pain and pain with swallowing. He was admitted to the general medicine service for esophageal candidiasis.

DAY 1

- Refuses some nursing care and threatens that "someone is going to get it" if he is woken up overnight for routine care.
- Refused morning labs, threatened to leave AMA.
- Found to be RPR positive but refuses PCN treatment. ID consultant now concerned for HSV/CMV and patient discharge is postponed.
- ***Curbside consult to CL psychiatry service*** due to concerns that mental health is preventing patient from having insight into his medical needs
- Patient says he feels everyone has given up on him since he was dismissed from hospital-affiliated HIV clinic for sending abusive messages to providers and staff

DAY 2

- Feels disrespected that his room lights were turned on and proceeds to storm toward nursing station but is stopped by security
- Patient placed in restraints and a 1:1 sitter was placed at his bedside
- Talks to attending and acknowledges his inappropriate behaviors, agreeing to stay in restraints for staff and roommate safety. Attending recommends filing criminal charges if his behaviors occur again.
- NP discussed case with Risk Management and Patient Advocate.
- Patient eventually has two sitters, apologizes to RN, but admits he does not know if he will act out again.
- Tells primary team he will likely not take his antibiotics after discharge because he wants to be with his deceased mother.
- ***Psychiatry formally consulted for safety evaluation due to statements, concern for suicide.***
- Chaplin visits patient and the patient becomes tearful and talks about how he wants to change his life
- Psych evaluation: pt with help-seeking help-rejecting behaviors and impulsive outbursts more indicative of a characterological pathology rather than primary mood disorder

DAY 3

- Patient now with active SI, so his room is searched by security for weapons. He threatened to choke himself with restraints (which he later attempted and had to be placed back into restraints)
- Patient claims he will shoot himself once he gets home versus his initial plan to wait until his birthday next week. He later threatens staff in front of NP and three security officers, including threatening to return to the hospital with a firearm.
- Patient informed threats were suggestive of criminal assault; he tells staff he does not care because he has previously been to jail.
- Psychiatry is called to evaluate the patient again. Patient's symptomology is most consistent with antisocial personality disorder with borderline traits and threats of suicide should be understood in the context of his historical ability to manipulate clinical situations to facilitate his needs be met (i.e. psychiatric admission). He was logical, linear, organized, polite, calm; he notes he is suicidal but also future oriented with desire for EGD and inpatient psych admission
- SW is asked to notify patient's probation officer about firearm as that is against his probation regulation. Per the probation office, an ERPO is not indicated at this time.
- Later in the evening patient says he is ready for discharge and forcibly tries to leave. Primary team NP is notified and is okay with discharge at this time.
- Due to threats to self and others, and self-report of guns at home, ERPO is filed and is temporarily granted/approved by court

DAY 6

- ERPO from day 3 of hospitalization was served and patient was brought to the Emergency Department by police on an Emergency Petition in order to receive a psychiatric evaluation
- During his ED evaluation, the patient admits that he was just angry when he claimed SI and wanted more attention from nurses
- He refused labs, tried to leave, was yelling aggressively at staff as he was tired of waiting and asked for discharge, but eventually he agreed to stay and complete workup.
- Following psychiatry evaluation, patient was deemed safe for discharge home

Six months later…

- Patient evaluated in the ED with complaints of vomiting and inability to hold down food x5 days
- Patient eventually becomes more agitated demanding to know when he will be seen, threatening to slap a nurse, and attempted to get into the triage room. Patient was escorted out by security.

Discussions

- We must recognize that mental health diagnoses alone are not always enough to explain patients' aggressive behaviors in the medical setting , and it has been found that often interpersonal and theoretical factors are crucial in generating anger and aggression (Whittington).
  - We can consider the risk of aggression may increase when patients have more stressors placed on them during an admission. These might include:
    - Pain
    - Anxiety related to the upcoming treatment
    - Major loss
    - Threat of death
    - Reduction in a sense of control over everyday choices, or,
    - Lack of alternate communication mechanisms when conventional methods are insufficient.
  - However, management of aggression in patients that do not have a pharmacologically treatable mental illness, such as patients with ASPD, can be more difficult due to illness pathology.
- As of 2023, there are 21 states/jurisdictions that have ERPO laws in place. Of those, only three (MD, HI, & D.C.) allow physicians to petition for the ERPO
  - The utility of allowing physicians to petition depends on their knowledge of ERPO legislation and willingness to incorporate this role into their practice (Blackwood).
  - At this time it is unknown if ERPOs will effectively reduce gun violence, however, experts suggest that it may have a positive impact on outcomes.
    - In cases such as these where there is no pharmacologic treatment and psychiatric hospitalization is not warranted, utilizing an ERPO allowed us to modify a significant risk factor in a patient who had threatened harm to himself and hospital staff.
- A survey of nurses in the National Health Service (UK) was conducted to assess aggression against workplace staff within a general hospital (Whittington):
  - Precursors for assaults included: confusion and/or high arousal mental states; receiving care and treatment from staff; delay in receiving care or treatment.
  - In this study, only 10% of respondents had attended some form of violence training during their career, though this was more prevalent in those staff who had been assaulted previously
- How does aggression and/or violence in the workplace affect staff?
  - On study found that staff who had been exposed and/or threatened with workplace violence experienced higher levels of stress and poorer mental health, including symptoms of PTSD (Elsevier). Victims of violence were found to describe feelings of anger, sadness, disappointment, fear, and less enjoyment in working with patients.
  - Caregivers can become more on-guard with patients, spend less time with them, and become less responsive

Conclusion & Reflections

- The primary focus with this population of patients is de-escalate, set boundaries, and try to understand the motivation for their actions.
- Evaluate and thoroughly document a risk assessment, indicating what treatments would and would not be helpful for the patient in question.
- The approach to these patients is often interdisciplinary—do not be hesitate to involve risk management, social work, hospital security, police (if needed).
- Look into whether your state has ERPO laws that may help mitigate risk of gun violence.
- Advocate for training at your hospital of how to interact with violent patients including skills of verbal de-escalation, physical breakaway techniques and guidance for coping after an assault.
- Understand that even though this is a difficult patient population, we must try to check our biases and work toward a common goal of safe treatment and discharge.

Questions for Reflection:
1. If your state is one of the 21 that have ERPO laws, would you feel comfortable advocating for it to be used in certain patient cases?
2. In your practice, how do you approach difficult and/or hostile patients? Does your hospital offer any training for this population?

References

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