THE ESSENTIALS OF RISK MANAGEMENT

PREVENTING AND RESPONDING TO ADVERSE AND CRITICAL INCIDENTS AND ADVERSE PERFORMANCE OUTCOMES – FOR BEHAVIORAL HEALTH MANAGERS AND EAPS

Including an Example of an Internal Death Review and Identification of Factors

Introduction to This Risk Management Course. In any responsible private practice or program or company operation, there should be an ongoing, functional Risk Management Plan (RMP) in place. RMPs seek to PREVENT Critical and Adverse Incidents which are a threat to our legal, professional, and financial safety, and seek to CORRECT problems when Critical or Adverse Incidents occur.

At the front end, the Risk Management process identifies or ANTICIPATES the unique Critical and Adverse Incidents which are INHERENT in the work of the organization and attempts to prevent them from happening with a Prevention Plan. The Prevention Plan answers the question, "Now what can go wrong here?" and seeks to prevent it.

- 'INHERENT RISK' is *risk which is closely associated with* the type of business we are operating and the type of clients we serve – and it's invariably present even if the organization is following a good set of Policies and Procedures.

- There are unique INHERENT RISKS in all behavioral health and human service programs and in all other organizations which Employee Assistance Programs (EAPs) and other professionals serve. There is inherent risk in hospitals, mental health and addiction treatment programs, the military, industrial and manufacturing plants, high-tech IT companies, and in any other business which is accountable for safety, productivity, quality, and compliance with rules.

- The RISK which we are seeking to contain often includes the loss of critical things – money, operating contracts, licenses or certification, employees, clients, customers, or reputation. RISK may involve death or serious injury of clients or employees or customers, allegations of professional negligence, workforce crises, violation of rules and regulations, criminal activity, fire and other disasters, and legal repercussions.

- The Risk Management Committee (RMC) within the workplace develops a targeted plan at the front end to PREVENT these inherent risks from materializing, based upon *eliminating* or *controlling* the factors which they know *from experience* could result in an Incident.

Risk Management

activity is primarily the responsibility of Managers but ideally occurs in collaboration with employees and external consultants when feasible – for example, EAPs and behavioral health QM consultants.

Risk Management activity anticipates and seeks to prevent and correct serious risks that are inherent in the work that we do.

When Critical and Adverse Incidents occur, they are 'Opportunities for Improvement.'

- Risk Management also responds to Critical and Adverse Incidents when they do in fact occur by identifying the Contributing Factors which led to *or may have led to* the Incident. A Correction Plan (a.k.a., IMPROVEMENT Plan) is then developed to prevent recurrence.

- When an Incident of any type does in fact occur, the Contributing Factors associated with that Incident must be *identified* and *eliminated* or *controlled* to prevent recurrence.

- In our field, we are primarily concerned with identifying the HUMAN Factors which <u>could</u> result <u>or have</u> resulted in an Incident – and as always, we pay close attention to the associated legal issues. The goal: PREVENTION of *occurrence* or *recurrence.*

- All Critical and Adverse Incidents are viewed as *'Opportunities for Improvement'* and, as such, should be embraced by all levels of employment.

- For EAPs consulting with the Management of Military or corporate organizations: If a Risk Management program is not already in place as a regular activity within the workplace, EAPs can collaborate with Management to set up a formal Risk Management protocol, with a Risk Management Committee (RMC) and written plans for prevention and correction of identified factors which can *or may have* contributed to Adverse and Critical Incidents.

  The EAP can serve as Risk Management Coordinator and scribe for the Risk Management Committee activities, which are discussed in Parts 1 and 2 of this course. EAPs also provide debriefing services to Management following Adverse and Critical Incidents, setting the stage for the Risk Management action pertaining to the incident.

Are There Different Categories of Risk Incidents? Yes, there are '<u>Critical</u>' Events and '<u>Adverse</u>' Events.

⊕ **CRITICAL Incidents or Events** involve the highest degree of risk or vulnerability and include a broad range of circumstances. Such events are our first priority.   Critical Incidents involve, for example,

- death or serious injury of a client or employee on the job, by suicide or otherwise
- misappropriation of pharmaceuticals or significant assets
- elopement of a client from a Detox, Inpatient, Residential or Intensive Outpatient Program
- overdose of street drugs or meds requiring medical intervention
- medication error requiring medical intervention
- a lawsuit or other allegation of professional negligence
- notification of potential loss of a program license or a contract to provide services
- a pattern of denial or recoupment of payments for services rendered, by insurance or contractor
- loss or theft of a client's treatment record
- alleged sexual assault involving clients, employees, or visitors
- injury of any combination of clients and/or employees by another, under any circumstances.
- sexual harassment allegations by an employee or client
- fire or other serious damage to property
- discovery of contraband drugs on premises
- violation of client confidentiality
- military training accident with critical injury or fatalities

Critical and Adverse Incidents

can and do occur, everywhere – including the best-run programs, companies, facilities, large organizations and Military installations.

A Critical Incident is defined here as a workplace event which may be traumatic or catastrophic in nature and presents a major risk to the organization's integrity or legal, professional, and financial safety. Who can be affected? Witnesses, employers, employees, colleagues, customers, clients and/or family members. Each such impact creates RISK.

Rapid identification and correction of the potential Contributing Factors associated with the Incident are essential to prevent further damage and recurrence.

The Joint Commission has historically said that an active Quality and Risk Management program is the BEST DEFENSE against lawsuits and other legal repercussions including loss of licensure or certification or financial integrity to perform the work we do.

Are we taking active steps to PREVENT the Critical and Adverse Incidents which are INHERENT in the work we do – including unacceptable Performance and Outcome measurements?

Are we making CORRECTIONS and are we monitoring the success of our corrections?

ADVERSE Incidents or Events.   Adverse Incidents or Events are typically not as serious or traumatic as Critical Incidents. However, Adverse Incidents pertain to *inadequate performance measures* (levels of achievement which are below expectation) and *non-compliance with procedural requirements* (violation of rules, regulations, established procedures). Adverse Incidents can therefore have significant implications and can escalate to Critical Incident status if not corrected promptly, or if the problem re-occurs after corrective action. We are working with two types of Adverse Risk:

- 'Performance' and 'Outcome' Risk – the risk that the company won't meet the required levels of productivity, efficiency, effectiveness, or work quality

- 'Compliance' Risk – the risk that the employees or Management will be non-compliant with important internal or external rules or regulations or contract requirements

Risk Management Committee actions for Performance and Outcome Risk:

1. PERFORMANCE INDICATORS. The Committee identifies the organization's <u>most important</u> 'must do' areas of performance and quality, which the company must achieve in order to continue in business. The criteria establish the goals for 'success.' *Example:* We must produce 2000 Widgets per day, and 95% of them must work. *Example:* We must serve at least 10 people in the detox unit per day, and 80% of them must be ready to step down to the Intensive Outpatient Program within xx days. *These are the 'Performance and Outcome Indicators' that become part of a Prospective Risk Management Plan.*

2. CONTRIBUTING FACTORS: The Committee identifies the Contributing Factors that could *prevent* the organization from meeting each goal.

3. PREVENTION PLAN: The Risk Management Prevention Plan is developed to ensure that the Performance Indicators are met and that the Contributing Factors are eliminated or controlled.

4. MONITORING: The Committee then creates Risk Management Monitoring Mechanisms for all identified Risk Issues, i.e., how will we track it.

Risk Management Committee actions for Compliance Risk:

1. COMPLIANCE INDICATORS. The Committee identifies the organization's <u>most important</u> 'must do' areas of compliance pertaining to either internal procedures and/or external rules and regulations. <u>These are areas in which the organization must be compliant to safely continue in business</u>. *Example:* We must have an 'active shooter' practice drill in the building once every six weeks. *Example:* We must reduce the number of accidents in the unit or the warehouse to no more than xx per month. *Example:* We must complete 100% of the Biopsychosocial Assessments for every admission, and 85% will be completed within 6 hours of admission. *Example:* We must maintain a secure personnel/client records location with checkout procedures, and we will misplace or lose 0% of records per month. *The Compliance Indicators are added to the Prospective Risk Management Plan.*

2. CONTRIBUTING FACTORS: The Committee identifies the Contributing Factors which could *prevent* the organization from meeting each compliance goal.

3. PREVENTION PLAN: The Risk Management Prevention Plan is developed to ensure that these Contributing Factors are eliminated or controlled.

4. MONITORING: The Committee then creates Risk Management Monitoring Mechanisms for all identified Risk Issues, i.e., how we will track it.

All of this activity is PROSPECTIVE Risk Management, and the result of the activity is a 'Prevention Plan.'

Implications of Having Problems in These Two Categories of Risk

- **Performance or Outcome Problems** usually pertain to a *failure to meet workplace or program goals* in one area or another – *failure to achieve expected results*. These failures oftentimes pertain to CONTRACT or FUNDING requirements. The failure can be due to problems with the physical plant or equipment which might prevent us from meeting contract or funding goals. Or, we might not have enough resources to produce the targeted result.

  But oftentimes, the failure is due to poor performance or productivity of personnel, or due to problems in internal communication or workplace dynamics which result in failure to achieve the expected result. It them becomes a serious matter to identify the HUMAN factors that are present. Otherwise, we may lose our contract or funding stream.

- **Non-Compliance Problems** pertain to *violation* of an internal or external rule, or failure to follow a specified procedure, or violation of a contract provision or license requirement. Adverse Non-Compliance Incidents are *usually (but not always) more serious than* Adverse Performance or Outcome Incidents because *they are a legal vulnerability* and more likely to result in a lawsuit. Such violations can also result in the loss of a license to operate if the problem is not corrected or if it recurs after correction or if it is discovered *concurrently with* a Critical Incident by a surveyor or external compliance auditor.

Outcome and Compliance Indicators are Risk Management tools. These monitoring mechanisms answer the questions, 'What we are trying to accomplish here?' . . . 'How well are we doing it?' . . . 'Are we achieving our goals?' . . . 'Are we performing at or above expectations?' . . . 'Are we compliant with prevailing rules and regulations?' . . . 'Is there an issue here which is moving into the critical zone?'

Examples of Adverse PERFORMANCE and OUTCOME Incidents:

- an employee turnover percentage (e.g., 21%) that exceeds the established maximum 15% per Fiscal Quarter
- an unacceptable number of non-critical employee accidents in the workplace, e.g., > 3 per month
- an unacceptable rate of re-admission to a 24-hour treatment setting, for Dual Diagnosis clients, e.g., > 20%

- an unacceptable school dropout rate for adolescent clients in the SUDs Rehab program, e.g., > 10%
- an unacceptable medication error rate [in which no medical intervention is required], e.g., > 1%
- an unacceptable pattern of denials by Care Management in response to requests for a specific Level of Care, e.g., > 5% for inpatient requests, > 3% for Intensive SUD Outpatient Programs
- an unacceptable percentage of admissions in which the Biopsychosocial Assessment has not been completed before admission, e.g., > 15%
- an unacceptable rate of 'sick days' taken by employees in any workplace setting per Fiscal Quarter, e.g., > 3 days
- failure to hire at least one bilingual supervisor, in a workplace with at least 20% non-English-speaking employees
- unacceptable levels of employee dissatisfaction with the overtime payment rate, e.g., > 25%

We Must Ask Why.   When Adverse PERFORMANCE and OUTCOMES such as these occur, we must ask 'why' they occurred. What are *the Contributing Factors*?   For example, what is contributing to our failure to meet contract deadlines? Are there physical plant issues which are adversely affecting productivity? Or employee issues? – or both? What is contributing to the increase in the after-school detention rate in the Intensive Home-Based Program? Or what is contributing to the high rate of re-admission to the Psychiatric Inpatient Program or the Detox Program – or a high medication error rate – or too many employee sick days taken – or excessive accidents in the warehouse – or an increase in employee dissatisfaction?

Examples of Adverse NON-COMPLIANCE Incidents:

- a first occurrence of partial or untimely compliance with an important accreditation requirement
- failure to consistently document the routine 'count' (a.k.a., an 'inventory') of medications kept in a company's QuickCare Employee Clinic or in a treatment program of any type
- inconsistent documentation of equipment functionality checks, including Fire Extinguishers (a favorite target of on-site licensing reviewers)
- administration of any medication to the wrong individual in an Employee Clinic or treatment program [without the need for medical intervention]
- failure to consistently document and maintain background checks on employees prior to hiring
- inconsistent documentation of random drug screens within an addiction client's treatment record – or within the protected personnel files for factory workers or military personnel – or within DOT SAP Program Records for transportation employees in certain categories of monitored recovery.
- a first occurrence of temporary misplacement of Employee Personnel Records or Client Treatment Records
- a first occurrence of a physician failing to document his or her impressions of 'Mental Status' and 'Risk for Harm to Self and Others,' at every medication clinic appointment
- failure to obtain the individual's signature and date on a Treatment Plan or Employee Improvement Plan

- a first occurrence of failure to re-train employees in a Chemical Spill Procedure within the timeframe mandated by OSHA

Adverse Non-Compliance Incidents such as those above have a significant chance of escalating from 'Adverse Incidents' to 'Critical Incidents.' *Any* of the <u>Adverse</u> Non-Compliance Incidents above can become <u>Critical</u> Non-Compliance Incidents. Why? Because Non-Compliance Incidents pertain to violation of rules or laws and regulations and may pertain to the safety of employees or clients, effectiveness of services, or a threat to licensure or certification status.

- **Note:** When an Adverse Non-Compliance Incident is cited as a violation *during an audit or survey by external examiners*, we must correct the issue immediately and prevent it from escalating to Critical Incident status. Why is this so important? Auditors pay specific attention to compliance issues which were *known but not corrected and then escalated.* Failure to correct the issue will likely be viewed as *professional negligence* if a related event becomes the target of a lawsuit.

    We *do not ignore* Adverse Incidents of any type, because all Adverse Incidents can <u>become</u> Critical Incidents if they persist. Critical Incidents can result in lawsuits and other legal sanctions, as well as loss of contracts and licenses.

Additional Note: The impact of <u>any</u> Adverse Incident is COMPOUNDED when it's discovered <u>concurrently</u> with a Critical Incident. Examples:

- A failure to document the regular completion of a medication inventory in a QuickCare Employee Clinic or treatment program, when it is discovered *concurrently* with the investigation of theft or misallocation of Controlled Substances.

- A failure to document regular equipment functionality checks when it is discovered *concurrently* with an on-the-job injury or death due to malfunctioning equipment.

Risk Management Is More . . . Than Just Policies and Procedures!

Despite the international growth of Risk Management programs, there are still many managers and senior employees who have difficulty with the concept of a formal Risk Management program. The three primary questions are (1) why do we need an additional layer of managerial responsibility, and (2) isn't it a bad thing to document our failures, and (3)   aren't Policies and Procedures enough to protect us?

If you work in this field long enough, you know that despite a comprehensive set of Policies and Procedures, Critical Incidents CAN and DO occur – and it's not something we can hide. Policies and Procedures *are not sufficient* to prevent Critical Incidents in the military or in mental health and addiction treatment programs or in industrial or corporate settings.

- When a Critical Incident occurs – aside from the need to carefully address emotional responses to the event within the organization and with any affected family members – we must recognize it as an Opportunity for Improvement, i.e., to *identify* the Contributing Factors, develop a *plan of correction*, and *reduce the risk* of it happening again.

What is the essential difference between 'Policies & Procedures' and 'Risk Management Plans?'

- First, note that P and Ps are primarily 'upbeat' and present the picture that *everything is expected to 'go as planned.'* Policies and Procedures (P and Ps) are the 'broad stroke' of organizational operation – hitting the high points of normal operation and routine safety plans, plus the key requirements of contract and regulatory compliance. P and Ps focus upon how things are expected to be. P and Ps do not focus upon 'what can go wrong.'

  - Risk Management Plans (RMPs), on the other hand, take the attitude that there is no such thing as 'going as planned' – that certain things can and do go wrong, and can cause great damage to the organization from a legal, professional, and financial perspective.

  - The FOCUS of Risk Management is identification of potential and actual PROBLEMS – procedures which are NOT 'going as planned' or could potentially 'jump the track.'

  - The RM process develops strategies for PREVENTION of problems and IMMEDIATE CORRECTION of things that go seriously wrong – i.e., prevention of the problems that are inherent in the workplace, and correction of those which have 'jumped the track.'

- Policies and Procedures are predominantly 'absolute' – 'It IS this way.' However, Risk Management is always looking ahead and behind to monitor how things are *actually* functioning in the light of day – recognizing that things can and do go seriously wrong.

- *Prospective* Risk Management Plans focus upon control of the vulnerabilities that are inherent in the workplace – as if to say, *"We know that this event has a high potential to 'go wrong' and we are determined to prevent it."*

- *Retrospective* Risk Management Reviews address those Critical or Adverse Incidents that have *already occurred* – focusing upon WHAT happened, WHY it happened, and HOW can we fix it? What can we do differently to *prevent a recurrence* (i.e., what improvement can we put into place)?

- Retrospective RM Reviews look closely at whether the Policies and Procedures have been violated, including the requirement to train employees and document the training. Or were the Policies and Procedures insufficient or 'off target' in the first place? Was something missing?

Below are some actual [de-identified] examples of Critical Incidents which have occurred in behavioral health programs *despite a standard set of Policies and Procedures which the employees had in fact followed.* The Management believed that they had included everything in the P and Ps that was needed to protect them legally.

For each of these vignettes below, can you identify something which had apparently not been addressed in the Policies and Procedures? What Contributing Factor or Factors would likely be identified during Retrospective Review of the Incident, which then needs correction? What correction would you put into the Improvement Plan?

> A preview hint: When the Supported Housing apartment complex burns to the ground following a kitchen fire in a client's apartment, it is not the fire that is the "Achilles' Heel." It is the *failure to document the detailed training which had been provided* to the Supported Housing clients when they moved in. Fires happen. 'Failure to train' must never happen. When training is not documented, from an auditor's perspective "it did not happen."

Read on, for examples of Critical Incidents in which there were Contributing Factors *which were not anticipated* when the Policies and Procedures for the situation were written. In other words, staff had failed to thoroughly analyze "What can go wrong here?" when they developed the P and Ps for the event or circumstance.

In each case, you can correctly assume that staff followed the established Policies and Procedures to the letter. What, then, must have been left out? What potential critical factor (i.e., what "risk issue") was not anticipated when the P and Ps for the situation were written?

- The accidental overdose death of a dual-diagnosis IOP client with Bipolar Disorder and SUD. Client was receiving well documented counseling and psychoactive medication which was compatible with SUD treatment. Program staff were unaware that the client was also receiving a second type of psychoactive medication and a pain reliever from his Primary Care Physician, which he had begun taking shortly after admission to the program. [Critical Incident]

- The line was long at the methadone clinic, and the combat veteran with chronic severe back pain and a history of self-medicating for pain was miserable. He took a double dose of oxycodone while waiting his turn in the methadone dosing line – unaware that a life-threatening medication interaction could occur. 25 minutes after he left the clinic, he collapsed on the bus. Passengers and then EMTs administered CPR and provided transport to the hospital. [Critical Incident]

- Multiple adolescents from a residential treatment program are taken on an overnight camping trip in which two of the adolescents elope, resulting in an unplanned pregnancy [Critical Incident]

- A breach of confidentiality involving a prominent client in a private Addiction Treatment program occurs, in which a case note was inadvertently left on the Xerox machine which sits outside the reception office, in the hallway between the lobby and the guest restroom. The forgotten case note was purloined by another client and then became widely disseminated

public information. [Critical Incident involving a civil lawsuit and a regulatory response to violation of State and Federal confidentiality statutes]

- Two months after eight Supported Housing residents moved into a new apartment complex, the complex burned to the ground – ignited by a kitchen fire in one of the Supported Housing apartments. The Housing Manager assured the Program Director and the Fire Marshall that they had conducted extensive fire prevention training of the Supported Housing clients when they moved in. In fact, she was sure that it was either one day or two days before they moved in to the new complex; she would have to consult her appointment book to be sure. [Critical Incident]

- A fire erupts in a 28-day CD program, and residents and the night staff frantically try to extinguish it. The fire results in a fatality, caused by failure to evacuate the premises in a timely manner. [Critical Incident which could occur in an industrial plant or any other utilized structure]

- An adolescent in an inpatient facility suffocates while being restrained face down on a bed by a person who came on the job two weeks after the once-monthly training on Restraint and Seclusion had been given. [Critical Incident]

- Discrepancies appear in the audit records of a controlled substance stocked in a QuickCare Employee Clinic, in which one person is responsible for doing the 'pill count' audit. [Critical Incident]

- A court-committed adult inpatient is left alone in an unlocked room for four to five minutes, sitting in a wheelchair with wrists restrained to prevent self-injury, while one-to-one observation staff step out to intervene in a loud altercation in the hallway. The restrained wheelchair patient is attacked by another patient, with critical injuries resulting. [Critical Incident]

- Clear prohibitions against any type of sexual harassment are detailed in the written Policies and Procedures which are maintained in the Management Office, and new factory workers are trained by the Bilingual Personnel Director on the policy. Workers then sign a Verification of Understanding form in their preferred language, before entering the factory line. But the company's Board Chairman believes that it is unprofessional and insulting to train managing and supervising professionals in such 'offensive' topics. "They already know this." A lawsuit is filed following allegations by a factory supervisor that the Chief Financial Officer sexually harassed her, and he then fired her when she resisted. [Critical Incident]

Opportunities for Improvement

> *Has a Critical Incident already occurred at your organization? Or is there a performance issue which is seriously impacting your organization's functioning – and is threatening your certification or your contracts? If so, this is an 'Opportunity for Improvement.'*

When an Adverse or Critical Incident occurs, it is an Opportunity for Improvement. Management must identify and confront the 'Contributing Factors' which are – <u>or may be</u> – associated with the event and correct them. This type of in-depth analysis is not a 'solo' activity. It can be emotionally painful and stressful. Bringing in additional participants to form a Risk Management Review Team broadens the OWNERSHIP of the problem and the remedies to be considered.

Involving senior clinical and supervisory staff is essential, whether we are looking at Critical Events of Adverse Outcome Indicators. These people live 'in the thick of it' and may have a better sense of what has gone wrong that anyone else. But because staff can also be *too close* to the situation to see some of the issues, the addition of a knowledgeable consultant is also helpful – an extra pair of eyes and ears. If the issue involves personnel issues, an Employee Assistance Program professional is a good addition to the team – as has been discovered by the US Military, all the Fortune 100 and 500 companies, and every Department of the US Government.

No matter how upsetting and painful it is when a Critical Incident occurs, the incident is an *Opportunity for Improvement.* The Joint Commission coined the popular use of the term 'Opportunity for Improvement' to describe the occurrence of an Adverse or Critical Incident or Unacceptable Performance Outcome.

Joint Commission surveyors emphasize that the term 'Opportunity for Improvement' is NOT just a euphemistic way to refer to 'a bad situation.' It is an ATTITUDE about the task at hand. We are acknowledging the Critical or Adverse Incident as an Opportunity for Improvement which we will now address with a Corrective Action Plan to prevent recurrence. The US Military has also adopted this attitude in identifying issues during post-combat 'after-action reviews.'

Let's take a closer look at PERFORMANCE and OUTCOME Indicators in the following section. Although Adverse Incidents – problems with statistical indicators of performance and outcome – are not generally as serious as Critical Incidents, poor performance in any area of the organization can play havoc with success and sustainability. In fact, the entire commercial and not-for-profit universe has locked on to the careful monitoring of Performance and Outcome Indicators as the key to success vs. failure of an organization.

Outcome Indicators – Everybody's Doing It!

Risk management is BIG in healthcare – but it's not limited to healthcare. And it's not just attention to 'critical incidents.' Risk Management maintains *hyper-alertness* for indicators of 'Adverse Outcome' or 'Adverse Performance' in its earliest stages. Why? Adverse performance 'sinks' organizations far more often than critical incidents.

Managers throughout the free world are monitoring their Outcome Indicators: Medicare and Medicaid, SAMHSA and CSAT, State-funded behavioral health programs, insurance plans and their provider networks, Big Business traded on Wall Street, high-risk manufacturing plants and high-stress IT corporations in most countries . . . the US Military . . . and Employee Assistance Programs (EAPs) – all these work organizations are monitoring selected Outcome Indicators.

It does not matter whether you are a school district, a behavioral health treatment provider or a giant company like Amazon or Google or Toyota, the US Military, a mid-sized carpet manufacturer, or an EAP. Your Risk Management Plan must include monitoring of Outcome Indicators.

Yes, everybody's doing it! It's not just in health care.

- Critics of the auto industry have switched their evaluation focus – now focusing upon what works and what doesn't work, rather than focusing upon the style and the number of new rollouts. It's no longer 'how many new models did they produce this year, and what's the appeal of the body designs.' Instead, the focus is on the safety and effectiveness of the mechanical design and the thoroughness with which the engineers pre-tested for potential problems. It's 'How reliable are the latest models?' and 'How do the cars perform in crash testing?' and 'What are people saying on Facebook and Twitter' about the safety and quality of the various models?'

- US Military operations are inherently 'at critical risk.' The difficult challenges of the wars in the Middle East have introduced new forms of life-threatening risk. Therefore, the Military changed up its strategic approach in order to *effectively manage the risk.* They now have an 'After-Action Review' (AAR) process.

Risk Management begins its work by identifying the risks that are INHERENT in the work that the organization does, i.e., 'What are the obvious things that can go wrong here?' What factors could lead to poor performance and failure to meet our goals? What factors could result in an Adverse or Critical Incident?

A PREVENTION PLAN is then formulated, and monitoring mechanisms, i.e., Performance Indicators, are set up.

PERFORMANCE INDICATORS (or Outcome Indicators) answer the questions, 'What are our goals? What are we trying to accomplish here? And how well are we doing it?'

Risk Management rigorously monitors Outcome Indicators, for signs of trouble – and when something goes wrong, we have to determine 'WHY?'

When something goes seriously wrong, Risk Management identifies and analyzes the Contributing Factors. "WHAT happened here? WHY did it happen? And HOW can we correct it, to prevent recurrence?"

Incidents are ALWAYS an Opportunity for Improvement.

- Specifically, the Military has restructured its autocratic approach to battle planning, and now uses a two-way exchange of ideas following every combat mission. Based upon this exchange – 'The After-Action Review' – an Improvement Plan is developed, which serves as the basis for Military Command decisions for new combat encounters.

  - Regardless of rank, everyone who was involved in a combat mission – whether in the middle of the firefight or watching from the drone communication bunker – is involved in the Military's version of Retrospective Risk Management Review.

- Online retailers – Amazon, Wal-Mart, eBay, pharmaceutical giants such as CVS and a host of others – have launched a major emphasis on the management of every aspect of customer satisfaction. They are continually on the alert for any aspect of their service delivery which is not acceptable, i.e., for things that 'go wrong'.

- Some Medicare Part D insurance companies (those who fund and manage the approval of medications for Medicare recipients) have switched from their traditional role of anonymously overseeing that their medication program meets Medicare standards – approving and disapproving medications from afar.

These organizations now utilize a *personal approach* in which they talk directly with members about their medications, their history of medical issues, and the ease of recipients' access to their refills. They send a follow-up satisfaction survey by email after the phone contact. They send text message reminders to 'Refill your blood pressure medications now!' What are they doing here? Their Outcome Indicators include PREVENTION OF re-hospitalizations caused by non-compliance with the medication regimen.

- When you visit your Primary Care Physician or the local hospital ER, you most likely will receive an emailed survey to complete online about your personal experiences and your evaluation of the care you received. What are they doing here? Their Outcome Indicators include stability of the Primary Care Physician-Patient relationship.

 The consistent demonstration of *'good outcomes'* is a Risk Management challenge. Why? Because so many things can go wrong in any type of work, and each of these is a 'risk' which must be addressed.

You are still working in Part I of this course. After the brief Clarification Note that explains the difference between 'the cause' <u>vs</u> 'contributing factor,' we will provide an introduction to the first two of four Risk Management activities:

1. Prospective Risk Management Planning with a resulting Prevention Plan
2. Retrospective Risk Management Review with a resulting Correction and Improvement Plan

Cause vs. Contributing Factor

Clarification notes about Cause vs. Contributing Factor: Why do we use the term 'Contributing Factor' when we analyze the reasons why an Adverse or Critical Incident occurred? Why don't we just say, 'this is what caused it'? There is a difference between 'Cause' and 'Contributing Factor.'

CAUSE is 'definite.' A cause is a condition that definitely, without question, <u>produces</u> a specific effect – usually referring to an undesirable effect or result or incident. It's the essence of cause-and-effect. Eliminating a cause(s) will definitely eliminate the effect/incident.

CONTRIBUTING FACTOR is a condition or situation that <u>influences</u> the undesirable effect or result by increasing its likelihood; by affecting the severity of the consequences; by helping to bring about a specific undesirable result; by exacerbating the result; by acting as a factor in the occurrence of the event or incident.   NOTE: Eliminating a contributing factor(s) won't definitely prevent the effect/incident from recurring, but eliminating a contributing factor <u>will reduce the likelihood</u> of the effect/incident recurring, or will reduce the severity of the effect/incident.

- There are no precise formulas for determining exact cause and effect in the Behavioral Health field, because everything we do involves *human behavior*. Human behavior is inherently variable and not precisely controllable or predictable.

- Therefore, in Behavioral Health Risk Management, we must work to determine all of the CONTRIBUTING FACTORS associated with an Adverse or Critical Incident, even though we cannot say that we have determined the exact 'cause.'

- In Behavioral Health, *eliminating a contributing factor won't guarantee* that the Incident will never happen again, but it significantly *reduces the likelihood of recurrence of the Incident*.

End of Course Introduction

1. Introduction to 'Prospective Risk Management Planning'

Many of the major incidents which occur in the workplace could be avoided by *'prospective thinking' – thinking ahead*. First, by identifying the INHERENT risk factors in the workplace or situation (i.e., what can obviously go wrong here?), and second, by addressing these inherent risk factors in a Prospective Risk Management Plan (i.e., a 'Prevention Plan').

When managers fail to think prospectively about the obvious risks OR fail to respond to a 'red flag' warning of trouble, they are in a legally vulnerable position if something does go seriously wrong. In a court of law, they will likely fall short on that infamous question: "Did the employer or employee fail to take an action which he or she knew, <u>or should have known,</u> would have or could have prevented this Critical Incident?"

Very few Adverse and Critical Incidents occur 'out of the blue.' There are typically warning signs or indicators that special care or attention needs to be given to a specific 'risk situation.'   <u>When left unheeded</u>, the warning signs of 'trouble' (the red flags) can evolve into Adverse and Critical Incidents.

Analogy: When we are traveling down a freeway and see men waving red flags, our first thought is "why." What's going on up there? We want to know, in advance, the 'CONTRIBUTING FACTORS' that are bringing traffic to a standstill. Do we need to turn around and go a different way? Is there an unsafe condition on the highway? Busy program managers or supervisors may fail to notice the 'red flags of trouble' when they appear, and subsequently *fail to identify and prevent emergent problems*.

Molehills Can Become Mountains. Prospective Risk Management which results in a Prevention Plan is essential if we are to prevent 'molehills' from becoming 'mountains.'   'Molehills' become 'mountains' in the workplace when we "fail to notice the train speeding toward us on the track" . . . or when we have failed to address an issue which has an *inherent potential* to morph into a Critical Incident.

These types of issues are often pushed to the side because those in authority believe that there is only an outside chance that a critical event will occur. Workplace pressures may also absorb the momentum of management – or there might be a fear that correction of the issue will disrupt other procedures which are working well.

2. Introduction to 'Retrospective Risk Management Review'

Note that <u>Prospective</u> Risk Management Planning and the development of a <u>Prevention</u> Plan (discussed briefly in 1. above) are the first steps that we take in the prevention of Adverse and Critical Incidents – looking ahead, anticipating, and planning to prevent problems. However, the most challenging Risk Management activity is the RETROSPECTIVE Risk Management Review of an Adverse or Critical Incident which has occurred in the workplace – *looking backward to see what went wrong*. The result is a CORRECTION plan (a.k.a. Improvement Plan).

In Retrospective Review, we analyze and identify the FACTORS which contributed to – or <u>may have contributed to</u> – the occurrence of an Adverse or Critical Incident in the workplace in order to correct the problem, thereby preventing recurrence.

- **As mental health, addiction, and EAP professionals, we are primarily analyzing *human factors* which may have been associated with the incident. We leave the technical and mechanical issues to the IT and Engineering Departments.**

> 🌎 **Awareness of the 'Human Factor' Has Hit the Pentagon, the IT Industry, Healthcare, Education, City Government, Big Business, and the Local Cat Food Factory.**

'Human Factors' can, and typically do, contribute to any Adverse or Critical Incident within any workplace. Retrospective Review of an incident <u>always</u> attempts to identify the Human Factors – employee or management issues or both – *which did or may have* contributed to the incident.

This work can be challenging because it may identify on-the-job conflicts and performance issues, or the lack of 'failsafe' mechanisms, or failure to anticipate potential repercussions of a new policy or procedure. Communication failure from the top down or from the bottom up are often contributors to Critical Incidents, as is a lack of clarity about what we were trying to accomplish prior to the incident.

Less obvious, are those situations in which the existing policy or procedure is basically flawed, or what we are trying to accomplish in a given situation does not actually make sense or has significant gaps in implementation.

- The Retrospective Review process requires that Management put their natural protective posture aside, to identify potential Contributing Factors. This is difficult to do if one is simultaneously struggling with trauma, feelings of guilt (whether that guilt is 'earned' or not) or preoccupation with a potential visit from Occupational Safety and Health Administration (OSHA) or a State Licensing Compliance Division.

It's a Team Effort.   *Regardless of the workplace*, when a Critical Incident occurs, Risk Management works best as a TEAM EFFORT, to identify all factors which may have contributed to the incident. EAPs have proven to be invaluable additions to the Management Team, since the 1970s when Federal Law mandated an EAP in every Federal Department (Justice, Defense, Education, Health and Human Services, Homeland Security, etc.)

Some of these Contributing Factors pertain to the interaction between managers and employees – or lack of interaction. Some pertain to communication or judgment issues, including changes in the workplace without an adequate pre-implementation analysis. Some pertain to the clarity of the target outcomes. Some Contributing Factors pertain to compliance with existing procedures, or the need for new procedures.

We will soon give you *two checklists* to serve as a guide for identifying Contributing Factors involving human behavior. Analysis of these 'human factors' is essential to determine what happened, why it happened, and how to prevent it from re-occurring. These same issues would almost certainly be questioned in a court of law, in the event of a Civil Lawsuit following a Critical Incident.

However, in civil lawsuits and sometimes in criminal cases, the verdict of culpability oftentimes boils down to one primary issue:

"Was there failure to take an action which the employer or employee(s) knew, _or should have known,_ would have or could have prevented the Critical Incident?"

NOTE: This is arguably the *most common* situation for which Risk Management Specialists and lawyers are summoned, in the event of a Critical Incident. Most civil lawsuits which involve a Critical Incident (and some criminal cases) focus specifically upon this issue – failure to take an action "which the Respondent knew or should have known" would have or could have prevented the event. *In a civil lawsuit or criminal case*, every detail involved in the case is scrutinized to persuade the judge or jury that the Managers or Employees *"knew or should have known"* to take a certain action which might have prevented the incident.

In behavioral health programs – including EAPs – it can be a challenge to determine [with certainty] the 'HUMAN FACTORS' or personnel issues which have contributed to (or may have contributed to) a Critical Incident. Human Factors are present in every workplace, regardless of the nature of the business. However, in comparing Critical Incidents which occur in commercial and industrial settings vs. those occurring in primary behavioral health treatment programs, the Human Factors may be more challenging to identify in the commercial and industrial settings.

A Case Study of an EAP's Assistance to Management in the Retrospective Review Process. Determining the Human Factors.

The following is a case study of an EAP consultant's dialogue with a warehouse manager following an accidental death in a warehouse. *This case study* demonstrates the destructive result of managerial changes in the workplace which are made without a Prospective Risk Management analysis of the *potential impact* of the change upon employees. The CEAP's task is to assist management in the identification of the CONTRIBUTING HUMAN FACTORS in the aftermath of a Critical Incident.

- Let's assume that there has been a traumatic accidental death of a warehouse worker, which occurred when a high-loading machine in operation in the warehouse rolled backward instead of forward and killed the individual who was standing behind the loader. The employee who was operating the machine insists that he doesn't know what happened – how or why the loader rolled backward.

- The employees at the plant have worked together a long time and are severely traumatized by the death. Work at the plant has come to a stop. The Manager is not sure where to proceed from here, but he has pending contracts to deliver and is worried. At the suggestion of the CEAP who provides employee-related consultation to the warehouse Management, a Retrospective Review of the incident begins, beginning with Engineering.

- The CEAP does not participate in the Retrospective Review of the potential mechanical problems which could have caused the machine to malfunction. That's not the CEAP's area. That's a mechanical issue for the engineers to evaluate. The CEAP turns his attention to crisis intervention with the family and employees.

- Meanwhile, the engineers determine that there was no mechanical malfunction that could have caused the accident. However, a review of the video surveillance tape determines that the normally high-functioning machine operator (who also has supervisory responsibilities) was 'asleep at the wheel' – literally. This moves the discussion into the <u>human factors</u> area – i.e., "turning over the rocks" to identify the CONTRIBUTING HUMAN FACTORS involved in this Critical Incident. The CEAP joins the discussion at this point.

- CEAP: "Is there something unusual going on in the warehouse recently? …. Has something changed in 'who does what?' or in how they do their work? . . . In how employees are scheduled on a day-to-day basis? ….. Any change in employee attitudes? Etc.…"

- After a bit of probing it is acknowledged that heavy-machine operators have been pulling *double shifts* for the past three months. And why is that?   The factory is *understaffed* due to an unusually high rate of turnover among the heavy-machine operators, which began four months ago. *Reasons for the increased rate of turnover are not immediately clear.*

- As the discussion with the CEAP continues, the Manager does recall several events in the past few months which suggest that something has changed in the general attitude within the warehouse. Longtime workers are not as friendly to management. And for the past four months, there seems to be more heated arguments between employees, with a couple of fist fights in the parking lot. And someone ripped the OSHA poster off the wall over the timeclock – a clear act of frustration and anger.

- CEAP: "Did anything unusual happen in the factory five or six months ago, that preceded this down-hill slide?"

- Manager: "Not much." The only thing the manager recalls *is that he had decided to* split the one lunch period into three different scheduled lunch periods – and he randomly assigned each worker into one of the three lunch groups. The Manager congratulated himself on devising a way which allowed for "work to be going on at all times in the warehouse, which has to be GREAT for business – right?"

- CEAP: "But . . . what effect do you think that change might have had on your warehouse workers?"

- Following a half hour discussion between the CEAP and the Manager, it was recognized that the change had a critical impact. *The change began to unravel the social structure of the warehouse and eliminated the workers' mechanism for relief of day-to-day stress.*

- There was no longer a break where the warehouse workers could get together with their own personal 'lunch bunch' to discuss whatever was bugging them at the moment. There was no time

in the day when workers could share personal work-related stressors and get feedback from people they trusted.

- No time to resolve interpersonal disagreements. No time to safely let off steam in a collegial setting. And since most were hard-working family men, they typically headed for home right after work.

- The tension in the warehouse continued to build. *Eventually, the heavy machine operators – whose jobs entailed a lot of stress – began to quit.* Those who remained – including the operator of the high-loader – had to work double shifts. Stress and fatigue took their toll. *The operator fell asleep at the wheel, the high-loader machine rolled backward, and the worker behind him was killed.*

The hypothetical Case Study, above, is a good example of how RETROSPECTIVE REVIEWS can identify the HUMAN FACTORS which CONTRIBUTED to a Critical Incident. Since the Manager's mind was on the efficiency of running the company, making every dollar count, and then worried about contract deadlines, he was not thinking about the interpersonal impact which his scheduling change had for the workers. The CEAP's participation helped to 'turn over the rocks' to identify RISK FACTORS which contributed to the death.

Prospective Risk Management (Prevention Planning) is the first step in creating a safe and productive workplace. The integration of an Employee Assistance Program (EAP) into an organization's Management team is quite valuable in the operation of an effective Risk Management Program. Given that employees are the heart of the organization, an understanding of human behavior, dynamics, and motivation is essential, in order to address the issues which most often contribute to Critical and Adverse Incidents in the workplace.

- EAPs' provision of consultation to Management is a time-honored practice in the prevention and resolution of employee-related problems. *Since the 1970s, all Departments of the US Government* (Department of Education, Department of Justice, Department of Health and Human Services, Department of Defense, Department of Veteran Affairs, etc.) have utilized the services of EAPs as standard practice, in compliance with Federal law (the Hughes Act).

- The US Armed Services and the VA use externally contracted EAPs throughout the military and veteran 'workplace' including every US Military Base and every VA Medical Center. EAPs are now firmly established *within all the Fortune 100 and Fortune 500 companies* and within 77% of Corporations in America.

EAPs provide consultation to Management about the HUMAN FACTORS which are typically associated with Adverse and Critical Incidents and with undesirable trends in organizational performance. EAPs also provide coaching to Management in effective supervision of difficult employees – another key factor in prevention of Adverse and Critical Incidents.

'Your worst day is an Opportunity for Improvement.'

Introduction to Part II

The Details of Four Categories of Risk Management Activity

In Part I, we provided an introduction to the first two categories of Risk Management: 1. Prospective Risk Management Planning and Prevention, and 2. Retrospective Risk Management Review and Correction. In Part II we will provide more details about these two categories, plus two more.

Risk Management (RM) is not the most delicious piece of fruit on the Management Tree. Why? Because much of RM focuses on PROBLEMS and the CORRECTION of errors or omissions in policy, procedure, implementation, and judgement – which would suggest to some that Management has not done its job effectively. But all organizations have such issues because they employ HUMANS with the unpredictability that this implies. Further, as businesses expand and take on new challenges, formerly stable details of operation can morph into the week's worst headache.

CEAPs and QM/RM professionals who are assisting Management with employee issues and Risk and Incident Analysis in the workplace are oftentimes greeted with ambivalence by supervisory employees. Why? Because the 'human factors' which may be identified as having contributed to the incident were present on the Supervisor's watch. These issues must now be examined in depth and must now undergo correction. Supervisors universally would like to say, "Those things don't happen on MY watch!" But …. yes, they do.

Therefore, CEAPs and QM/RM consultants wisely approach the Risk Management task with a careful relationship formula: 2 parts cheerleader to 1 part auditor and 1 part teacher. And always, the philosophy shared with management and employees is that 'Your worst day is an Opportunity for Improvement.

In this course, to facilitate an orderly presentation of the material, we have organized the four most critical Risk Management functions into four categories. In Part I of the course, we gave you a quick overview of the first two categories of Risk Management prevention and correction activity. In this Part II, we'll take a more detailed look at all four categories of Risk Management activity.

THE FOUR CATEGORIES OF RISK MANAGEMENT

- Prospective Risk Management Planning
  - Identify Inherent Risks
  - Develop a Prevention Plan
  - Seven-Factor Analysis Prior to Major Changes Prospective Risk Management Review

- After the Incident – Retrospectively Review
  - Identify Contributing Factors
  - Develop a Corrective Action Plan (i.e., the Improvement Plan)

- Contingency Response Planning for <u>Unpreventable</u> Disruptive or Catastrophic Events
  - The US Military and the EAP Partnership – A Good Example

- Community-Wide Contingency Response Planning for <u>Unpreventable</u> Catastrophes – e.g., fire, flood, tornado, mass property destruction, mass shootings, serial bombings
  - Hurricanes Irma, Harvey, and Florence
  - The Las Vegas Shooting Massacre

Please note that in both forms of CONTINGENCY RESPONSE Planning (3 and 4 above), we are not doing a 'Prevention Plan' because these are unpreventable incidents. Instead, we are developing a 'Contingency' Plan – i.e., planning how we will respond when and if a specific unpreventable catastrophic or highly disruptive event occurs or recurs – with the goal of reducing the IMPACT of the event and speeding RECOVERY. After catastrophic events, a Retrospective Review should be conducted, looking at which preparation actions and recovery actions worked well vs. which actions would benefit from improvement. An Improvement Plan can then be done, which is essentially a NEW Contingency Plan for the next unpreventable event.

1. The *Details* of Prospective Risk Management Planning (Prevention Planning)

At the front end of the Risk Management process, we are *anticipating and preventing* those Critical and Adverse Incidents which we know are INHERENT risks in the work we do. We ask ourselves, "What can obviously go wrong here?" Our goal is to PREVENT these Adverse and Critical events from happening.

How to do this? After identifying the inherent risks (what can go wrong), we put our experience and our common sense to work – identifying the CONTRIBUTING FACTORS which typically precede the occurrence of each of the identified risks, and we eliminate or control them. That's our Prevention Plan.

This is PRIMARY PREVENTION at its best. We are taking action at the front end to prevent the problem. We are identifying the factors which can turn a 'potential problem' into an 'actual problem.' If we can identify potential Contributing Factors before incidents happen, so much the better. We have saved ourselves time, trouble, and organizational stress.

- When we hear our inner voice say that 'It's an accident waiting to happen' we know that it is time for a Prospective Risk Management Plan to address the issue.

- When we hear someone say, 'I just KNEW that was going to happen!' we know that someone failed to develop a Prospective Risk Management Plan for something that they 'saw coming.'

They ignored the RED FLAGS. Now they must move into Step 2 – Retrospective Risk Management Review and Correction.

But we don't limit Prospective Risk Management to identification of problems in our current operation. Prior to making *major changes* in the workplace, we must do a structured Prospective Analysis of how the change will IMPACT the organization in seven specific areas. As we saw in the case study of a warehouse manager, making a significant change in scheduling – which disrupted the sociological and stress-relieving features of the workforce milieu – making major changes without understanding the potential impact can result in Adverse or Critical Incidents.

> **When *major changes* in the operation are contemplated, we must first analyze the potential for an undesirable impact in several areas. We are asking, "what negative impact might this change bring?"**

This type of Prospective Risk Management looks at how the change could impact the organization's day-to-day and longer-term functioning, the availability of resources, and the quality of what is delivered. The analysis also considers the impact which the change might have upon our employees, clients, and customers – and upon the reputation of the organization. Without a prospective analysis of the potential impact, any major change in the workplace may bring about negative results that are difficult to cram back in the box.

For example, Management may plan a major expansion of the program or business without considering the *currently available human resources*. The thought is that they will hire additional staff when the new project begins to bring in new funds. But if the current workforce is already 'allocated' (fully committed to other projects), the plan for expansion will have a negative impact on the deployment and productivity of employees within <u>multiple</u> projects. The expansion project may fail, and current projects may deteriorate or degrade in quality or effectiveness.

- *Faulty prioritization* such as this can trigger a decline in employee performance, and may cause resentment, confusion, and resignation of good employees – all of which can result in negative Performance Indicators (a.k.a., Outcome Indicators) and/or Adverse or Critical Incidents in the workplace.

When significant changes are planned for the workplace, CEAPs and QM specialists can encourage Management to utilize a 'Seven-Factor Impact Analysis' as the framework for a discussion of the planned changes before final decisions are made. This process ensures that only ***informed changes*** are made in the workplace. Details of the potential issues to be discussed and analyzed are seen below.

<p style="text-align:center">**'The Seven-Factor Impact Analysis Checklist'**
A Guide for Informed Changes in the Workplace</p>

When *major changes are planned in the workplace*, there are at least <u>seven factors</u> which should be prospectively evaluated prior to implementation of the changes. These seven factors are Risk Management 'hot spots' which focus upon the IMPACT which the change will have upon

employees, workplace functionality, and the quality of products or services. This is a Risk Management Tool. The following list of seven areas can be converted to a checklist and comments format:

How will the change *impact* the following four areas?

1. The quality of employee-employer interaction, including clarity of communication, up and down the ladder
2. The clarity of employee and management roles within the workplace
3. The quality and the reputation or desirability of the service or product which is produced
4. The management of stress in the workplace including safety of the environment for employees and clients and customers

Is there a clear vision about what we are doing?

5. Will this change result in a negative impact upon ANY <u>Outcome Indicators</u> pertaining to employees, productivity, safety of the product or service, financial stability, or the satisfaction of clients or customers?
6. Are we clear about what we are trying to accomplish with this change? Does it make sense? Should we be doing this based upon knowledge in the industry?
7. Are there enough *human resources* to effectively make the change without disruption of other operating requirements?

These seven 'hot-spots' can result in Adverse Outcomes and Critical Incidents if they are ignored prior to making significant changes in the workplace. It doesn't matter if the workplace is an Addiction Treatment facility or a Purina Cat Food factory – these issues must be thoroughly discussed prior to implementing a major change.

> Note: When analyzing the potential risk of making changes in the workplace, there may also be Technical or Mechanical Factors to consider; but in our professional field, Human Factors are our primary focus. We leave the technical and mechanical issues to the IT department and the engineers.

Is *Impact Analysis* a universally popular approach to making changes in the workplace?
No, it is not. The need to do an Impact Analysis may grate on some Managers' nerves simply because the Manager's style of leadership conflicts with anything which challenges his or her convictions.

Following are two ***Hypothetical Case Studies*** which demonstrate the need for Prospective Risk Management Analysis *prior to* making significant changes within an organization, using the 'Seven-Factor Impact Analysis' described above.

<u>CASE 1</u>

A tech-minded Business Administrator of an addiction treatment facility is more comfortable with the things he can control, and he is therefore enamored with the new computerized 'Individual Assessment Booklets' released at the latest 'Technology in Behavioral Health' conference – rendered in English, Spanish, Mandarin, and Pashto.

The Administrator announced the following to staff through an intra-office email:

> "We need more standardization and efficiency in how we assess the need for Addiction Treatment. Therefore, from this point forward, clients will complete the new computerized 'Individual Assessment Booklets' <u>before</u> an initial face-to-face appointment with a Counselor.
>
> And, we'll set up a few laptops in the intake area which will be screwed to the tables – and they will open to the 'This Is Your Assessment' page. We can gather all of the demographic information at the same time – including the history of their addiction and run-ins with the law, and any sexual behaviors which are associated with their substance abuse issues. After we have electronically scored the booklets, we will review the completed documents, assign a counselor, and invite the individual to come back for a face-to-face session."

After the announcement, the program's Clinical Director rummaged through her PC's hard drive and found a quote by SAMHSA in 2014 which said, "Screening is often the first contact between the client and the treatment provider, and the client forms his or her first impression of treatment during this intake process. Thus, how screening is conducted can be as important as the actual information gathered, as it sets the tone of treatment and begins the relationship with the client."

The Clinical Director placed the quotation in an email which she sent to the Business Administrator, marked URGENT. He read it and hit the 'DELETE' key. The change proceeds as planned . . .

And now the Manager is perplexed when 45% of the clients assessed by computer failed to return for the first face-to-face intake appointment. No-shows for intake had never been higher than 9% in the past. This increase in no-show rate is an Adverse Outcome Incident which will soon become a Critical Incident if the trend continues.

As to Critical Incidents, two of the 32 clients who failed to return for the face-to-face visit fatally overdosed within ten days of their computerized assessment.

IMPACT: It appears that factors 1#, #2, #3, #4, #5, and #6 listed in the 'The Seven-Factor Impact Analysis' should have been addressed prior to making the change. Now these 'potential factors' are Contributing Factors for one Adverse Incident and two Critical Incidents. A Retrospective Review of the three Incidents would no doubt identify these factors.

CASE 2

A highly competitive, 'fast-forward' female CEO of a large auto manufacturer is convinced that a woman's value in the automotive industry is defined by the number of new models released each year. Despite some fatal roll-over accidents which some critics say are associated with the most recently produced lightweight body design, she is determined to send two more versions of this model to the showroom this year, 'no matter what it takes.'

The CEO insists that the initial reports of accidents were biased and were actually due to driver error. She fires her Safety Director who vigorously opposes the continued production of the model due to what appear to be design flaws. The Safety Director takes five of the company's most critical engineers with him when he is terminated – all of whom assume new positions with a competitor. The CEO moves ahead with her plan.

Some months later she is bewildered by the increase in the total number of Critical Incidents (deaths and critical injuries due to automobile roll-over accidents) associated with the new models in the 9 months following their release. The Safety and Value ratings for the entire fleet of cars produced by this company have deteriorated due to insufficient engineering oversight, and there has been a massive sell-off of the company's stock as the Fiscal Third Quarter comes to a close. The competing manufacturer, which hired the CEO's engineers, is thriving.

IMPACT: It appears that all seven of the factors listed in 'The Seven-Factor Impact Analysis' should have been addressed and analyzed prior to making this hypothetical change. Now these 'potential factors' are Contributing Factors in a number of individual lawsuits and one Class Action Lawsuit in which the National Transportation Safety Board has entered as a Plaintiff.

What Are the Most Common Legal Vulnerabilities for which we need to Prospectively Plan and Monitor? If we work in this field long enough with a broad range of clients, there is every chance that a Critical Incident will occur, calling into question the organization's level of accountability. Lawsuits are always possible, but investigation by a licensing or regulatory authority is more likely. Good Risk Management Programs are one of the most effective protections against sanctions, penalties, and litigation.

Some organizations are more at risk than others. Addiction professionals and others treating co-occurring disorders and major mental illness in an inpatient or residential setting are likely at greater risk for Critical Incidents than those treating individuals in an outpatient setting with a single mental health diagnosis. The clients of EAPs such as the US Military, the manufacturing industry, and the transportation industry, are likely to experience more Critical Incidents of a traumatic nature than those in the primary Mental Health and Addiction fields.

But no one is exempt from risk.   The goal for all is to reduce the *vulnerabilities* that are inherent in the work we do, including those issues which are commonly known to draw the attention of regulators and the legal profession.

For example, we know that there are some specific mis-steps upon which investigators and attorneys are guaranteed to focus. *'Failure to correct known issues'* and *'failure to document'* are the most common 'Achilles' Heels' in professional negligence litigation and in Critical Incident investigations. Regardless of the reason for the lawsuit or investigation, be it an accidental death or a failure to comply with a contract, these two issues come front and center.

Failure to Document: When an incident has occurred, and a lawsuit follows, the focus of the suit may not be an egregious action of the employee or the Management which caused the Critical Incident. The issue may be that we can't PROVE what we did of a positive nature because we FAILED to DOCUMENT what we did or why we did it. Because there is no documentation, we have no defense against allegations of clinical or administrative failure. Remember the most famous of auditors' concluding statements: "If it is not documented, it did not happen."

Failure to Correct Known Issues: This is typically an error in judgement or negligence. Failure to correct known issues goes beyond 'ignoring a red flag.' We have been warned about 'Known Issues,' and have either inadvertently or negligently failed to take action to correct the problem.

Therefore, Management is wise to implement a Prospective Risk Management program to address, monitor, and prevent both of these vulnerabilities. Following, are a few examples of these two vulnerabilities – failure to correct known issues, and failure to document what we did or why we did it:

1. **Vulnerability for all organizations:** When we fail to respond to a 'red flag' warning of trouble, we are in a legally vulnerable position if something goes seriously wrong. In a court of law, we will likely fall short in our answer to the question that is ALWAYS asked in a professional negligence case:

> **"Did you fail to take an action which you knew, <u>or should have known</u>, would have or could have prevented this incident or outcome?"**

This issue is a standard focal point in professional negligence lawsuits and sometimes in criminal prosecutions. Surveyors are certain to pinpoint this issue, in a review of a Critical Incident.

Therefore, the first step is to <u>prevent</u> 'red flag' situations from progressing further, to an incident. Take immediate action to correct the apparent problem, *and document what you have done.* If your attempts to correct the issue are not effective and an incident does occur, move quickly to address it. It is important to gather the documentation of *all previous efforts* to address the problem and the subsequent monitoring activity.

2. **Vulnerability in Behavioral Health:** Failing to document a clinical rationale for not including one or more presenting problems in the treatment plan.

<u>Example</u>: The client's mother called in to secure an outpatient intake appointment for her 16 year old son. She told the Intake Coordinator that her son has been expelled from school when contraband drugs were found in his backpack, but she says she is primarily concerned because he has been chronically depressed and angry, and his grades have dropped. The school would not readmit him until he had obtained counseling.

The intake coordinator noted all of this information on the Telephonic Intake Form. However, aside from the notation about drugs being found in his backpack, *there is no documentation in the Clinical Assessment or in the Treatment Plan or in the Progress Notes* about drug use or possible SUD, until the youth overdosed and died in the Senior High bathroom three months into counseling. The Toxicology report identified his current medication for Major Depressive Disorder plus two street drugs which produced a lethal interaction.

How is something like this possible? Unfortunately, it is more common than you would think. When busy handling multiple clients and more waiting in the lobby, it is difficult to foresee the need to document 'details' which you are setting aside in the case. It's even more difficult to see details morphing into what they can become: A Risk Management trauma.

During Retrospective Review of this Critical Incident, the counselor verbally said that she had discussed the issue of drug use with the client during the Clinical Assessment – including the issue of the backpack containing drugs – and he was clear that his use of drugs was minimal and episodic and "that's not why I need to come here." She said that in her professional opinion, the drug use was simply a spin-off of the Major Depressive Disorder and did not meet the criteria for Substance Use Disorder. Her Clinical Impression was that stabilizing the affective issues was an urgent priority.

The counselor also said that she had discussed the treatment focus with the psychiatrist who was managing his medication for depression, and that he appeared to be OK with that approach. There was, however, no documentation of that discussion. The counselor and client moved forward to work on a cognitive approach to management of his mood issues and its impact on his school performance, and there was good documentation of those sessions.

The risk issue: No exploration of the client's drug use was documented in the record. The counselor's clinical rationale for prioritizing treatment of his MDD over further exploration of drug use may have been valid, but the rationale was not documented – and so from an audit and legal perspective, the client's use of drugs was not given adequate clinical attention.

If a structured Clinical Assessment format for identifying adolescent SUD had been available and completed by the counselor during the Clinical Assessment, that documentation could have supported the counselor's clinical impression that use of drugs at that time was minimal. Such a document would, at minimum, have provided the data upon which she based her conclusion. Without documented assessment of the recognized factors which are typically present with child and adolescent substance use, there may also be an issue of Scope of Practice in this case.

3. **Vulnerability in Behavioral Health:** When clinically assessing a child or adolescent for a mental health issue, an AOD assessment to identify or rule out substance use issues is essential. It is unwise to perform such assessments 'on the fly', with a yellow legal pad. The use of a structured AOD assessment format, upon which the youth's responses to specific AOD-related questions can be recorded by the professional, provides support for the assessor's conclusion that AOD issues are, or are not, present.

4. **Vulnerability in all organizations:** Failure to address a risk issue which was <u>previously identified</u> and is later associated with a Critical Incident.

   <u>Example</u>: "Yes, the last equipment inspection indicated that we had some safety problems on that shredding machine, but we re-classified it to 'insignificant' when we learned that the inspector was having a very bad day – you know, mood swings."

5. **Vulnerability in all organizations:** 'Assuming too much' *without validating our assumptions.*

   <u>Examples</u>: "I assumed that she no longer had any suicidal inclinations, since she never brought it up in our counseling sessions."

   "I assumed that the brakes had been fixed because I placed written instructions on the Fleet Manager's desk when I left yesterday afternoon."

6. **Vulnerability in all organizations:** Negating an identified issue without *documenting* a logical *reason* for the decision which could support the action that was taken.

   <u>Example</u>: "I knew that he harbored a hatred of his brother, with a desire to kill him, and he spoke of it frequently – but practically speaking, I felt that it was not something I needed to pursue

because the brother lived 2300 miles away, in Canada, and the client is indigent."   Documented? Unfortunately, no.

7. **Vulnerability in all organizations:**   Failure to internally communicate important information *within* the organization, about identified risk situations.

   Example: Failure to effectively transfer information up *and* down the ladder – such as an engineer discovering a potentially critical error in a high-pressure gas line where 35 employees are working. Instead of sending a "runner" to the third floor, he left a voice mail on his boss's phone asking for permission to shut down. But the boss had gone home at noon with the stomach flu and had failed to inform his engineers of his departure.

8. **Vulnerability in all organizations:** Insufficient training or certification in an intervention or new technical assignment – *or* failure to document the training.   In Behavioral Health, the risk is the provision of services which are "outside your scope of practice" due to insufficient documented training. In corporate businesses, the risk is assigning an employee to a task for which there has not be sufficient prior training.

Summary of Common Legal Vulnerabilities for Which We Must Develop Prevention Plans. Failure to document and failure to follow-through on identified risks can backfire with a Critical Incident. Without good prior documentation and follow-through, we have no defense against allegations of culpability in the event of a Critical Incident. Remember the most-quoted of auditors' and investigators' summary statements: "If it is not documented, it did not happen."

- Many adverse decisions in civil litigation are based upon 'what was NOT documented' in the record. This occurs far more often than adverse decisions based upon what WAS documented.

- It is possible to do this type of documentation within a Computerized Patient Record (CPR) system – which is defined as "electronically maintained information about an individual's lifetime health status and healthcare." *Electronic records are not simply yes or no checkboxes.*

- When auditing records, surveyors refer to records as "holding together" or "not holding together" – i.e., are the records of operation without gaps and contradictions? From the perspective of a surveyor, in behavioral health the client record should present a clear, integrated clinical 'picture' of the client and his course of treatment without the need to obtain a verbal explanation from the treating professional. In industry, records of permits, employee training, expansion designs, equipment maintenance, etc. should be consistently maintained and without gaps and contradictions.

- Prospective Prevention Plans should put a formal structure in place to monitor the adequacy of documentation in organizational records, including personnel records, training records, client records, etc.. Good documentation discourages allegations of professional negligence. As always, if missteps in documentation are discovered, a Retrospective Review and CORRECTION Plan are in order.

Prospective Planning for Response to Accidental Death and Critical Injury

EAPs provide support services to both Management and employees in the US Military and in industrial settings such as manufacturing plants, coal mines, and large construction companies. Accidents resulting in injuries or death are an inherent risk in such workplace settings and – except in the Military – are frequently the subject of litigation. Accidental client deaths are also an inherent risk in Mental Health and Addiction Treatment Programs.

NOTE: In commercial organizations such as factories and other industrial settings, conventional wisdom holds that the *risk of litigation* in response to such events is *reduced* when Management *proactively reaches out* to family survivors and involved co-workers after the Incident has occurred, to provide emotional support. This may not be immediately allowed in some facilities for legal reasons, particularly those which are operated by State or local government.

In working with non-military organizations, EAPs should collaborate with Management, and the legal team if there is one, to develop a Prospective Risk Management Plan for responding to family and co-workers following an accidental death or critical injury in the workplace. The goal of the activity is to *anticipate* the potential human reactions to the event and the emotional support which will be needed – thereby to *reduce or manage the impact* of the event upon survivors. Steps to be taken *and actions to be avoided* should be clearly delineated in the plan, *including an understanding of legal boundaries* which must be respected.

Behavioral Health programs and facilities should also develop a Prospective Risk Management Plan for handling of deaths and critical injuries within the organization and with the surviving family members. *In governmental and private businesses,* the organization's legal department may have established specific procedures with an eye to prevention of legal complications. But as with all other situations, it is important that Program Management coordinate with the legal division to ensure that essential emotional support can be provided to the family and to co-workers, particularly in horrific and traumatic accidents. This is a critical Risk Management step which seeks to reduce the IMPACT of the event upon survivors, and which also reduces anger and the inclination to sue.

The Military has highly regimented, formal procedures for death notification, which typically involve two specially trained officers, typically commissioned rather than NCOs, who deliver the news of the tragedy personally to the next of kin, including a standard script from which the death notification officer is not to deviate. There are many resources and supports immediately made available to the family, including contacts for financial affairs, insurance and death benefits, and Mortuary Affairs. EAPs provide therapeutic support and counseling to the families, and coordinate with Military support resources to assist the family in the process of transition to civilian life.

2. The *Details* of Retrospective Risk Management Review and Correction (Post-Incident Corrective Action Plan, a.k.a., Improvement Plan)

When something goes seriously wrong, the Critical or Adverse event is an *Opportunity for Improvement.* The RM Committee conducts a RETROSPECTIVE review of everything pertaining to the Incident – people, places, circumstances, issues, perceptions, communications, and so forth. We are looking 'backward' to accurately identify the CONTRIBUTING FACTORS – those things which could or did contribute to the occurrence of the incident. We answer these questions: "<u>What</u> happened here?" and "<u>Why</u> did this happen?" And finally, "<u>How</u> can we fix it?" i.e., "What do we need to change or add to prevent recurrence?"

This type of Risk Management activity is *the most difficult* of the four categories of Risk Management Review and Planning. When something goes seriously wrong, we must *leave no stone unturned* – sometimes referred to as 'turning over the rocks' – to uncover the Contributing Factors attributed to the incident. It's a good analogy: Before you turn over a rock, you don't know what's underneath.

In the workplace, what we find may be an issue or a practice that no one really wants to address. It may even be a 'Sacred Cow' whose usefulness has passed. And thus, the temptation is to leave the 'rock' where it is, undisturbed. But painful as it may be, there must be a change or an addition of something new**,** to either eliminate or offset the Contributing Factors which are associated with the Incident.

How to proceed in a Retrospective Review?

- First, we define what happened. Not 'why' . . . 'WHAT.'   As in, the boiler in Warehouse 3 blew up and two people were injured. Or, we have lost seven records in the detox unit. Or, there was a fire at the new Supported Housing location, and the entire complex is burned to the ground. Or we have been given notice that our funding is being reduced by 20%. In the case of accidents, there may be different perceptions about exactly what happened. Hear them all. Clarity comes with working through the process.

- Next, we identify all of the FACTORS which contributed to <u>*or may have contributed to*</u> the Incident, including the Human Factors**.** These factors often include the actions or inactions of employees, Management, or both; misperception of the problem or situation; communication issues or interpersonal conflict; confusion of roles or misunderstanding of procedures; lack of a clear or reasonable target for production or service; factors which impair employees' ability to do their job, etc. *[We will provide two checklists of the most common factors, momentarily.]*

- After identification of the Contributing Factors, we develop the CORRECTIVE ACTION PLAN – a.k.a., the Improvement Plan – making changes to prevent recurrence of the incident. The changes might include a modification of a current procedure or the development of new procedures, staff training, enhancement of communication, correction of communication errors, adjustment of perception errors, a change in the chain of command, reassignment of specific responsibilities, adjustment of the goal or target activity, etc..

- There will almost certainly be a change in what one or more employees or Managers do, or in how they do it, or how they document it, and how they monitor for the effectiveness of the corrective action. The changes should extend into the manager's office – the primary seat of responsibility.

- In working within Military installations, the EAP does not participate in the Commanding Officer's After Action Review of the combat scenarios; but if the incident is brought about by interpersonal violence or suicide, the EAP will most likely be asked to pay a significant role in a Retrospective RM Review and Analysis, to identify personnel-specific ('human') factors which may have contributed to the incident.

NOTE: Retrospective Review is an 'Internal Audit' Function. In the Risk Management process, all organizations must learn to think like an 'auditor' or 'investigator' of their own procedures, records, actions, and capabilities. The things you examine will vary, depending upon the nature of the business, but includes such things as personnel records, activity logs, treatment records, production logs, performance outcomes, available resources, procedures, and staff capability.

The practice of conducting an Internal Audit has been in place since businesses began to hire or contract with Certified Public Accountants (CPAs) to uncover the business's own financial missteps. CPAs are expected to think like an IRS agent, digging deep into file cabinets and computer hard drives to uncover the source of the error on 'line C84' of 'Schedule Z' in the company's Federal Tax Return. *Internal Audit* is a valid Risk Management model which works to *uncover the less-obvious Risk Factors* which have contributed to an Incident or performance problem within the organization.

Given the broad scope of factors which should be considered in a Retrospective Review of an Adverse or Critical Incident, it's easy to overlook a potential Contributing Factor. Therefore, we recommend that the Risk Management Committee use a *structured format* in its search for Contributing Factors.

- Below, we present a **'Basic Checklist Guide to Identification of Contributing Factors'** – fourteen (14) issues which are often identified as Contributing Factors during Retrospective Review of incidents. These issues should be considered first, for relevance to the Incident.

- We also present an **'Expanded Checklist Guide'** which contains additional Contributing Factors to be considered if the review of the 'Basic Checklist Guide' does not provide a clear path to Correction and Improvement. The second checklist contains a number of items which pertain to human dynamics and interaction.

The 'Basic Checklist Guide' to Identification of Contributing Factors

The following list is a basic Retrospective Review tool – a tool to facilitate consideration of the factors which are most often identified as 'Contributing Factors' after a Critical or Adverse Incident has occurred. We are attempting to answer the question, "What went wrong here, and what corrections do we need to make?"

These fourteen factors pertain primarily to the clarity of management-employee communications and perceptions about what we were trying to accomplish when the incident occurred; the viability and appropriateness of what we were trying to do; workload-related stress, role confusion or misinformation; the need for new or changed procedures; inadequate physical plant and resource issues; or *failure to act.*

The 'Basic Checklist Guide' is not a complete list of Contributing Factors to be considered in a Retrospective Review, but it contains the *fourteen (14) factors which should <u>always</u> be considered first* during review of an Adverse or Critical Incident. There may be technical, mechanical, and strategic issues to be considered as well, particularly in the industrial and technology fields and the US Military, but we leave those issues to the appropriate division of management.

1. Need for additional procedure(s)
2. Need for change in a specific procedure
3. Failure to follow procedures – training issue vs. negligence
4. Physical plant functionality or working environment
5. Workload-related stress and/or fatigue – employees or management or both
6. An unexpected, significant change in assignments or procedures, affecting employees
7. Unclear or problematic performance benchmarks
8. Inaccurate perception of the issue or situation – management or employees or both
9. Role confusion or misinformation as to 'who' was responsible for 'what'
10. Ineffective communication of critical information in the workplace, up or down the ladder or laterally
11. Failure to develop "failsafe" mechanisms to serve as a barrier or early-warning mechanism to prevent mishap
12. Lack of clarity about what we are trying to accomplish – confusion about the goals or intent of the activity in question
13. Required resources – are we under-allocated?
14. ** Did we fail to take an action, that we knew, or should have known, would have or could have prevented the incident?

The 'Expanded Checklist Guide' to Identification of Contributing Factors

When consideration of the fourteen items on the Basic Checklist Guide fails to fully identify (or inconclusively identifies) the Contributing Factors associated with an Adverse or Critical Incident, the Risk Management Committee proceeds to consider the Expanded Checklist Guide, below. These items move further into the area of workplace and human dynamics. Regardless of the employment setting, factors such as these are frequently identified during Retrospective Review of a complex Critical Incident.

1. Human interaction patterns and dynamics within the organization or installation
2. Failed or ill-advised Policies and/or Procedures – need for a major overhaul
3. Ineffective communication routes which impact delivery of the message
4. Interpersonal conflict – manager-manager, manager-employee, or employee-employee
5. Ineffective or stifled communication from workforce to Management

6. Unpredictable deadlines in job assignments resulting in employee stress
7. Financial difficulties and stressors within the organization that may inhibit problem solving
8. Conflicts between the work organization and its affiliates, partners, vendors, and/or users of its products or services
9. Appropriateness of what we are trying to accomplish – should we be doing this?
10. Level of commitment to the goal – everyone on board?
11. The impact upon military families of repeated deployments to the war zone
12. Redeployment to the home base, after an extended deployment to combat
13. On-the-job pressure to achieve in high tech industries including the IT industry
14. Lingering emotional distress following a traumatic Critical Incident, affecting surviving employees and families and managers
15. The use of drugs and alcohol to relieve stress, anxiety, and symptoms of PTSD
16. Need to pause and address emerging issues before adding new services

An External Perspective Can Be Helpful. You may have noted that the Contributing Factors on these two lists are likely to cause many managers to cringe. The process of correctly identifying the Contributing Factors in a Critical Incident can, at times, become so disconcerting that Management and supervisors can't do it without an *external perspective* which is devoid of bias. The EAP must carefully work through the managerial 'wall' which is "one part denial to two parts apprehension" – a natural defense against unanticipated events which require 'change'.

In the Military and in Corporate business settings, Managers can benefit from – and often need – this perspective in order to overcome barriers in their 'executive vision.' In fact, all Military Installations and VA Facilities have an EAP program in place, as do 100% of Fortune 100 and 500 Companies. The external perspective of an experienced EAP consultant can bring the attention of Management to sensitive employee-related Contributing Factors in a constructive way. 'Administrative myopia' is a natural defense against unanticipated workforce disturbance and the need for change.

In Behavioral Health organizations, Managers are oftentimes on their own in performing Retrospective Risk Management Reviews unless their funding level allows for contracting with a Quality/Risk Management consultant on a prn basis. For-profit psychiatric and addiction treatment facilities do typically have external Quality/Risk Management consultants or may hire such a position internally.

In all such situations, speed is of the essence. When a Critical or seriously Adverse Incident occurs, we must not wait to take action until OSHA or State Licensing or other authorities are on the doorstep. The Risk Management Committee meets promptly to prepare for a briefing of employees and to begin the first steps of Retrospective Review, using the Checklist Guides above to identify Contributing Factors.

Remember that when a Critical Incident occurs, the task of the RM Committee is to "leave no stone unturned." In keeping with this mandate, every factor which the committee believes '*may have contributed to*' the incident, as well as those which *did* contribute, need to be addressed in the Correction and Improvement Plan.

Retrospective Review of Accidental Death and Critical Injury: The assumption is that a Prospective Risk Management Plan has been created and should be followed. The immediate post-event involvement of the EAP or QM professional is appropriately limited to (1) crisis intervention with clients, supervisors and employees who are traumatically impacted by the death or injury and (2) guidance to Management regarding an effective response to employee and survivor reactions to the specific incident which has occurred. How well this stage of the response is handled is a crucial Risk Management element.

Following the stabilization of the acute trauma in the workplace, the Retrospective Review of the incident should proceed, in order to identify Contributing Factors which did contribute, or may have contributed, to the Critical Incident. The use of the two Checklist Guides to Contributing Factors should be utilized, to not overlook the less-obvious 'human factors' which may have been associated with the Critical Incident.

- In working within Military installations, the EAP does not participate in the Commanding Officer's After Action Review (the AAR) of combat scenarios. But if the nature of the incident is interpersonal violence or suicide, the EAP will most likely be asked to pay a significant role in briefing and Retrospective Review and Analysis, to identify personnel-specific ('human') factors which may have contributed to the incident.

Before we move on to the third and fourth categories of Risk Management, let's take a closer look at the role of Employment Assistance Programs (EAPs) in Risk Management, and who performs Risk Management functions in Behavioral Health Programs.

More About the Role of Employee Assistance Programs (EAPs) in Consultation to Management and Implementation of Risk Management Programs

In addition to providing direct services to an organization's employees and their families, EAPs serve as consultants to the organization's Management Team, to build awareness and understanding of the human factors and workforce dynamics which impact performance and productivity. EAPs utilize a *coaching and consultation* approach to enhancing supervision skills with difficult employees and recommending operational changes, but EAPs do not make administrative decisions.

The recognition of stress-related behavioral health issues in the workplace, and the need to do something about it, has increased in recent years. Managers in large organizations are confronted with employees' depression, anxiety, and stress from the pressure of deadlines to produce, associated misuse of alcohol and drugs to relieve stress, suicide, PTSD following the death or critical injury of a co-worker or client, and the unrelenting danger which is present in some industries and on the battlefield.

> **The EAP-Management partnership works to improve employee and organizational performance, including the effectiveness of supervision and the efficient and safe deployment of human resources. EAPs assist Management in the improvement of workplace dynamics and workforce communication up and down the ladder. The partnership works to 'prevent molehills from becoming mountains.' All of these activities dovetail with Risk Management.**

In development of Risk Management Programs, EAPs play a significant role in the following activities, *which are also essential to operation of Behavioral Health programs*:

- the development of relevant performance and compliance indicators and tracking of outcomes,
- debriefing managers and employees following Adverse and Critical Incidents,
- conflict resolution,
- OSHA compliance,
- disaster preparedness, and
- collaboration with internal and external resources to secure the organization's place at the 'community roundtable.'

In Behavioral Health **Programs, 'who' does 'what' in the list above is determined by Management.**

We can summarize the goals of EAP programs into five broad categories, all of which are directly relevant to Risk Management:

1. Enhance Management's understanding of the <u>human behavior factors</u> which are associated with inadequate Performance Outcomes and the occurrence of Adverse and Critical Incidents

2. Enhance Management's skill in <u>making *informed* changes</u> within the workplace

3. Enhance Management's <u>communication and supervision skills</u> in the handling of difficult employees and in fostering improvement in workforce morale and performance

4. Put a viable <u>Risk Management Program</u> in place, including both prospective and retrospective phases of risk reduction.

5. *Conduct one of more debriefings* following a Critical Incident, as part of Risk Management. Debriefing sets the stage for the Retrospective Risk Management Review process.

Note: Debriefing is a structured on-site group intervention that occurs shortly after a traumatic incident, led by a mental health professional (and in our current context, an EAP-certified mental health professional). Debriefings provide basic information about the traumatic event and provide individuals an opportunity to discuss their feelings and thoughts about the event in a controlled and rational manner. Employees learn about normal stress reactions, the symptoms of PTSD, and the availability of short term follow-up counseling to reduce stress and support resilience.

To achieve these five broad goals, EAPs perform a variety of functions in support of Management. These functions pertain to workforce performance, workplace dynamics, achievement of the organization's goals for outcomes, compliance with applicable regulations, and prevention and correction of Critical and Adverse Incidents. Breaking these down into discreet elements, all of which pertain to RISK MANAGEMENT:

- Coaching in effective supervisory practices and the constructive resolution of conflict
- Consultation regarding realistic performance expectations
- Development and tracking of performance indicators and outcome measurements,
- Consultation in the use of positive methods of stimulating optimum performance and adherence to safety and established procedures,
- Recognizing signs and symptoms of PTSD and SUDs,
- Recognizing when a current practice or communication style has become detrimental to workforce morale and/or performance
- Providing an external perspective of *workplace dynamics* and the impact of workplace *changes* upon the workforce; clarify how mismanagement of change can result in Critical and Adverse Incidents.
- Developing *Prospective Risk Management* Prevention Plans, with specific attention to effective management of 'human factors' in the workplace
- Conducting *Retrospective Risk Management Reviews* of Critical and Adverse incidents involving employees and the 'human factors' within the workplace [Engineering and technical issues are not part of an EAP's focus.]
- Identifying the *Contributing Factors* pertaining to incidents – particularly the 'human factors'; work with management to develop *Correction and Improvement* plans.
- Tracking the implementation of Correction and Improvement plans
- Conducting one or more *debriefing sessions* with employers and employees within 24 hours of Critical Incidents which involve a traumatic event – informs about symptoms of PTSD, facilitates and is also a first step in Retrospective Risk Management Review.
- Establishing harassment policies
- Developing in-house injury and illness prevention programs
- Establishing hiring practices with an eye to Risk Management considerations
- Conducting termination reviews at request of management

- Disaster preparedness and recovery
- Collaboration with both internal and external resources within the community as needed.

NOTE: EAPs have provided these services to business management for decades. Employee Assistance Programs (EAPs) began in the 1940s by providing employee services that primarily focused on the effect of alcohol use and abuse on job performance. By the 1970s, this emphasis was broadened to include consultation and employee-related guidance to Management.

Also in the 1970s, Federal legislation [Hughes Act] was passed which requires the inclusion of Employee Assistance Programs *in all Departments of the US government*, either internally or through external contract.   Therefore, you will find EAPs in the Departments of Energy, Education, Homeland Security, Defense, Veteran Affairs, etc.. And *corporate America* has followed suit. In fact, 77% of incorporated US businesses and all Fortune 100 and 500 companies utilize EAPs, either through hiring internally or contracting externally. EAPs are now an essential part of Risk Management programs in all of these venues.

Risk Management in Public and Private Behavioral Health Treatment Programs? Yes.

Does this course have applicability to public and private mental health and addiction treatment programs – or is this just for EAPs?   This course is applicable to all Behavioral Health Treatment Programs, including hospitals, outpatient clinics, private practices, behavioral health networks, and schools. The Risk Management activity described in this course – including the protection from litigation through rigorous documentation of what we did and why we did it, in specific vulnerable areas – should be implemented whether a behavioral health program hires an external Quality/Risk Management consultant for this activity or performs its own Quality Assurance and Risk Management functions.

Although an EAP program is not a psychiatric or addiction treatment program, the EAP should develop a Risk Management protocol for the outpatient counseling aspect of its services. Counseling provided to the employees of corporate organizations has the same risk element that is found in any outpatient mental health or addiction treatment program in the community. When EAPs work with US Military personnel and their families, the counseling risks can be significant, given the high-stress nature of the employment and the inherent risks to life.

Risk Management programs in Behavioral Health can be – and often are – developed 'in house' and are operated by the workplace management team without any external contracted assistance. Given their innate knowledge of human nature, these programs can then combine their understanding of employee dynamics with the standard Risk Management functions described within this course.

The Protected Death Review at the end of this course will demonstrate the challenges involved in positively identifying the Contributing Factors when a Critical Incident occurs. This is one reason why we don't ignore those factors which "MAY have contributed" to the incident. Instead, we develop a plan to strengthen all areas which have been identified as "a possible factor."

Let's Move Forward to Categories 3 and 4 of Risk Management Activity

3. Contingency Response Planning for Unpreventable Internal Disruptive or Catastrophic Events

We have designated this category of Risk Management as Category 3: *Contingency Response Planning*. This refers to Risk Management activity in which we are planning our RESPONSE to an unpreventable Critical or Adverse (or seriously 'Disruptive') event which we know has a significant chance of occurring at some point in time within our organization. Because the event is unpreventable and may or may not occur, and because we are planning how we will respond to it, this type of Risk Management plan is a CONTINGENCY RESPONSE Plan. Contingency Response is an ANTICIPATORY activity.

The response has two goals: To reduce the IMPACT of the event when it occurs, and to speed the RECOVERY from the aftermath of the assault. It's the Risk Management version of 'don't stick your head in the sand' when something we can't control has a significant potential of occurring.

'Contingency Response Planning' is occurring throughout the country right now, in response to a spate of natural disasters which seem to be hitting the 'high water mark' in places which have never or rarely seen this level of destruction, stretching from Florida to Texas and up to the Carolinas. Some organizations are more at risk than others. For example, in Houston, buildings which are physically located near one of the city's bayous or near the ship channel are more at risk of being flooded than those which are located further up Interstate Highway 10, if a hurricane hits the city again as it did with Hurricane Harvey. Likewise, all communities around the Gulf of Mexico which are literally at sea level have no protection from storm surge.

Not all unpreventable events are natural disasters, and not all are catastrophic. An event does not need to be catastrophic to seriously impact an organization. Some unpreventable events fall into the 'adverse' category and are seriously DISRUPTIVE to organizational operation and capacity. Therefore, we have two types of UNPREVENTABLE Risk Events. Let's label them 'Unpreventable Type A – Traumatic or Catastrophic,' and 'Unpreventable Type B – Adversely Disruptive.'

When we refer to unpreventable DISRUPTIVE Incidents, we are referring to events of a business or personnel nature which would have a *negative impact* upon our workplace operation is we don't reduce the impact by compensating in some way. If not addressed with a targeted Contingency Plan to reduce or offset the impact, such disruptions can put a business 'out of business' just as easily as destruction of their building can.

Unlike the first two of the four Risk Management categories, in Contingency Planning we cannot prevent the occurrence or recurrence of certain events because they are a function of *external influences which we cannot control*. But we can develop a plan *to reduce the impact* if it occurs or recurs. This includes prioritizing the *initial response* and developing a plan for as *rapid a recovery* as possible.

A. Contingency Plan for Response to Unpreventable Traumatic or Catastrophic Events Within an Organization – a.k.a., Recovery Plan

Naturally-occurring calamities are unpreventable and may impact an individual organization rather than an entire city or community. All organizations should assess their vulnerability to specific, unpreventable calamities which are indigenous to the area or to which the organization is vulnerable for whatever reason, and develop a Contingency Response Plan (a.k.a., a plan designed to reduce the IMPACT and to speed the RECOVERY – i.e., Damage Control). Examples of unpreventable catastrophes: Torrential rain caves in the majority of the organization's roof. An earthquake rattles a building and sections of the building crumble, making entry unsafe. A coal mine implodes due to unexpected shifts in the strata, trapping miners inside. A tornado touches down near an organization located in Oklahoma's 'Tornado Alley' and does major damage to a factory.

In the past few years there have been several traumatic events which seriously affected individual organizations, among them being a mass shooting at a Military Post, a massive explosion at a fertilizer plant, flooding of hospitals and nursing homes in which evacuation of bedfast residents was extremely difficult or impossible, floods and fires closing entire manufacturing plants, a couple of mass casualty school shootings and a church shooting.

In the case of school and church shootings, much uncertainty remains, from the local organization to State and National government, about how to *defend* against and *minimize the damage* inflicted by this type of virtually unpreventable catastrophe. An 'active shooter' who suddenly appears outside a church or a school or restaurant and begins to fire into the crowd is effectively 'unpreventable.'

This does not mean that there is no point in a school's or shopping mall's efforts to halt or contain such events – such as installing metal detectors on doors, hiring security guards in vulnerable places, training and arming teachers in strategic locations, planning escape routes for children, holding drills, establishing codes for action over the PA system, etc.. All such actions should be part of a Contingency Response Plan to attempt interception of the assault, and to contain the damage if possible.

- All Contingency Response Plans for unpreventable events should be very clear about the immediate 1-2-3 actions to be taken to reduce or contain the impact as it is occurring, and very clear about the 1-2-3 actions to be taken immediately afterward, when the assault has been halted. These actions should become ingrained in the operational management of the organization.

We can take our cue from certain parts of the country, where organizations regularly 'buff and polish' their Risk Management Contingency Plans with an eye to DAMAGE CONTROL, rapid RECOVERY, and RESILIENCE in the face of unpreventable catastrophes. They know they *can't prevent* certain destructive events, but they are determined to survive them as best they can. They understand that damage control, including rapid implementation of organized post-event recovery activity, are the foundation of resilience.

Revisiting and revising the organization's Contingency Response Plan following an unpreventable catastrophe is a modified version of *Retrospective Review*. However, in this version of Retrospective Review, the goal of the review is not prevention of a recurrence [because these events are

unpreventable] – and it's not a 'correction plan.' Rather, the goal is to identify any factors which increased the organization's *vulnerability* to damage when the unpreventable catastrophe occurred. An Improvement Plan can then be developed to further reduce the IMPACT if the event recurs, i.e., *damage control*. Improvements could include such steps as reducing evacuation time, developing early warning mechanisms, redesigning the first responder crew, improving interagency coordination, etc..

Mining – A Good Industrial Role Model for Contingency Response Planning.   The modern day mining industry is a good example of conscientious Risk Management. In the past, mining disasters were oftentimes due to mishandling of electrical equipment around explosive substances such as coal dust, unsafe drilling or blasting practices which resulted in the collapse of the mine, and an array of unsound mining principles which reduced the availability of oxygen to trapped miners.

Mine explosions and collapses are now unusual in developed countries due to Retrospective Review and Correction of the factors which contributed to such collapses in the past. Nevertheless, mine catastrophes can and do still occur, due to unprovoked shifts in the geological strata or other unpreventable 'earth' phenomena.

Mining companies therefore have developed *Contingency Response Plans* for the different forms of mine catastrophe, addressing every possible detail of rapid rescue and recovery. The goals of the industry's Contingency Response Planning are (1) rapid RESPONSE with sophisticated rescue equipment and maneuvers which (2) significantly reduce the IMPACT of the collapse upon those trapped in the mine, and (3) speed the RECOVERY of both survivors and fatalities.

B. Contingency Plan for Response to <u>Unpreventable</u> <u>Adversely Disruptive</u> Incidents or Events Which Have a Negative Impact on the Functioning of an Organization

Catastrophic events are not the only type of unpreventable occurrence for which Management should prepare through Contingency Response Planning. Most organizations periodically experience ADVERSE situations which are UNPREVENTABLE because they are a function of external influences which we cannot control.

These events affect the *business and financial* aspects of the organization, rather than the physical plant, and some affect the availability of an adequate workforce. Although these events and circumstances are typically not catastrophic, they *significantly disrupt* the organization's normal business or program functioning, its capacity and achievement, and its technical functioning – unless Management can reduce the IMPACT and speed the RECOVERY through Contingency Planning.

Responding to Recurring Adverse Disruptions.   Unpreventable Adverse Disruptive events *are much more likely to occur* than are unpreventable catastrophic events. In fact, they tend to assume a *recurring pattern* – something that has the potential to hit the organization repeatedly over the years, sometimes cyclical, sometimes not. Risk-minded organizations develop Contingency Plans and they learn – from one recurrence to the next – how best to reduce the impact upon the organization and how to speed recovery.

These three elements are always found in Contingency Response Plans which address recurring, unpreventable <u>Adverse Disruptions:</u>

- RESPONSE in a timely manner with modification of procedures or goals or reconfiguration of resources

- MODULATION of the impact or effect upon employees and the core functions of the business by compensating for the losses or complications in some way

- Facilitated RECOVERY with an eye to development of RESILIENCE.

What 'Recurring Unpreventable Adverse Disruptions' are we referring to? One or more of the following high-risk situations apply to most organizations at one time or another, whether it's a behavioral health treatment program or an IT corporation or an industrial manufacturing plant or the US Military.

- a *reduction in the demand* for the organization's services or products due to downturn of the economy or normally recurring seasonal shifts – resulting in revenue reduction, reduced hiring capability, forced layoffs, and/or a dip in performance and outcome measurements until the situation stabilizes.

- a periodic wave of *resignations* or departures of valuable staff for reasons which are *unrelated to* employee-employer relationships – due to recruitment of your talented personnel by a competitor or the end of a funding stream, or conclusion of a contract, or retirement.

- In behavioral healthcare, a significant *reduction in fees paid* to providers by Medicaid, HMOs, County Commissioners, and other contract managers – resulting in reduction of incoming revenue, financial stress, a need to modify the service model to fit the new reimbursement rates and a search for replacement funds.

- the appearance in the marketplace of *new purchase or service options* offered by competitors which have caught your current customers' eye – resulting in a downturn of your revenue and a need to reevaluate the service model or product

- periodic *freezing of vacant positions* by a Board of Directors or the State Budget Office – resulting in decreased efficiency of operation, increased stress throughout the workplace, and deadlines more difficult to meet.

- an *epidemic* of an extremely contagious viral or bacterial infection, or exposure to an industrial toxin which impacts a significant number of employees for a period of time – resulting in temporary reduction of workplace capacity and supervisory oversight, temporary cessation of some services, and the need to turn away new business until the situation stabilizes.

Beginning to plan only when the wolf is at the door is not an effective approach to management. Any Adverse Disruptive situation such as those above can occur unexpectedly as a function of the economy, the world markets, shifting commercial trends, a decrease in State or

Federal funding allocations, a change in contractor preferences, or a run of 'unavoidable bad luck'. Effective management requires some pre-planning for RESPONSE to such possible events.

> **Contingency Response Planning should not be a 'reactive activity.' Making workforce and service delivery adjustments 'in the heat of the moment' is not constructive management practice. That's why we engage in Contingency Planning.**

NOTE: EAPs should encourage their Management clients to develop, on paper, an array of contingent service delivery adjustments which can be put into place depending upon the severity of the disruption. Such plans should be 'broad outlines' which are developed in advance of crisis. This type of Risk Management (Contingency Response Planning) is particularly important when the remedial action may require a step-down or reconfiguration of employees and services.

Risk Management supports the capacity for a resilient response to unpreventable challenges. Organizations which systematically 'look down the road' at unpreventable problems which may affect their organization are more RESILIENT than those organizations which don't prepare for things which they cannot prevent. Pre-planning for the potential event, and reducing the degree of the impact when possible, helps to reduce the RISK to the organization's productivity and interim functioning.

Some managers resist the process of Contingency Planning for any situation which they cannot prevent. Why? Because they mistakenly believe that if the catastrophe or internal disruption cannot be prevented, it is *unmanageable*.   Note: EAPs working with Managers who are hampered by this type of thinking can provide supportive consultation *which makes a distinction between 'inevitable' and 'unmanageable.'*

Management vs. employee reactions to implementation of a Contingency Plan. For some managers, Contingency Planning to prepare for events which cannot be prevented is a normal part of Risk Management operation. They know that there will be periodic, unavoidable shifts in revenue due to changes in the funding base or the client base, seasonal trends and cycles, changing regulations, or a decrease in the demand for a particular service or product. They also know that the Contingency Plan will need to be implemented from time to time.

Seasoned managers simply 'roll with the punches' to REDUCE the financial IMPACT through these INTERIM ADJUSTMENTS: freezing of vacant positions, temporary or longer-term layoffs, unpaid forced 'days off', delay of merit raises, and exploration of new product markets.

- *Employees and their families may be much less resilient in the face of these interim adjustments than are managers*. And managers may be *oblivious to the impact* which these changes have upon the workforce and their families.

- *Consultation and coaching provided to Management* about the potential for *human repercussions* within the workforce is important, in order to maintain as much stability as possible during the up and down cycles.

- When employees and their families have unexpected human reactions to the necessary changes, it can impact the workplace in unpredictable ways. Repercussions may include an increase in accidents, injuries, and no-shows for work when employee reactions take a toll on attitudes, confidence, and commitment. Such reactions are worsened by confusion about why these things are occurring and how long it will continue.

- Clear communication with employees as well as creative ways to reduce the impact is important. For factory workers who are placed on a reduced-hour workweek and reduced pay, such compensations as a weekly 'bread basket' day with access to free canned goods and household staples can be considered.

Learning from other's experiences. Management doesn't have to personally go through a catastrophic or disruptive event in order to do a respectable Contingency Plan. When an unpreventable event such as an environmental disaster or a reduction in funding has struck other parts of the country, Management – *and the EAPs who provide consultation to Management* – can learn from others through collaborative consultation. EAPs are encouraged to establish communication with *EAPs in other locations* to learn how their clients responded to a specific unpreventable Adverse or Critical event and the lessons learned from those experiences.

Example of an Uncontrollable Adverse Event in the Professional Sector: An Influx of Competitors and Corporate Raiding. Recruitment of an organization's key employees by competitors is an internally disruptive circumstance which can seriously affect an organization. The IT (computer technology) industry is a prime example of competing organizations raiding the talented workforce of other companies. This type of disruptive event is a particular risk in cities such as Austin, TX, where City Management is recruiting competing IT companies. Hospitals can also be stiff competitors in the recruitment of nurses from other facilities. A new factory in town seeking supervisory personnel would almost certainly present a disruptive situation for existing manufacturing plants. Likewise, a new Residential Treatment Center or Addiction Treatment Facility preparing to open would put stress upon existing facilities.

Management is advised to develop a Contingency Plan to reduce the impact of such threats to stability, to be implemented if and when disruption of the workforce occurs. Strategies may include varying draft reconfigurations of employee responsibilities which will maintain key functionality, and re-evaluation of current products and services vis-à-vis the workforce resources required to deliver them. Some reconfiguration of 'who does what' is oftentimes a necessary Risk Management move.

Example of a Contingency Response to an Unpreventable Sudden Reduction in Workforce Capacity: Alternative Schedules or Down-Scaling of Operation.   Preparation of a Contingency Plan for an unpreventable *acute reduction or incapacitation of the workforce* due to a

disruptive or catastrophic event is an essential element of Risk Management, no matter what kind of business it is.   Contingency Planning is necessary to reduce the IMPACT of sudden workforce reduction. The plan should make provisions for a detailed 'Plan B' which temporarily shifts the organization into an alternative method or scale of operation.

- Example: If an HN viral infection incapacitates half of the employees in your behavioral health program at some point, do you know TODAY how you will pick up the slack until employees can return to work? Will you discharge 24-hour clients who are essentially stable? Notify pending intakes that services are temporarily 'on hold?'   Temporarily switch some sessions to a group format? Transfer unstable 24-hour clients to other providers? Hire a few short-term contacted employees [and do you maintain a list of short-term contacted employees that you could access *today* if needed – with current phone numbers?]

- For industrial organizations, do you shut down the plant? Drop to a Schedule B of limited operation? And if so, exactly how is Schedule B configured and staffed? Are supervisors fully aware of Schedule B? All such decisions are worked into a *Prospective Contingency Response Plan, in advance of the need to implement.*

The US Military, the VA, and the EAP Partnership
A Good Example of
'Contingency Response Risk Management Planning Within an Organization'

NOTE to Behavioral Health and EAP Professionals working in civilian environments: The goal for every workplace is to minimize the IMPACT of an unpreventable Adverse or Critical incident or situation if or when it occurs, and thereby to introduce some elements of control. Managers within civilian Behavioral Health Programs and EAPs in industrial plant settings face some of the same issues as this US Military example. Depending upon the type of work you do, when reading these examples, you can think 'manager' instead of 'commanding officer' or 'NCO'. . . and 're-assignment' and 'new priorities' and 'partial-layoffs' instead of 'deployment' and 'redeployment' and 'reduction in force' – and 'resignation' instead of 'voluntary departure or separation from the military.'

The Role of EAPs in Risk Management Contingency Planning Within the Military

Employment in the US Military is a high risk occupation. We indicated in an earlier section that EAPs provide consultation to Military Managers under contract with the Department of Defense, in the same way that they provide consultation services to Corporate Managers, for Prospective Analysis and Prevention and for Retrospective Review and Correction. However, there are numerous situations and events in the military which *cannot be prevented* – including traumatic or catastrophic events and disruptive events. Contingency Response Planning ('Contingency Response') is therefore needed to reduce the impact of all such events. EAPs are a part of this Contingency Response Planning, as it pertains to effective management and retention of personnel and reduction of PTSD.

The VA and the Department of Defense (DoD) recognize the value of an EAP's insight into the behavioral health challenges associated with managing employees who are inherently under significant stress – many of whom are struggling with PTSD. They also recognize that stability of the workforce depends upon maintaining stability of the front line employees – in this case, Enlisted Personnel.

The Military and the VA have therefore entered into a collaborative contract relationship with privately operated EAP organizations in various locations throughout the country, to assist Military managers in resolving employee difficulties when they occur, providing professional intervention services to the employees and their families, and helping to retain the stability of the workforce.

EAPs are in an excellent position to provide direct consultation to Commanding Officers (COs) and NCOs about the human factors which impact workforce reactions and behavior, because EAPs serving Military installations work with military personnel and their families through all phases of deployment. Deployment is an ongoing stress in the Military – deployment to the home base, deployment back and forth to the War Zone or other deployment locations, and multiple re-deployments to combat zones. Transition from Active Duty to Reserve or Veteran status has also become a recent focus because of the high incidence of PTSD and how it impacts employment.

EAPs provide consultation and coaching to Military Command in the effective management of difficult employees and difficult behavioral health situations, as well as those incidents which may impact the entire base. EAPs participate in the review and analysis of Critical Incidents from the 'human' perspective and provide debriefings. EAPs educate COs (Commanding Officers) and NCOs (Non-Commissioned Officers – the "backbone of the US Military) in the identification of and approach to PTSD and SUDs.

Below, we describe some specific areas in which EAPs participate in Contingency Response to Unpreventable Event in coordination with the US Military and the Department of Veteran Affairs.

The EAP's collaborative consultation with military command, combined with direct services provided to individuals and families, serve to maintain a stabilized military workforce and Veteran population – despite the occurrence of unpreventable disruptive and catastrophic circumstances such as the following examples.

1. The Potential Turnover of Front Line Personnel vs. The Need for Workforce Stability.

An example of an Unpreventable Disruptive Event in the Military is the voluntary separation of valuable Active Duty Enlisted Personnel returning to civilian life or Reserve or Veteran status when their Enlistment Contracts have been fulfilled, rather than re-enlisting. When occurring in large numbers, such decisions to separate can have a significant impact upon the strength and efficiency of the military workforce around the world – particularly in the combat units, in the NCO corps, and in technical operations.

It is therefore important that experienced first-term Enlisted personnel and NCOs *re-enlist* when their Active Duty obligation ends, to ensure stability of the Armed Services. The longer personnel

remain in the military, the less likely that voluntary separation will occur until retirement criteria are met. Part of the Military's *Contingency Response Plan* for these potential threats to stability focuses upon steps to encourage the retention of functional and experienced personnel, in addition to enlistment of new personnel. Lucrative contract bonuses, which vary by need, are also an important feature for both new enlistees and those who choose to re-enlistment – particularly for the technical jobs, special forces, and combat units.

Since the end of the military draft, the primary Contingency Plan to offset periodic personnel shortage has been an increase in *recruitment* activity, to fill the gaps. The many recreation and support services which the military provides at each of its bases to normalize family life for spouses and children are also part of the Contingency Plan to retain skilled and experienced personnel.

But these approaches are not sufficient to maintain the military workforce. Multiple re-deployments of *on-call* National Guard and Reserves to combat zones are the stopgap Contingency Response measure. This pattern of re-deployment to fill the gaps is recognized by the Department of Defense to be less than ideal, from the perspective of stress and disruption of lives, taking its toll on personnel and families. Unlike deployment of Active Duty personnel to combat zones, the unpreventable re-deployment of National Guard and Reserves can be extremely difficult for families who have begun to settle in to civilian life, and difficult for the re-deployed individual.

Repeated deployment of *Active Duty* personnel to combat zones can also be a factor which prompts separation from Active Duty (i.e., retirement for those who have completed their contract with the military, and transfer to Reserve status for those who are eligible though years of service). Separation is all the more likely if the individual has experienced years of deployment to dangerous locales.

However, despite the trauma of the combat zone, the pressure to retire may come primarily from spouse and children rather than something that the individual wants. The Military mindset and loyalty are imbedded in the majority of Military personnel. There is a bond that is hard to disrupt. EAPs play a role in helping ambivalent Enlisted Personnel to work through their ambivalence, through individual and marriage counseling.

EAPs play a key role in some other Military Contingency Response Plans. We describe a few of these below. NOTE: EAPs must develop clearly understood RESPONSE PLANS of their own, in coordination with Military Management, for all of these difficult situations – tailored to the type of event and the protocols of the local Command.

2. **Maintaining Functionality During Multiple Military Deployments and the Return to Home, Including Stabilization of PTSD.**

As indicated above, maintaining a stable front-line offensive workforce is essential to the functioning of the US Military. The Department of Defense (DoD) recognizes the benefit of readily available *counseling services,* for valuable personnel who are experiencing PTSD and other traumatic stress injuries. Unless the stress injuries can be stabilized, separation from the Military is inevitable. PTSD also results in stress within the home and marriage, which can result in marital discord and domestic violence.

Traumatic stress effects including PTSD are the 'signature injury' of those who have been deployed to the Middle East. EAPs provide free counseling to stabilize these conditions. Treatment requires a combination of trials on the various new medication regimens approved by the FDA for PTSD in Military Personnel, and therapy with a mental health professional who understands what works and what doesn't work with battlefield-induced PTSD. Marriage counseling is a critical addition to the treatment process. EAPs provide all of these services, in coordination with the Military Medical Corps.

The instance of PTSD is significantly higher in Military Personnel than in the civilian population. Some creditable studies report that one-third of current Active Duty personnel in the combat zones report PTSD, and 47% of Post-9/11 veterans who were deployed to a combat zone have indicators of PTSD. PTSD is a significant RISK ISSUE in the military – a contingency that EAPs and Military Medical personnel must address on an ongoing basis.

Active duty combat troops – particularly those who are redeployed multiple times and those who are deployed *outside the Forward Operating Base in a Combat Outpost (COP, referred to as Outside the Wire)* – experience an austere and extremely dangerous situation for months on end, developing both physiological and psychological Traumatic Stress Injuries. These personnel have the highest instance of PTSD.

These stress injuries (often referred to as 'silent injuries') are characteristic of the Wars in the Middle East, where an Improvised Explosive Device (IED) is 'around every corner' and 'only a footstep ahead.' PTSD and physiological sequelae are the most common results. Symptoms including anger, irritability, depression, traumatic stress effects that include flashbacks and neuro-physiological sequelae which are the result of the continuously threatening environment in Iraq and Afghanistan. Substance Use Disorders are common as self-medication.

Both Military Managers and Civilian Managers may have difficulty recognizing the symptoms of PTSD or Traumatic Brain Syndrome (TBI). EAPs can provide valuable coaching to Management about identification of these issues. The therapeutic approach combines anger management and control of anxiety with various forms of Cognitive-Behavioral Therapy, with carefully monitored administration of new medications which are of specific help to War Zone veterans with PTSD. EAPs can help military personnel communicate with their physicians, about the disturbing after-effects which they are experiencing, in order to obtain the best-fit medication.

Active Duty Personnel and Veterans both suffer from internal conflict about their role in the war, precipitated by witnessing or participating in atrocities and the death of female and child civilians, in the process of successfully completing an anti-insurgent mission. They often experience survivor's guilt when a buddy could not be saved.

When not addressed, any or all of these unpreventable traumatic stress injuries can lead to Critical Incidents including suicide, domestic violence, and inability to hold a job. The impact is not only upon the individual but also upon other enlisted personnel on the base and in the deployed unit. The issues can impact the ability to return to combat, and the process of rejoining the civilian workforce upon transition to Reserve or Veteran status. Thus, the partnership between the Department of

Defense and EAPs is a Risk Management Contingency Plan to *reduce the impact* of unpreventable stress injuries and *speed the recovery* process.

All of these circumstances underscore the importance of the role that EAPs play in the Military's Contingency Response Plan to retain qualified personnel who can maintain stability. And for those who decide to separate from the Military, EAPs provide counseling to ease the transition, including working with civilian employers to better absorb Veterans into their workforce. Some of this work is now done under contract to the DoD as well as through the VA.

3. Work Performance Issues – Military Management Referrals to the EAP.

EAPs provide coaching and consultation to COs and NCOs in effective management practices and the supervision of problem employees. The same type of work performance issues occurs in a Military installation as in any other workplace. However, in the Military workplace, precipitating factors may be the *stress and unpredictability* associated with Military assignments. Work performance issues may also be exacerbated by Traumatic Stress Injury and its sequelae, in personnel who have been deployed to the War Zone. There are also the same type of domestic conflict and financial concerns which can contribute to workplace functionality problems in any profession. Commanding officers and NCOs refer individuals to the EAP when there are employment problems and other functionality issues, such as PTSD, which interfere with performance on and off the battlefield.

An *'Informal Management Referral'* is made when a Supervisor suggests that an employee seek assistance with a personal, family, financial, or emotional problem. A *'Formal Management Referral'* is made when an employee is referred by a supervisor/manager due to declining work performance. Individuals are not forced to participate in EAP services, but the conventional wisdom among enlistees holds that it is best to follow the CO's or NCO's lead and recommendation.

Important Note: The services of the EAP are not simply to promote good mental health in those receiving counseling. The services are part of a Risk Management Contingency strategy put into place by the US Military. It is an essential strategy to respond to the inevitably disrupting nature of the work. The contractual relationship between the EAP and the DoD covers multiple categories of Risk Management – Prospective RM Planning, Retrospective RM Review and Correction, and the Risk Management Contingency Response.

4. Unemployment and Under-Employment of Recently Released Veterans – EAPs and the VA.

The VA has implemented new pilot programs to ease the transition of Active Duty Military personnel to Veteran civilian status. EAPs work in concert with the VA to help veterans *regain meaningful civilian employment* and thereby avoid the personal and family crises that can otherwise occur in veteran populations.

For those personnel who do choose separation from service, the US Military and the VA want that transition to civilian life to be successful. EAPs have been contracted by the VA to support that transition, including support of training for suitable employment, finding a job, and keeping a job.

Such transitions to civilian life are often difficult due to the persistence of post-traumatic stress effects including PTSD, anger, unearned guilt, and the sequelae of Traumatic Brain Injuries (TBIs). SUDs are common among Active Duty and Veteran personnel as a way to self-medicate the disturbing post-traumatic stress effects.

Retraining for civilian employment and retaining employment in the new environment are particularly challenging for Veterans. This is a significant RISK for Veterans which is included in the VA's *Prospective Response Plan* and in its Contingency Plan for influx of Veterans who are wholly untrained for Civilian work. The US Department of Veterans Affairs and EAPs are working collaboratively in pilot projects which facilitate successful employment transitions for unpredictable numbers of Veterans – a perfect example of Prospective Contingency Response Planning.

> The **training modules** which have been developed by the VA for EAPs and employers about working with Veterans provide a good understanding of how the military culture carries over to civilian life. These training documents provide a good foundation for EAPs who want to work with Veterans. These resources are a good example of Contingency Response Risk Management, with the goal being successful transition of Veterans to civilian life and work *despite the unpreventable after-effects* of multiple deployments.

5. **Contingency Response to Critical Incidents in the Military Community.** Unpreventable critical incidents in the Military include individual and mass casualties by enemy and friendly fire, in both combat maneuvers and in training accidents. Other unexpected Critical Incidents include suicide of personnel and family members, domestic violence, and occasional homicide.

    All branches of the US Military have formal, highly structured face-to-face notification of next of kin procedures for deaths, MIAs, and critical injuries which occur in combat and in training accidents. There are also structured procedures for Mortuary Affairs and defined pathways to obtaining social and financial support including insurance and survivor benefits.   Post-notification counseling with the family can be done by the EAP.

    As with all unpreventable tragedies, the EAPs' task is to *minimize the impact* and *facilitate recovery* – in this case, working with surviving family members. EAPs may also provide counseling for other personnel who were close to the deceased and/or who witnessed the death, in order to work through trauma and prevent PTSD. In the event of suicide or domestic violence or civilian homicide, the EAP may be asked to participate in Retrospective Review of the incident, and in debriefing.

    EAPs provide free counseling to the family for grief work, comfort, and emotional support, and assist them in the difficult process of moving forward.   These events are challenging, and a plan needs to be in place for how responding EAPs handle the contacts with the family and coordination with Military personnel. What to do first? What to do and not do? How to coordinate with Military and community social supports? How to assist the family in their transition to a new life without the loved one? All of these Contingency Response activities should be addressed in the EAP's Risk Management Contingency Plan for response to Critical Incidents in the Military, in coordination with the installation's COs.

4. Community-Wide Prospective Response (Collaborative Contingency Planning for an Unpreventable Community Catastrophe – e.g., hurricane, flood, tornado, fire, mass shootings, mass property destruction).

'Contingency Response' Risk Management in this category is community-wide planning for a *potential* catastrophe which we effectively cannot prevent, which has a significant possibility of occurring at some point in time, affecting an *entire community or a large proportion of it.*

Such planning requires individual organizations to collaborate with other organizations, and the plan which is formulated answers the questions, "If or when this event happens, how can each organization within the community *respond* to the catastrophe, in order to *reduce the impact on a community-wide basis?*" And, *"How quickly can we recover?"*

- Logically, EAPs should be a part of this planning at the front end, because currently, EAPs are hired by companies, social service organizations, and local government on an ad hoc basis to assist in the event of widespread trauma to a population – such as major airline disaster in a foreign country, environmental catastrophes which impact the workforce such as floods and forest fires, and industrial plant tragedies. Following the recent Texas hurricane disasters, EAPs and Social Service organizations were extensively involved for months, working with State and local organizations to redirect community resources, stabilize employment, provide temporary alternative housing and jobs, and provide crisis intervention to organization managers, employees, and families.

Collaboration and Priorities – Internal and External. Collaborative Planning in advance and following a community catastrophe (such as a mass shooting or an environmental disaster) is quite complex and requires *external resource collaboration.* Internal post-incident recovery efforts are clearly a priority *within* any given work organization; *but some reprioritizing may need to occur,* to accommodate coordination of recovery efforts *with other* community organizations.

EAPs can be helpful in the post-disaster response to community catastrophes – particularly in coordinating communication between employers and employees within the community, and in organizing support groups for people who are left at 'loose ends' due to the catastrophe. Such was the role of EAPs in the disappearance of Malaysia Flight 370. EAPs in the region coordinated with airline management to provide effective support to distraught family members and employees for months after the disaster. CEAPs organized information centers and provided education to the local population on how to best support a grieving family.

Strategic National Response Stockpile (SNS). The US Government is engaged in Contingency Response planning in ways not usually imagined. For example, the US Government is currently stockpiling the first FDA-approved medication intended for the treatment of Smallpox (TPOXX – tecovirimat), as a contingency response to be used in the event of a biological warfare attack on the United States. On July 13, 2018, FDA Commissioner Scott Gottlieb, M.D. announced the newly approved treatment: "To address the risk of bioterrorism, Congress has taken steps to enable the

development and approval of countermeasures to thwart pathogens that could be employed as weapons. Today's approval provides an important milestone in these efforts . . .This new treatment affords us an additional option should smallpox ever be used as a bioweapon." TPOXX will be available only through the US government's Strategic National Response Stockpile (SNS) and is supplied as 200 mg strength capsules.

Community-Wide Organization for Contingency Response Planning.   Entities which routinely function community-wide include hospitals and clinics, the National Guard, schools, large facilities used as shelters (such as churches, some factories, and sports arenas), Fire Departments, law enforcement (local and Federal), and social services organizations.

Military bases also serve a community-wide function, in assisting the broader community beyond its base boundaries. Although a large Military installation (base) is a community in and of itself, Military bases typically reach out to assist the broader community in which its base is located [e.g., the Navy's offer of support to the entire Florida coastline population during Hurricane Irma, and participation of the Navy and Air Force Medical Corps in saving countless lives during the Las Vegas shooting massacre].

- **The logical starting point for community planning** for disaster preparedness and recovery is the collaborative development of a *list of priority services or activities* which must be provided within the community in the event of a specific Critical Incident which impacts a significant portion of the community. Businesses, programs, and public service organizations are then assigned to the service or activity for which they are a *'best fit.'*

  EAPs are a 'best fit' for interagency coordination and services to both employees and managers of organizations residing within a disaster area – such as the active role played by EAPs following the disappearance of Flight 370 in Malaysia. EAPs formed groups for families to constructively express their anxiety and mistrust in a way that allowed Management to continue with the tedious work it needed to do, to try to locate the plane and to identify Contributing Factors which may have led to the disappearance.

Variable Levels of Preparedness. Some communities are more prepared for disasters and catastrophes than others. As was seen in Florida with Hurricane Irma in 2017, major adjustment was rapidly made to normal operations for both military and civilian personnel and their families. There was massive organized evacuation of families and agencies. Hundreds of navy personnel, ships, and aircraft were immediately deployed to the area to provide humanitarian relief and support as needed for both military and civilians. The community-wide Prospective Response Plan was quite successful.

Although the Texas Coast was seriously unprepared for the overwhelming magnitude of Hurricane Harvey in 2017, the outcome in terms of loss of life and property was <u>better</u> than it would have been without the Prospective Response Planning that was done along the southern Texas coastline in the aftermath of Hurricane Camille in 1969, Hurricane Alicia in 1983, and Hurricane Katrina in 2005. Those catastrophes served as a 'red flag' for communities in Texas, Louisiana, and Alabama, and much contingency planning had been put into place. *Nevertheless*, the Response and Recovery in the

aftermath of Harvey was not as effective as the Response and Recovery from Irma in Florida. Much work remains to be done to prepare for the next catastrophe in these areas of Texas. The recent hurricanes in the Carolinas and in the Florida panhandle and Georgia were clearly devastating and, at the time of this writing, have not yet begun to recover. No doubt there will need to be extensive interagency coordination there to begin the recovery process.

A Community-Wide Shift in Priorities. In situations where mass casualties or major environmental damage have occurred – such as hurricane devastation, the volcanic eruption in Hawaii, and the shooting massacre in Los Vegas, NV – it is clear that in some organizations, *everyday Management priorities had to be set aside and reset* to accommodate the community response and recovery process.

Therefore, it is important for EAPs working with both public service and corporate organizations to assist Management in development of a *Contingency Response Plan which includes a rapid change-up of the normal routine* to participate in community recovery efforts, until the acute stage of a crisis has stabilized. EAPs may need to do 'consultative prodding' of Managers to design a temporary modification of the normal workplace operation, i.e., a Plan B. Planning for every unpreventable catastrophe cannot be done, but a plan for the potential catastrophes which are indigenous to the area is a good place to start.

Lessons from the Las Vegas shooting massacre.   The mass shooting in Las Vegas was the deadliest mass shooting ever committed by an individual in the United States, and ultimately left 58 people dead and 851 injured including over 400 people who had been shot. This is an example where a community *had extensive Contingency Response plans already in place* for a mass casualty situation, which saved countless lives – but community leaders realized after the fact that they needed to expand and enhance those plans.

After the acute phase of the tragedy was passed, the public service organizations in Clark County *shifted to post-incident Retrospective Review mode . . .* analyzing WHAT happened, WHY the tragedy occurred, WHY some aspects of local coordination were not quite as seamless as desired, and HOW to prevent or respond to such a tragedy in the future. This community realized that despite its previous hard work to develop a Contingency Response Plan for mass casualty, it needed *improvement.*

- **The response which did occur was remarkable:** Navy and Air Force physicians and their mental health personnel shared the emergency response load with multiple community hospitals, multiple EMT and ambulance units, the Clark County NV Fire Department, the Las Vegas Metropolitan Police Department, and other community agencies. *ALL of these organizations had Contingency Response Plans in place which were rapidly implemented, saving countless lives despite the staggering loss.*

- *However,* **no agency was prepared for the magnitude of the massacre**. Since the event, public service agencies in Las Vegas have engaged in Retrospective Review of the disaster, identifying several lessons learned from the situation, and have identified other areas in which they are still seeking solutions. A new Contingency Response Plan is being developed.

- **Community-wide PTSD services and better interagency coordination during the immediate aftermath of catastrophe** has been cited as needing improvement in Clark County, NV. Multiple work organizations have cited *the need for an expanded approach to community-wide* PTSD. Countless cases of PTSD were identified within the Las Vegas community following the massacre, and a better response to PTSD on a community-wide scale has been placed on the list of needed improvements.

    All of these improvements will enhance the community strategies which were *already in place* in Clark County to address PTSD, which included these constructive features:

    - Personnel in multiple public and corporate organizations were immediately provided with current contact information for EAPs within Clark County, as well as contact information for behavioral health organization (BHOs) and Peer Support Teams

    - A basic understanding of the need to reduce the IMPACT of the tragedy was already in place in organizations: For example, after the incident, the Clark County Fire Department Chief called all department employees into a *mandatory peer support session,* at which they were praised and thanked for their efforts at the shooting, and advised to go home, rest, stay off the phones, and avoid the media.

Thus, there are four phases to Risk Management activity for community-wide catastrophe:

- FIRST, External Contingency Response Planning – to put into place a community-wide plan for immediate response to a catastrophe which is anticipated at some point, but which cannot be prevented.

- SECOND, immediate coordinated response to the acute phase of the catastrophe, which includes immediate recovery or triage actions.

- THIRD, a community-wide Retrospective Review of the event – What worked well? What not so well? Are there any Contributing Factors which we may be able to eliminate or impact?

- FOURTH, development of the community's Improvement Plan for Contingency Response to the recurrence of an unpreventable catastrophe.

We will now look at a de-identified Protected Internal Death Review Report, to see how one small Risk Management Committee performed a Retrospective Review, identified possible Contributing Factors and Opportunities for Improvement, and used the information to enhance program operation and safety – from computerized documentation upgrades which protected both the client and the organization, to a new communication approach which ensured intra-staff communication of potential risk issues with individual clients.

Patient: "CLIENT"
Age: 37
Gender: Female
Organization: "PROGRAM"
Program Components: Supported Housing, Rehab Services, Intensive Case Management, Med Mgt.
Funding Authority: Medicaid HMO
Admission Date: /2008
Date of Death: /2008
Date of Review: /2008
Location of Incident: New Jersey
Those conducting the review: Executive Director, Clinical Director, Marsha Naylor, MA, LPC (Contracted QM Consultant)

Patient's Diagnosis(es) and treatment history: Bipolar Disorder with Psychotic Features. Long-term disorder, unable to sustain employment, intermittent psychotic features which are currently well-controlled by Symbyax medication. Hx of alcohol abuse to intoxication as an adolescent and young adult to age 26, and abuse of prescription drugs from age 30 to 31 with suicidality, relapse at age 34. At admission was in sustained remission for drug and alcohol abuse. Previously diagnosed as MDD at early treatment facilities.

History of relapsing to abuse of prescription drugs with suicidality two years ago at age 34 in a nearby city, consistent with her historical pattern of overdose via Trazadone and Klonipin. Diagnosis changed to Bipolar Disorder with Psychotic Features at that time while treated at an inpatient unit in _____, and subsequently spent 36 days in a stepdown Residential Treatment program. Began attending NA during residence and continued after release to Intensive Outpatient treatment.

She has had no known relapse to either alcohol or abuse of prescription or other drugs in the past two years. She has demonstrated good clinical response to Symbyax since admission; and she had previously taken Symbyax, Zyprexa and Prozac separately at other community programs with good results over the past two years.

Introduction to this review. As part of PROGRAM's QM/RM process, the Executive Director shall as needed hold a *Protected Internal Retrospective Risk Management Review* of a Critical Incident involving a mental health, addiction, or dual diagnosis client, or an employee or the program at large. Treatment Failure or AMA Withdrawals of a client from treatment are included as appropriate subjects of review, as are all deaths or serious injuries requiring emergency medical treatment.

This process is intended to internally identify 'Causative Factors' and 'Contributing Factors' and 'Opportunities for Improvement' of patient care, through examining the circumstances of

the situation at hand. The identification of these Opportunities for Improvement will, in turn, prompt relevant action and new policies and procedures intended to improve the quality of care and reduce the risks involved in treating the SMI and Dual Diagnosis population on an outpatient basis.

This specific Risk Management Review pertains to the death of [CLIENT] on _____.   This written report summarizes relevant Quality Management findings and therefore is protected by case law, i.e., is not subject to external review, release, or discovery. The written QM/RM Review is not made a part of the client's clinical record. It is understood that the FACTS which are the basis of our conclusions are subject to exploration within a Court of Law if the death of this client becomes the subject of a civil lawsuit or criminal investigation. The Contracting Authority (Medicaid) may conduct its own investigation without limitation, per the Contracted Agreement. The Improvement steps which the RM Committee has developed may be released to the Contracting Authority following review by Program's Board of Directors.

NOTE: It is recognized that when we provide treatment to persons with severe mental illness, addiction, or dual diagnosis on an outpatient or Supported Living basis, there are many variables which we cannot control, because our clients do not receive 24-hour supervision. However, part of the Quality Management and Risk Management process is intended to gain *as much control over such variables as is organizationally possible*, through identifying 'best practices' and implementing checks and balances.

Subsequent to this Death Review, we have identified the need for certain new practices within the program which we feel will REDUCE RISK and promote more effective treatment, particularly with individuals with depression and bipolar disorder. These augmentations in treatment and documentation will be implemented immediately.

The Precipitating Event Which is the Subject of This Protected Internal Risk Management Review: CLIENT committed suicide in her Supported Housing apartment on _____, through an overdose of her Symbyax medication. [Symbyax is a combination of olanzapine, the active ingredient in Zyprexa, and fluoxetine, the active ingredient in Prozac. It was the first FDA-approved medication for the depressive episodes that occur in bipolar disorder or bipolar depression.]

Client had made plans to spend her birthday weekend with her sister and brother-in-law and had received a program pass to leave for the weekend. The plan was for her to be transported to the sister's home by the sister. According to notes in her chart made by both her counselor and her care manager this week, Client had expressed delight about the planned weekend because she had not seen or heard from her sister in several months. Client has only one other living relative, a brother with whom she says she is 'not close.'

According to her roommate, CLIENT became acutely despondent over a call from her brother-in-law, relaying that he and CLIENT's sister had made a decision to divorce, that the sister had left the couple's home and gone to stay with a girlfriend, and that the sister would therefore not be coming to take CLIENT to their home for her birthday weekend. CLIENT was packed and waiting for the sister to arrive when she received the call. She apparently then went into her bedroom, turned up the radio, closed her door and overdosed on her Symbyax. At some point later in the afternoon, she was found by the roommate, reportedly without a pulse. The roommate called 911 and paramedics took her to the hospital where she was pronounced deceased.

Scope of Review. This review focused upon the assessment and treatment which was provided to the client and documented in her client record from immediately before her admission until her death on _____, with an eye to the identification of 'causative' factors and other 'non-causative' factors which either did contribute or may have contributed to her suicide.

From the identification and review of potential Contributing Factors, we have identified OPPORTUNITIES FOR IMPROVEMENT in our current documentation protocols and in our management of seriously depressed clients. Although these programmatic areas *are not perceived to be causative* in the death of CLIENT, they nevertheless represent an opportunity for important augmentations in clinical management of depressed clients which will be put into place, improving the safety of our care of semi-independent depressed clients, particularly those with Bipolar Disorder and Dual Diagnosis.

The Process. All the factors listed in the program's 'Clinical Record Audit Protocol' (below) were evaluated for applicability to this individual. No negative factors were identified from

that protocol which potentially contributed to her death. *However,* the RM Committee went further to explore our estabilished Risk Management list of *Potential Contributing Factors* which are oftentimes less obvious, from the following perspective: the completeness and integration of the clinical record including documenatation of psychiatrist's and clinical staff's assessent of her mental status and risk for suicidality; the precise known circumstances surrounding PATIENT's death; the specific content and timing of any documentation which was present in the record pertaining to her plans for the weekend; the communication between staff about the status of the client in the time period preceeding her death, as might be evident within the record and upon interview of all staff involved in her care; the level of attention to potential risk of exacerbation of depression; the understanding of what we seek to accomplish in this program with regard to seriously mentally ill clients; and the presence of any other factors which contributed or may have contributed to this Critical Incident.

 We also identified other administrative and programmatic areas which, although not relevant to the death of CLIENT, were nevertheless potential legal vulnerabilities in documentation design or in the funtionality of the electronic treatment record and therefore needed improvement.

BASIC CLINICAL RECORD AUDIT PROTOCOL
Utilized for Review of Treatment Failures and Critical Incidents Involving Clients

1. Was there *inadequate assessment or documentation of clinical issues before admission* due to:

   1a. Inadequate client preparation

   1b. Inadequate evaluation of existing or potential problems

   1c. Inadequate historical information

   1d. Ignored known factors which were prognostic of failure or risk

   1e. Inadequate documentation of the clinical assessment and diagnosis(es)

2. Was there *inadequate treatment planning or implementation* due to:

   2a. Inadequate or inappropriate treatment of or response to symptoms

   2b. Untimely intervention when earlier intervention was indicated

   2c. Failure to effectively address the problem(s) identified at or after admission

    2d. Treatment plan not implemented appropriately by staff (staff error or inappropriate action or interaction)

    2e. Staff not fully cognizant of high-risk issues

    2f. Failure to modify treatment plan in the face of persistent clinical problems

    2g. Staff violated established policy

    2h. Other clinical failures [*specify*]

3. Were there *treatment complications or unresolved issues* hindering progress, including:

    3a. Combativeness/aggressiveness

    3b. Psychiatric impairment too severe for modality

    3c. Requires too much 1:1

    3d. Inability to obtain family support, where this is dynamically crucial

    3e. Diminished capacity for response due to organic impairment factors

    3f. Acute biomedical condition(s)

    3g. Other (specify below)

4. Was there *inadequate documentation* within the record, including:

    4a. Individual Treatment Plan (ITP) poorly delineated the known clinical issues

    4b. Assessments did not fully articulate risk issues or problems

    4c. ITP did not address known clinical issues or provide a rationale if not addressed

    4c. Progress Notations are incomplete or missing

    4d. Progress Notations do not adequately reflect the ITP and/or the course of treatment

    4e. Progress Notations do not <u>justify</u> the need for continued treatment or the client's designated level of care

    4f. Progress Notations failed to reflect one or more <u>known or suspected indicators</u> that the client was regressing or not progressing, such that there <u>should have been</u> a re-evaluation of the current ITP.

5. Were the services provided to the individual *inappropriate* relative to his or her needs?

    5a. The condition cannot be effectively treated in PROGRAM's treatment settings

    5b. PROGRAM does not yet offer the service needed by the client, and this service was an alternative

    5c. A medical/physical condition exists that interferes with or affects treatment options

5d Individual is/was unable or unwilling to cooperate with treatment objectives – a circumstance which we <u>could not or did not effectively address</u>

5d. Individual is/was experiencing an intensification of symptoms after admission, i.e., regression with no likelihood of stabilization within any of PROGRAM's current service programs

6. Is there evidence that staff failed to communicate known information to other involved staff about this client after admission, according to established procedures?

6a. ** If Yes. Details of known issues or circumstances were_not communicated according to <u>established procedures</u> – MUST be attached by addendum.

6b. ** If No. There is no evidence that a failure to communicate known issues or circumstances to others occurred according to <u>established procedures</u>.

** Note: Evaluate need for additional communication methods and procedures.

SUMMARY FINDINGS AND RECOMMENDATIONS FROM THIS RM REVIEW

The review of the circumstances and facts surrounding CLIENT's suicide <u>did not</u> reveal <u>causative factors</u> emanating from the operation of the program or the actions or inactions of staff. There were no internal failures or violations of <u>current</u> policies and procedures.

- *However*, this Internal Risk Management Review – as with most such reviews – has resulted in the identification of OPPORTUNITIES FOR IMPROVEMENT in the program's community-based care of persons with severe mental illness including a major depression or bipolar disorder, addiction, or dual diagnoses.

- The goal of this Internal Death Review is to put into place certain procedures which may REDUCE the RISKS of service delivery to adults with SMI, addiction, and dual diagnoses in Supportive Housing and Intensive Case Management programs <u>and</u> the RISKS associated with how we document that care.

Analysis and conclusions forthcoming from this Internal Risk Management Review have resulted in identification of specific <u>procedureal enhancements</u> which we will make in how we work with persons who are at highest risk for self-harm or suicide in a Supported Housing and Intensive Case Management environment.   Details of the issues listed below will appear in the Action Grid.

1. Although not relevant to the death of this client, in the process of review of the electronic client record, we have identified in-house issues and corrective actions in our ability to <u>electronically</u> document new/updated clinical assessment data following initial data collection, which can protect us from general legal vulnerability, i.e., the perception of irregularities in the gathering and documentation of client information.

2. From the perspective of general legal vulnerability, we have identified the need for systematic collection of copies of original clinical data from referring resources at the time of admission, to ensure a seamless clinical picture of the client within the clinical record.

3. We have identified the need to think PREEMPTIVELY about potential RISKS which may accompany abrupt or significant CHANGES in the plans or expectations of clients with depressive disorders, and the need to involve the client as an *active partner in* DEFLECTING *the emotional impact of such unexpected events.*

4. We have identified a need for a more deliberate, systematic, and structured approach to the documentation and 'Assessment of Acute Risk' at the time of the initial Biopsychosocial Assessment and *on an ad hoc basis* when a potential crisis in a client's life is at hand.

5. An ongoing preemptive approach to potential risk issues pertaining to the day-to-day events in a client's life should be a priority, with a form of documentation of potential crisis which is readily available to all staff working with clients, *rather than being 'buried' in the client's clinical record.*

<div align="center">Proceed on to the Findings and Action Grid.</div>

Note to CEU By Net Continuing Education participants – things to look for: This is a Retrospective Review of a client death in a Supported Housing program. There was extensive clinical documentation in this case, which met the prevailing standards of care in the industry. However, remember that this individual committed suicide, and if the family or a healthcare contractor felt compelled to legally press the issue, is there something here that could have potentially been problematic, or of which the opposing attorney could make an issue? Something that we would want to improve and prevent in the future? An *Opportunity for Improvement?*

Were there any 'causative' factors in the death of the client? [Refer to the definition of 'cause' in the text of the course.] What was the identified potential Contributing Factor *which may have been associated* with this death, which we decided was in need of a Correction and Improvement Plan? In addition, although not related to the death of the client, *what* did we believe could be problematic in the event of any legal challenge in court, regardless of the client, which we needed to correct?

Client Name:	**Action Plan Subsequent to Internal Risk Management Review** **Date of Internal Review: _____ 2008**	**Follow-Up Date to Assess Effect of Action**
	FINDINGS AND RESULTING ACTION(S)	

BACKGROUND of CLINICAL RECORD FORMAT: The program currently maintains an <u>electronic</u> client record which contains all computerized Biopsychosocial Clinical Assessments, Individual Treatment Plans, counseling and therapy Progress Notes, prescriptions, consent forms, scanned case management contact notes *which document unusual events,* and the scanned copy of the psychiatrist's completed assessment forms and notations. This record contained all of these items without gaps or inconsistencies.

Printouts of these electronic documents are placed in a 'hard copy' or 'working copy' record which is maintained in the Medical Records room and checked out and back in through an assigned Records Keeper. *The hard copy record also contains the daily Contact Notes handwritten by case managers and other clinical and support personnel,* the client's schedule for the week, off-site passes if the client travels away from the program, and similar routine items.

The handwritten Contact Notes from Case Managers are not scanned into the electronic record unless there is an unusual or concerning event or circumstance which needs to be alerted and documented. In such cases, after scanning into the electronic record with an electronic 'alert tag', the handwritten Contact Note is placed *at the front of the hard copy record with an 'alert' tag* where it is easily seen by clinical and support staff *and is initialed by all clinicians and support staff who read the note.* These front-facing alert notations are periodically retired to the regular Contact Note section of the hard copy record. There were no 'alert' tags in this record, until the suicide of the client.

When a client record is reviewed or audited, BOTH records are reviewed – the electronic record and the hard copy record – with an eye to inconsistencies or gaps. Within the year, we will have all Case Managers' Contact Notes scanned into the electronic record, but that is not possible at the moment. There were no inconsistencies in this case when comparing the electronic record and the hard copy record.

FINDING 1A: The Clinical Director (LCSW B) currently completes her routine Biopsychosocial Clinical Assessment at admission on her laptop as she conducts the interview with the client, in a standardized electronic format. In the case of this client, her brother was present for the bulk of the interview, and CLIENT refused to answer certain mental status exam questions during that session. At the conclusion of the session with CLIENT and her brother, LCSW B electronically <u>signed and saved and printed</u> the computerized clinical assessment for insertion into the 'hard copy' or 'working copy' record.

- After the intake appointment, due to a delay in transportation, CLIENT was able to stay behind and talk with LCSW B for an additional period, and then answered the remainder of the mental status exam questions.

- <u>LCSW B recorded the mental status exam and her impressions on a yellow legal pad</u> because there is currently no way to add amendments to computerized clinical assessments when they have been electronically signed, dated, and saved. These handwritten mental status notations by LCSW B were <u>scanned</u> into the electronic record and <u>inserted</u> into the hard copy record – attached to the back of the copy of the computerized clinical assessment.

  Issue: Due to the limitations of the computerized clinical assessment program, the information from the handwritten mental status exam could not be added to the initial computerized clinical assessment even though the mental status exam was performed and documented within an hour of the initial assessment. The mental status exam was, therefore, a handwritten "add-on" notation.

FINDING 1B. Our standard Biopsychosocial Clinical Assessment format does not currently contain a section specifically devoted to <u>systematically</u> assessing all the factors which are clinically associated with Acute Risk. Although most clinicians mentally run through a checklist of areas to explore with the client about the potential risk of self-harm or harm to others, we don't currently have a <u>written format</u> which addresses all the factors that should be considered.

However, the Clinical Director administered the Beck Depression Inventory to CLIENT, which was completed and signed by the client. The

Beck is routinely scanned and electronically added to the computerized record and the hard copy record before the close of business.

- In the Beck inventory, CLIENT checked that *"I have thoughts of killing myself, but I would not carry them out."* Because of this notation, LCSW B subsequently asked the program's psychologist to see CLIENT the next day to further evaluate current level of risk.

- Dr. C (Ph.D. psychologist on PROGRAM staff) re-assessed CLIENT the following day, on _____. A well-developed differential diagnostic interview report is electronically completed and also placed in the hard copy record. *Dr. C concluded in his assessment notations on that date,* that CLIENT did not appear to be at risk of suicide or self-harm, and that there was no indication that this client was relapsing to psychosis or abuse of prescription drugs or suicidality. She was, in fact, looking forward to spending her birthday with her sister a few weeks hence.

Analysis of 1A and 1B:

1A. The content of the Clinical Director's handwritten amending notations on the yellow legal pad included a mental status exam and her impressions. The assessment by the Psychologist the following day concurred with the conclusions of the Clinical Director that there was no indication of suicidal intent or risk and no evidence of psychotic process. In the Review Panel's opinion, there was no information in either the psychologist's assessment or the Clinical Director's handwritten notations which presaged the deadly outcome of this case.

However, the review panel is uncomfortable with the 'CLINICAL APPEARANCE' of the <u>handwritten</u> Mental Status notations attached to the printout of the computerized Clinical Assessment which had already been electronically signed and dated. In the event of a legal challenge in this case, the addition of a handwritten notation about something of this level of importance would certainly be raised in cross-examination.

Summary of problem 1A.: There is currently no way to electronically add amending, updating information to the computerized assessment after it is electronically signed and dated. This electronic limitation is in no way causative in this death, and it is not a Contributing Factor in the death. However, this needs remedial action and therefore presents an *Opportunity for Improvement.*

1B. A review of the entire clinical record does not yield any indication that CLIENT was at acute risk for suicide. According to statements in assessments and progress notes, she was eagerly looking forward to spending her birthday with her sister and brother-in-law. The unexpected cancellation of the visit at the last minute apparently led to CLIENT'S impulsive and rapid suicide by overdose that same day.

- At every contact with the client by the Psychiatrist, the Clinical Director, the Psychologist, and the Case Manager, there was good documentation of the client's mental status including affect and mood. There was no documentation which indicated that CLIENT was experiencing an increase in depression or that she was at acute risk for suicide, at any time since admission to PROGRAM.

Issue: The Review Panel believes that, in addition to the Beck instrument, we need a formalized instrument to be used by the Assessing Clinician as part of the Biopsychosocial Assessment, which is an 'Assessment of Acute Risk.' The clinician's professional opinion about the presence or absence of suicidal risk should be based upon a systematic review which is reflected with notations and entries on rating scales, in a structured format. The benefit of this format ensures that the clinician does not overlook any factors which are known to impact suicide or homicide risk.

Without such a formalized assessment of risk, in a legal challenge there would almost certainly be the suggestion that "You didn't look closely enough." To defend against such allegations, it would be valuable to have [within the record] a brief but clear documentation of clinical impressions *as it pertains to the SPECIFIC FACTORS which are known to impact the likelihood of suicide or homicide.* Preferably these impressions would be in a simple rating scale format.

- We recognize the auditing principle which proclaims that "If it is_not_written in the record, it did_not_happen."

- We also recognize the auditing principle which proclaims that "If we have not documented the information which led us to our conclusions, then we did not adequately assess the situation."

- Therefore, particularly when working with clients with major depression (including in an EAP environment with Military Personnel or with high-risk industrial clients), the basic principles of Risk Management call for documentation of "WHY we have concluded what we have concluded" about the potential for acute risk of suicide or homicide.

PLANNED ACTIONS IN RESPONSE TO FINDINGS 1A and 1B:

- New Procedure for 1A: Changes will be made to the computer program which allows additional, dated information to be added to the electronic clinical assessment. When additional information is received after the initial assessment has been electronically signed and dated, the assessor will <u>retroactively and electronically stamp the initial report as 'PRELIMINARY'</u> with the date and time of that notation. This entry notifies the reader that additional information has been obtained and added to that which was originally signed. The new information can then be added electronically to the assessment as an ADDENDUM, signed and dated. The assessment is then marked AMENDED with date and time.

    - The ability to electronically add additional clinical information to the computerized assessment will now be standard practice instead of staff making such additions with a handwritten notation. *In the hard copy* record, the copy of the 'Amended' assessment is placed <u>on top of</u> the copy of the original assessment. The original assessment is never removed from the record.

- New Procedure for 1B: A formal '*Screening for Indicators of Acute Risk'* document will now be included in the computerized initial Clinical Assessment performed at or before admission. The instrument addresses specific parameters which are empirically supported for the assessment of Acute Risk of harm to self or others.

    - A 'Screening for Indicators of Acute Risk UPDATE' will be performed at every ITP Review event.

    - When an admission decision must be made with <u>insufficient time to perform a full Clinical Assessment</u>, the Screening for Indicators of Acute Risk instrument will *always* be completed –

either electronically (whenever possible) or manually when a computer is not available.

- A 'Screening for Indicators of Acute Risk UPDATE' shall be completed and signed as <u>a free-standing screening</u> when risk indicators arise other than at admission and during the ITP Review process.

- Professional staff should also complete the instrument <u>on an ad hoc basis</u>, when a traumatizing situation has occurred with a client with a history of severe depressive episodes – *such as the cancellation of an eagerly-awaited family visit, or the anniversary of a traumatic event, or the sudden loss of something that is very important to the client such as a friend or relative or pet.*

- The *Screening for Indicators of Acute Risk* rating instrument should include:

  - inquiry about previous and current suicidal and homicidal ideation, plans, or attempts,

  - the level of detail and potential lethality,

  - the access to means or methods to carry out the plan,

  - *information from other sources that may conflict* with statements of denial by the client, and
  - any recommendations for protective action.

EXPECTED RESULT for AREAS 1A and 1B:

- 1A. Computerized assessments can now be electronically supplemented with new information obtained after the initial assessment which is electronically dated and signed – removing the questionable appearance of a handwritten addendum.

  - Fewer or no handwritten 'post notes' to assessments will appear in the record.

  - There will be a clear indication of what is 'preliminary' vs. what is 'amended and added' in the computerized Clinical Assessment.

- 1B. The completed screening instrument will provide a structured, DOCUMENTED BASIS for the assessor's impressions of the potential for self-harm or harm to others and will enhance the safety of treating clients with serious disorders within the community.

_____

FINDING 2: CLIENT was seen four times in this program by Dr. Jim (program's contracted psychiatrist) for assessment and medication management, between her admission on _____ and her death on _____. The fourth time she was seen by Dr. Jim in our program was three days before her death, on _____, at our program's Medication Clinic.

On all four occasions, Dr. Jim prescribed Symbyax for bipolar depression with psychotic features – which was the medication with which the consumer overdosed, leading to her death. As noted in the introduction, CLIENT had demonstrated a good clinical response to Symbyax since admission, and she had previously taken Symbyax, Zyprexa and Prozac separately at other community programs with good results.

CLIENT was originally seen by Dr. Jim at a community medication clinic on _____ before admission to our program [i.e., was seen at Mount Hillburton's community-based medication clinic].

Issue: In this review, we discovered that we do not have a copy of the Mount Hillburton assessment by Dr. Jim. We failed to have the consumer sign a release to obtain information from this referring provider, at admission.

- However, when Dr. Jim saw CLIENT for the first time at our program on ___ he summarized his initial mental status impressions of the consumer when he had seen her at Hillburton, which was one week prior to admission.

- Dr. Jim also conducted and documented a current mental status exam at admission to our program and at each med management visit thereafter, including the visit three days before CLIENT'S death.

- *There is no indication in Dr. Jim's notations that he viewed this individual as presenting with suicidal risk or psychotic process, either at Hillburton or in our program.*

- The lack of a COPY of Dr. Jim's psychiatric assessment done at the referring program (Hillburton) before admission to our program *is not, in the opinion of the review panel, either a Causative Factor or a Contributing Factor in the suicide of this client.* Dr. Jim's thorough psychiatric assessment which was performed shortly after admission to our program contains a clear statement summarizing his original contact with CLIENT at Hillburton as well as his admission assessment here in our program. No indicators for suicidal risk are said to be present.

Note to CEU By Net participants: The psychiatric notations which were made when Dr. Jim saw the client in our program are thorough and in compliance with the *prevailing standards of care within the industry.* But in the event of a legal challenge in this case, could there be an issue made of the 'after-the-fact recap' of a previous assessment of this client which was done at another clinic? Does Dr. Jim's recap [recollection] of that previous assessment suffice as irrefutable <u>background information</u> about this client? Even though it did not become a significant issue in this case, do you see an *Opportunity for Improvement* here?

<u>Analysis of 2</u>: Although it is not currently a legal issue in this case, there should have been a COPY of the original Hillburton medication clinic assessment notes in CLIENT'S record, signed and dated by Dr. Jim, who saw CLIENT at Hillburton Clinic prior to her admission to our program. It would have been good, irrefutable background documentation leading up to her admission here, if this case had become a legal challenge.

- Hillburton Clinic refers many clients to our program. Occasionally, our psychiatrist will also see our clients at Hillburton when he is scheduled there, for expediency. Therefore, we need a standing procedure to ensure that a Release of Information from Hillburton Clinic is <u>routinely obtained</u> from all admitted clients.

PLANNED ACTIONS IN RESPONSE TO FINDING 2:

- Consistently obtain all consumers' signatures on a Consent to Obtain Medical Records from Hillburton <u>upon admission</u> to our program. Follow this same practice whenever a client is to be seen by providers other than Hillburton, outside of our program.

EXPECTED RESULT for AREA 2:   There will be complete medical records at our location when consumers are seen by our psychiatrist or other provider at another location, either before or after admission to our program, for assessment or medication management. Think of it as an 'integrated paper trail.'

_____

Note to CEU By Net Continuing Education Participants: Mental health and addiction professionals are not required to be mind readers or predictors of unanticipated shifts in the personal lives of clients. However, we saw an *Opportunity for Improvement* **which would enhance the safety of client care, based upon this case. Furthermore, it would also be helpful documentation to have in place, in the event of a legal challenge.**

Specifically, could we have done more to assess and document and take action to reduce this individual's level of risk for suicide? If certain procedures had been in place, would it have been possible to proactively preempt this client's reaction to the abrupt cancellation of her plans for her birthday weekend? Do we need to do more ANTICIPATORY thinking and communication about such risks?

FINDING 3:   As clinicians, we recognize that a sudden shift in circumstances can lead to a sudden shift in a client's functionality – and that without support to adapt to the shift, deterioration can occur quickly. We also know that clients may not reach out for help under such circumstances, which was the case with this client.

- An ITP was developed with the participation of this client, as part of the admission process, addressing her depression and goals for recovery. The ITP was signed by CLIENT and by all staff who worked directly with her. The client's ITP addressed the need to be aware of major depressive symptomatology and to reach out for help if such symptoms occurred.

- Our Individual Treatment Plan (ITP) for those with major depressive disorders *does currently address the goals of* <u>identifying triggers of depression</u> *and of deterring or reducing self-defeating and self-harming behaviors including suicide.*

Analysis of 3: If there is a legal challenge, will our current ITP content be considered sufficient? Even if the ITP content is consistent with the Prevailing Standards of Care in the industry, would we be expected to have "done more" to prevent the suicide of this individual?

Clinical services could be improved by a focused programmatic goal to 'think preemptively' at all times when working with seriously depressed clients – particularly when there is the <u>potential for</u> *an unexpected upset in the client's plans or routine.* The client is a participant in this process, which is a Cognitive Behavioral approach to suicide prevention.

- 'THINKING PREEMPTIVELY' recognizes the *potential for a negative turn of events in the client's life or plans* and prompts the development of a plan by the client and his or her case manager to minimize and adjust to the issue.

- Examples of events about which to 'think preemptively': There is always <u>the potential</u> that a client's family may not 'show up' for a planned occasion or may abruptly cancel visitation plans. Other events about which to think preemptively: This may be the first Christmas or <u>anniversary</u> following the death of a much-loved individual *or pet.*   Or, there is always <u>the potential</u> that the newly accepted job may fall through, and so forth.

- Clients with an affective disorder should (1) play an active role in the development of their personal strategic plan, identifying his or her historical triggers which tend to worsen depression, *and then* (2) develop a 'game plan' when such events occur.

- Specifically, *with the help of staff,* clients can

    - learn to ANTICIPATE the POSSIBILITY that a given plan might fall through or that an event might trigger difficult-to-handle emotions, and

    - know how to reach out for help if the event or emotional reaction occurs.

PLANNED ACTIONS IN RESPONSE TO ISSUE 3:

To increase staff's awareness of the need to 'THINK PRE-EMPTIVELY' when working with clients with major depression, we will do the following:

- At the Morning Meetings (Monday through Friday), all staff persons are responsible for highlighting clients' pending personal events or situations which have a POTENTIAL to "go wrong" or "backfire" thereby placing the client at potential risk of increased depressive symptoms.

- In the morning meetings, necessary PRE-EMPTIVE INTERVENTIONS are discussed, and identification of person(s) who are responsible for the intervention are documented in the client record and on the duty calendar.

- An 'events calendar' which is located in a secure area of the program's office (protected from clients' and visitors' view) will notate clients' significant upcoming events or new situations *which have the potential to go awry,* with client identity limited to initials. Name of responsible Care Manager is also noted.

  Examples of calendar notations:
    - KT starts new job this week.
    - RT – roommate requested to be moved out of shared apartment.
    - VG - anniversary of mother's death.
    - PV - family is planning to visit on client's birthday.
    - WG - client's cat is very ill.
    - PB – client has expressed his intent to 'come out' to the client community within the next month.

- Clients with major depressive disorders will develop an enhanced awareness of his or her personal PRECURSORS or triggers of depression, anxiety, and self-harm, and will work with assigned staff to develop a DIVERSIONARY ACTION PLAN which includes reaching out to staff for support.

    - Within 7 days of admission, all clients whose ITP targets Area 3 (Affective Issues) will develop with their therapist a list of 'Triggers and Safety Actions for Depression Symptoms' as a therapeutic tool.

▪ A 'No Suicide' Contract. The assessing clinician will seek to obtain a *'No Suicide Contract'* from all clients who present at intake with a history of suicide attempts or ideation and all those with bipolar depression or other major depressive disorder. The 'No Suicide Contract' will be sought *whether or not* he or she appears to have (or professes to have) suicidal ideation or intent or known history thereof.

▪ The *'No Suicide Contract'* will clearly outline the STEPS that the client promises to take if he or she begins to have thoughts about suicide or self-harm – such as "immediately contact my assigned staff person or the on-call staff person", etc..

▪ The client's attending clinician will <u>regularly review</u>, with the client, *the steps which the client promises to take at the first sign of suicidal ideation.*

- Clinical supervisors will emphasize the need to **'think pre-emptively'** during supervision sessions with supervisees.

- Clinical Director LCSW B will present an in-service to staff on depression and suicidality – including the need for staff and clients to **'think pre-emptively'** about management of situations which have a potential risk for a negative outcome. The in-service will be repeated for new staff members.

EXPECTED RESULTS for AREA 3:

Through the development of a **pre-emptive approach** to the potential impact of a personal crisis in our clients' lives, there will be fewer instances of suicide or attempted suicide. Clients will become active partners in the development of a plan to dissipate the impact of sudden changes in their lives, thereby reducing the risk of self-harm.