Quality of Care

Policy Statement: TAC affirms that to improve outcomes and reduce early mortality, the mental health care system must ensure timely access to high-quality, evidence-based care for people experiencing serious mental illness (SMI) with psychosis, delivered in a manner that is compassionate, trauma informed, and oriented toward an improved quality of life.

Summary: High-quality mental health care should be available to all individuals experiencing SMI with psychosis, regardless of whether treatment is provided voluntarily or involuntarily. Policies and practices should promote adherence to evidence-based standards of care, reduce the use of seclusion and restraint, ensure proactive management of medication side effects, and strengthen accountability for the identification and treatment of co-occurring medical conditions. Patient rights protections should uphold the wishes of individuals with decisional capacity and safeguard the dignity and well-being of those who lack capacity. To support sustained treatment engagement and better outcomes, services should be trauma informed and delivered not only to improve symptoms but to enhance quality of life. Ongoing improvements to clinical protocols, provider training, and oversight, including the systematic use of lessons learned from adverse event reviews, are necessary to strengthen care and reduce preventable harms.

Background:

Provider training needs improvements. Evidence clearly shows that medication combined with other therapies can reduce SMI symptoms, improve quality of life, and reduce premature mortality rates.[12] However, outcomes are consistently poor when care is inadequate[3] or delivered in ways that are dehumanizing,[4] traumatizing,[5] or lacking in fidelity,[6] regardless of whether a person sought care voluntarily or accessed services through an involuntary pathway.

Providers may lack training in psychosis, treatment adherence challenges, and medication management. Psychosis is not an area of competency for frontline staff, such as social workers, and is typically excluded from core training for physicians and nurses.[7] While health care providers may lack the requisite knowledge they need to deliver optimal treatment, they also tend to hold more negative attitudes toward people with psychosis than those with other mental health conditions.[8]

Psychiatrists often don't accept insurance,[9] opting to treat those who are able to pay for care out-of-pocket. That often leaves the care of people with the most complex conditions, many of whom rely on public insurance,[10] in the hands of providers with less specialized training. Roughly two-thirds of primary care physicians are unable to connect their patients to outpatient mental health services[11] and therefore must lead care planning or abandon those patients to no care. The system will

improve only as it works to recruit, train, and properly reimburse and support providers at all levels who are positioned to treat people with complex psychotic conditions.

Seclusion and restraint are for extreme safety risks only. When providers are not trained for managing psychosis-related behaviors, they may struggle to de-escalate crises. This can result in higher uses of coercive measures, such as the isolation of individuals in barren, locked cells and/or restraint by mechanical or chemical means.

Seclusion and restraint are interventions of last resort.[12] The intention is to protect the person and others in the vicinity from imminent harm and for the intervention to end as soon as the immediate safety risk is no longer present.[13] These extreme measures must not be used as a matter of convenience for staff or to punish, coerce, or manage a person because staff lack the training or problem-solving skills to try less coercive alternatives.

Seclusion and restraint can be traumatizing[14] and may cause physical harm if done incorrectly. They also can cause feelings of powerlessness[15] and lasting negativity toward psychiatric care.[16] Interventions designed to reduce the use of seclusion and restraint have shown mixed results, pointing to a need for more research and clearer guidelines.[17]

Addressing and treating physical health conditions must be a standard for SMI care. People with schizophrenia spectrum disorders have a life expectancy 15 years shorter than the general population.[18] This mortality gap is in part from self-harm, injury, and suicide—all of which disproportionately impact people with schizophrenia.[19] However, the largest contributor to the mortality gap is from physical health conditions like cardiovascular disease, pneumonia, diabetes, and cancer, which too often go untreated or undertreated in persons with SMI.[20]

Compared to the general population, people with schizophrenia have a 600% higher risk of dying from pneumonia and a 200-300% higher risk of dying from infections, respiratory diseases, diabetes, and other health conditions.[21] While people with SMI often have more contact with the health care system than the general population, they are less likely to receive physical check-ups and health screenings.[22] People with SMI are also more likely to lack dental care, which contributes to higher rates of missing and decayed teeth [23] and can increase risks for other serious health conditions.

Routine medical and dental screenings should be the standard for people receiving treatment for SMI, especially those who present with psychosis and may lack capacity to make informed decisions about their mental and physical health. Medical screenings are also critical to determine if the psychosis may be caused by an autoimmune condition,[24] epilepsy,[25] substance misuse,[26] or another condition that may require a different treatment approach.

Side-effect management improves treatment adherence and overall outcomes. Antipsychotic medications are an evidence-based treatment to reduce the severity and frequency of psychotic symptoms,[27] but they frequently cause adverse side effects that impact treatment adherence. Some side effects may be temporary and minor, such as dry mouth; but others can be permanent or life-threatening, such as involuntary movements from tardive dyskinesia or infections from agranulocytosis, when medications are not properly monitored and managed.[28]

Patients with schizophrenia report that the benefits of antipsychotic medications outweigh side effects for reducing acute symptoms; however, side effects may contribute to treatment non-adherence after stabilization.[29]

Balancing side effects with treatment efficacy is a critical component of the medical imperative to do no harm when providing treatment to patients.[30] In addition to monitoring for co-occurring health conditions, prescribers must make side effect management a standard for whole person care offered at each appointment.[31]

Recommended Actions:

Prepare health care professionals to effectively treat SMI with psychosis. Primary care physicians, nurses, social workers, peer support specialists, and other health care professionals should recognize signs of psychosis and know how to engage individuals who experience anosognosia. All should be prepared to make appropriate referrals when needed or offer ongoing quality care when no specialist is available. To lower the high rates of disability[32] among people with poorly managed SMI, all mental health training programs should include dedicated modules on SMI with psychosis, with specific clinical approaches to serve clients with impaired insight, thought disorganization, and altered perceptions of reality. Academic institutions, professional associations, and other organizations that provide continuing education credits should build robust and consistent courses on SMI with psychosis. Advocates can consider contacting medical, nursing, and social work programs to share their personal experiences and perspectives with current students.

Establish clear protocols for use of seclusion and restraint. Because isolating or restraining a person by physical or chemical means can cause harm, these measures should be used only as a last resort to mitigate an extreme safety risk and never for punishment, coercion, or staff convenience. Facilities that utilize these extreme interventions must establish clear guidelines for assessing a situation, attempting less restrictive measures, documenting when and why seclusion or restraint was begun and ended, and whether the intervention was stopped in the moment that the risks for harm ended. Every report should trigger a review by a neutral party to assess whether policies were followed and what alternative measures must be tried first into the future. Facilities must require training in de-escalation techniques specific to psychosis, including ways to modify the environment to reduce stimulation and remove potentially dangerous items.

Require screening for co-occurring medical conditions and medication side effects. To reduce the mortality gap, medical facilities serving patients with SMI must also screen, treat, and support physical health, including with robust monitoring of medication side effects. Providers must understand that poor self-awareness of illness can complicate how a person might perceive or manage an infection, heart disease, diabetes, cancer or another co-occurring physical health condition. All clinicians must be trained to ask patients about general health and medication concerns, incorporating patient preferences into treatment decisions whenever possible while also protecting those who lack the capacity to understand or self-manage their mental and physical health needs. Whenever possible and appropriate, providers must be accountable to collect and consider collateral information from care partners for a complete picture of a person's condition and needs.[33] To secure their right to quality care, individuals receiving involuntary treatment should also have a choice to change providers and seek an independent review if they feel their concerns are not being heard or adequately addressed.

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