Monitoring Nurses and Other Healthcare Professionals with Mental Health &/or Behavioral Problems
John C. Tanner, D.O., DFASAM, DABAM, CCFC, MRO

- **For NOAP Conference in West Palm Beach - Thursday, March 17, 2016 9:00AM to 10:30 AM**

I - GENERAL ISSUES

A. Why should there be monitoring with a mental health diagnoses or behavioral problems?
   - Safety issues for the public receiving healthcare.
   - Safety issues for the nurse or healthcare professional themself.
   - Issues that create an unsafe or unstable workplace or environment that is less therapeutic for patients or may disrupt their care.

B. Monitoring of behavioral and mental health disorders is far more complex than monitoring of substance use disorders and this may be the reason why many monitoring programs do not address mental health issues, even though mental health disorders clearly can pose a risk of impairment and jeopardize public safety.

C. Most psychiatric disorders may transiently or episodically have a significant impact on emotions. Based on neuroscience; strong emotions increase limbic activity and decrease cognitive activity thereby adversely impacting concentration, focus, judgment and even impulse control. Negative effects on his areas of important functioning can potentially jeopardize public safety.

D. Significant research by monitoring programs is needed in this area to more clearly define best practices and assure public safety.

II - SAFETY ISSUES INVOLVED (impacting on patient care or jeopardizing the therapeutic work environment resulting in medication errors, procedure mistakes and other types of negative patient outcomes)

A. Impulse control issues (i.e. shooting a syringe full of blood onto the ceiling in an operating room during a fit of rage.)

B. Cognitive impairment in various realms such as impaired math or calculating capacity, word finding difficulties, spatial awareness, etc. (i.e. impairment disrupting or ending a surgical procedure in mid-procedure, impaired spatial awareness when assisting in or performing a procedure, or miscalculating the dose of a medication to be administered).

C. Complex thought disorders (i.e. with schizophrenia or schizoaffective disorder with disordered and irrational belief system resulting in unpredictable and risky behaviors).

D. Judgment or reasoning impairment (i.e. poor decision-making regarding when there is a need to intervene in an urgent medical situation; poor ethical decision-making).

E. Impairment of fine or gross motor skills (sometimes linked to mental health disorders or neurobehavioral disorders and linked to stress related catecholamine release).

F. Boundary violations (sexual such as inappropriate touching; dis-respecting personal privacy; and other personal boundaries such as breach of a patient confidentiality with HIPPA violation).

G. Psychotic disorders (reacting to visual, auditory or tactile hallucinations or delusions).

H. Impairment of focus or concentration (i.e. with Attention Deficit Hyperactivity Disorder or Attention Deficit Disorder or impairment in concentration due to strong emotions - for instance this could cause carelessness resulting in wrong side surgery).

I. Harming thoughts (towards self or others – may be associated with a number of psychiatric disorders).

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II - SAFETY ISSUES INVOLVED (impacting on patient care issues, jeopardize the therapeutic work environment, medication errors, procedure mistakes and other types of negative patient outcomes)

J. Anger or rage (i.e. Volatile emotions or explosive disorder issues resulting in violent or dangerous behaviors or threats made towards a patient or co-worker).
K. Strong religious preoccupation with negative effects on the patient/provider role and/or relationship(s). Disrespect for a patient's personal beliefs.
L. Cultural, ethnic and/or LBGT insensitivity issues.
M. Dissociative identity disorder (DID) and role confusion.
N. Impaired memory (both short-term and long-range memory resulting in confusion about a situation or loss of previously learned professional skills).
O. Impaired motivation and/or drive (resulting in an inability to maintain workload or accomplish needed patient care).
P. Patient abandonment (i.e. abandoning a patient in the midst of receiving important treatment).
Q. Disorders such as Munchausen by proxy or personal beliefs about who should live or die (i.e. intentionally causing infections in patients).
R. Axis II issues, primarily Cluster B (resulting in counterproductive manipulation or other disruptive behaviors).
S. Use of psychiatric medications that impair functioning (including: various sedatives/benzodiazepines, psychostimulants and a variety of sedating psychiatric medications).
T. Traumatic brain injury or craniotomy, which are known to result in; complex forms of impairment, secondary psychiatric complications, and substance use disorders.
U. A variety of medical conditions which can result in behavioral types of impairment (i.e. hypoglycemia, cerebrovascular accident or transient ischemic attack, tuberose sclerosis, temporal lobe seizures, metabolic syndromes etc.).

III - IMPORTANCE OF STARTING WITH AN ACCURATE DIAGNOSIS AND DECIDING IF IT SHOULD BE MONITORED

A. Is it a primary psychiatric disorder and are appropriate psychiatric medications being utilized?
   - Requires an accurate baseline diagnosis.
   - Scrutiny of medications being used and appropriate medication management.

B. Is it psychiatric disorder related to an underlying medical condition that may mimic behavioral disorders?
   - Is a medication causing behavioral problems? Examples: Testosterone, when replaced at higher than therapeutic levels can trigger aggressive behaviors.
   - Is there an undiagnosed or inadequately treated medical condition? Example: Hypoglycemia can trigger impaired judgment and cause irritability. Traumatic brain injuries can trigger a constellation of psychiatric disorders.
   - Is there a neurological disorder that may be triggering abnormal behaviors? Examples: small vessel disease, brain tumor, tuberose sclerosis or temporal lobe seizures etc.

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C. What are the tools used to establish an accurate diagnosis?
- Thorough and careful psychiatric evaluation by an experienced psychiatrist to understands healthcare related safety sensitive issues. Having vetted and approved providers helps immensely with this.
- Comprehensive psychological or neuropsychological evaluation with an appropriate battery of neurocognitive psychometric testing to properly assess the potential disorders and guide treatment.
- In some select cases it may be appropriate to have neurological imaging including: 3 Tesla magnet MRI scanning that includes: functional MRI (fMRI); diffusion tensor imaging (DTI); neuroquantitative analysis; magnetic resonance spectroscopy (MRS).
- Medication trial (i.e. in some cases a trial and error process may be needed to establish the most therapeutic medications and thereby clarify an underlying diagnosis).
- So-called "Diagnostic Monitoring" or monitoring for a briefer period of time to assure that an underlying psychiatric diagnosis does not manifest during that time. Some disorders do not have consistent manifestations and only present with symptoms on an episodic basis. A one or two year period of monitoring will almost always allow sufficient time for identification if a problem exists. A Diagnostic Monitoring contract is useful when there is not a clear diagnosis; however there is sufficient safety concern based on historical issues that rise to a level so that monitoring will help assure that a significant problem does not exist.

D. What mental health diagnoses should be monitored and why should they be monitored?
- Bipolar Affective Disorder Type I, II and NOS (Impulse control, poor judgment, energy and mood regulation problems, noncompliance with medications and psychosis).
- Major Depressive Disorder that has not been in remission for 5 years, especially if there has been suicidal risk or psychotic features.
- Severe Obsessive Compulsive Disorder (untreated it can interfere with work functioning).
- More severe forms of Anxiety Disorder, Panic Disorder or Phobias that may interfere with practice.
- Posttraumatic Stress Disorder.
- Eating Disorders (Anorexia Nervosa and Bulimia Nervosa).
  a) Hypoglycemia and malnutrition can interfere with cognitive functioning and judgment.
  b) Electrolyte imbalance can jeopardize health and functioning.
- Schizophrenia, schizoaffective disorder and similar diagnoses (poor judgment and psychosis).
- Axis II or personality disorders (i.e. Sociopathic, Borderline, Narcissistic) which may result in problematic behavior in a healthcare setting.
- Cognitive disorders, traumatic brain injury or learning disorders (Inability to process needed requirements for job, impulse control, and/or poor judgment).
- Pain Disorder Associated with Psychological Factors and medical Condition (severe pain can impair cognitive functioning).
- Attention Deficit Disorder or Attention Deficit Hyperactivity Disorder (Impulse control, poor judgment, inability to focus and inattentiveness).

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D. What mental health diagnoses should be monitored and why should they be monitored?

- Impulse Control Disorders not otherwise specified.
- Sexual Disorders (especially those associated with significant risk of boundary violation).
- Dissociative Disorders (Dissociative Identity Disorder, Dissociative Amnesia).
- Alzheimer's disease, multi-infarct dementias and a number of progressive neurological disorders such as Parkinson's disease that may progress to cognitive or behavioral impairment.

E. Contract development and monitoring issues should be based on first establishing an accurate diagnosis.

- Consider duration of monitoring depending on the diagnoses and severity. For example Bipolar Affective Disorder Type I, Schizophrenia, Schizoaffective Disorder or other significant psychotic disorders may need licensure-long monitoring (i.e. for assurance of medication compliance issues) due to these being life-long diagnoses with poor outcomes if medications are discontinued. If long-term monitoring for years shows good stability, the participant may petition to successfully complete.
- Depending on the diagnosis and the severity of the mental health issue, psychiatric disorders may otherwise be as little as 1 or 2 years (i.e. for a more minor problem or diagnostic monitoring), but is usually a 5 year contract.
- Specifics of the contract should be based on potential problems identified with the diagnosis or historical issues (i.e. if there is a history of medication noncompliance, a component may be a requirement for quarterly drug level reports or documented administration of a long-acting injectable medication).

IV - MONITORING TOOLS AVAILABLE

- Monitoring must be modeled around having a good evaluation with accurate diagnoses: (i.e. differentiating Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder from Bipolar Affective Disorder spectrum, which has many shared symptoms); identification of all safety risks; arranging appropriate treatments (medication management and psychosocial treatments/supports) - then developing and implementing an appropriate monitoring process designed to assure public safety.
- Psychiatric medication management with a psychiatrist or psychiatric nurse practitioner with quarterly reports.
- Therapeutic drug level testing intermittently may be indicated in select cases, especially when there is a history of medication noncompliance (i.e. atypical antipsychotic medication blood level tests periodically).
- In some cases a psychological evaluation with an appropriate battery of neurocognitive psychometric testing (i.e. with the Minnesota Multiphasic Personality Inventory-2 (MMPI-2) and the Million Clinical Multiaxial Inventory-III (MCMI-III) and/or other tests for diagnostic clarification, confirmation of an unclear diagnoses, verification of

cognitive functioning sufficient to have safety to practice nursing. In some cases such as after head trauma, this may need to be done serially until reaching a sufficient safety level; or in some cases to assure there is not deterioration resulting in impairment of function that risks safety).

IV - MONITORING TOOLS AVAILABLE

- Weekly Mental Health Facilitated Nurse Support Groups (if available in the area) with quarterly reports.
- Outpatient individual therapy with a master's or higher level trained therapist or psychologist and quarterly reports.
- Community mental health mutual support groups (i.e. support groups for Bipolar Disorder or other specific mental health diagnoses)
- Therapy groups with a psychologist.
- Work performance evaluation by supervisor with quarterly reports.
- Disruptive monitoring with behavioral contracting and specific behavioral interventions (a number of programs are available).
- Limitations or restrictions of the workplace environment for those with cognitive limitations
  a) Gender specific settings for some sexual boundary violators.
  b) Slower paced work demands or lower distraction type of workplace environment based on guidance provided from neurocognitive testing.
  c) More direct supervision.
  d) Restriction or avoidance of specific settings (i.e. No Emergency Rooms, busy skilled care settings or critical care units).

V – SUMMARY

- Mental health problems can result in behavior that may jeopardize public safety and they should be monitored.
- It is important to first establish an accurate diagnosis and then decide if it creates any potential safety risk that should be monitored
- The Monitoring Contract should be based on the diagnosis/diagnoses and identified safety risks and it should be structured to help assure those risks are significantly reduced or eliminated.
- There are a variety of monitoring "tools" available for monitoring programs to implement to help ensure safety to practice.