A PRAXISONE PERSPECTIVE

The Hidden Cost of Hindsight

Why behavioral healthcare's most serious events are the ones seen too late — and what it takes to see them sooner.

Executive summary

In behavioral healthcare, the most serious events — a patient safety crisis, an assault on a staff member, a preventable readmission — rarely arrive without warning. The signals are usually present beforehand: a missed observation, a rising risk assessment, an incident logged on another shift, a gap between what one team member knows and what another does. But those signals live in different systems, on different shifts, and in different people's heads — so they are most often assembled only *after* the event, in a retrospective review. This paper argues that behavioral health's defining operational problem is not a shortage of information but a shortage of foresight. The industry runs on hindsight by default. We examine the evidence, the human and financial cost of seeing too late, and the shift from retrospective review to real-time operating intelligence — always under human oversight.

1 The pattern hiding in the data

In 2024, The Joint Commission reviewed 1,575 sentinel events — unexpected occurrences involving death or serious harm. Suicide, or death by self-inflicted injury, was the fourth most common, accounting for 122 of them. In behavioral healthcare, it is the most consequential event of all.

But the number that should stop a reader is not the count. It is the cause. Among the leading contributing factors The Joint Commission identified across these events was *inadequate shared understanding among members of the care team* — alongside non-adherence to established policies. In plain terms: the information needed to prevent the event usually existed somewhere in the environment. It simply was not assembled in one place, in time, in front of the right person.

> **75%**
>
> of the inpatient and post-discharge suicides reviewed occurred within seven days of discharge or while the patient was receiving intensive behavioral-health care — the very windows of closest contact and observation.
>
> *The Joint Commission, Sentinel Event Data 2024 Annual Review*

These are not events that happened in the dark, far from clinical attention. They happened in the bedroom (56%) and the bathroom (32%), inside the walls of organizations actively caring for the patient. The window was open. The signals were in the building. They were seen clearly — in hindsight.

2 Hindsight is the industry's default operating mode

The tools that dominate quality and risk management in behavioral health look backward. Root cause analyses, morbidity-and-mortality conferences, chart audits, incident debriefs — each is essential, and each is reactive by definition. They begin *after* harm has occurred. They are an autopsy, not an early warning.

This is not a criticism of the people doing the work; it is a description of the instruments they've been given. Retrospective review is very good at explaining what happened and why. It is structurally incapable of changing the outcome of the event it is reviewing, because by the time it runs, the event is already in the past. Meanwhile, the data that would support a forward-looking view is generated continuously — and largely goes unwatched in the spaces between reviews.

3 Behavioral health is signal-rich and sightline-poor

A behavioral health environment produces an enormous stream of relevant signal every hour: safety observations, risk assessments, incident reports, medication events, staffing levels, documentation timeliness, changes in behavior and acuity. The raw material of foresight is abundant.

The problem is that it is fragmented — scattered across the Electronic Medical Record and a dozen other systems, split across shifts, and divided among roles. No single clinician can hold the whole picture, because the picture is distributed by design. The Joint Commission's finding — *inadequate shared understanding among the team* — is not a story about individual carelessness. It is a structural feature of how the information is stored and moved. The signal exists; the sightline does not.

4 The cost of seeing it late

When risk is recognized only in retrospect, the cost lands in three places at once.

The human cost.

The sentinel events above are the sharpest edge of it — preventable harm to the very people an organization exists to protect.

The workforce cost.

Behavioral health is one of the most dangerous places to work in America, and late-seen risk is absorbed first by staff.

> **124.9 per 10,000**
>
> workers in psychiatric and substance-abuse hospitals suffered a nonfatal workplace-violence injury in 2018 — roughly twelve times the rate across general healthcare, and far above every other industry. Healthcare workers accounted for 73% of all nonfatal workplace-violence injuries.
>
> *U.S. Bureau of Labor Statistics, Workplace Violence in Healthcare, 2018*

Every one of those injuries is also a signal — an escalation that, seen sooner, might have been de-escalated. Protecting patients and protecting the people who care for them is the same problem, viewed from two sides.

The system cost.

Preventable events convert into liability premiums, litigation, settlements, and payer clawbacks — costs an organization carries whether or not it ever names them. And the strain compounds against a workforce already stretched dangerously thin.

> **122 million**
>
> Americans live in a designated Mental Health Professional Shortage Area. Fewer people are carrying more acuity — which means fewer eyes on more signal.
>
> *Health Resources & Services Administration, State of the U.S. Health Care Workforce, 2024*

5 From hindsight to foresight

The answer is not more retrospective review. It is a different posture entirely: *operating intelligence* — continuously connecting the signals already present across the environment, identifying what needs attention now, and turning it into accountable action while there is still time to act.

This is the distinction that matters, and it must be stated plainly: foresight of this kind is not automation replacing clinical judgment. It is the opposite. It gives the people doing the work a sightline they cannot otherwise have — assembling the scattered picture into one view — and then leaves the decision where it belongs, with licensed professionals. The system informs; the human decides. And every step is recorded, so there is an auditable path from the first signal to the final resolution.

6 What proactive looks like in practice

A responsible model for foresight in behavioral health rests on five principles:

1. **Unify the signals.** Bring the fragments — across systems, shifts, and roles — into a single, shared line of sight, so no one is asked to hold the whole picture in their head.
2. **Surface early.** Flag rising risk while intervention is still possible, not after the fact.
3. **Keep humans in control.** Recommendations inform; licensed clinicians and administrators decide. The technology never acts on a patient on its own.
4. **Make it auditable.** Every signal, action, owner, and time is recorded — both to support the team and to stand up to scrutiny.
5. **Measure honestly.** No promises of guaranteed outcomes — a disciplined framework for observing what actually changes.

7 The choice in front of every organization

Every behavioral health organization is already paying for hindsight — in preventable harm, in workforce strain, and in the buried costs of risk realized after the fact. The spending is not optional; only its direction is. It can continue to flow reactively, after events, or it can be redirected toward seeing sooner.

Behavioral health runs on hindsight. It does not have to.

About PraxisOne

PraxisOne is the operating intelligence layer for behavioral healthcare. We connect the clinical, operational, and behavioral signals that already exist across an organization's environment, identify what requires attention, and turn intelligence into accountable, auditable action — with human oversight at every step. Our platform, Haleux, is delivered through two products: Haleux Care, which brings governance to the front line of patient care and documentation, and Haleux Assure, which operationalizes QAPI as a continuous, evidence-backed discipline.

To discuss how foresight could work in your environment, visit **praxisoneinc.com** or request a demonstration.

References

1. The Joint Commission. Sentinel Event Data 2024 Annual Review. Published 2025.
2. U.S. Bureau of Labor Statistics. Workplace Violence in Healthcare, 2018. Fact sheet, April 2020.
3. Health Resources & Services Administration (HRSA), Bureau of Health Workforce. State of the U.S. Health Care Workforce, 2024. November 2024.

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