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ASHRM/AHA Behavioral Health White Paper Series Behavioral Health Care in the Inpatient Medical Setting

Authors:

Kristen Lambert, JD, MSW, LICSW, CPHRM, FASHRM
System Vice President Risk Management & System Privacy Officer
Covenant Health
Tewksbury, MA

Doris Fischer-Sanchez, DNP, APN-BC, CPHRM
Senior Clinical and Enterprise Risk Management Consultant
National Healthcare Industry Practice
Willis Towers Watson

Reviewers:

Monica Cooke, BSN, MA, RNC, CPHQ, CPHRM, DFASHRM,
CEO Quality Plus Solutions LLC

Caitlin Gillooley, MS
American Hospital Association (AHA), Senior Associate Director Quality Behavioral Health Policy, Washington DC

Paul Rains, RN, MSN
System SVP, Behavioral Health, Common Spirit Health, President St. Joseph's Behavioral Health Center, Stockton CA

Harsh K. Trivedi, MD, MBA
President and CEO, Sheppard Pratt Health System, Baltimore, MD

AHA Behavioral Health

AHA Data & Insights

The American Society for Health Care Risk Management (ASHRM)
of the American Hospital Association
155 North Wacker Drive, Suite 400
Chicago, IL 60606
(312) 422-3980

ASHRM@aha.org
www.ASHRM.org

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INTRODUCTION

Behavioral health disorders present in every area of the inpatient hospital setting. Patients can be admitted for a medical issue and also have behavioral health and/or substance use issues or develop a behavioral issue as a result of being hospitalized or dealing with chronic or terminal illnesses. Health care providers treat patients with behavioral health issues daily. Providers who routinely treat patients primarily for medical issues also must know how to treat or manage patients who have behavioral health issues.

Mental illnesses are specific, diagnosable disorders characterized by intense alterations in thinking, mood and/or behavior. Mental illness falls under two categories: any mental illness (AMI) and serious mental illness (SMI). AMI refers to all mental illness; SMI refers to a more serious subset of AMI.[1] According to the National Institute of Mental Health, nearly one in five American adults lives with a mental illness. This number totaled 46.6 million in 2017.[2] Substance use disorders occur when the "recurrent use of alcohol and/or drugs causes clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home."[3] Substance use disorders are prevalent in the United States; however, in 2016, only 11 percent of the 19.9 million persons identified as having a substance use disorder received treatment.[4]

Persons with behavioral health care needs may experience either or both types of conditions as well as physical comorbidities that are treated in the inpatient hospital setting. This publication, the third in a series, explores topics pertaining to concerns, challenges, and disorders that may be encountered when treating patients with behavioral health issues in the inpatient hospital setting.

Depending on the setting, inpatient medical/surgical units may not be equipped with sufficient facilities, staff, transfer options or specific resources needed to treat behavioral health patients. These issues can create challenges in effectively treating patients with behavioral health disorders.

In 2020, the COVID-19 pandemic has affected everyone in the U.S. Approximately 22 million people filed unemployment claims within just a four-week period.[5] Many states issued stay-at-home orders and many individuals have been restricted or confined to home for extended periods. At the peak, 94% of the U.S. population was affected through some form of stay-at-home or shelter-in-place order.[6] These restrictions can cause significant stress and place those with behavioral health and substance use disorders, and their families, at increased risk. For example, individuals seeking care at the hospital may have experienced domestic violence or abuse. A study found that the number of people who have contacted domestic violence hotlines have increased since the beginning of the pandemic.[7] Victims also delayed reaching out to health care services until the late stages of the abuse cycle.[8] Patients or their family members who have substance use issues are at increased risk of use or relapse. Patients or family members also may have experienced financial stress, lack of food, isolation, and limited access to in-person resources due to closure of care and treatment programs.

Patients with behavioral health disorders will continue to be seen in the hospital; however, adequate services to care for them may not be available within or outside of the health system. As the need continues, hospitals may have to implement creative strategies to provide care and use newer models of delivery such as telebehavioral health or distance treatment.

The publications in this series, emphasize that each health care organization is unique. Therefore, variations may exist in how services are offered, creating differences in potential liability exposures. Hospitals and health systems should seek risk management or legal advice specific to their organization and state.

LOGISTICS, FACILITIES AND ENVIRONMENTAL SAFETY/SUPPORT

Patients with behavioral health needs are found throughout the continuum of care. Individuals who experience a mental health crisis are treated on psychiatric units, in the Emergency Department (ED) as well as on medical-surgical or other specialty units.[9] As the number of medical-surgical patients with co-occurring mental health disorders continues to grow, so does the need for behavioral health care in general medical-surgical and other specialty areas of health care facilities.

Behavioral health patients who receive care on a hospital general or specialty floor spend the majority of their day in their room, where they typically eat, sleep, have visitors, see their doctors and receive treatment. Alternatively, patients with behavioral health issues who are hospitalized in a mental health facility or on a psychiatric floor of a general hospital are encouraged to stay out of their rooms for treatment, medication, meals and group therapy for the majority of their day. As a result, these two inpatient treatment locations were designed differently. Psychiatric patients with coexisting illness may not have much experience on medical-surgical floors and could have trouble confining themselves to their rooms. This can cause anxiety, fear and irritation with staff who need to spend time looking for them, encouraging them to stay in their rooms and who are not well-trained or competent in the therapeutic process for behavioral health care. As a result, behavioral health patients may react by escaping, attempting or committing suicide, threatening litigation or complaining to family and friends.[10]

One approach is integrated inpatient facilities. Integrated health care treats the whole person and all of his or her diagnoses including behavioral health issues.[11] These integrated units are designed to care for medical and psychiatric issues in an environment that is functional, attractive and safe for all patients regardless of their behavioral health status.[12] Specific design elements can include: security glazing applied over the inside face of existing exterior windows, light fixtures with polycarbonate lenses and tamper-resistant fasteners, tamper-resistant fire sprinkler heads, medical beds that are specifically designed to be safer for these patients, and televisions positioned behind polycarbonate covers built into millwork.[13] Many of these types of safety design elements can be incorporated into current inpatient medical rooms without new construction. Keep in mind, beyond national certification, there may be variations in state and local requirements that organizations need to be aware of before making facility improvements.

POLICY MATCHING TREATMENT IN THE INPATIENT SETTING

It is important that facility policies match the treatment provided. The standard of care should be the same whether the patient receives care on an inpatient medical unit or an inpatient psychiatric unit. Policies should address steps and strategies to reduce the potential for patient or staff harm if patients are at risk to themselves or others. Policies should be in place that address:

- When psychiatric consultations are indicated and how they are initiated.
- Documentation of patient care.
- Notification of rights, when indicated.[14]
- Release of information that complies with HIPAA, or other applicable state privacy regulations, and when providing substance use related care, under CFR 42.

STAFF COMPETENCY

Consistent staff training in triage; comprehensive behavioral health assessment; diagnosis; verbal de-escalation techniques; psychopharmacology; and avoidance of coercion, seclusion and restraints is as important as training for any other processes addressed in medical management. The most important aspects of staff training for managing patients with behavioral health issues include:

- Anxiety management.
- Risk assessment for suicidal ideation.
- Substance use/abuse.
- Agitation management
- Medical complexity identification.
- Screening and crisis intervention for self-harm or violence.
- Psychoeducation.[15]

Health care professionals working with patients that have behavioral health issues also should recognize and appreciate when social problems, such as family stressors, homelessness, job loss, financial issues, among others, contribute to a patient seeking care and to the decline of the clinical picture. Ideally, a multidisciplinary team or a behavioral response team should provide wraparound services to a patient with behavioral health issues.[16]

MANAGING AND PROVIDING TREATMENT WHEN RESOURCES MAY NOT BE AVAILABLE

Coverage of and increasing demand for psychiatric services are occurring at the same time as a growing shortage of outpatient and inpatient programs. Lack of access has created a crisis throughout the U.S. health care system that is harmful and frustrating for patients, their families and other health care providers, and is becoming increasingly expensive for payers and society.[17] The field of psychiatry is uniquely positioned to impact high-cost populations with improvements in workforce, reimbursement and policies encouraging psychiatrists and advanced practice providers to practice up to the level and scope of their licensure.[18]

Further complicating these issues is a lack of resources within the hospital system and in the community. COVID-19 has impacted facilities across the country; therefore, staff may be tired and stretched. Hospitals across the country also are cutting costs by implementing furloughs, layoffs or pay cuts, with nearly 270 hospitals and health systems furloughing workers in response to the pandemic.[19] These staffing issues can present challenges when treating patients with behavioral health issues on the medical floor. It is important to involve the psychiatry, social service and case management departments to assist in providing care and treatment while the patient is in the hospital and to set up appropriate follow up after discharge.

ACUITY, ROUNDING, AND DOCUMENTATION

Patients with behavioral health issues can contribute significantly to the acuity of a unit. Patients with substantial psychiatric comorbidities can have significant and rapid mood and behavioral changes as well as sudden, volatile and aggressive outbursts - both verbal and physical.[20] Individualized treatment plans, focused rounding, increased communication within the team about which interventions are effective and which require revision, along with thorough documentation, should make the inpatient stay less challenging for both the patient and the treatment team.should

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ELOPEMENT

Elopement is a significant risk on medical units. An elopement occurs when a patient is aware that he or she is not permitted to leave but proceeds to do so, and includes patients who may not actually leave hospital grounds.[21] The Joint Commission identifies an elopement as a sentinel event if it leads to death, permanent harm or severe temporary harm to the patient.[22]

It is important to determine the level of risk of elopement upon admission or when there is a change in patient status. Patients who have attempted suicide may be treated on medical units until they are medically cleared for admission to a psychiatric unit or hospital. Patients who have dementia or confusion as a result of medical, psychiatric or substance use/detoxification also may be at risk to elope. A number of steps can be taken to minimize risk:

- Create standard policies/procedures across the system, including chain of command for reporting.
- Implement training for staff and consider mock safety drills.
- Assess elopement risk when a patient presents to the hospital/inpatient unit.
- Position the patient closest to the nurses' station.
- Provide nurses with clear views of the exits.
- Closely monitor at-risk patients.
- Communicate risk to all providers.
- Re-assess risk and communicate risk status at handoffs and shift changes.
- Educate staff to be aware of patients who may be in the hall and appear confused. Simply talking with a patient could prevent an elopement.
- When indicated, assign a safety companion or a staff member to sit in the patient's room or outside of the room.
- Understand state regulations regarding patients who elope.[23]

If a patient does elope, it may be necessary to breach confidentiality. In these circumstances, immediately inform relevant departments of the incident. Risk management, legal, security and media relations staff likely will need to be involved in this communication. If the patient is being held involuntarily, security and local law enforcement should be informed immediately. Health care organizations should provide police with patient photos and identifying information, if available, and thoroughly document actions taken to locate the patient.

LEAVE AGAINST MEDICAL ADVICE (AMA)

There may be instances when a medical provider determines a person requires hospitalization and is not under involuntary admission, but the person chooses to leave the facility against medical advice. AMA discharges in psychiatric populations range from 3% to 51% (average, 17%).[24] If a patient leaves without being seen or AMA and an adverse event occurs, there may be liability risk for the hospital and provider. Keeping the patient, other patients and staff safe is critical, especially when a patient presents an imminent risk of danger to self or others. Proper steps and processes should be followed.

Documentation is critical when a patient cannot be held. Hospitals should have proper protocols in

place that include having the patient sign a designated AMA form acknowledging that the patient received and understood medical advice, chose to leave, and that providers should document the situation completely. If a patient leaves an inpatient unit and safety is a concern, staff should determine whether authorities can be contacted, and a well-person check requested of local law enforcement.

There are number of steps to be taken that may minimize risk that a patient on an inpatient unit may leave AMA:

- Consider implementing a nurse advocate. Research indicates a 30% decrease in total AMA discharges among psychiatric inpatients in a private hospital that used a nurse as a patient advocate who had the responsibility of exploring a patient's preconceptions about hospitalization and addressed fears and complaints.[25]
- Ensure proper communication and expectations about treatment.
- Maintain a non-judgmental and compassionate attitude toward all patients.
- Pay attention to early warning signs that the patient may be experiencing psychological stressors including stress, anxiety, depression, and/or possible signs that he/she may leave AMA.
- Consider having clinicians use motivational interviewing when communicating with patients.[26]
- Address substance use issues early in treatment.

Patients may have the capacity to decide to leave the hospital AMA on a voluntary basis, even though it may not be a sound medical decision. It is important to document the patient's assessed risk at the time of the AMA decision.

If a patient is on a medical unit or is awaiting medical clearance to be transferred voluntarily or involuntarily to a psychiatric unit/hospital, additional steps should be considered including:

- Determine if a behavioral competency validated sitter (or 1:1) should be indicated. In the event that the patient attempts to leave the hospital AMA, he/she should alert the appropriate professional(s). If a patient has been deemed a risk to self or others and seeks to leave AMA, it is important to attempt to de-escalate the patient and consult providers with specialized skills, such as psychiatry or social services.
- When indicated and in accordance with regulations, restraints such as manual restraints or chemical restraints may need to be implemented. (For more information, see Restraint and Seclusion section of this publication.)
- Notify the security department or relevant authorities, if indicated.

TRANSFER TO AN INPATIENT PSYCHIATRIC UNIT/HOSPITAL

There may be times when a patient requires transfer to an inpatient facility. When the diagnosis is unclear, and the behavioral issues are the main symptoms of what is likely delirium or other cognitive impairment, it can be frustrating for clinicians. The potential combinations of agitation, assaultive behavior, verbal outbursts and the occasional need for restraint can create significant challenges on medical floors, and too often staff request that patients be transferred to psychiatric units. Sometimes this occurs even though medical stability has not yet been achieved, and when the underlying illness would more commonly be dealt with in the general medical hospital, were it not for the agitation.[27]

Problems arise when there are significant medical comorbidities, perhaps causally related to the presenting psychiatric symptoms. In addition, a facility may not have an in-house psychiatry service to manage presenting behavioral health issues. As such, providers may need to consult with a local state agency to assess the patient. Common situations may include:

- Dementia with worsening agitation or confusion.
- Substance use disorders with complicated intoxication or withdrawal.
- Delirium of unknown cause.
- Patients with known serious and persistent mental illness with a comorbid medical condition who are unable to care for themselves.[28]

There are times; however, when it is not safe for the patient, staff or other patients to continue caring for or be around the behavioral patient on an inpatient medical unit. Safety is of the utmost importance. If the patient is not able to be effectively cared for on a medical unit, a higher level of psychiatric care may be necessary. It is vital to be aware of obligations under Emergency Medical Treatment and Labor Act (EMTALA).[29] Providers should involve a psychiatric team member and obtain a consultation when making this determination.

It is essential to document the need for a higher level of care. It is as important to document changes in behavior, ability to care for one's self and suicidal or homicidal ideation as it is to document vital signs or cardiac rhythm changes. This information is critical to supporting the rationale for transferring a patient to psychiatric care, whether voluntarily or involuntarily. Additionally, as behavioral health patients present with increased regularity, organizations may need to consider a clinical psychiatric service even in the absence of an on-site psychiatric unit.

DISCHARGE PLANNING AND KNOWING COMMUNITY RESOURCES

A variety of issues can occur when a patient is discharged from the hospital, and providers must ensure that a safe discharge plan is in place. Staff may encounter a child, elder or disabled person who will be at-risk after discharge; a patient who was a resident in a nursing home that will not take him/her back following discharge; or lack of alternative placement options for a patient. These issues can be taxing on staff. They also can impact revenue when the organization is not reimbursed if a payer determines that hospital-level care was no longer necessary, or insurance benefits have been exhausted.

Community resources may not be available to help patients upon discharge or staff may not be aware of them. When inpatient providers are faced with a challenging discharge plan, it is important to involve individuals from case management, risk management, social services or other providers who may be aware of additional resources. It is also important to be aware of applicable laws, including a safe discharge law, which could preclude discharge when the patient does not have a safe plan of care. Further, there may be applicable laws regarding follow-up after the patient is discharged.

USE OF TECHNOLOGY FOR BEHAVIORAL HEALTH IN THE INPATIENT SETTING

As of 2019, there were 4,627 designated mental health shortage areas across the country, with over 100 million people without adequate access to mental health services.[30] There is potential for decreased or lack of reimbursement for patient care, potential for follow-up, and delayed discharge due to a variety of issues including lack of screening. Telehealth has grown considerably, and the use of telebehavioral health specifically is only expected to continue to grow. Utilizing telebehavioral health on inpatient units can have a number of positive outcomes, including: providing behavioral health/psychiatric services that may not be available otherwise; reducing potential for patient elopement through monitoring and assessment for potential risk; decreasing staff burden; and reducing potential for staff injury. This technology also can be used for family meetings, court proceedings and potential follow-up visits when patients are discharged, reducing costly and challenging patient travel. Expense reductions also can result from decreased use of patient boarding and sitters (safety assistants) and decreased patient length-of-stay.

Hospital systems, clinics and providers have had to adapt quickly to implement tele-behavioral health programs during the COVID-19 pandemic, and the field has seen a surge in the use of these programs. One telebehavioral health company reported that their platform experienced an increase in services of 312% in New York and 700% in Washington State alone.[31] At the time this white paper was written, it is unknown if this is a permanent change to healthcare. Nevertheless, treatment strategies and approaches are expected to grow and evolve as long as insufficient providers and services are available.

If a patient on an inpatient unit requires a behavioral health consult, but a provider is not available at all times, telebehavioral health services may be used for screening and assessing patients in a timely manner and providing services that may not otherwise be available. In addition to direct provider-to- patient care such as psychotherapy sessions or rounding, telehealth also is being used for provider-to-provider consultations and communication with family members. For example, many hospitals have implemented restrictions on family/friends visits and telehealth has been utilized for family meetings and other interactions.

Rules, regulations, and reimbursement policies for using telebehavioral health vary by state, service, location, provider type, and payer. As such, providers should become aware of them, and other guidelines, as well as any temporary waivers to these rules that have been put in place due to the COVID-19 public health emergency. (See Appendix A - Additional Resources).

WORKPLACE VIOLENCE

Violence in health care is not a new phenomenon and is not specific to behavioral health units. There are many reasons for the acceptance of aggression as a normal part of the job. These include staff believing that patients or families are ill, anxious or stressed and; thus, should be given latitude; worksite culture that violence comes with the territory and staff need to understand and accept it; executive or administrative staff not being responsive; and staff not wanting to stigmatize mental health patients who experience a psychotic episode and then return back to baseline and have no recollection of their behavior.[32] Violence is not always perpetrated by patients on staff. Patients also can be victims of violence in a health care facility, and aggressors can include staff and visitors.

From an organizational perspective, development of staff competencies and a patient awareness campaign to prevent aggression and violence is key. Features that contribute to a successful violence prevention program include:

- A philosophy that violence and aggression are not tolerated.
- Conveying to staff that the organization values their wellbeing and safety in the workplace.
- Conveying to hospital patients and consumers that violence will not be tolerated, and that the organization will take action.
- An immediate response to low-level incidents of aggression that considers both patient and staff safety.
- A risk management framework that includes a process for assessing potential risk of violence and developing subsequent strategies.
- Active involvement of senior clinicians and administrators in the incident response system.
- Debriefing and defusing mechanisms to support staff who have been exposed to aggression and violence in the workplace.
- Ongoing evaluation and development of programs to ensure the needs of staff, patients and the hospital continue to be considered.
- An educational program, accessible to all staff, that focuses on controlling the risk of violence and aggression.[33]

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) AND PATIENT PRIVACY IN THE INPATIENT SETTING

At the time this white paper was developed, HIPAA privacy rules had been relaxed in the wake of COVID-19.[34] It is unknown how long this will continue. It is important to understand current, applicable federal and state rules concerning patient privacy. Despite the current relaxed standards under HIPAA, it is always good risk management practice to maintain patient privacy.

Patient privacy can be an issue when patients are on an inpatient medical unit. For example, this can occur if a family member calls to inquire or there is a lack of patient authorization for the staff to communicate with outside providers. It is important that all staff, particularly those charged with answering phones, receive training about HIPAA and state privacy rules and are educated on what can and cannot be communicated and to whom.[35] Specific regulations exist pertaining to behavioral health and substance use treatment. The U.S. Department of Health and Human Services (HHS) offers a number of useful online resources, including decision charts.[36] Health care providers also should implement policies concerning release or communication of protected patient mental health and substance use information.

It is important to note that patient records concerning substance use treatment is regulated by federal law under the Confidentiality of Alcohol and Drug Abuse Patient Records – 42 CFR Part 2. Under this regulation, heightened protections exist concerning exchange of information that concerns substance use disorder treatment.[37] HIPAA does not require patient authorization for sharing patient health information (PHI) for purposes of treatment, payment or health care operations. On July 13, 2020, 42 CFR Part 2 was partially revised.[38] While the rule did not alter the basic framework for confidentiality protection of substance use disorder patient records, it did offer some flexibility for disclosure for patients and under certain declared natural disasters and for research.[39]

PAYER SYSTEM ISSUES AND REIMBURSEMENTS

It is estimated that an average of 8,000 patients with a behavioral health diagnosis are being treated on general non-psychiatric units daily.[40] Costs for their care is considerable. In 2012 for example, the average cost to deliver care was highest for Medicare and lowest for the uninsured: schizophrenia treatment, $8,509 for 11.1 days and $5,707 for 7.4 days, respectively; bipolar disorder treatment, $7,593 for 9.4 days and $4,356 for 5.5 days; depression treatment, $6,990 for 8.4 days and $3,616 for 4.4 days; drug use disorder treatment, $4,591 for 5.2 days and $3,422 for 3.7 days; and alcohol use disorder treatment, $5,908 for 6.2 days and $4,147 for 3.8 days.[41]

Per the American Hospital Association Trendwatch, the 2013 expenditures for treatment of mental health disorders reached $201 billion, surpassing spending for heart conditions by $54 billion and cancer by $79 billion.[42] However, behavioral health providers are being reimbursed less than primary care providers by 20% and underfunding of mental health agencies continues to be a barrier.[43] As the need for care increases and the availability of beds diminishes, more transparency in pricing, improved policies addressing disparities in the availability of care, and improved financial incentives to halt the further disappearance of inpatient psychiatric treatment services will be needed.[44]

RELEASE OF INFORMATION AND CONSENTS

At times information needs to be shared or exchanged to best treat a patient. At the same time providers should be aware of the patient's right to privacy, particularly as it relates to mental health and substance use treatment. (For more information see the *Health Insurance Portability and Accountability Act (HIPAA) and Patient Privacy in the Inpatient Setting* section of this publication.) Providers also should be aware that patients who present to an inpatient unit with behavioral health and/or substance use disorders may be at risk of harming themselves or others and may not be able to make informed or rational decisions concerning their care or treatment.

Hospitals should use a release of information and consent form that contains a specific section pertaining to behavioral health and substance use Protected Health Information (PHI). This form should comply with state and federal regulations. Patients can revoke consent at any time. If the patient requests that a provider cannot communicate with someone, this request should be adhered to. There may be times when legal consultation should be sought, particularly if a substitute decision maker is needed or has already been appointed.

Providers should understand that:

- Informed consent should be documented fully and completely.
- For minors and those with diminished capacity, obtain consent from the person who has the legal authority to provide it. This should be done prior to initiating treatment. A guardian or substitute decision maker may have been determined through court documents and orders, a divorce agreement, custody agreement, or documentation concerning guardianship.
- When a challenging situation exists (for example, family members who do not agree on treatment), it is always best to get advice from an attorney or risk management professional before beginning treatment.
- If the patient is undergoing a more invasive treatment, such as Electroconvulsive Therapy (ECT) or treatment with antipsychotic medications, ensure a consent form is used that specifically addresses the risks of the treatment.
- Unless there is an emergency, it is always best to have the necessary documentation before beginning treatment.

RESTRAINT AND SECLUSION

When treating patients with behavioral health disorders, the least restrictive treatment method is always preferred. However, patients sometimes are unable to control their behavior, and seclusion or restraint become necessary to assist with de-escalation and to ensure the safety of the patient, staff and possibly other patients.[45] Some risks are associated with these restrictive interventions, such as further escalation in behavior or exacerbation of a physical condition that may require intervention.[46] Use of restraints may occur more often on a medical unit when a patient is confused or agitated. This can happen with elderly patients who could be exhibiting agitation, psychosis, or delirium due to a medical issue. Elderly patients also may be agitated or confused, when daylight begins to fade, a condition referred to as "sundowning."[47] Elders who experience sundowning may yell or become agitated, which can affect staff and other patients. Strategies to address these situations may need to be implemented. Although restraints may be necessary, their use also can result in confusion, falls, decubitus ulcers and increased length of stay.[48]

Issues to consider regarding restraint and seclusion include:

- The least restrictive treatment method is always preferred.
- Utilize when necessary.
- Attempt to de-escalate the patient.
- Ensure the safety of the patient, staff and other patients.
- Ensure policies comply with regulations.
- Be aware of applicable rules and guidelines.
- Ensure oversight is an integral part of an organization's performance improvement.
- Collect/record data for potential inspection.
- Provide routine staff competencies
- Be aware of risks.

When implementing these strategies, SAMHSA has a resource available online which may be of assistance.

SUICIDE AND HOMICIDE RISK ASSESSMENT

Providers likely will encounter patients who are suicidal or homicidal. These patients may require inpatient medical treatment/clearance prior to being transferred to an inpatient psychiatric unit/facility, being discharged to an outpatient program, or discharged home. These patients also create unique, high-risk situations.

Suicides are often not long-planned acts, and providers should keep this in mind when caring for patients on an inpatient unit. In the second white paper in this series, the authors cited a 2001 study of people aged 13 to 34 who survived a near-lethal suicide attempt. Participants were asked how much time had passed between when they decided to take their lives and when they actually made the attempt. The study found 24% said less than five minutes; 48% said less than 20 minutes; 70% said less than one hour; and 86% said less than eight hours.[50] This study reveals how difficult it can be for a provider to determine if a patient is likely to commit suicide. Another study focused on people who were seen in a hospital following a suicide attempt. They were asked how long before their attempt did they first started thinking about attempting, and 48% said within 10 minutes of making the attempt. These studies show the importance of documentation if a lawsuit results following a patient suicide.[51]

It is vital to ask all patients questions about risk of harm to self or others. Asking questions such as, "Have you ever had thoughts about hurting yourself?" and "Have you ever had thoughts about hurting others?" can provide useful information and should be asked with each patient who presents to a medical unit. These questions may have been asked if the patient was seen in the ED prior to being transferred to an inpatient unit; however, it is important to re-evaluate upon admission to an inpatient unit. It is important to pay attention to indicators that may increase risk of harm to self or others:[52]

- Look for signs of acute suicide and homicide risk in all patients.
- Assess each patient for suicide and homicide risk by incorporating evidenced-based standard questions with each new patient encounter. National Institute of Mental Health (NIMH) has a resource available which may be of assistance.[53]
- Ask about firearms access and be aware that some states have regulations concerning whether providers can ask about firearm access. Consult with legal counsel should questions arise.
- Look for warning signs of suicide and homicide.

If a patient is suspected to be at risk of suicide, additional probing questions should be asked, including:

- Have you ever thought of dying or that life is not worth living?
- Have you ever thought about ending your life?
- Do you have a plan?
- What steps have you taken?

If a patient is assessed to be at risk of harm to self or others, steps should be taken to minimize risk of harm, including:

- Determine if a sitter or 1:1 person is needed.
- Implement checks at five- to 15-minute intervals.
- Implement seclusion and/or restraint.
- Minimize environmental risks.[54]

If a patient is admitted to an inpatient unit following a suicide attempt or has committed a violent act/incident toward others, it is important to keep the patient and staff safe. Implement a 1:1 person, when indicated, be aware of the potential for elopement or repeated attempts and take proper precautions to reduce risk. If a patient attempts or commits suicide while on an inpatient medical unit, it is important that staff are aware of relevant policies, procedures and reporting requirements. Staff should debrief the event. It also may be important to involve social services or Employee Assistance Program (EAP) staff.

SAFETY CONTRACTS

Providers have used safety contracts when a patient is perceived to be a risk to himself/herself or others. These contracts can provide a false sense of security, are often overvalued and their effectiveness have been questioned and are often overvalued.[55] In addition, it is not recommended that provider on a medical floor without background and training in behavioral health initiate a safety contract with a patient. A consult should be pursued with a behavioral health provider.

The following issues should be considered when using a safety contract with a patient.

- Safety contracts are not legal documents. They cannot be used as exculpatory evidence. Simply because a patient "contracts for safety" does not mean that there is no liability risk. Courts often look at foreseeability if an adverse issue occurs - whether the harm was foreseeable and if the provider could have done something to prevent the harm.
- Safety contracts should not take the place of an adequate and complete risk assessment.
- It is more important to routinely assess the patient. Ask questions such as: "Do you feel safe?" or "Are you having thoughts of self-harm?"

OTHER UNIQUE MEDICATIONS/SUBSTANCES

According to the Substance Abuse and Mental Health Services Administration (SAMSHA), one of the most significant changes in detoxification services in recent years has been the increase in the need for detoxification from more than one substance.[56] Clinicians need to be aware that patients may admit to abusing one substance but not another, and they may not even be aware of the number of substances that they are withdrawing from.[57] Toxicology screening may be important to determine how to best treat the patient.

Mental health and substance abuse issues present together 15-43% of the time, and co-morbid medical conditions often accompany these issues and may be interpreted as somatic complaints.[58] As a result, individuals with mental health and substance abuse problems and co-morbid illnesses have a heightened need for coordinated care.[59]

At times, these patients could be managed on an outpatient basis. However, careful assessment of psychosocial and biomedical aspects of the patient's condition, including lack of transportation, the risk of violence, and inability to carry out routine medical instructions may indicate that the patient may require treatment in a 24-hour supervised setting such as a residential detoxification or inpatient treatment program.[60]

CO-OCURRING DISORDERS AND DETOXIFICATION PROTOCOLS

Patients who use substances can present with a variety of conditions found in the general population and usually management of co-occurring medical conditions does not differ. The medications used for detoxification, however, can cause problems with the co-occurring medical condition. Certain modifications may need to be made: detoxification medications may need to be titrated so that the patient's medical condition does not worsen, the patient may require higher level monitoring due to the medical risks involved and subspecialists may need to participate in the detoxification protocol so that co-occurring illness can be simultaneously managed.[61]

SAFETY AND SECURITY

Safety and security of all patients and staff is paramount. Patients should not have access to items that can potentially lead to self-harm or harm to others. Prior to being transferred from the emergency department to an inpatient floor, the patient and any visitors should have been checked for contraband. This includes: weapons, medications, sharp articles, ropes, toxic fluids and strings. It is critical to document the search and be aware of any laws concerning searches. Obtaining an order for routine searches of patients and the environment may be necessary, particularly if visitors are present. Providing a locked storage area for visitors' belongings also can help ensure patient and staff safety.

Security department staff should be involved where indicated. Law enforcement may be necessary to secure weapons, such as guns; however, it important to be aware of any applicable state laws. When indicated and to ensure safety, assign a safety companion or a 1:1 staff member to sit in or outside of the patient's room.

Hospital code systems should include a code for identifying violent patients, staff, or visitors. While proper staff training and patient interventions can help avoid the need to announce a code, health care organizations should have policies and procedures in place that staff understand how to implement when necessary.[62]

UTILIZING METRICS FOR ROOT CAUSE ANALYSES (RCAs)

The development of quality measures for behavioral health is not as advanced in comparison to those in general medical care, and there are even fewer measures at the interface of behavioral and physical health care.[63] The reasons for this disparity include lack of a sufficient evidence base from which to develop valid and strictly defined measures, inadequate infrastructure to capture all elements of a behavioral health system, and lack of a cohesive strategy to apply behavioral health quality measurement across different settings.[64] Measures, therefore, tend to concentrate on single conditions or focus on limited care processes and use imperfect data sources.[65]

The RCA is a structured approach to an investigation that attempts to identify the true cause of a problem and what actions to take to prevent the problem from repeating. The benefits of RCA as a method to reduce the incidence of untoward events with behavioral health patients are still in the process of standardization, but the RCA process has been shown to be more consistent, efficient and less threatening to staff especially when dealing with a very difficult occurrence such as on unit suicide.[66] It is also important for organizations to understand that for value-based payment models to appropriately reimburse high-quality care, consensus must exist about which measures will be used when evaluating behavioral health and problems that can arise on inpatient units.[67]

TREATMENT OF SPECIFIC PATIENT POPULATIONS

Providers and risk managers should be aware of issues related to the care and treatment of specific patient populations with behavioral health conditions while they are on an inpatient medical unit. Some of the issues related to caring for pediatric patients and minors, adults and geriatric patients, victims of domestic violence and other populations that also have behavioral health disorders are discussed below.

Pediatrics and Minors

- **Child Welfare and Reporting Obligations**
  Providers who work with pediatric patients with behavioral health issues, particularly on an inpatient pediatric unit, should be aware of and understand their duty to report as well as regulations related to their obligations as mandated reporters. It is critical that providers are aware of when they are required to report suspected child abuse or neglect to relevant state and local agencies. Social service, pediatric, psychiatric, risk management and legal staff should be involved when indicated. In addition, providers should have routine training on how to recognize signs of abuse and neglect.
- **Management and Safety**
  Managing and ensuring the safety of a child in psychiatric crisis on an inpatient medical floor can be challenging, particularly if the child remains on an inpatient unit for an extended period of time. Health care organizations should institute policies concerning care and treatment of pediatric

behavioral patients, ensure that staff are trained, and follow these policies. It is important to involve the relevant departments as indicated above. It is important to implement a sitter, when needed, early in the process. Providers should be aware of applicable rules and regulations concerning seclusion or restraint before these methods become necessary and are initiated.

Staff should be aware of how to obtain a pediatric/adolescent evaluation if needed. In addition, depending on the state and the minor's insurance, an outside agency may need to come into the facility to evaluate. It is important to be aware of any applicable state regulations before an evaluation of a minor patient is needed.

- **Lack of Placement Options**
  Lack of placement options may be a concern when treating minors with behavioral health issues on an inpatient unit. If the minor is awaiting a transfer to an inpatient psychiatric hospital/unit, the wait time for a bed to become available may be considerable; therefore, the patient may be boarded on a medical floor for an extended period of time. Often the patient may remain in the ED versus being transferred to an inpatient unit. However, there may be circumstances, such as medical complications or clearance that require inpatient medical treatment. Providers also may encounter a child in psychiatric crisis who comes from a group home, foster care or a home to which the patient cannot return.

  Relevant health care organization departments and outside agencies should be involved early in the process. Providers must understand with whom they can and cannot communicate. If a child is in the custody of a state agency and a non-custodial parent is seeking protected health information (PHI), providers must know whether or not they can communicate with the parent before doing so. A number of state agencies also may be involved in the child's overall care and treatment; therefore, it is important to involve the organization's social service department to help coordinate patient care and services. In addition, if your facility is under the Affordable Care Act purview, be aware of obligations to conduct a community health needs assessment (CHNA).[68] It is advised that the risk manager collaborate with departments such as case management to ensure that this up to date.

Adults

- **Comorbid conditions**
  Over the past few decades, the prevalence of co-morbid medical and behavioral conditions has been increasing.[69] This has been noted in adults across age groups. It can be easy for clinicians to overlook co-morbid conditions, particularly mental illness.[70] The converse can be true for psychiatrists: missing co- morbid illness over a mental health issue.

- **Management, Safety, and Treatment Options**
  Frequently, in rural areas no specialized psychiatric beds may be available. In urban areas the limited number of available psychiatric beds may all be filled when a person needs admission for intensive psychiatric services. Most general hospitals provide acute inpatient services to patients with mental health disorders. When these services are provided in general hospitals without special psychiatric units they are often labeled psychiatric "scatter beds."[71] Appropriate assessment of the patient, both physical and psychiatric, is critical regardless of location within the hospital.

  Clinicians need to accept that comorbidity of various diseases and in particular, the simultaneous occurrence of mental and physical disorders, is the rule rather than an exception and that an integrated approach is essential.[72]

- **Geriatric**
  Over the past 10 years, the number of adults over age 65 increased by 33 percent.[73] This population is projected to almost double in 2060.[74] The 2017 U.S. Census Bureau's National Population Projections show that by 2030, all baby boomers (people born in 1946-1965) will be older than age 65.[75] Approximately 20 percent of adults that are age 65 and older will experience mental health issues, and up to 4.8 percent will have an SMI.[76]

- **Decisional Capacity: Substitute Decision Makers, Guardianship and Conservatorship**
  A person may present to a medical floor confused, disoriented, combative and agitated and may be unable to make informed decisions. These issues can result from an emergent behavioral health issue, such as substance use/detoxification, or be symptoms of a medical issue, such as infection. In such cases a person who lacks capacity to make informed decisions may need care and treatment. A patient also may be admitted to a medical floor and then decompensate and be unable to make informed decisions. Safety for the patient, staff and other patients is paramount. It is important to determine when a true emergency exists, so that medication may be administered absent informed consent, and when it is necessary to obtain a substitute decision-maker such as a guardian or conservator.

  Sometimes a patient has a temporary medical issue that affects the ability to make informed decisions, but later resolves with treatment. This may occur for a patient who is admitted heavily under the influence of drugs or alcohol. In the interim, it will be important to consult with legal counsel, be aware of the rules concerning behavioral health treatment, and understand what constitutes an emergency and whether the patient can be treated without the temporary capacity to consent.

  Each state has its own rules concerning guardianship and conservatorship. Many states model their rules on the Uniform Probate Code (UPC). The UPC defines an incapacitated person as "an individual who, for reasons other than being a minor, is unable to receive and evaluate information or make or communicate decisions to such an extent that the individual lacks the ability to meet essential requirements for physical health, safety, or self-care, even with appropriate technological assistance."[77]

  Patients also may have an advance directive appointing a health care proxy or agent for medical issues, if the patient has a SMI or a psychiatric advance directive. Providers should be aware of their states' rules concerning advance directives and understand that this is an evolving area.

- **Management and Safety of Elders**
  Elders are vulnerable to rapid decline and safety issues when behavioral health and co-occurring illness are not managed comprehensively. To improve acute care hospitalization interventions and outcomes of critically ill older adult patients with comorbid psychiatric disorders, it is important to obtain the patient's current psychiatric status.[78] Other information of importance includes: psychiatric diagnosis and current psychiatric provider contact information; past psychiatric hospitalizations; suicidal/homicidal history; prior psychotropic drug trials; and occupational, functional, social and mental status history. Family members or friends may be of assistance if they know about the patient's recent life events, can describe the patient's baseline and symptoms of psychiatric decompensations, and if they know who the patient's spokesperson or surrogate will be, if necessary, while hospitalized.[79]

- **Lack of Placement Options**
  When a nursing home resident is transferred to a general acute care hospital, federal and state rules require that the bed be held at the nursing home for up to seven days. If the hospitalization exceeds seven days, the facility must provide the resident with the first available bed in the

nursing home after he or she is cleared for return.[80] Residents who require hospitalization for acute and/or behavioral health care should not have to worry about losing their placement in their nursing homes, unless the facility is not equipped to handle a particular diagnosis.

SPECIAL CONSIDERATIONS CONCERNING DOMESTIC VIOLENCE

Behavioral health issues may also arise if a person is experiencing domestic violence/intimate partner violence. Intimate partner violence has been found to place women at risk for increased mental health and substance use disorders.[81] It is important to understand applicable state laws for reporting domestic violence incidents, including penalties for failing to report.[82,83] As a part of ongoing assessment and treatment providers should inquire about whether the patient feels safe, discuss abuse and ensure thorough documentation in the patient's medical record. Reporting obligations also may exist if children, elders or disabled persons live within a home where domestic violence occurs. Providers should review state obligations and ensure they are up-to-date with changes in regulations.

ADDITIONAL CONSIDERATIONS

A number of additional populations may require heightened attention and care; however, detailed analysis of their needs exceeds the scope of this publication. Clinicians should be aware of particular populations including:

- **Pregnant Women**. Pregnancy can be a high-risk time for a woman with a history of psychiatric illness. Up to 20% of women suffer from a mood or anxiety disorder during pregnancy.[85] A pregnant woman may be hospitalized for a variety of reasons. She also may have co-occurring behavioral health issues, either currently or in her history. A pregnant woman with a history of mental illness may be concerned about the effects of medications on her unborn child, decide to discontinue treatment and may then decompensate or have a relapse.

  A study prospectively followed a group of women with histories of major depression across pregnancy. Of the 82 women who maintained antidepressant treatment throughout pregnancy, 21 (26%) relapsed compared with 44 (68%) of the 65 women who discontinued medication. This study found that women who discontinued medication were five times as likely to relapse as compared to women who maintained treatment.[85] The decision to restart psychiatric medication has many risk and benefit implications. It is important to seek obstetrical and psychiatric consultation for these complex patients. Additionally, it is important to be aware of mandated reporter responsibilities and testing for substances, such as opioids, that may impact the unborn fetus.[86]

- **Post-partum Women**. Providers may encounter post-partum women who could be inpatients on a maternity unit, visiting their newborns in the NICU, or hospitalized on an inpatient unit with medical complications. Particular attention should be paid to symptoms of post-partum depression, post-partum psychosis, heightened stress and anxiety. Providers should employ a set of questions to assess mental status and coping. Providers also are encouraged to seek consultation and be aware of potential mandated reporting considerations should there be safety concerns for the infant.

- **Individuals/Youth at Risk for Violence**. Individuals or youth who are at risk for violence could be hospitalized before an incident occurs. Signs and symptoms may exist that should not be overlooked. Providers should evaluate and document patterns of behavior and engage in frank communication about issues, including access to firearms and thoughts of suicide or depression, to determine potential indicators of violence. Providers should not take lightly social media posts, passive threats or patients having increased difficulty with others or at school. It is important to refer the patient to a specialist when necessary.

- **Human Trafficking**. It is important to be aware of signs of human trafficking, know what steps to take and seek consultation when necessary.[87] Individuals who are victims of human trafficking may be at increased risk for behavioral health issues such as post-traumatic stress disorder (PTSD), depression, and anxiety.[88] The Joint Commission provides helpful advice for health care workers on how to recognize victims of human trafficking and when to contact law enforcement.[89]
- **Lesbian, Gay, Bisexual, Transgender, Questioning (LGBTQ)**. There are unique considerations when treating LGBTQ patients in the inpatient hospital setting. These individuals may have experienced issues with social discrimination, been victims of harassment or abuse, and experienced health care discrimination. A study found that 70% of transgender patients surveyed have experienced discrimination in health care; 25% of transgender respondents reported that they were denied health care because of their transgender or non-conforming gender status; and 10% of LGT respondents reported that health care professionals used harsh language toward them.[90] It is essential that providers treat all patients equally regardless of their sex or gender identity, or sexual orientation.

  LGBTQ patients should be fully assessed for suicidality and potential stressors.[91] LGBTQ youth contemplate suicide at approximately three times the rate of heterosexual youth; and 40% of transgender adults reported having made a suicide attempt, with 92% reporting the attempt before the age of 25.[92] LGBTQ youth were approximately five times as likely to require medical treatment as heterosexual youth, and suicide attempts of LGBTQ youth are 4-6 times more likely to result in injury, poisoning or overdose that would require treatment from a medical provider as compared to their heterosexual peers.[93]
- **Veterans**. Inpatient providers may encounter military veterans. Only 16.9% of veterans surveyed used the Veteran's Administration as their primary source of health care.[94] Physical and psychological symptoms can continue for years after service. It is important to ask and evaluate additional needs including: treatment for depression, suicidality, anxiety, PTSD, traumatic brain injury and substance use. Further, there may be financial considerations that impact stressors of the veteran patient and or family/caregivers.
- **Forensic Patients**. At times forensic psychiatric patients are admitted to the hospital for higher-level assessment or care. They may come from a county or city jail that does not have behavioral health services or from a prison, due to exacerbation of comorbid medical illness. These patients are afforded the same standard of care as any patient. They do, however, require a level of security that includes guards that accompany them to and remain with them on the inpatient unit, arriving and remaining in shackles, and no opportunity for privacy.

  It is important to have clear policy, procedure and staff training about the safe care of forensic patients. Security personnel need to be present for patient and staff safety, and providers should understand that the guards accompanying the forensic patient are responsible for the patient. Constant communication between clinical staff, security and guards combined with frequent risk assessments will curtail the possibility of violence, escape or both.[95]
- **Patients with Disabilities**. Patients with disabilities may also have behavioral health conditions. Variations between states exist about when to report suspected abuse against elders and disabled persons. This may not only include physical abuse, but also instances of financial exploitation or situations where an elder is at risk. It is important for providers to be aware of applicable rules within their state.

  The American with Disabilities Act (ADA), a federal civil rights law, provides protection to those with disabilities in employment, transportation, state and local services, public

accommodations, telecommunication and health care accessibility. It is likely that all providers will treat a patient with a disability. It is important that providers are aware of applicable laws to ensure effective and competent care.

Title III of the ADA applies to places of "public accommodation," which includes health care settings.[96] Providers should be aware of obligations regarding provision of care and communication with patients including: when auxiliary aids, such as translators, are needed to ensure effective communication;[97] when reasonable accommodations should be given for service animals;[98] and accessibility requirements for those in wheelchairs or other devices, particularly when seclusion, restraint or both are required.[99]

- **Patients with Service or Comfort Animals**. Service animals on an inpatient medical floor can present unique challenges. A service animal is defined by the ADA as a dog individually trained to perform work or tasks directly related to the patient's disability, including a physical, sensory, psychiatric and intellectual or other mental disability. If trained to perform tasks directly related to the patient's disability, miniature horses are also considered service animals by the ADA. A hospital should have a policy in place to determine how to provide reasonable accommodations.[100] If the patient is in a room on an inpatient unit that requires special air quality for patients who are being treated or at risk for infection, in the ICU, is isolated or on precautions, the hospital may refuse to allow the animal. In addition, if the patient's behavioral health issue may result in danger if the animal visits, the hospital may refuse to allow the animal access.[101]

  The health system should have a policy on how to handle situations where the animal goes to the bathroom in the hospital. Ensure the policy addresses which department to notify, such as environmental services, and have a process in place to inform the patient. If your system has staff resources responsible for service animals, it is important to involve these staff as soon as possible when a patient who has a service animal is admitted.

  Some controversy exists concerning requirements for comfort or emotional support animals (ESAs). The ADA does not protect ESAs or companion animals used primarily for comfort, therapy and support, unless they are used in planes and in some residences that do not normally allow pets. Providers should review applicable state and federal rules and regulations to determine what may be required at their facilities.

- **Children at Home and Primary Caregivers**. Just as in the ED, providers may encounter patients who are hospitalized for psychiatric issues on an inpatient unit, but care for others in their homes. In these circumstances, it may be necessary to involve relevant local authorities and state agencies for reporting or protection of those individuals. Providers and staff from social service, risk management, legal, case management and discharge planning departments should be involved to ensure that those impacted are safe and not at risk of harm.

  Patients with behavioral health issues who are hospitalized also may care for pets in their home. This can be a significant stressor for the patient and can impact whether he/she leaves AMA. Pets also may be at risk if the patient is hospitalized. It is important to ensure accommodations are made for their pets as well.

- **Homeless Persons**. Providers may be faced with a patient who either presents to the inpatient unit and is known to be homeless or during the course of his/her hospitalization, it becomes apparent that the patient does not have a place to be discharged to. This can present significant challenges, particularly if the patient requires continued medical treatment, for example dressing changes or requires additional care after discharge. Patients with mental health and/or substance use issues present further complications. Discharge planning, access to outpatient resources and follow-up may be challenging when providers encounter homeless

patients. Social service or discharge planning departments should be involved in overall case management and discharge planning. Providers should be aware of applicable state laws. California, for example, requires hospitals to attempt to secure a sheltered location, provide transport to the discharge location, offer the patient weather-appropriate clothes, offer the patient a meal and provide referrals to other health resources.[102]

- **Persons with Eating Disorders**. Hospitalizing a patient with an eating disorder is not that common. When necessary, it can be lifesaving.[103] Inpatient treatment can be very challenging for the patient and clinicians. A cohesive approach encompassing management of the patient's medical and psychological needs, and ambivalence toward medical intervention is needed.[104] Approaches to treatment include establishing short- and long-term goals and collaboration with a range of health professionals from multidisciplinary teams. A study found that physicians agree that they could not treat a patient with an eating disorder alone. They refer these patients to specialists, including psychiatrists and dieticians, to assist with treatment.[105]
- **Patients with Substance Use Disorders Who Are Treated/Monitored**. Hospitals traditionally have provided detoxification treatment of alcoholism. The Centers for Medicare & Medicaid Services (CMS) has specific criteria for withdrawal care: when the high probability or occurrence of medical complications (e.g., delirium, confusion, trauma or unconsciousness) during detoxification for acute alcoholism or alcohol withdrawal necessitates the constant availability of physicians and/or complex medical equipment found only in the hospital setting, then hospital care is considered necessary and reasonable during this period.[106] Similarly, inpatient treatment for substance use also is a covered inpatient service, if reasonable and necessary.[107]

MEDIA

Facilities may encounter high-profile patients or situations where news media may seek to obtain information. For example, a well-known patient may require inpatient medical treatment and have a behavioral health diagnosis. Staff must be aware not to disclose confidential PHI to the media and, if this occurs, action should be taken to address the issue, including staff discipline. Providers should have a process in place and designated spokespeople to handle media contacts. Staff should be informed that at no time should they acknowledge to the media that a patient is or was in their care. Even though HIPAA regulations have been relaxed and states may have emergency orders that relax privacy, in the wake of COVID-19, it is important that staff are educated not to disclose confidential information. Staff must remain vigilant, particularly given that some facilities may not now allow non-patients access to medical units.

DUTY TO WARN/PROTECT

ASHRM/AHA's Behavioral Health Care in the Ambulatory Care Outpatient Setting mentions that most providers will, at some point, treat a patient who is at risk of harm to self or others. It is therefore important for all providers to understand whether they have a Duty to Warn and Protect. For more information refer to ASHRM/AHA's Behavioral Health Care in the Ambulatory Care and Outpatient Setting and The National Conference of State Legislatures.

SUSTAINING A HIGH LEVEL OF CARE ACROSS AN ENTERPRISE

Whether the patient with behavioral health issues is being treated in the outpatient/ambulatory care center, the Emergency Department, or on an inpatient medical unit, it is important to identify areas of need across the system. It is important that:

- Health system policies and procedures reflect the care provided.

- A multidisciplinary committee exists, especially now when needs related to behavioral health disorders and substance use is expected to be on the rise.
- All patients with behavioral health issues are treated with dignity and respect.
- Systems and strategies are implemented to provide better management and care for patients with behavioral health issues.
- The standard of care should be the same when providing psychiatric care, whether on an inpatient medical unit or an inpatient psychiatric unit. Processes should be in place to correct deficiencies and continue to improve going forward.

CONCLUSION

Patients with behavioral health issues who are hospitalized on inpatient medical units may present unique challenges for medical providers. Providers should ensure that policies and procedures are well-developed and followed and be aware of risks that may place the patient, other patients and staff at risk, including patient elopement/escape and risk of suicide/homicide. It is important that providers are competent to manage patients effectively, comply with the standard of care, take steps to reduce overall risk and, when necessary, obtain consultation from relevant professionals. Involving the appropriate professionals and ancillary staff in the patient's overall care and treatment can decrease risk of an adverse outcome. Providers also should be aware of relevant regulations such as mandated reporting, seclusion or restraint, and Duty to Warn/Protect. As behavioral health care is a specialized area of practice, providers are encouraged to obtain consultation from a risk management or legal professional when questions arise.

FINAL THOUGHTS

This publication completes the three-part series addressing treatment of patients with behavioral health issues in outpatient/ambulatory care, the emergency department and on inpatient medical units. Each area has unique challenges and risks. Providers are encouraged to review all three publications for information, resources and checklists. It is important that staff are trained and prepared to encounter risks. Staff should adhere to the standard of care and recognize that all patients, regardless of circumstance, should be treated with dignity and respect. Finally, it is important for providers to obtain consultation from specialized providers or, when indicated, from legal counsel. Appendix A includes a checklist of resources for inpatient treatment.

APPENDIX A

CHECKLIST OF RESOURCES FOR INPATIENT TREATMENT

Questions	Resources	Y	N
Do you have Guidelines on Psychiatric Evaluation of Adults?	https://psychiatryonline.org/doi/pdf/10.1176/appi.books.9780890426760		
Do you have Guidelines on Psychiatric Evaluation of Children and Adolescents?	Evaluation and Management of Children and Adolescents With Acute Mental Health or Behavioral Problems. Part I: Common Clinical Challenges of Patients With Mental Health and/or Behavioral Emergencies: Thomas H. Chun, Sharon E. Mace, Emily R. Katz, American Academy of Pediatrics, Committee on Pediatric Emergency Medicine, and American College of Emergency Physicians, Pediatric Emergency Medicine Committee, Pediatrics, Sep 2016, 138 (3) e20161570; DOI: 10.1542/peds.2016-1570 https://pediatrics.aappublications.org/content/138/3/e20161570		
Facility Resource Guide for Behavioral Health	T, J., Sine, D., McMurray, K., Behavioral Health Design Guide. Behavioral Health Facility Consulting, LLC., Ed. 8.1. June 8, 2019. http://www.bhfcllc.com/wp-content/uploads/2019/06/Design-Guide-8.1-web.pdf		
Do you have management for psychiatric patients with COVID-19?	Augenstein, T., Pigeon, W., DiGiovanni, S., et.al. (2020). Creating a Novel Inpatient Psychiatric Unit with Integrated Medical Support for Patients with Covid-19. New England Journal of Medicine Catalyst. https://catalyst.nejm.org/doi/full/10.1056/CAT.20.0249		
Geriatric Psychiatric Care.	https://acl.gov/programs/health-wellness/behavioral-health https://innovations.ahrq.gov/qualitytools/get-connected-toolkit-linking-older-adults-medication-alcohol-and-mental-health https://www.samhsa.gov/homelessness-programs-resources/hpr-resources/substance-use-treatment-older-adults https://store.samhsa.gov/sites/default/files/d7/priv/pep19-olderadults-smi.pdf		
Ligature and Restraint Guidelines.	https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-18-06.pdf https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/QSO-19-12-Hospitals.pdf https://www.aha.org/system/files/2019-01/2018-dec-hfm-ligature-risk.pdf		

Questions	Resources	Y	N
Are you familiar with Psychiatric Advanced Directives?	The Joint Commission Quick Safety 53: Improving Care With Psychiatric Advanced Directives https://www.jointcommission.org/resources/news-and-multimedia/newsletters/newsletters/quick-safety/quick-safety-issue-53/		
Are you utilizing the American Hospital Association resources on behavioral health?	https://www.aha.org/advocacy/access-and-health-coverage/access-behavioral-health		
Are you implementing the Substance Abuse & Mental Health Services Administration (SAMSHA) Treatment Improvement Protocol?	https://store.samhsa.gov/sites/default/files/d7/priv/sma15-4131.pdf		
Co-occurring disorders and other conditions.	https://www.samhsa.gov/medication-assisted-treatment/medications-counseling-related-conditions/co-occurring-disorders		
Do you have Centers for Medicaid & Medicare (CMS) Behavioral Health Documentation Guidelines?	https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/docmatters-behavioralhealth-factsheet.pdf https://www.qualityreportingcenter.com/globalassets/ipf-tools-and-resources/ipfqr-program-manual_v4.1_20181219_final508c.pdf		
Clinical risks associated with psychiatric inpatient care.	Slemon, A., Jenkins, E., & Bungay, V. (2017). Safety in psychiatric inpatient care: The impact of risk management culture on mental health nursing practice. Nursing inquiry, 24(4), e12199. https://doi.org/10.1111/nin.12199		
HIPAA Regulations for Psychiatric Care	https://www.hhs.gov/hipaa/for-professionals/special-topics/mental-health/index.html		
Firearm licensure state by state (including states that require Firearm ID (FOID)/ mental health reporting)	https://lawcenter.giffords.org/gun-laws/state-law/50-state-summaries/licensing-state-by-state/ https://www.team-iha.org/files/non-gated/education/foid-card-act-11-1-18.aspx		
Recognizing Human Trafficking	https://www.aha.org/combating-human-trafficking Quick Safety. Identifying Human Trafficking Victims, The Joint Commission, Division of Healthcare Improvement, Issue 42, June 2018. Retrieved from, https://www.jointcommission.org/-/media/tjc/newsletters/qs_41_human_trafficking_6_12_18_final1pdf.pdf?db=web&hash=3DCCB6D913AEE7163280AD4DE164E999.		
American Board of Psychiatry and Neurology Core Competencies.	https://www.abpn.com/wp-content/uploads/2015/02/2011_core_P_MREE.pdf		
Non-violent crisis intervention.	https://www.crisisprevention.com		

Questions	Resources	Y	N
Working with LGBTQ during psychiatric hospitalization.	https://www.psychiatry.org/psychiatrists/cultural-competency/education/best-practice-highlights/working-with-lgbtq https://www.samhsa.gov/behavioral-health-equity/lgbtq https://www.apa.org/pi/lgbt/resources/promoting-good-practices		
Addiction Resources.	Alcoholics Anonymous: https://www.aa.org/ Narcotics Anonymous: https://www.na.org/ Al-Anon: https://al-anon.org/		
Mental and Behavioral Health and Opioid Overdose release of information.	https://www.hhs.gov/hipaa/for-professionals/special-topics/mental-health/index.html		
Alcohol and other substance use disorders in pregnancy.	Clinical Guidance for Treating Pregnant and Parenting Women with Opioid Use Disorder and Their Infants https://store.samhsa.gov/sites/default/files/d7/priv/sma18-5054.pdf The American College of Obstetricians and Gynecologists, Opioid Use and Opioid Use Disorder in Pregnancy (2017) https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2017/08/opioid-use-and-opioid-use-disorder-in-pregnancy		
Geriatric psychiatric assessment.	https://ps.psychiatryonline.org/doi/pdf/10.1176/appi.ps.55.6.639		
State by state mandatory child abuse reporting laws.	https://www.childwelfare.gov/pubPDFs/manda.pdf Childhelp National Child Abuse Hotline – 1800-4ACHILD https://www.childhelp.org/hotline/		
Reporting suspected elder abuse.	https://ncea.acl.gov/Suspect-Abuse/Reporting-Abuse.aspx 1-877-ELDER 80 https://elderprotectioncenter.com/state-elder-abuse-hotlines/		
Domestic Violence.	National Domestic Violence Hotline- 1800-799-7233 https://www.thehotline.org/help/		
Do you know the Civil Commitment procedures in your state?	https://www.treatmentadvocacycenter.org/component/content/article/183-in-a-crisis/1596-know-the-laws-in-your-state https://www.samhsa.gov/sites/default/files/civil-commitment-continuum-of-care.pdf		

Questions	Resources	Y	N
State-by-state Duty to Warn/ Protect Rules.	The National Conference of State Legislatures http://www.ncsl.org/research/health/mental-health-professionals-duty-to-warn.aspx		
Suicide Prevention Resources.	https://www.jointcommission.org/standards/national-patient-safety-goals/-/media/83ac7352b9ee42c9bda8d70ac2c00ed4.ashx National Suicide Prevention Lifeline: 1-800-273-8255 211 — National Suicide Hotline		
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This whitepaper was made possible by the American Society for Health Care Risk Management.

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