Navigating the complex terrain of the behavioral health patient

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Limiting violence by behavioral health patients requires understanding of the causes along with planning, leadership, and training. Many helpful resources are available.

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A young man bursts through the emergency department (ED) doors complaining of a severe headache, a panic attack, and feelings of depression for the past week. After a quick assessment, the triage nurse determines there is nothing life-threatening that requires an emergency response. She moves the young man to a patient waiting area for further assessment and treatment.

Within minutes, the ED becomes a chaotic scene. An ambulance delivers multiple patients seriously injured in a three-car collision. Some are critically ill, requiring urgent response. Emergency staff immediately deploy life-saving procedures to manage this surge of patients according to the acuity and severity of injuries.

Not understanding the situation, the young man begins to become more agitated and frustrated at not being seen by anyone. His eyes dart around the ED

taking in the activities. He stops everyone he sees and asks when a doctor will be in to help him. He does not get an answer. He begins to breathe rapidly. He paces around his bed and then dashes into the hallway. Without warning, he begins shouting and threatens violence if someone does not help him immediately. He finally grabs a nurse in the hallway and demands that she attend to him "now!"

This scene is an example of a potentially violent behavioral health patient in the ED. (In the healthcare environment, behavioral health is the preferred term over mental health and is often thought to be more inclusive.) A person struggling with his or her behavioral health may also face stress, depression, anxiety, relationship problems, grief, addiction, ADHD, learning disabilities, mood disorders, or other psychological concerns.

According to the National Council for Behavioral Health, a mental disorder or mental illness is a diagnosable illness that affects a person's thinking, emotional state, and behavior—and disrupts the person's ability to work or carry out daily activities and engage in satisfying personal relationships [1]. In the United States, one in five adults experience mental illness in a given year—about 46.6 million people [2]. Although a significant amount of violence in the ED can be attributed to behavioral health patients, in general, people who live with mental health disorders are no more likely than a member of the general population to commit a violent act. In fact, they are more often a victim of a crime [3]. Why, then, do we continue to observe violence being perpetrated by this patient population within this setting? And what can be done?

ROOTS OF VIOLENCE

Perhaps not surprisingly, studies by the American College of Emergency Physicians have concluded that the prevalence of mental illness combined with a lack of resources to care for those affected by it in the most appropriate setting is a national crisis. Another barrier to providing adequate care is ED overcrowding, caused in part by too few inpatient psychiatric beds and by the opioid epidemic. Overcrowding stretches staff too thin and can affect the avail-

ability of resources. As Rebecca Parker, a past president of the American College of Emergency Physicians, has noted, "the severe shortage of psychiatric beds in almost all hospitals and intensive outpatient resources is leaving these behavioral health patients stranded for hours and even days" [4].

Environmental triggers in the ED or hospital—such as chaos, noise, and lengthy wait times—can contribute to acts of violence by patients who are frustrated or angry. The IAHSS publication *Security Design Guidelines for Healthcare Facilities* includes specific design guidelines that provide an excellent overview plan for building or renovating space in the ED and areas designed specifically for behavior/mental health patients in ways that can minimize exposure to environmental triggers. OSHA has also published some structural guidelines in its handbook *Guidelines to Preventing Workplace Violence for Healthcare and Social Service Workers.*

Physical and psychological triggers can also contribute to acts of violence by patients who are already frustrated or angry. Behaviors of concern provide visible precursors to acts of violence, which can often be mitigated by clinical and security responders who have proper training in early intervention. IAHSS has published helpful advice in its Spring 2018 *Industry Guidelines Handbook,* which addresses, among many other topics, behavioral health patients, violence in healthcare (including targeted violence), security in the ED, and threat management.

Because behavioral health patients can pose risks relating to self-harm and to violence toward others and can consume considerable security resources, the *IAHSS Industry Guidelines Handbook* recommends conducting periodic assessments of internal and external vulnerabilities. Among other things, it also recommends establishing procedures to address patient elopement, patient restraint, response to combative behavior, seclusion room management, assessing patient history to determine previous dangerous behavior, security of patient belongings, patient searches, visitor control and screening, and other security risks [5].

PROPER PLANNING IS FOUNDATIONAL

Keeping the ED free from violence can be a daunting task. The healthcare facility should develop a security plan that provides for the unique needs of the population that uses the emergency services of a hospital. It is recommended that the ED waiting area be separated from the ED treatment area. Access to the ED treatment area should be limited. A separate area in the ED should be available for the treatment of behavioral health or other high risk patients. The ED should be capable of immediately locking down or restricting access in the event of an emergency. Safeguards should be developed to protect vulnerable patient populations who may be at risk for elopement, abduction, or abuse—such as other behavioral health patients, the elderly, and children [6].

Healthcare facilities should encourage the central reporting and the evaluation of threats and all acts of violence. A violence management and response plan should be developed and include an assessment process so that each situation receives an appropriate response. The actions listed in Table 1 should be part of the plan [7,8,9].

LEADERSHIP CHAMPIONS DETERMINE SUCCESS

According to studies conducted by the Emergency Nurses Association, clinicians who perceived that their hospital administration and ED management were committed to a violence-free workplace were less likely to experience workplace violence. The association lists the following elements as essential to training and education on workplace violence [10]:

- organizational and personal readiness to learn
- readily available, evidence-based, organizationally supported interventions
- skilled and experienced facilitators who understand the audience and issues
- training on early recognition and de-escalation of potential violence
- healthcare-specific case studies with simulations

The culture of violence that surrounds our behavioral health patient population demands that

Table 1. Elements of a Violence Prevention and Response Plan

Identify	Assess	Validate	Mitigate	Respond
• Take threats seriously • Activate an emergency response • Promote timely reporting • Encourage early awareness and identification • Evaluate formal or informal reports • Review trends in threat management	• Assess formal or informal reports • Address reported incidents or threats immediately • Evaluate all possible information and data • Conduct thorough research on situations • Determine severity of threats	• Confirm risks of threat • Document threats and all details • Engage internal/external responders and affected parties • Communicate directly with potential victims of threats	• Implement timely intervention plans • Alert HCF staff and others at risk • Create and monitor safety plans • Address the problem/conflict precipitating a threat • Draw insights from prior experiences or historical events	• Take immediate action if an incident occurs or is imminent • Notify law enforcement as needed • Provide victim advocacy, support, and counseling • Document all details • Conduct after-action debriefing sessions • Evaluate and revise plans based on debriefing

security leaders go beyond the all-important mandatory compliance training they tackle on a continuous basis and consider a more comprehensive approach. The security leader who is most adept at navigating the complex terrain of the behavioral health patient may consider a program with the following attributes:

- training of the security and clinical staff together in "Mental Health First Aid" (https://www.mentalhealthfirstaid.org/)
- fostering collaboration between security and other service lines
- implementing a "Fit for Duty" standard for security staff
- delivering training programs to security (and other staff) that include but are not limited to:
  - severity of behavioral health illness

- precursors and dangerous behaviors
- triggers for violence
- verbal non-escalation and de-escalation and crisis intervention
- identifying behaviors of concern
- anger management
- stress management
- crisis management

It is also very important that the security leader coordinate with the appropriate hospital clinicians to ensure that appropriate and timely restraint training is being conducted and that the security officers are included and trained to assist (to the extent that hospital policy, state laws, and regulations allow) with patient restraints.

Many professional organizations and associations offer resources to assist with this complex journey. A decrease in behavioral health patients in the ED setting is not likely. Thus, it is essential to better understand the patient and proactively take steps to increase the safety for all.

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