

# *Department of Mental Health*

## *Inpatient Licensing Division*

### ***Clinical Competencies/ Operational Standards Related to Severe Behavior/ Assault Risk***

Inpatient psychiatric facilities licensed by the Department of Mental Health are expected to have the capability to provide care to patients who require inpatient psychiatric hospitalization and who present with high level of acuity, including severe behavior and assault risk.

**Each general inpatient psychiatric facility shall assure that it has the capacity to:**

- Provide treatment to patients with severe behavior/assault risk, including evaluating patients during the intake and admissions process to determine if additional staffing supplementation is required.
- Adjust staffing levels to meet varying levels of unit acuity.
- Evaluate and document care needs during the referral and acceptance process which serves as preparation for direct care staff and others to incorporate risk and individualized crisis prevention planning (ICPP) upon admission. (While safety tools are generally completed within 48 hours of admission, a person admitted with this risk level should have their safety tool or ICPP completed as soon as possible after arrival.)
- Provide a range of intervention approaches to address the needs of patients with higher levels of acuity. Aggressive, assaultive patients may benefit from behavior management plans, anger management, relaxation techniques, occupational therapy, and social skills development. Consideration for consultation with behavior specialists should be given.
- Provide ongoing training and demonstration of competencies in verbal de-escalation, including hands on experience, to reduce likelihood of harm.

De-escalation and Preventative Skills that can assist direct care staff to safely respond to patient agitation or aggression include but are not limited to:

- Motivational Interviewing
- Trauma Informed Care
- Person-Centered Approaches
- Stigma/ Countertransference
- Mindfulness
- Flexible Rules
- Strength-based interventions
- Approachability of staff for providing help
- Anger Management
- Leadership Rounds regularly on units
- Security specialists/ guards who may participate in direct interactions with patients experiencing episodes of severe behavior or assault risk should have training (e.g. CPI, Handle

With Care, MOAB) that is consistent with training received by the direct care psychiatric inpatient staff, as should any additional staff who may participate in such episodes.

- Ensure robust debriefing processes, including incidents that qualify as “near misses.”
- Provide Medication Management with proactive use of PRNs and use of withdrawal protocols as indicated.
- Ensure that staff on all shifts have access to Sensory Tools, and the training required to select and work with patients to use these tools as coping skills and methods for decreasing frustration and aggression.
- Involve community treaters, state agency representatives, and the legal system (if involved) in treatment and discharge planning as soon as possible after admission in order to assess the patient’s current continuum of care and foster successful outcomes.
- Ensure that wraparound community services are in place (e.g., get/fill medications, an outpatient medication/injection clinic (if needed), access transportation to appointments, stable housing, and case management).
- Engage patients who are identified as having “personality disorders or traits,” utilizing Trauma Informed Care (TIC), Motivational Interviewing (MI), Sensory Tools, attention to diet (e.g., polydipsia, excessive caffeine or sugar intake), and Mindfulness Training.
- Work with court system, families and/ or guardians to expedite the process of commitment if necessary.
- Provide increased security presence, specialized psychopharmacology interventions, and active treatment with the patient to identify and practice greater behavioral control skills.
- Ensure all staff receive consistent education and maintain current trainings and certifications (i.e., upon hire, as needed, and annually) to work with and care for these patients.

**Each general inpatient psychiatric facility is recommended to consider:**

- When possible, create flexibility in the physical plant for non-restraint and seclusion management of behavior. This can involve providing special observation/single rooms and higher staffing ratios for patients requiring assault precautions to mitigate the risk to roommates and other patients on the unit. It is ideal that a unit be able to provide a distinct, spacious area for the most acute patients with specialized group programming, activity space, and comfort space (if possible). Patients could move to the regular section of the milieu when able to tolerate more stimulation.
- Consideration should be given to the inclusion of Peer Support Specialists in milieu treatment.

A facility with available beds may deny admission to a patient whose needs have been determined by the facility medical director, or the medical director’s physician designee when unavailable\* to exceed the facility’s capability at the time admission is sought. The medical director’s determination must be written, and include the factors justifying the denial and why mitigating efforts, such as utilization of additional staff, would have been inadequate. [See DMH Licensing Bulletin #18-01 - *Documentation of Unit Conditions and Facility Denial of Inpatient Care* and 104 CMR 27.05 (3) (d).]

\* The medical director’s physician designee must be a physician who is vested with the full range of the medical director’s authority and responsibility in the medical director’s absence.