

## Psychiatric Inpatient Environmental Architecture

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### From the Editor

- Design of Clinical Encounters in Mental Health Care 197  
Rebecca Grossman-Kahn, MD, MBA

### Case and Commentary

- How Should Suicide Prevention and Healing Be Expressed as Goals of Inpatient  
Psychiatric Unit Design? 199  
Jennifer T. McIntosh, PhD, RN, CNE, PMH-BC, NEA-BC and Mona Shattell, PhD, RN

- Should Dignity Preservation Be a Precondition for Safety and a Design Priority for  
Healing in Inpatient Psychiatry Spaces? 205  
Róisín Plunkett, MD and Brendan D. Kelly, MD, PhD

- When Should Inpatient Psychiatric Care Include Access to the Outdoors, Despite  
Elopement or Other Risks? 212  
Allie Slemon, PhD, RN and Shivinder Dhari, MSN, RN

- Should Patients' Boredom in Locked Inpatient Psychiatric Units Be Considered  
Iatrogenic Harm? 219  
Carrie Tamarelli, MD, Angela Cao, and Rebecca Grossman-Kahn, MD, MBA

### Medical Education

- What Should Students and Trainees Learn About Patient-Centered  
Documentation? 225  
Nubia Chong, MD, Maria Mirabela Bodic, MD, Peter Steen, MD, Ludwing Salamanca,  
MD, PhD, and Stephanie LeMelle, MD, MS

- What Should Health Professions Students Know About Countertransference in  
Inpatient Psychiatric Environments? 232  
Erik Levinsohn, MD and Marta Herschkopf, MD

### In the Literature

- Why Patient-Centered Built Environment Standards Matter More Than Numbers of Beds in Inpatient Psychiatry 237  
Morgan C. Shields, PhD, Zohra Kantawala and Ramesh Raghavan, PhD

### Medicine and Society

- How Inpatient Psychiatric Units Can Be Both Safe and Therapeutic 248  
Matthew L. Edwards, MD and Nathaniel P. Morris, MD

### History of Medicine

- What Does the History of Inpatient Psychiatric Unit Design Tell Us About Balancing Safety and Healing for Patients With Suicidal Behaviors? 257  
Alice J. Liu, David S. Im, MD, and Laura D. Hirshbein, MD, PhD

### Art of Medicine

- How Better Architecture of Health Care Structures and Spaces Can Help Avoid Iatrogenic Harm 264  
Sudhiksha Srinivasan, MArch

### Viewpoint

- Virtual Eye Contact 270  
Christy A. Rentmeester, PhD

### Podcast

- Participatory Design in the Spaces and Structures of Mental Health Caregiving: An Interview With Stefan Lundin



## AMA Journal of Ethics®

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### FROM THE EDITOR

#### Design of Clinical Encounters in Mental Health Care

Rebecca Grossman-Kahn, MD, MBA

Psychiatric conditions are leading causes of hospitalization across all age groups.<sup>1</sup> Today, most acute psychiatric care is provided in an emergency department or other hospital setting. Strategies to prioritize patient and employee safety have been developed in response to **suicides** and other sentinel events in hospital settings,<sup>2</sup> but efforts to reduce suicide, self-harm, and elopement are at odds with creating and maintaining therapeutic spaces. In this issue of the *AMA Journal of Ethics*, contributors explore what a psychiatric care site should look like, both in terms of its built environment and policies that shape caregivers' work and individuals' experiences.

Unlike past inpatient psychiatric settings, where some patients once stayed for months or years, inpatient psychiatric stays today are designed to be short. Many insurance plans limit how long inpatients can receive care, after which time they are generally discharged to outpatient or partial hospitalization settings. Lengths of stay began to decrease in the 1990s; after 1994, an average inpatient psychiatric stay in the United States was fewer than 10 days.<sup>3</sup> Today, a primary goal of psychiatric inpatient hospital admission is acute crisis stabilization, for which patients' conditions must meet criteria for their risk of harm to themselves or others.

Many patients admitted to psychiatric units are at high risk for suicide or self-harm, so safety is prioritized in the **design of inpatient psychiatric units**. The architecture of psychiatric care structures and spaces is guided by several sources, including national regulations (eg, the Joint Commission's "Special Report: Suicide Prevention in Healthcare Settings"<sup>2</sup>) and individual organizations' policies. Design requirements significantly influence the look and feel of psychiatric units<sup>4</sup>: door handles deter ligature attempts; furniture is bolted to a floor; doors contain anti-barricading features. Patients might be required to wear distinctly colored clothes, even on locked units, until they are deemed to not be at risk of absconding. Some recreational items (eg, books and exercise equipment) are deemed potential weapons and are thus prohibited.

This issue considers whether and to what extent well-intentioned design and policies can impede recovery, harm patients, or influence patients' willingness to seek clinically indicated care.<sup>5</sup> This issue also considers how tolerable risk levels ought to be determined and which design criteria could help prevent **adverse outcomes** without unjustly or unnecessarily limiting all patients' freedoms. Contributors draw on cross-disciplinary research to consider ethical questions about designs of psychiatric care sites. By considering how to reduce risk while promoting healing, we hope to

illuminate how more effective and supportive healing environments might be created for inpatients in psychiatric care settings.

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## AMA Journal of Ethics®

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### CASE AND COMMENTARY: PEER-REVIEWED ARTICLE

#### How Should Suicide Prevention and Healing Be Expressed as Goals of Inpatient Psychiatric Unit Design?

Jennifer T. McIntosh, PhD, RN, CNE, PMH-BC, NEA-BC and Mona Shattell, PhD, RN

##### Abstract

Inpatient psychiatric units' policies and restrictions for suicide prevention can exacerbate harm rather than promote wellness. This commentary on a case examines ethics concerns about prevention policies that overly rely on liberty restriction, as expressed in the design of inpatient psychiatric unit structures and spaces. Person-centered approaches to design are key to promoting healing and preserving dignity.

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##### Case

KA is a 44-year-old patient with a history of major depressive disorder who is hospitalized for suicidal ideation. On day 3 of hospitalization, KA would like to spend time writing letters and journaling and asks Dr B for pens. Dr B is aware of the hospital policy that restricts access to pens for patients with active suicidal ideation due to the risk of self-harm. He also knows that writing would likely be therapeutic for KA. Dr B wonders how to respond.

##### Commentary

Mental illness is associated with an increased risk of suicide.<sup>1,2</sup> When individuals are admitted to an inpatient psychiatric unit, they become even more vulnerable, given the burden of their disease and the clinical environment. Hospitalization can highlight their experiences of trauma and stigma, and their presenting symptoms may also contribute to the loss of autonomy, social role, and overall control that are associated with inpatient admission to a psychiatric unit.

The case of KA and Dr B illustrates a common dilemma: to provide a safe environment that also facilitates healing. As experienced acute care psychiatric mental health nurses who have worked on these units and had to grapple with these issues firsthand, we understand well the delicate balance between safety and healing. In the case presented here, Dr B realizes that KA's request for a pen to write letters and to journal can be therapeutic. However, Dr B faces the dilemma of whether to transgress the boundaries

established by a hospital policy that prevents persons with active suicidal ideation from using writing utensils, such as pens. Whether Dr B chooses to explore this dilemma with the care team and advocate for KA's use of a writing utensil or chooses to comply with the restrictive policy will significantly impact KA—for better or for worse. Or perhaps Dr B is contemplating a compromise: collaborating with KA and the team to design an individualized plan of care with interventions that are intended to convey compassion and facilitate KA's healing while ensuring KA's safety.

### **Balancing Safety With Autonomy**

In recent years, the need to reduce harm risks, such as suicide, in inpatient psychiatric units has emerged.<sup>3,4</sup> Despite interventions to reduce harm—such as multidisciplinary approaches to care, the use of standardized suicide risk assessment tools, psychopharmacology, and therapy— inpatient admission to a psychiatric unit is a significant risk factor for suicide.<sup>3</sup> Some posit that the circumstances leading to a patient's admission, such as suicidality, mental illness, and social factors, may increase their risk for suicide while an inpatient in the hospital.<sup>3</sup> Organizational-related factors, such as the **built environment**, the therapeutic effects of the milieu, and staffing may also impact inpatient suicidality. One meta-analysis estimated the number of admissions per inpatient suicide to be 676,<sup>5</sup> or the proportion of inpatient suicides to be 0.15% of all psychiatric admissions, and other studies have put the estimate at 0.1% to 0.4%.<sup>6</sup> While these incidence estimates might seem small, inpatient suicides account for approximately 5% of all suicides.<sup>7</sup>

There is no consensus on measures for preventing the occurrence of inpatient suicides.<sup>8</sup> Although the restriction of personal items, such as writing utensils, in inpatient psychiatric units is common, it is unclear whether these personal items pose a safety risk for individuals with active suicidal ideation or whether they have been used for suicide. In fact, published studies on inpatient suicide identify *hanging* as the most common method of suicide in inpatient psychiatric units,<sup>9,10,11,12</sup> with bathrooms and bedrooms being the most common locations for suicide.<sup>12</sup>

By its nature, admission to an inpatient psychiatric unit limits an individual's right to self-determination and self-governance. Physicians and nurses have an obligation to protect patients from harm. Yet the practice of exercising excessive caution that restricts patients in inpatient psychiatric units from accessing basic objects, such as writing utensils, may be more harmful than protective. Dr B thus may be concerned about violating the principle of nonmaleficence, or the obligation to abstain from causing harm to others,<sup>13</sup> if he does not (and the psychiatric nurses and administrators do not) protect and defend KA's right to receive respectful and dignified care.

### **Reconciling Safety and Healing**

It is important for organizational leaders to critically examine their policies to ensure that those that are meant to protect patient safety do not result in the unintended consequence of causing harm and impeding healing, since the ultimate goal is to prevent harm and to remove conditions that may be harmful.<sup>13</sup> The assumption that a choice must be made between safety and healing can be detrimental. Moreover, the lack of consensus on reliable risk assessment tools results in health care professionals either underestimating or overestimating risk of self-harm.<sup>8</sup> The overestimation of patients' risk of suicide is often associated with excessive caution on the part of staff, which, as mentioned above, deprives patients of their fundamental rights and access to therapeutic interventions.<sup>8</sup>

In KA's case, the excessive caution resulting from the **overestimation of risks** likely led to the policy of restricting use of writing utensils for individuals with acute suicidal ideation. While one may argue that restricting the use of writing utensils is in accordance with the principle of beneficence, its implications for a person's healing are worth considering. In the case of KA, an assessment of the possible therapeutic benefit of writing vs the increased risk of suicide from the writing utensil should be explored. Therefore, the approach to KA's care should be individualized and not "one size fits all."

Taking an individualized approach to care can augment safety while promoting healing. An example of a general approach that emphasizes safety is the US Department of Veterans Affairs hospitals, which reduced inpatient suicides by 82% over a 7-year period by managing environmental risks associated with inpatient suicide with the implementation of a Mental Health Environment of Care Checklist.<sup>14</sup> This 114-item checklist includes questions (items) such as counting flatware before and after meals, eliminating possible anchor points for hanging, and examining potential hazards on the unit.<sup>14</sup> However, taking an individualized approach, it can be argued that even when deemed to be risky for use, some restricted items, such as eating utensils (and pens?) can be made available to patients under certain circumstances and with caution and possible modifications (rather than being completely excluded or restricted).

### **Integrating Safety Into Healing to Inform Policy**

In the United States, it is estimated that 1500 suicides are completed in inpatient psychiatric units annually.<sup>11</sup> According to the National Violent Death Reporting System (NVDRS), 76.7% of hospital suicides were associated with a psychiatric admission in 2015, amounting to an estimated rate of 3.2 inpatient suicides per 100 000 hospital admissions.<sup>12</sup> Although one death by suicide is too many, it is important to evaluate the reported methods by which deaths by suicide occur in the inpatient psychiatric units globally in order to inform policies and procedures for suicide prevention in inpatient psychiatric units.

Let's look at the data. In the United Kingdom, hanging was identified as the most common method of suicide between 1999 and 2007.<sup>9</sup> In Switzerland, the most frequently used methods of suicide in inpatient units between 2000 and 2010 were hanging, self-defenestration, and voluntary drug overdose.<sup>10</sup> An analysis of US Department of Veterans Affairs hospital data found that hanging was the method used in 43.6% of suicides and suicide attempts.<sup>11</sup> Other methods reported were cutting (22.6%); strangulation (15.6%), and drug overdose (7.8%).<sup>11</sup> More recently, Williams et al reported that hanging was the most common method of inpatient suicide in the United States based on data in the NVDRS (33 of 46 suicides, or 71.7%) and the Joint Commission Sentinel Event Database (137 of 195 suicides, or 70.3%).<sup>12</sup> Common inpatient hospital locations were patient bathrooms (50.8%), bedrooms (33.8%), closets (4.1), and showers (3.6%). It is important to note that an older report estimated that one-third of deaths by suicide in US inpatient units occur while patients are on either one-to-one observation or every-15-minute checks.<sup>15</sup> While these data are significant, it should be highlighted that the availability of more current data on inpatient psychiatric unit suicides is limited. Furthermore, the coding of inpatient suicides often lack details that could support contextual factors, such as the observation status of the individual at the time of the suicide.<sup>12</sup>

Based on the above reports, it is critical that policies aimed at reducing patient harm do not unintentionally cause harm by impeding healing. While policies should be informed by research and practice, they must also incorporate provisions for an individualized or person-centered approach that engages the patient (and caregivers), as well as the treatment team, in decision making about treatment planning. This approach needs to focus not only on physical safety, such as ligature risks in private spaces, but also on the emotional safety and well-being of individuals.

### Conclusion

It is the responsibility of health care systems, physicians, nurses, and others who work within inpatient psychiatric units to maintain the safety of individuals in their care while also promoting patients' healing in a respectful, compassionate, and dignified milieu. Patients should not be faced with the burden of sacrificing their basic needs to ensure their own safety, and physicians and nurses should have and use better tools to assess risks and to design care and treatment that does not follow a one-size-fits-all approach.

To support new interventions for promoting safety on inpatient psychiatric units, we suggest that organizations take a multidimensional approach to promoting safety while also supporting healing. In addition to providing ethically sound, recovery-oriented care, such as trauma-informed care, organizations should instantiate a just culture to empower their employees to deliver individualized care informed by the patient's individuality, characteristics, clinical presentation and diagnosis, identified risk factors, lived experiences, and personal preferences. Dr B should not have to choose between safety and healing. What are some alternatives to the yes or no question of whether or not to allow writing utensils? Can KA use a pen or pencil while being monitored? The issue needs to be discussed among members of the care team with consideration of both practical issues—can it, or how can it, be done—and ethical issues—patient autonomy, nonmaleficence, beneficence, and justice.

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*The people and events in this case are fictional. Resemblance to real events or to names of people, living or dead, is entirely coincidental. The viewpoints expressed in this article are those of the author(s) and do not necessarily reflect the views and policies of the AMA.*

**CASE AND COMMENTARY: PEER-REVIEWED ARTICLE**

**Should Dignity Preservation Be a Precondition for Safety and a Design Priority for Healing in Inpatient Psychiatry Spaces?**

Róisín Plunkett, MD and Brendan D. Kelly, MD, PhD

**Abstract**

Therapeutic security in inpatient psychiatric settings requires careful planning and implementation if it is to support patients' safety and dignity. This commentary on a case considers patients' dignity experiences when restrictions on their freedom are used to keep them safe.

**Case**

BL is a 48-year-old woman suffering an initial episode of severe depression. She has been contemplating ending her life and, at her sister's urging, agrees to voluntary inpatient admission to be treated for depression. To her horror, she is asked to remove and relinquish her bra, her drawstring sweatpants, and her shoelaces, since straps and strings are viewed as a ligature risk. She is admitted, alone, and feels stripped and ashamed. Wearing no bra and ill-fitting hospital-issued clothing and footwear, she meets Dr Psych for the first time.

**Commentary**

This case demonstrates a common feature of inpatient psychiatric services. It is often the policy of inpatient units that patients are required, on admission, to relinquish items of clothing and property that are deemed to pose a potential risk of harm. This policy is ostensibly in the interest of patient safety because drawstrings, belts, and shoelaces can be used as ligatures. However, given the significant potential for humiliation and loss of freedom in such a practice, it is something that should be subject to discussion and review. As with many contentious issues in clinical practice, evaluation through the prism of medical ethics can bring new perspectives. Weighing the ethical risks of these types of restrictive practices against potential safety benefits is important in ensuring that the environment of a modern psychiatric inpatient unit is conducive to both healing and dignity, which are by no means separate considerations.

In this discussion, we consider whether patients can feel safe without retaining a sense of dignity, how clinicians should respond to patients in health care spaces that patients experience as neither safe nor healing, whether undermining of patient dignity in these spaces should be considered as iatrogenic harm, how clinicians' perspectives on safety

should be weighed against patients' experiences of dignity, and approaches to risk management that may promote dignity in the psychiatric inpatient setting.

### **Safety Without Dignity?**

A narrow definition of safety as protection from physical danger, risk, or injury can disconnect the concept of safety from that of maintaining dignity. However, the World Health Organization, which defines safety as "the reduction of risk of unnecessary harm to an acceptable minimum," specifically includes emotional harm in its conceptual framework of patient safety.<sup>1</sup> Given that harm to human dignity is an example of emotional harm,<sup>2</sup> in a health care context patient safety and dignity are interlinked.

Physical safety is of clear importance for patients in a psychiatric inpatient environment.<sup>3</sup> Patients, their families, regulatory bodies, and society as a whole have the expectation that harm to self and others should be prevented in an inpatient setting. Inpatient suicide is listed as a "never event" (also called a "sentinel event" or a "serious reportable event") in health care services the world over. Nevertheless, inpatient suicides occur. Rates vary, but one 2015 meta-analysis of 44 studies based on data from the United States, Europe, and Australasia found the pooled estimate of suicide rates per 100 000 inpatient years to be 147.<sup>4</sup> Prevalence estimates of suicide attempts and other acts of nonfatal self-harm are even more variable<sup>5,6</sup> due to methodological differences, such as sampling and assessment strategies.<sup>7</sup> Reported rates of nonsuicidal self-injury among psychiatric inpatients range from 4% to 70%.<sup>5</sup> A review article of 43 studies found a mean event rate of 3.2 attempted suicides per 100 psychiatric admissions per month.<sup>6</sup> The most common method of completed suicide in hospital is via ligature.<sup>8</sup> While much is done to remove ligature points from inpatient units, strangulation can occur even without identifiable ligature points. The apparent need to remove potential sources of ligature from patients on their arrival to an inpatient unit is therefore embedded in many admission protocols.

Although this practice is ethically justifiable to uphold patient safety, recognition and communication of its potential emotional impact is crucial to minimize the stigmatization and distress it causes. Good communication, wherein patients feel "heard" by staff, is an important feature of dignity experience.<sup>9</sup> Patients' perceptions of the fairness of coercive interventions during their treatment is a stronger predictor of their attitude towards psychiatric care than the number of coercive interventions they experienced.<sup>10</sup>

There are ethical complexities that need to be navigated in each individual case and across each inpatient unit. For instance, there is a clear tension between upholding the principles of beneficence (reducing risk and providing care) and nonmaleficence (avoiding harmful loss of dignity) while also respecting the principle of autonomy (the right to behave as one chooses). Balancing these principles becomes yet more complex when one considers that, in a congregated environment, even if a given patient presents a low risk of harm, the patient's drawstrings, belts, and shoelaces might be obtained by another patient who is at higher risk. Placing limitations on a patient not for their own safety, but for the safety of other patients, raises ethical questions of fairness and proportionality.<sup>11</sup> Balancing the rights of the individual with the rights of others requires managing inpatient units with an awareness of the complex, changing nature of risk and continually weighing considerations of dignity, beneficence, nonmaleficence, and autonomy at individual and group levels.

### Safe, Healing Spaces

To heal is to “make whole or ... restore to health.”<sup>12</sup> In relation to psychiatric conditions, healing may entail the resolution of psychopathological symptoms or the restoration of subjective well-being and observed functionality. In the above vignette, a woman who has self-presented to the hospital for treatment of a mood disorder is met with an institutional practice—removing her bra, sweatpants, and shoelaces before being interviewed by the psychiatrist—that results in her experiencing shame and horror. This practice, on its face, is in direct opposition to instilling a sense of safety and promoting healing. Patients’ subjective experience of coercion is negatively correlated with their perception of dignity.<sup>13</sup> In addition, **environmental restrictions** are associated with increased risk of self-harm.<sup>5,14</sup> More generally, factors such as feeling controlled by staff, having requests denied by staff, and experiencing restrictive practices are antecedents to self-harm in psychiatric inpatient units.<sup>6</sup> Therefore, strategies such as those outlined in the above vignette, while aimed at reducing risk of self-harm or suicide among psychiatric inpatients, may paradoxically have the opposite effect.

Patients’ relationships with staff and their sense of being treated as an ordinary human being are key elements of the patient experience of dignity in psychiatric inpatient settings.<sup>15</sup> Conversely, negative staff attitudes are a crucial component in patients’ experience of humiliation.<sup>16</sup> From a sociological perspective, a culture of respect and dignity promotes prosocial behavior in a group environment.<sup>17</sup> Therefore, the importance of clinicians responding to patients in a dignity-promoting manner cannot be overstated.

### Undermined Dignity as Iatrogenic Harm

The above vignette clearly outlines the negative emotional impact of removing personal items from patients on admission to a psychiatric unit. While this practice is aimed at reducing risk of self-harm, it nonetheless can increase perceived stigma, a factor that has been demonstrated to increase suicidality.<sup>18</sup> Many of the restrictions placed on patients in the name of safety are recommended and enforced by regulatory bodies, whose role it is to minimize harm in health care environments. If one does not consider reduction of privacy or undermining of dignity as a harm, then there is little reason to limit the restrictions placed on patients in inpatient units. Yet this reasoning is clearly unacceptable: undermining patient dignity is an iatrogenic harm, albeit one that is often systemic in origin rather than rooted in specific actions of health care staff at the individual level.

Complete elimination of risk of self-harm in an inpatient setting is impossible, especially given that an item as seemingly innocuous as a t-shirt can be used to self-strangulate, even by a patient under close observation in a secure setting.<sup>19</sup> Close nursing observation is an important factor in reducing risk of suicide in inpatient settings, but it does not entirely eliminate risk (as one study found that 18%<sup>20</sup> and another that 51%<sup>21</sup> of inpatient suicides occur in patients on intermittent observation, while 3%<sup>20</sup> to 9%<sup>22</sup> of inpatient suicides occur in patients on constant observation). Nevertheless, given the high rates of self-injury among people admitted to psychiatric inpatient units,<sup>6</sup> strategies to reduce risk of self-harm are certainly warranted and required. In order to strike a balance between protection from harm and personal freedom, regulators must consider that undermining human dignity is a potential **iatrogenic harm associated with some restrictions** and safety measures. Recognition of this fact by regulators, and associated limitations on and monitoring of restrictive practices, is required if psychiatric inpatient environments are to be both safe and healing for patients.

### **Perceptions of Coercive Practices in the Psychiatric Inpatient Setting**

It is important to note that staff, as well as patients, may find practices that limit patient freedom distressing. A qualitative study of staff and patients in a psychiatric inpatient unit in Norway found that some staff perceived house rules and limitations on patients' behavior to be a violation of patient dignity.<sup>23</sup> However, many patients accept that some level of coercion is necessary when they are acutely unwell.<sup>24</sup> Limitations on patient freedom is therefore a nuanced issue that requires a considered approach.

Research consistently demonstrates that clinicians experience patient suicide as distressing, with emotional responses ranging from guilt and blame to shock, anger, sadness, and grief.<sup>25,26,27</sup> It is understandable that clinicians and institutions wish to reduce the risk of suicide among inpatients as much as possible—firstly, in order to prevent harm coming to patients and, secondly, to avoid the implications (emotional, practical, legal, and otherwise) of an inpatient death. However, as described above, to attempt to entirely eliminate patients' risk of self-harm in psychiatric inpatient units solely by limiting access to means of self-harm would necessitate such intense restrictions and limitations that patient autonomy and dignity would be diminished to a harmful extent. Therefore, other strategies to reduce risk of suicide are required in order to promote both healing and safety.

### **Dignity-Conserving Risk Management Strategies**

Besides limiting access to means of self-harm and implementing special observation, other strategies that have been recommended for suicide prevention among psychiatric patients include involvement of families, improving communication, and providing effective treatment of illness.<sup>3,28</sup> In particular, active involvement of loved ones in patients' mental health care can lead to improved outcomes, including greater patient safety and engagement with care.<sup>29,30,31,32</sup> In addition to helping keep patients safe and improving the quality of care planning,<sup>31</sup> family involvement is significantly associated with attendance at follow-up appointments,<sup>30,31</sup> potentially improving patient health outcomes in the longer term. Strengthening family members' involvement in care through their inclusion in communication has been identified as a strategy to reduce suicide risk<sup>31</sup> while also empowering patients and their loved ones.<sup>33</sup>

### **Conclusion**

Therapeutic security in inpatient psychiatric settings requires careful design and planning if inpatient services are to optimize dignity as well as safety. The care environment is a key aspect of dignity preservation in psychiatric inpatient care,<sup>16</sup> and a **positive physical environment** has been demonstrated to promote healing in a variety of medical settings.<sup>34</sup> Clinicians should also endeavor to actively involve patients' loved ones in their care and care planning, particularly in relation to communication of risk.

In considering issues of safety and healing in psychiatric environments, we recognize that—at times—certain restrictions on patients' freedom are necessary to prevent harm (for example, restricting the leave of involuntarily detained patients when there is a significant risk that the person would not return from leave). Nevertheless, certain house rules that are common in psychiatric inpatient settings and not strictly necessary for safety (for example, restricting access to mobile phones or designating bedrooms as off limits during the day) risk increasing patients' experience of coercion and contravening their dignity without proportionate benefit.<sup>13,15</sup> It is therefore vital that restrictions on patients' freedom are limited to those that are essential, proportionate, and justifiable.

Additional strategies, such as involvement of families in care, fostering positive relationships with staff, and providing effective treatments for illness, are important adjuncts to measures that limit patient access to means of self-harm.

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## AMA Journal of Ethics®

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### CASE AND COMMENTARY: PEER-REVIEWED ARTICLE

#### When Should Inpatient Psychiatric Care Include Access to the Outdoors, Despite Elopement or Other Risks?

Allie Slemon, PhD, RN and Shivinder Dhari, MSN, RN

##### Abstract

This commentary on a case considers consequences of a so-called “zero-risk” paradigm now common in psychiatric inpatient decision making. Iatrogenic harms of this approach must be balanced against promoting patients’ safety and well-being. This article suggests how to collaboratively assess risk and draw on recovery-oriented goals of care.

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##### Case

LH is a 29-year-old woman hospitalized, so far for 11 days, for a severe episode of depression. Dr Psych estimates she will be hospitalized for another week and is working with risk managers to find a way to allow LH to leave the unit with a staff member to walk in the hospital’s garden, which LH can see from the unit’s windows. LH feels distressed about not having access to fresh air. Dr Psych makes a case to a risk manager for LH’s accompanied access to the garden: it will make her feel better, probably diminish her length of stay, and remove LH’s feeling “imprisoned” as an obstacle to trust and healing in their patient-physician relationship. The risk manager, however, states: “I’m sorry; we just can’t. Two years ago, a patient eloped after being allowed to walk in that garden.” Dr Psych considers how to respond.

##### Commentary

Health care systems, particularly psychiatric care settings, are currently dominated by a *zero-risk paradigm*: an approach to ethical decision making that upholds elimination of risk as a shared goal and moral imperative.<sup>1,2</sup> The widespread adoption of the zero-risk approach has given rise to dedicated roles for risk managers and a range of interventions and technologies, including, in inpatient psychiatric settings, the use of surveillance, locked doors, and seclusion rooms, all aiming to eliminate risks associated with people experiencing mental health challenges.<sup>3,4</sup> Yet growing empirical evidence demonstrates that the zero-risk paradigm and its associated strategies fail to effectively eliminate or even reduce risks associated with self-harm, interpersonal violence, or absconding and instead threaten therapeutic relationships between health care professionals and patients.<sup>5,6</sup> Furthermore, zero-risk approaches introduce iatrogenic

harms, including physiological side effects from chemical restraints, injuries from physical restraints, and reduced feelings of safety and well-being related to the carceral environment, all of which may additionally lead to worsened mental health symptoms.<sup>7,8</sup>

This commentary critiques the zero-risk paradigm and grounds the exploration of LH's case in a *safety paradigm*, which acknowledges and accepts the potential for some risk throughout the journey from hospitalization to discharge. A safety paradigm further prioritizes the well-being of all individuals in the health care setting—including the patient—with an intrinsic focus on promoting safety rather than eliminating risk. Here, we discuss 3 central strategies of a safety paradigm: conducting meaningful and collaborative safety assessments, employing the recovery model to reconceptualize overarching aims of inpatient psychiatric care, and reenvisioning psychiatric inpatient environments to respond to ethical challenges of lengthy involuntary admissions.

### **Collaborative Safety Assessments**

In its focus on Dr Psych's engagement with the risk manager, the case of LH presupposes that physicians independently conduct risk assessments, which may then be vetoed by risk managers. We instead propose that utilizing a collaborative, team-based approach to examining risk can elicit a more nuanced picture of the current mental status of a patient. Combining diverse clinical skills of and information from the members of the interdisciplinary team—including nurses, case managers, social workers, therapists, community health care workers, and family members—enriches the context of the assessment because these individuals have strong and potentially long-standing therapeutic relationships with the patient. Risk managers, by contrast, do not have a therapeutic relationship with the patient (due to their role's precluding meaningful patient engagement over extended periods of time), which therefore limits their ability to conduct a contextualized safety assessment that is responsive to the team's shared perspectives and tailored to the individual patient's circumstances. Furthermore, taking a collaborative approach to safety assessments diffuses the decision-making burden by creating a shared sense of responsibility among members of the team.<sup>9</sup> While allowing patients access to the outdoors may introduce an element of risk, conducting meaningful and collaborative safety assessments allows for that risk to be thoroughly assessed and potential harm to be reduced. This approach can be especially helpful to the psychiatrist in LH's case. By relying on a shared understanding of LH's mental status and risk, gained through a collaborative team-based approach to risk assessment, the psychiatrist can advocate on behalf of LH to the risk manager with increased confidence and support.

Additionally, safety assessments must be individualized, context-specific, and completed in partnership with the patient.<sup>9,10</sup> The dominant zero-risk paradigm in inpatient psychiatric environments does not provide structural support for patients to self-assess their risk or for their self-assessments to be valued. Conversely, including LH as a collaborator in her own care is vital in ensuring her autonomy, accountability, and empowerment over her own mental health and well-being, particularly with respect to activities deemed risky in the psychiatric setting. In the case of LH, the risk manager draws on a prior case of elopement while accessing the garden to inform decision making regarding LH's opportunity for outdoor access. While prior instances of elopement can increase fear among health care professionals and risk managers, assessment of risk should be based on LH's current mental status and circumstances, not on her own previous risk or the outcomes of a different patient. Rather, the emphasis should be on acknowledging and supporting LH's decision-making capacity in

tandem with interprofessional assessments. This approach would allow for an individualized, **context-specific response to risk management** that meets the unique needs of LH.

### **Recovery-Oriented Practice Model**

Recovery has been a goal guiding mental health service delivery since the 1990s. A recovery-oriented practice model has thus been developed for working with clients in both inpatient and community mental health settings.<sup>11,12</sup> A central tenet of this model includes understanding recovery as a personal, unique journey for individuals living with mental illnesses. Furthermore, recovery is considered to occur in the context of one's lifespan, from admission to discharge from inpatient psychiatric settings.<sup>13,14</sup> While this model of care has been incorporated widely in community and outpatient mental health settings, its integration into inpatient psychiatric settings remains limited.<sup>15,16</sup>

Reconceptualizing overarching aims of inpatient psychiatric care through the lens of the recovery-oriented practice model can be beneficial in this case and similar cases in which questions of safety and risk are being evaluated. As discussed, the current widespread adoption of a zero-risk approach in inpatient psychiatric settings aims to eliminate perceived risks associated with people experiencing mental health challenges and requires considerable reduction of symptoms—particularly symptoms considered “behavioral” or associated with potential harms—as a prerequisite for permitting “risky” activities, such as accessing the outdoors.<sup>6</sup> In addition to introducing iatrogenic harms, this approach precludes recognition of mental illness as a chronic condition and detracts from a primary focus on improvement of overall well-being of patients. Therefore, we contend that a safety paradigm grounded in the recovery-oriented practice model shifts goals of care from elimination of risks to a reduction in symptoms with a focus on recovery, as defined by the patient. Recovery-oriented goals both shape the aims of an inpatient admission and extend to the person's life outside the hospital in order to enhance the person's safety and well-being despite ongoing symptoms.

In the case of LH, Dr Psych's application of a recovery-oriented lens would affirm her autonomy and build her capacity for vigilance for her own safety and well-being; such an approach has been shown to reduce patients' feeling of being “imprisoned.”<sup>13,14</sup> Promoting LH's personal efficacy and responsibility might involve Dr Psych supporting activities—such as access to the garden—that include some element of risk but enhance her well-being and give her an opportunity to work toward maintaining her own safety during her inpatient stay. While supporting LH's access to the garden does have potential for risk, Dr Psych's taking a recovery-oriented approach to practice within a broader safety paradigm would reorient the goal of a psychiatric inpatient stay from risk elimination to collaboratively supporting the patient's skills and capacity for maintaining safety and well-being during and following hospitalization. Such arguments could further support Dr Psych in advocating with the risk manager for the necessity of introducing incremental risks, grounded in a recovery-oriented practice model, as capacity-building exercises for the patient en route to eventual discharge.

### **Reenvisioning Psychiatric Inpatient Environments**

Although collaborative safety assessments and a recovery model orientation are approaches that can be immediately implemented to guide ethical decision making related to outdoor access and other activities deemed risky within psychiatric care settings, we further argue that environmental and structural changes are needed for a fundamental shift from a zero-risk to a safety paradigm. Within current inpatient

psychiatric settings, zero-risk approaches have informed environmental design that prioritizes containment and security through door locking, secure windows, seclusion rooms, and surveillance technologies.<sup>17,18</sup> Although intended to reduce risk and protect patients, the inpatient environment is experienced by both patients and health care professionals as stark, cold, carceral, and not conducive to well-being or recovery.<sup>19,20</sup> Psychiatric care settings often do not have secure outdoor spaces, and many patients experience severely restricted access to the outdoors during hospitalizations, enhancing their **perceptions of imprisonment** and resulting in worsening mental health and well-being.<sup>21</sup> Furthermore, racialized groups (Black, Indigenous, and people of color) experience disproportionate negative impacts of the inpatient environment due to systemic racism, stigmatization, and resultant mistrust of health care services.<sup>22,23,24</sup> With the maximum average length of psychiatric inpatient hospitalization being 25 days in the United States and the average being 20 days in Canada,<sup>25,26</sup> we contend that it is an ethical imperative to ensure patient access to the outdoors that is not contingent on the perceived risks of an individual independently leaving the secure environment of the care setting for a period of time. While current psychiatric settings may not include outdoor space, establishing health system and government policies and standards can ensure that the right to outdoor access is upheld in future building construction.

Co-design of health care systems and processes is an approach that is gaining popularity for its emphasis on including clinician and patient perspectives in the development of innovative and effective solutions to health care problems, and it can be utilized to inform **redesign of psychiatric inpatient environments** to include secure spaces that also enhance well-being.<sup>27,28</sup> Involving patients in the design of inpatient psychiatric environments can further support a reorienting of care provision away from the elimination of risk (through refusal of the “privilege” of outdoor access) toward a system wherein patient safety and well-being are equally prioritized aims of an inpatient stay. It has long been established that outdoor access is a foundational contributor to and prerequisite for well-being,<sup>29</sup> and inpatient psychiatric environments must be designed with consideration of not only the implications of permitting outdoor access but also the consequences of restricting it.

### **Conclusion**

In sum, we contend that identifying an acceptable level of risk is a complex decision that must be centered on the individual’s self-assessment and collaborative decision making among members of the interdisciplinary team rather than be reliant on external approval from risk managers. In this case, we propose that Dr Psych engage in a collaborative, team-based approach in partnership with LH and conduct an individualized, context-specific safety assessment that informs the team’s decision making regarding LH’s outdoor access. We further suggest that this decision-making process be grounded in a recovery-oriented practice model that enables a focus on the patient’s capacity building and incremental introduction of risks. Such an approach constitutes a shift from a zero-risk paradigm to a safety paradigm that aims to enhance access to the outdoors and other contributors to well-being, acknowledging a degree of risk along the path toward mental health and recovery.

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## AMA Journal of Ethics®

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### CASE AND COMMENTARY: PEER-REVIEWED ARTICLE

#### Should Patients' Boredom in Locked Inpatient Psychiatric Units Be Considered Iatrogenic Harm?

Carrie Tamarelli, MD, Angela Cao, and Rebecca Grossman-Kahn, MD, MBA

##### Abstract

Patients often report experiencing boredom during inpatient psychiatry stays. Because patients' vulnerabilities and conditions can be exacerbated when they feel bored, this article considers ethical dimensions of inpatient units' designs that limit patients' autonomy or access to activities or interactions with others. This commentary on a case also considers whether and how boredom should be considered an iatrogenic harm and influence discharge planning.

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##### Case

NM is an adult hospitalized for depression and suicidal thoughts. She finds days in the hospital long and tedious. She attends all groups that are offered, sometimes as few as one per day on weekends. She watches TV, paces, and feels comfortable expressing her need for more stimulating programming if she is to heal. She broaches discharge planning with Dr Z, her psychiatrist, and states that she'd feel much better if she could be more active at home, which would help her mood.

##### Commentary

Boredom is both a universally understood experience and a nebulous concept. A theme in philosophical writings for centuries, boredom or ennui can be understood as an uncomfortable state devoid of meaning that is distinct from apathy or anhedonia.<sup>1,2</sup> The interaction of certain intrinsic or transient vulnerabilities unique to an individual (sometimes described in the literature as trait boredom) and an environment that is either under- or overstimulating could result in profound boredom.<sup>1</sup> As a result, some subsets of people might be prone to boredom regardless of their situation, and other experiences of boredom might be driven by a monotonous situation.<sup>3</sup> An external locus of control has been associated with increased risk of boredom.<sup>4</sup> In any case, a person who is bored is unable to effectively engage with their environment, as NM describes. Multidisciplinary research on the psychological phenomenology of boredom, as well as its implications (outside industry and education), is a relatively new area of study.<sup>5</sup>

This article considers the nature of boredom in hospitals, the possible iatrogenic harms and benefits of boredom, and how to weigh the risks of boredom against the benefits of discharge.

### **Psychiatry and Boredom**

Much of the research and qualitative commentary on boredom among hospitalized psychiatry patients has been published in the nursing<sup>6,7</sup> and occupational therapy<sup>5,8,9,10,11</sup> literature. Boredom is commonly reported in hospitals, where patients may sense that “time stands still.”<sup>12</sup> Many patients admitted to psychiatry are highly susceptible to boredom as a result of their illness, with depression, personality disorders, anxiety, and psychosis all found to increase risk of boredom.<sup>1,13</sup> Interestingly, a lengthier or involuntary admission is not associated with increased boredom.<sup>13</sup> Some speculate that the loss of autonomy on the unit contributes to loss of engagement or meaning that is associated with boredom.<sup>6,13</sup> Several aspects of inpatient psychiatric wards clearly contribute to patients’ experience of boredom. Despite staff perceiving units as “busy,” given their own job duties and group programming offered to patients, as much as 90% (weekdays) to 96% (weekends) of patients’ time (as measured in one secure Australian forensic unit) comprises passive activities.<sup>11</sup> Patients spend many unstructured hours without access to activities they can typically do at home, including chores, media consumption, or professional labors. Visiting hours with loved ones and time outdoors are restricted, if available at all. As our patient NM notes, programming is often further reduced on the weekend.

### **Boredom as Harm**

To assess whether boredom should be considered an iatrogenic harm in this case and more generally on inpatient psychiatric units, a definition of iatrogenic harm must be specified. Broadly, iatrogenic harm can be conceptualized as a medical intervention that reduces a person’s health or well-being or hinders their recovery. This harm can be either psychological (eg, by causing distress) or physical (eg, by causing pain or impairing functioning). Moreover, not only the presence of harm but also the severity of the adverse effect is relevant to assessing whether boredom is harmful, since medical decisions involve weighing potential risks and benefits of the proposed intervention against the risks and benefits of inaction or an alternative intervention.<sup>14</sup>

The impact of boredom on NM’s well-being can be assessed by examining the potential adverse outcomes associated with boredom. Psychiatric inpatient environments reduce patient autonomy, as patients are detached from their normal routine, isolated from loved ones, and separated from personal items and electronics.<sup>6,7</sup> Furthermore, the limited opportunities for stimulating structural interventions and programming are commonly cited as restrictive<sup>10,15</sup> and repetitive.<sup>10</sup> Any combination of these factors can exacerbate the distress of patients like NM and induce their mental disengagement from the treatment environment.<sup>13</sup> NM approached Dr Z after exhausting all available programming and resources. Her boredom prompts her to request discharge rather than continuing to engage with inpatient treatment.

Patient boredom is also correlated with, and can intensify, many core symptoms of mental health disorders and dysfunctional behaviors, as well as symptoms of depression such as anhedonia, amotivation, and impaired attention.<sup>8,13</sup> Suicidal thoughts and depression—the symptoms that led to NM’s hospitalization—can be amplified by her feelings of boredom on the unit, as the abundance of unstructured time can lead to ruminative thoughts, a sense of hopelessness, and worsened depressive

symptoms.<sup>7</sup> In addition, increased boredom is associated with substance use<sup>9</sup> and other risky or impulsive behaviors like violence and criminality.<sup>5</sup> Relatedly, patient boredom is a major risk factor for absconding from inpatient forensic facilities.<sup>10,16</sup> When experienced by patients like NM, boredom might not only magnify symptoms but also, in extreme cases, manifest as dysregulated behaviors, such as aggression, self-harm, or elopement from the unit.

NM's experience of boredom might also be critically influenced by the capacities of the unit staff.<sup>6,17,18</sup> Many psychiatric wards experience staffing shortages, thereby reducing individualized patient-staff interactions, support resources, and opportunities for socialization and engagement. A common reason that psychiatric inpatients report boredom is their experience of limited interaction and engagement,<sup>19</sup> which can be amplified for a patient who is physically isolated to comply with infection-control protocols. In addition, patient boredom might be trivialized or dismissed by mental health staff.<sup>6</sup> NM's feeling that her concerns about boredom are not heard or addressed by staff could amplify her psychological discomfort and its associated distress. Strained staff-patient relationships are antitherapeutic and can impair collaboration on treatment planning, leading to distrust and lack of rapport that can potentially jeopardize clinical treatment and outcomes.

### **Benefits of Boredom?**

On the other hand, some argue that boredom provides an opportunity for meaningful personal growth.<sup>20</sup> Extrapolating to hospitalized psychiatric populations, one could speculate that boredom might drive hospitalized patients to try new activities and undertake new experiences. If we conceive a possible benefit of boredom as an opportunity to enjoy quiet, NM's unregulated time on the unit could allow opportunities for her to engage in self-care activities, reflection, and psychotherapy. However, NM found the days in the hospital long and tedious and explicitly requested more stimulating programming to promote effective recovery. NM therefore might need more structured support and activities to aid her treatment and recovery.

Boredom might also lead to more socialization opportunities.<sup>20</sup> Patients experiencing boredom might seek interpersonal connections on the unit, leaving their rooms to participate in activities and engage with other patients and staff. However, as mentioned above, the limited opportunities for structured socialization in NM's inpatient environment might not provide a conducive environment for socialization. NM already attends all offered groups, and she may struggle to initiate additional unstructured socialization.

Boredom might additionally stimulate curiosity and creativity. Although it has been argued that situations and feelings of boredom can spark opportunities for creativity and promote innovative goal setting,<sup>5,20</sup> NM is in an environment that restricts her ability to pursue creative ideas. Psychiatric inpatients have often reported that they felt limited by their resources, spaces, and choices.<sup>11</sup> Additionally, in more restrictive psychiatric environments, including forensic<sup>10</sup> and intensive care<sup>17,18</sup> settings, there are even more limitations and constraints on what is permitted to be in patients' possession. These environmentally dependent factors pose significant barriers to cultivating creativity in the hospital.

### **Mitigating Harms of Boredom**

To mitigate prospective harms of boredom, interventions could address the internal or external risk factors for boredom discussed above. NM focuses on the latter, in particular the paucity of activities available to her over the weekend on the unit compared to her more stimulating home environment. If she were not already attending group activities, her treatment team could encourage and support her participation. Interventions suggested to reduce boredom on inpatient wards include popular, novel activities that include opportunities for creative productivity,<sup>3,11</sup> recreational activities such as exercise,<sup>21</sup> behavioral activation therapy,<sup>18</sup> and collaborative treatment planning with meaningful efforts directed at patients' recovery and future.<sup>5,10,20</sup> These interventions require interprofessional collaboration that can be resource intensive and time-consuming to implement, and care should be taken to ensure such programs are patient centered and foster autonomy.<sup>5</sup> For NM, revising unit program offerings before the weekend is not feasible. Even with abundant activities, she might experience boredom due to other environmental factors outside of Dr Z's control or due to inherent risk factors limiting her ability to tolerate distress or make meaning in this situation.

Therefore, Dr Z might consider interventions to target NM's intrinsic vulnerabilities that make her prone to boredom. On psychiatric units, the core intervention is treating the underlying psychiatric illness that prompted admission, illness that often inherently increases risk of boredom.<sup>13</sup> For example, as symptoms of depression—such as amotivation and impaired attention—resolve, patients might be better able to engage in meaningful endeavors. They might also be able to utilize more effective coping skills, such as mindfulness, which has been proposed as a useful intervention to combat boredom<sup>1,5,13</sup>; mindfulness is a skill that can be taught and cultivated on inpatient units. Treatment teams can discuss boredom with patients and develop a coping plan for it, much as patients cope with other sources of distress. To make this plan, a clinician might help a patient reflect on their previous experiences of boredom, anticipate triggers for future episodes, and identify strategies to cope, such as learning how to self-soothe, tolerate distress, or engage in activities aligned with their values. For example, NM could write a schedule that includes activities and goals for the weekend. Such strategies are core elements of behavioral therapies commonly introduced on inpatient psychiatry units. Follow-up could generate fruitful discussions about patients' progress and goals, highlighting what brings meaning to their lives. Such conversations between clinician and patient about a coping plan might also support formal safety planning, an element of discharge planning that has become standard of care.

Ultimately, potential harms and benefits of boredom for NM over the weekend would need to be weighed carefully against the risks and benefits of discharge now, as requested. Her admission was prompted by suicidal thoughts, so a careful suicide risk assessment will be essential. If concern for suicide remains high, keeping NM alive through hospitalization certainly trumps harms related to boredom on the unit. If, however, suicidal thoughts have resolved, her planned discharge date is close at hand, outpatient support is high, and proximity to psychiatric follow-up is close, Dr Z might consider potential discharge to be low risk relative to the harms of boredom on the unit and thus support discharge.

### **Conclusion**

Boredom is a harm that might result from psychiatric hospitalization and affects many—though certainly not all—patients. Boredom is justified in situations in which the likely harms of the alternatives to hospitalization are more severe than the harm caused by

boredom. On the other hand, boredom is *not* a justifiable iatrogenic harm if the reduction in psychological well-being induced by boredom outweighs the benefit of hospitalization. In this case, Dr Z should consider how boredom is harming NM and compare the risks of continued boredom vs the risks of discharge. Ample data support the conclusion that harm is caused by boredom in inpatient psychiatry environments, and psychiatric hospitals have an obligation to take reasonable measures to reduce boredom. Mental health clinicians should consider boredom as a risk of hospitalization and take it into account when making treatment decisions.

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*The people and events in this case are fictional. Resemblance to real events or to names of people, living or dead, is entirely coincidental. The viewpoints expressed in this article are those of the author(s) and do not necessarily reflect the views and policies of the AMA.*

**MEDICAL EDUCATION: PEER-REVIEWED ARTICLE**

**What Should Students and Trainees Learn About Patient-Centered Documentation?**

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**Abstract**

What clinicians document about patients can have important consequences for those patients. Paternalistic language in patients' health records is of specific ethical concern because it emphasizes clinicians' power and patients' vulnerabilities and can be demeaning and traumatizing. This article considers the importance of person-centered, trauma-informed language in clinical documentation and suggests strategies for teaching students and trainees documentation practices that express clinical neutrality and respect.

*Oppressive language does more than represent violence; it is violence; does more than represent the limits of knowledge; it limits knowledge.*

**Toni Morrison<sup>1</sup>**

**Introduction**

*It is the end of a long day, and you have just finished seeing a new patient for chronic lower back pain. In reviewing her records, you learn that she uses self-injury to manage overwhelming distress, has a history of childhood attachment trauma, and was previously diagnosed with borderline personality disorder, opioid use disorder, and chronic low back pain. It takes you 10 minutes to write the note, in which you are careful to provide the rationale for having lowered her pain medication and referred her to physical therapy. You feel the encounter went surprisingly well. She leaves seeming optimistic about the new plan, expressing that she didn't realize physical therapy could be so effective. She liked how the plan centered around being more active, which aligned with her goal for weight loss. She remembered how she used to enjoy long treks throughout her neighborhood. It had been quite some time since she allowed herself to picture getting back out there.*

*Upon follow-up, the tension in the room is palpable. She seems cold and distant. You are genuinely concerned and ask her how she has been doing and if she has been able to go to physical therapy. At first, her voice is quivering, but it grows confident with anger as she describes having read your documentation in the patient portal. "I thought you got me," she said. "Actually, I am glad the patient portal exists because now I can see, in black and white, exactly what my doctors really think of me. What does it even*

*mean to have ‘failed’ prior medication trials and made ‘inconsistent attempts’ at lifestyle modification for morbid obesity? Are you kidding me? Who do you think you are? Oh, and also, I haven’t been ‘drug seeking’ for years. What I have been seeking is treatment! That’s it. I don’t need the extra judgment.”*

Before you keep reading, take a moment to pause and see what occurs to you as you imagine the experience described above. Imagine reading a note alongside this patient during the next session. Are there thoughts about how this session might go or images or sensations that arise? Are you thinking about a particular patient you have worked with? Repeat the same exercise in your mind and switch your role: you are the patient in this situation. How might this experience affect you as a patient?

When you have completed the exercises, do what you need to do to refocus—perhaps by taking a few deep breaths or taking a short mindful break. Keep this exercise in mind as you continue reading.

### **Clinical Language**

The language clinicians learn and adopt is powerfully shaped by the dominant culture: medical language was shaped by paternalism,<sup>2</sup> and the remnants of this origin are still apparent today. Up until the mid-20th century, the paternalistic model of the patient-physician relationship<sup>3</sup> dominated the medical field, including behavioral health. In this model, the clinician is viewed as an authority figure who has something the patient needs, and the patient is seen as a sufferer in need of the clinician’s expertise.<sup>3</sup> Inherent in this model is an asymmetrical power dynamic in which the clinician can recreate the powerlessness a patient might have experienced when left with no autonomy or choice in a traumatic situation. For many people with marginalized identities, going to the doctor is already an anxiety-provoking and scary experience. One can imagine how the **paternalistic model** has the potential to further amplify the difficulty people might experience while seeking care, as an environment shaped by paternalism is not trauma informed and instead potentially retraumatizing.<sup>4,5</sup>

Even if unintentional, language reflecting the essence of paternalism leads to worse health care outcomes<sup>6</sup> and is often perceived as demeaning, shaming, or blaming, and it risks being delivered in an authoritative and even condescending tone. Examples of normalized, though clearly problematic, terms commonly used in electronic health records (EHRs) include the following: *noncompliant, drug seeker, manipulative, addict, morbidly obese, insane, hysterical, failed to..., claims to..., borderline tendencies, malingerer, frequent flier, and she’s a cutter*. What does this language say about how the clinician views this person? What do these labels convey to other clinicians? How do they affect trainees who learn from these clinicians? How do they impact the culture of the clinical environment? How might the person feel when they read these terms describing themselves?

With the passage of the 21st Century Cures Act,<sup>7</sup> providers in EHR incentive programs nationwide must attest to “meaningful use” of EHRs to avoid a penalty. Clinicians must now take into consideration the impact of their language on the care they deliver. A shift in the culture of medicine toward recovery-oriented and trauma-informed care models has led clinicians to be more mindful of the impact of their words on others and, specifically, to use unbiased descriptions of people seeking services without discriminatory undertones. These models interrogate the power structures upheld by paternalism and require clinicians to acknowledge their responsibility in forming a



collaborative environment that acknowledges the patient's expertise and authority in their care.<sup>4</sup>

### **New Approaches to EHR Documentation**

There are several frameworks that clinicians and educators can familiarize themselves with to improve EHR documentation and especially to teach a new way of approaching documentation. The Risking Connection framework<sup>8</sup> emphasizes that any relationship aiming to be therapeutic is defined by the following components: respect, information, connection, and hope (RICH). The RICH model is described as follows: *Respect* is conveyed through sensitive use of language and respect for the patient's views. Language that is respectful emphasizes abilities over limitations without a demeaning or shaming undertone and has the power to reduce stigma and discriminatory practices in medicine.<sup>9</sup> Useful *information* is shared with patients to empower them with knowledge about their experience. *Connection* through empathic attunement is critical for healing and not just an afterthought. It requires sensitive responses, empathic understanding, and careful listening. *Hope* is communicated through actions, words, and body language and is ultimately fueled by capacity for compassion. The RICH model is inherently empowering, as persons accessing care play a central role in their treatment team, and all team members work collaboratively to help them achieve their goals.

For example, in the vignette, the note in the patient portal uses labels (eg, "failed," "drug seeking") and diagnoses ("lower back pain") that emphasize pathology rather than focusing on resilience factors and explaining how and why the patient might have developed the behaviors and symptoms leading to the diagnosis. There is a key difference here between the approach taken in the vignette and the RICH model: the former emphasizes "what is wrong with the patient" and the latter "what went wrong to lead the patient to make those adaptations." The former may lead to unintended patient blaming and labeling, which does not make for a therapeutic interaction or environment. For example, in the statement, the patient "'failed' prior medication trials and made 'inconsistent attempts' at lifestyle modification for morbid obesity," the term *failed* implies that the patient is at fault. It would have been more respectful and information-focused to write in the note, "the medications tried were not helpful." Moreover, the term *inconsistent attempts* does not explain what led the patient to act the way she did. It does not address possible difficulties she experienced in trying to change her lifestyle, such as lack of access to a gym, inability to afford specialty foods, or there being no grocery store with fresh produce near her home. Avoiding negative language and including possible explanations for her behavior in the note might have been received more positively by the patient.

Shifts in clinicians' approaches to EHR documentation must go hand in hand with shifts in how they care for patients. Shaping a curriculum for medical students and residents requires thoughtful unlearning of the paternalistic model and joining with patients in their recovery. The National Harm Reduction Coalition published a fact sheet on undoing stigma and the importance of person-centered language in this process, emphasizing that "A person is a person first, and a behavior is something that can change—terms like 'drug addict' or 'user' imply someone is 'something' instead of someone. Stigma is a barrier to care, and we want people to feel comfortable when accessing services. People are more than their drug use and harm reduction focuses on the whole person."<sup>10</sup>

## Improving Curricula

A solution to problematic language in health record documentation cannot be a 1-hour “cultural competence” or “patient-centered language” didactic. For example, the Columbia University Public Psychiatry curriculum,<sup>11</sup> with which all of the authors are currently or were previously associated, adopts recovery-oriented, systems-based practice and justice and trauma-informed frameworks in patient care that are woven throughout the entire curriculum. Understanding that trauma-informed care must avoid marginalization—including linguistic marginalization—because all marginalization is traumatizing, the Columbia University curriculum has also implemented an **antiracist lens**.

To apply these lenses, the Columbia University curriculum starts by having students step out of the medical model, which focuses on symptoms, diagnosis, and treatment of disease. It then has them focus on *Who is this person and how can I help them?* This question completely reorients students from thinking, *I am the doctor with the knowledge and will treat this illness* to *I am a trained professional who can collaborate with this person to try to get their needs met*, which is a recovery-oriented, person-centered approach. The curriculum also requires trainees to understand the community and the medical and social structures that the person has to navigate to get their needs met, which describes the systems-based practice approach.<sup>12</sup> (Teaching antiracism and social justice requires a safe and brave learning environment<sup>13</sup> that allows trainees to have open discussions about the systematic marginalization of people who are “othered” in our society because race and ethnicity cannot be ignored in the way medicine is practiced.)

Implementation of the SMART Tool<sup>14</sup> developed by the American Association for Community Psychiatry is one way to create a learning environment that honors patients. Another is through the co-creation of a curriculum with people with lived experience, or the Peer Advisor Program.<sup>15</sup> This program includes experiential longitudinal learning through monthly meetings with a certified peer advocate throughout the training.<sup>16</sup> This program also flips the hierarchy, as the person with lived experience serves as the advisor.<sup>17</sup>

While implementation of change in EHR documentation is a lengthy process, it is worthwhile, given the impact on outcomes and satisfaction such change could have on people who have access to their records.<sup>18</sup> Medical schools and residency programs committed to equipping their trainees with the skills needed for inclusive and nonjudgmental documentation might consider consulting with trauma-informed care organizations for in-person training tailored to faculty and students. While didactics on therapeutic interactions and the impact of language on the therapeutic environment are imperative, they are rarely enough to affect meaningful change in practice.<sup>19</sup> Faculty modeling for students healthy and respectful communication about patients when they are not present, as well as during rounds and all other clinical interactions, is critical if we hope to change the culture of medicine. Experiential learning, such as role-playing clinical interactions with certified peers or standardized patients, has been proven to have a lasting impact on trainees’ interactions with patients.<sup>20</sup> A particularly engaging exercise used in training and workshop settings involves the rewriting of a typical note. Trainees are encouraged to critically examine their documentation and rewrite it in a patient-centered, **trauma-informed**, empowering tone.<sup>21</sup> Once a critical mass of newly trained clinicians adopts these principles, they may influence the existing culture.

## Conclusion

Going forward, it would be prudent for medical education to be informed by the 21st Century Cures Act and its ramifications. Training programs will need to make a cultural change to become more person centered and recovery oriented. To mitigate harm to patients, education for medical students and trainees will also need to modify didactics to include a focus on language used in notes and the message being conveyed, such that the audience for the note includes the subject of the note. This linguistic change would highlight that patients are now integral members of the clinical team.

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**MEDICAL EDUCATION: PEER-REVIEWED ARTICLE**

**What Should Health Professions Students Know About Countertransference in Inpatient Psychiatric Environments?**

Erik Levinsohn, MD and Marta Herschkopf, MD

**Abstract**

Inpatient psychiatric units are heavily regulated physical environments designed around the twin aims of treatment and containment. Less formally regulated but no less important are emotional norms and tones that also contribute significantly to psychiatric care environments. Inpatient psychiatric units are co-created by patients and clinicians, but clinicians have authority that patients do not. This means that clinicians' management of their own transference and reactions is clinically and ethically important. This article defines transference reactions and draws on case examples to canvass how positive and negative transference reactions can influence inpatient care of patients who are suicidal.

**Transference, Countertransference, and the Therapeutic Environment**

Inpatient psychiatric units are heavily regulated physical environments designed around the twin aims of treatment and containment. Less formally regulated but no less important is the emotional environment of the unit, a space co-created by patients and clinical staff. Clinicians bring more to the therapeutic encounter than their years of clinical training; for better and worse, treatment occurs in the context of their life experiences. Understanding and managing clinicians' emotional responses to patients, termed *countertransference reactions*, is an important part of creating an optimal therapeutic environment for everyone.

The twin concepts of countertransference (how clinicians feel about their patients) and transference (how patients feel about their clinicians) were born from psychodynamic theory, initially developed by Sigmund Freud.<sup>1</sup> Although countertransference was initially defined as the unconscious feelings that patients evoke in their psychiatrists, we will be using a more contemporary and inclusive definition that includes conscious as well as unconscious emotions and behaviors and patterns of thought.<sup>2</sup>

Although countertransference (and transference) reactions exist in all patient-clinician interactions, they are often particularly pronounced when clinicians treat suicidal patients in the inpatient psychiatric environment who are experiencing a moment of crisis: the psychiatrist fears a bad outcome and often the patient and care team lack a shared understanding of the underlying problem and corresponding solution. Stereotypic

adverse countertransference reactions to suicidal patients include anxiety, anger, and helplessness and are associated with worse patient outcomes.<sup>3</sup>

In this article, we explore common patterns of countertransference evoked by our work with suicidal patients on inpatient units, as well as techniques to mitigate their potential adverse effects on the patient care environment.

### **Common Countertransference Reactions**

*Anxiety and fear.* Mr G presents to the inpatient unit with depression. He tells the psychiatrist, “This treatment is my last shot before I kill myself.” Discomfited, the psychiatrist spends several days before selecting a medication, then raises the dose far above the recommended maximum when the patient reports no effect. Later, the same psychiatrist contends that the patient has a personality disorder and should be treated with psychotherapy only. The unit psychologist counters that the patient requires medication management. The team social worker observes that the desperation of the patient has been adopted by the team and wonders aloud how it has negatively influenced his care.

*Commentary.* Faced with a daunting ultimatum, the team vacillates between being avoidant and overly aggressive. This reaction manifests as the psychiatrist giving in to an urge to abandon the patient or allowing feelings of fear to dictate deviating from the standard of care. A framework for the staff’s management of such a situation could involve (1) identifying the presence of significant countertransference dynamics, (2) naming the underlying emotion, (3) validating the response as a normal aspect of treatment, and (4) mindfully proceeding in treatment planning. In this vignette, the social worker has opened a space for a discussion of these issues to take place. The treatment team can acknowledge the patient’s frustration, build a therapeutic alliance upon a shared understanding of the problem, and **collaboratively explore options** for further treatment.

*Anger and hatred.* Recently fired from his prestigious job, Mr L is admitted to a psychiatric teaching unit and states that he has nothing left to live for. He refuses treatment options proposed by his team and insists that he meet with the chair of the department for daily individual therapy. When told that this is impossible, he avers that if he were at a more prestigious hospital “then maybe I would actually get some help.” The psychiatry resident angrily tells the patient: “Fine, you want to go to a different hospital? We can arrange that.” The resident later discusses the case with her attending physician and realizes that, while she felt personally humiliated by Mr L due to her own preexisting feelings of self-criticism, his behavior partly reflects his own insecurities. This observation allows her to feel some empathy in her future interactions with him. During their next meeting, the resident agrees with Mr L that he deserves the best possible care and outlines a treatment plan that she describes as “the gold standard.”

*Commentary.* Before any progress can be made in addressing countertransference reactions with patients, clinicians must start by **developing self-awareness**. Countertransference reactions occur due to a combination of patient and clinician factors; without an understanding of one’s self, one will have, at best, half the picture. The value of supervision aimed at identifying countertransference is underscored by the presence of “T groups” for psychiatric residents—the practice of encouraging trainees to obtain their own psychotherapy—and even developing “autognosis,” or “knowing one’s self,” rounds for medical and surgical trainees.<sup>4,5,6</sup>

One characteristic of an optimal therapeutic environment is the opportunity for all clinicians to seek supervision to help manage countertransference reactions. Such supervision is especially important when the countertransference reaction may be seen as “unprofessional.” Prior to the mid-20th century, medical literature did not explore the uncomfortable truth that clinicians sometimes hate their patients. Influential work by Groves,<sup>7</sup> Maltzberger and Buie,<sup>8</sup> and Winnicott,<sup>9</sup> among others, acknowledged this reality, noting that some patients may evoke a dislike so intense that otherwise empathetic and professional physicians could potentially act out their hateful feelings through abandonment or even sadistic behavior. Supervision provides an opportunity to check these impulses in favor of more appropriate clinical care. As noted in the example of *the demanding patient* above, acknowledging that the patient deserves excellent care and channeling the patient’s entitlement into collaboration with rather than antagonism toward the team is one way that clinicians can work through adverse countertransference reactions.<sup>8</sup>

*Helplessness and hopelessness.* Ms N was psychiatrically hospitalized for 6 months following a suicide attempt. She was treated with intensive psychotherapy, multiple medication trials, and several courses of electroconvulsive therapy. Confident that the patient is much improved, the treatment team discharges her. Hours later, she presents with an overdose and is readmitted to the same inpatient treatment team. During rounds, the medical student on the team asks about options for treatment-resistant depression but is cut off by the senior psychiatrist who states: “Don’t waste your time. That’s not going to do anything for her.” The next time the patient is mentioned in rounds, her name is met with silence, and nobody suggests any changes in her treatment plan. Unlike other patients, she is not strongly encouraged to attend group therapy. The psychiatric trainee posits that both the team and the patient may have given up.

*Commentary.* Every clinician has seen a patient experience bad outcome after bad outcome and wondered if the patient is a “lost cause.” Although such a belief may in part be based in reality, it may also be an internalization of the patient’s same feeling of lack of hope. Here, while Ms N herself may not be consciously experiencing helplessness, her despair manifests in the actions of her team. When clinicians reflexively take on the fatalism projected by their patients, they risk actualizing the patient’s belief that they cannot be helped. As with advanced heart disease or metastatic cancer, psychiatrists also encounter severe illness that is treatment refractory. Such cases should galvanize reformulation, consideration of untried treatments, and seeking second opinions rather than embracing fatalism.

Notably, this situation also illustrates how countertransference can actually be leveraged for the patient’s benefit. Discussion of transference and countertransference in the inpatient setting has even been developed into a form of psychotherapy that can be used in the acute inpatient setting.<sup>10</sup> The clinician’s inquiring as to whether the patient is feeling helpless and whether she feels that her team has given up on her may provide valuable diagnostic information, strengthen a tenuous rapport, and perhaps open a door to reestablishing a path forward for treatment.

*“Positive” countertransference.* Ms H recently immigrated to the United States as a refugee. She presents to the emergency department reporting symptoms of posttraumatic stress disorder. Although there is usually a time limit on phone calls, her



treatment team feels that the patient has already “been through so much” and allows her to skip group therapy to talk with her friends on the phone. The psychiatry resident finds himself staying late on the inpatient unit to meet with the patient a second and third time during the day and offers to treat her as an outpatient after discharge, even though this is not standard practice. However, as the patient improves and becomes more active, the resident feels a sense of protectiveness that prevents him from ever challenging Ms H or encouraging her to take a more proactive role in her treatment. During a community meeting, other patients on the unit demand to know why there is one set of rules for some patients and different rules for “the rest of us.” After meeting with his supervisor, the resident meets with the patient, acknowledges his mistake, and reestablishes boundaries with the patient.

*Commentary.* Not all countertransference evokes negative feelings that contribute to bad outcomes. However, as this vignette shows, positive countertransference reactions can also adversely affect patient care. Clinicians are most comfortable in a relationship dynamic in which they feel helpful, competent, and appreciated. When clinicians start making treatment decisions based on emotional responses, they risk being drawn into situations in which their care deviates from accepted best practice. Psychotherapists use the term *frame* to capture the context in which treatment occurs. Having a predictable and mutually accepted frame for patient and clinician means that both parties share an understanding of what to expect during treatment. Examples of the treatment frame include the frequency of meetings, limitations to confidentiality, and the responsibilities of both patient and clinician. Countertransference dynamics can pull the clinician toward violating the terms of the frame—for example, by the clinician’s spending more or less time with patients or bending rules due to “special circumstances.”

In this vignette, the treatment team, guided by an affinity for the patient, has found it hard to enforce unit rules or to encourage the patient to make the most of the therapeutic environment. In the process, the team has upset other patients, who rightly wonder why they are being treated differently. Whenever a deviation from the treatment frame occurs, clinicians (with the assistance of supervision) should clarify for themselves why the treatment frame has changed, and for whose benefit.

### **Conclusion**

Designing an optimal therapeutic environment requires that all clinicians be aware of countertransference reactions, particularly when working with suicidal patients. By recognizing countertransference as a natural consequence of working with hospitalized suicidal patients (and not necessarily a harmful one, as countertransference can evoke sympathy or compassion), clinicians can reduce the distress that such interactions engender and ultimately improve patient care. Although this article focuses on the role of recognizing countertransference reactions in one’s self, clinicians may find that, with practice, they are also better able to identify countertransference reactions in their peers. With practice and guidance, all clinicians can improve their ability to manage complex and intense countertransference reactions even in the most acute settings, such as the inpatient psychiatric environment.

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**IN THE LITERATURE: PEER-REVIEWED ARTICLE**

**Why Patient-Centered Built Environment Standards Matter More Than Numbers of Beds in Inpatient Psychiatry**

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**Abstract**

This article canvasses extant literature about values, evidence, and standards for inpatient psychiatry units' design. It then analyzes apparent trade-offs between quality of care and access to care using empirical and ethical lenses. From this analysis, the authors conclude that standards for the built environment of inpatient psychiatric care should align with patient-centeredness, even if a downstream consequence of implementing new patient-centered designs is a reduction in beds, although this secondary outcome is unlikely.

**Iatrogenic Harm**

Inadequate access to inpatient psychiatry has received outsized attention in both the academic and the popular press compared to the quality of care provided in these settings.<sup>1,2,3,4</sup> News reports describe prevalent boarding of patients in the emergency room, concluding directly or through implication that more psychiatric beds would lead to better population health outcomes.<sup>1,4</sup> This assumption reflects a privileging of access to a bed over its therapeutic value—a position for which there is little empirical or ethical justification. Over a century's worth of testimony and narrative reveals concerns about the quality and even iatrogenic harm of inpatient psychiatric care.<sup>5,6,7,8,9,10,11,12,13,14</sup> While conditions may have improved since the 1950s, patients continue to raise concerns about dehumanizing aspects of modern inpatient psychiatric care settings, both regarding the built environment and the treatment they receive on an interpersonal level.<sup>7,14,15,16,17</sup> Moreover, evidence suggests that minoritized and disenfranchised patients are more likely to receive care at inpatient psychiatric facilities with higher rates of complaints and episodes of restraint and seclusion,<sup>18</sup> highlighting the social justice implications of continuing to sideline quality of inpatient psychiatric care. Given this evidence, it seems unreasonable to prioritize the expansion or preservation of psychiatric beds over the utility (ie, quality) that such care has for the patient, the central stakeholder.

In this paper, we describe the need to adopt national standards for patient-centered built environments, implementation of which will raise the floor for what we consider acceptable care and enable subsequent efforts to systematically implement patient-centered environments.

## Built Environments

Patient-centered care—respecting patients’ needs, preferences, and autonomy—is a value<sup>19</sup> identified by health care consensus bodies, such as the Institute of Medicine, similar to the values of safety and effectiveness.<sup>20</sup> In the context of inpatient psychiatry, principles of patient-centered care can be seen in evidence-based, trauma-informed care models; these models are effective in preventing and reducing violence, trauma, restraint, and seclusion in inpatient psychiatric settings.<sup>21,22,23,24</sup> Patient-centered inpatient psychiatric care has also been associated with improvements in patients’ trust in mental health professionals, their willingness to engage in postdischarge care, and the likelihood that they will have an outpatient visit within 30-days of discharge.<sup>25</sup> Patient-centered care is, therefore, both an outcome that we value in its own right and a factor that is related to other desirable outcomes (eg, safety, engagement with care). In what follows, we will describe how patient-centered care values can be embedded within the built environment through specific design features and how the implementation of these design features can be enabled by clear standards that articulate their foundational importance.

*Patient-centered design features.* While patient-centered care is often discussed within the context of interpersonal relationships, operationalizing patient-centered care relies on many structural components, including facilities’ built environments. We identified several features of patient-centered design relevant to inpatient psychiatry in the literature (See Table).<sup>26,27,28,29</sup> These features range from hallways’ structures, to unit décor, to **accessibility of nature**. The fundamental objectives of these features are to support patients in feeling safe, comfortable, and reasonably autonomous (eg, able to control their environment and have their privacy respected). Although complete autonomy and choice in these settings may not always be appropriate, evidence suggests the importance of maximizing choice through a trauma-informed lens in order to mitigate institutionalization’s negative consequences and maximize its potential benefits.<sup>30</sup>

**Table.** Different Design Features Identified in the Literature

Domain	Shepley (2013) <sup>26</sup>	US Dept of Veterans Affairs (2021) <sup>27</sup>	Carr (2017) <sup>28</sup>	US Dept of Veterans Affairs (2017) <sup>29</sup>
<b>General</b>				
Flexibility for patients (eg, ability to control immediate environment; space promotes autonomy and spontaneity)	x	x	x	x
Homelike environment with familiar and noninstitutional materials	x	x	x	x
Regularly maintained finishings, furniture, and landscaping	x		x	
<b>Patient rooms</b>				
Privacy (physical, visual, acoustic)	x	x	x	x
Low-density patient rooms	x	x		x
<b>Dayroom</b>				
Dayrooms and common areas that encourage social interaction and sense of community	x	x	x	x
Mix of seating arrangements	x	x		x
Designated smoking spaces	x			

<b>Staff spaces</b>				
Spaces for one-on-one interactions between patient and staff	x	x	x	x
Staff stations that look out on patient wings and activity areas	x	x	x	x
<b>Light/nature</b>				
Well-illuminated interior spaces that maximize use of daylight	x	x	x	x
Indoor and outdoor spaces for therapeutic activities	x	x	x	x
Visual or physical access to nature	x	x	x	x
<b>Safety</b>				
Enhancement of staff safety and security	x	x	x	x
Avoidance of architectural elements that can be used as weapons	x	x	x	x
Anti-ligature and secure design	x	x	x	x
<b>Layout</b>				
No long corridors or blind corners. Direct and obvious travel paths	x	x	x	x
Pod-like designs to separate patients and support privacy		x		x
Meeting area for patients and visitors (family, guests)	x	x	x	x

*Standards for patient-centered design.* Standards are a foundational instantiation of our values of care quality; they can be understood as the institutional or procedural counterparts of clinical recommendations or practice guidelines. They are intended to reflect our values as a society and the latest evidence, articulating a baseline floor for quality and informing subsequent accountability parameters. We evaluated language in standards outlined by leading national clinical professional and other organizations (the American Medical Association,<sup>31</sup> the American Psychiatric Association,<sup>32</sup> the American Psychological Association,<sup>33</sup> and the National Fire Protection Association<sup>34,35</sup>) and regulatory bodies (the Joint Commission,<sup>36</sup> the Centers for Medicare and Medicaid Services,<sup>37</sup> and the Patient Safety Authority<sup>38</sup>), with respect to principles of patient-centered care as they apply to the built environment. We found little clinical professional association language related to the built environment that could further patient-centered care. The language of the National Fire Protection Association and regulatory bodies like the Joint Commission focuses primarily on fire safety and access to ligature points.<sup>34,35,36,38</sup> Current language used in standards related to the built environment thus emphasizes physical safety through means of containment. In this way, the established standards and rules undermine, rather than promote, patient-centered care. Arguably counterproductive to safety, this lopsided focus applied in psychiatric settings likely increases the risk of interpersonal violence and harm to both patients and staff<sup>7,21,23,30</sup> while creating a type of pervasive psychological harm to patients that is difficult to quantify.<sup>39</sup>

### **Empirical and Ethical Analyses**

It seems clear that there is a need to consider raising the floor of acceptable standards for care quality in inpatient psychiatric settings. Standards for the built environment should align with both the empirical literature and society's expressed **value of patient-centered care**. However, an argument against raising the baseline of standards is that

there are trade-offs between quality and quantity. These trade-offs are not exclusive to inpatient psychiatry—they are widely discussed in inquiries concerning the sociology of mental health,<sup>40</sup> physician labor supply,<sup>41</sup> and public health services,<sup>42</sup> among other topics—and there is even a journal called *Quality & Quantity*, in which some of the work on such trade-offs has appeared. But is this trade-off between quality and quantity relevant to inpatient psychiatry—in other words, will strengthening standards for the built environment lead to reductions in psychiatric beds, and are we faced with a bed shortage? Is access to anything better than nothing? We evaluate these concerns using empirical and ethical frameworks.

We begin by examining the current evidence for patient-centered standards causing a reduction in bed supply. A consequentialist ethical framework positions us to evaluate actions in terms of their consequences and is one approach to evaluating trade-offs (eg, between access to and quality of care<sup>43</sup>) posed by updates to standards that result in reduced bed supply. A consequentialist might ask, “What is the evidence that the adoption of patient-centered standards will result in a reduction of psychiatric beds?” There is no evidence to suggest that adoption of patient-centered standards for the built environment would reduce psychiatric beds. One can look to the Centers for Medicare and Medicaid Services’ Inpatient Psychiatric Facility Quality Reporting Program (IPFQR) as the most proximal comparison in terms of time, place (United States), and orientation towards quality.<sup>44,45</sup>

The IPFQR is a national quality measurement and reporting program that attempts to hold facilities accountable on metrics related to baseline standards of care treatment. While it has included some structural measures of quality (eg, presence of electronic health information exchange, measurement of patient experience<sup>44</sup>), the program currently focuses primarily on care process (eg, care coordination, screening for metabolic conditions) and utilization outcomes (eg, follow-up visits, readmission rates).<sup>46</sup> Since the program was implemented in the last quarter of 2012, there were no observed reductions in psychiatric beds.<sup>47</sup> In fact, over the years, a growing share of inpatient psychiatric beds are now owned by large for-profit companies, with new construction and continued investment projected for the future.<sup>47</sup> That these beds are increasingly owned by profit-maximizing firms<sup>48,49</sup> is a concerning trend, further emphasizing the need to strengthen our accountability mechanisms and direct attention to quality of care. However, the evidence does not support a narrative that improving quality standards will reduce access to psychiatric beds.

Furthermore, the fact that the built environment is a fixed feature of a facility and does not vary based on patient characteristics reduces the likelihood that a facility would face perverse incentives to cherry-pick more desirable patients and thereby reduce access. By contrast, process and outcomes standards, such as restraint use and readmission rates, might incentivize facilities to cherry-pick patients they expect will help them perform better on those standards, thus limiting access to certain patient groups.<sup>50</sup>

Moreover, even if the standards outlined structural requirements that could only be addressed through a change in space and occupancy, details of the *implementation* of these standards—or the specific regulatory rules, incentives, and supports—would likely moderate the degree of fidelity that hospitals would be compelled to meet. For example, existing facilities could be “grandfathered” in when faced with certain mandates, such that the formal rules of the fixed architecture of buildings would primarily apply to new builds (the approach taken by the Americans with Disabilities Act).<sup>51</sup> Thus, improved

standards for the built environment are unlikely to lead to cherry-picking of patients or reduction of beds, and the operationalization of standards and specific regulatory rules, incentives, and supports can mitigate reductions in access.

What is the ethical justification for updating standards even if doing so reduces psychiatric bed supply? Consequentialism is centrally concerned with the utility, or consequences, of actions.<sup>39</sup> Under this framework, revising standards might be unethical if, overall, it reduced access to beneficial care (or the amount of “happiness” across persons). In order for this cause-effect relationship to hold, there would, firstly, need to be a reduction in access to inpatient psychiatric care directly attributable to the revision of standards. Secondly, the care that would have existed absent the revision of standards would have to have had a net benefit to most of those patients in the counterfactual world. We have previously disposed of the first proposition. As for the second, the justification for more psychiatric beds is that greater availability of beds promotes the well-being of individuals and society. This is a problematic assumption for several reasons.

First, a bed is a venue of care, not a type of care. For the past 5 decades, the thrust of US mental health policy has been on attempting to deliver high-quality care in alternate venues, (ie, in ambulatory settings); such initiatives included attempts to expand access to community mental health care under the Kennedy Administration.<sup>52</sup> This shift is also reflected in the *Olmstead v LC* Supreme Court decision, which mandated community services for people with disabilities, including those with serious mental illness, and clarified that needless institutionalization of psychiatric patients is discrimination.<sup>53,54</sup> Scholars working on the ethics of alternatives to hospitalizations have proposed, for example, that objective consequentialism be used to justify care in least restrictive environments.<sup>55</sup>

Second, access to *any* bed, regardless of its quality, could cause more harm than benefit.<sup>11</sup> Recognition of this fact is why civil commitment processes operate under close judicial scrutiny and are designed to ensure that hospitalization is used for protective or therapeutic rather than for custodial purposes.<sup>56</sup> Indeed, empirical evidence demonstrates that patients’ experiences of patient-centered care while hospitalized are related to outcomes; those discharged from facilities rated poorly for patient-centered care were more likely than those discharged from highly rated facilities to experience negative outcomes, such as a reduction in trust and willingness to engage in care.<sup>25</sup>

Third, the effectiveness of inpatient psychiatry as a population-level intervention to prevent suicide and improve outcomes lacks evidence, despite its effectiveness for both suicidal and nonsuicidal patients having been studied since the 1950s.<sup>57,58,59,60,61</sup> In fact, suicide rates have increased by about 30% since 2000,<sup>62</sup> with the risk of suicide being about 300 and 200 times the general global rate within the first week and month of discharge from inpatient psychiatry, respectively.<sup>63,64</sup> Experts have questioned if some of this increased suicide risk is due to iatrogenic harm of inpatient psychiatric care (eg, experiences of dehumanization and hopelessness) rather than being attributable entirely to patient selection or external factors in patients’ personal lives.<sup>65</sup>

Finally, bed availability is not synonymous with access. Indeed, emergency department boarding of psychiatric patients is related to inpatient facilities’ preference for more “desirable” patients (eg, those who are easier to manage and place postdischarge and

who have desirable insurance)<sup>66</sup> and the difficulty in making beds available through discharging clinically ready patients due to a lack of community-based services.<sup>67</sup>

A calculus here is which treatments, delivered in which settings, best promote which individuals' recovery. Bed availability is one of several possible elements, not the sole element of recovery. Our empirical analysis suggests that **improving standards for the built environment** will not reduce bed availability, and our ethical analysis suggests that even if such reductions occur, they might not be entirely undesirable. Consequently, the default conclusion is to revise standards for the built environment to align with patient-centered care. Raising the floor on care quality will likely lead to greater net benefit than if we were to continue to accept the status quo.

### Conclusion

Current national standards for the built environment applied to inpatient psychiatric care do not appropriately reflect the empirical literature or society's value of patient-centered care. Based on our empirical and ethical analysis, we have concluded that there is a need to improve standards for the built environment to better reflect society's value of patient-centered care, even in a world where updating standards would cause a reduction in beds, though this scenario is unlikely.

Focusing on the current system's capacity, which lacks evidence of its utility to patients and communities, prevents the type of disruption needed for a more patient-centered treatment system.<sup>7</sup> Improved standards would provide the foundation needed to support implementation of patient-centered built environments. Moreover, some actions can be taken by implementers of standards to mitigate, monitor, and address unintended consequences of implementation in ways that respect the spectrum and nuance of the care needs of a diverse patient population as well as the operationalization of patient-centered care.

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## MEDICINE AND SOCIETY: PEER-REVIEWED ARTICLE

### How Inpatient Psychiatric Units Can Be Both Safe and Therapeutic

Matthew L. Edwards, MD and Nathaniel P. Morris, MD

#### Abstract

Inpatient psychiatric units should be therapeutic environments that support dignity and recovery. When adverse outcomes (eg, self-harm, violence) happen in these settings, clinicians and administrators can face litigation and other pressures to prioritize risk management over supporting patients' access to personal belongings, exercise equipment, and private spaces. This article describes these downward pressures toward sparser, controlling environments in inpatient psychiatric settings as a *safety funnel* and suggests strategies for balancing safety, humanity, and recovery in these contexts.

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#### Evolution of Inpatient Psychiatric Units

Inpatient psychiatric units are supposed to offer therapeutic environments for patients to recover from severe psychiatric symptoms. As far back as 1847, Thomas Story Kirkbride, a US physician, published “Remarks on the Construction and Arrangements of Hospitals for the Insane.”<sup>1,2</sup> This treatise focused on all aspects of the design and organization of hospitals for people with mental illness,<sup>2,3</sup> such that, as Tomes argues, “every detail, from the design of the window frames to the table settings in the ward dining rooms, had to be arranged to sustain the impression that here was an institution where patients received kind and competent care.”<sup>1,3</sup> Long-term psychiatric hospitals in the United States and elsewhere, often referred to as asylums, occasionally had sprawling facilities with acres of land, gardens, chapels, or other amenities for engendering tranquility among the inhabitants.<sup>4,5,6</sup>

Although large, often state-run, facilities played a considerable role in the care of people with mental illness into the 20th century, by mid-century, increased public awareness of the conditions inside certain facilities, growing emphasis on patients' rights, and other developments led to a shift away from these types of facilities toward community-based care.<sup>7,8</sup> In parallel, the goal of psychiatric hospitalization shifted from long-term psychiatric and custodial care to short-term stabilization.<sup>7,9</sup> The evolution of inpatient psychiatric settings toward brief stays has coincided with increased clinical and legal emphasis on promoting safety and preventing adverse events. This article describes the

downward pressures toward sparser, controlling environments—what we refer to as the *safety funnel*—in inpatient psychiatric care. Given potential counter-therapeutic effects of this phenomenon, this article suggests how to balance safety, humanity, and recovery in these clinical settings.

### Frequency of Adverse Events

Adverse events, such as self-harm, violence, harassment, and privacy breaches, can occur in inpatient psychiatric settings and can harm patients, staff, and others. For example, pooled estimates based on international data indicate that approximately 147 suicides occur per 100 000 psychiatric inpatient years,<sup>10</sup> with one study finding a rate of suicide among psychiatric inpatients that was nearly 50 times greater than in the general population.<sup>11,12</sup> In the United States, estimates suggest that approximately 30 to 50 patients receiving inpatient psychiatric care die by suicide each year.<sup>13</sup> International estimates suggest that anywhere from 4% to 70% of patients on psychiatric units engage in some degree of nonsuicidal self-injury (eg, cutting, head banging).<sup>14</sup> Even with environmental interventions (eg, reducing ligature points), monitoring (eg, placing high-risk patients under staff observation), and other precautions to decrease risks of self-harm, self-injury remains a challenge for staff tasked with caring for patients hospitalized for acute psychiatric symptoms.<sup>13,15</sup>

Violence may also occur in inpatient psychiatric facilities. A 2015 systematic review examining violence in inpatient psychiatric settings found that approximately 17% of patients committed at least one act of physical violence when data were pooled across roughly 24 000 patients in 35 studies from high-income countries.<sup>16</sup> In addition to perpetrating violence, patients may experience physical injury, fear, difficulty recovering from psychiatric symptoms, and other complications related to violent victimization from peers or staff; moreover, inpatient psychiatric staff also face these challenges. According to a 2021 systematic review, approximately 25% to 85% of survey respondents working in inpatient psychiatric facilities in the United States reported experiencing physical aggression in the year prior to the survey.<sup>17</sup>

Various other adverse events may occur in inpatient psychiatric settings, ranging from breaches of privacy to sexual harassment.<sup>18,19</sup> When self-injury, violence, or other adverse events occur in these settings, inpatient psychiatric staff and administrators may face punitive repercussions. Examples might include sanctions by regulatory agencies (eg, loss of accreditation by the Joint Commission, fines by the Occupational Safety and Health Administration), litigation by patients or their families, and litigation by staff, among other possibilities.<sup>20,21</sup> According to a 1993 article, “the most common legal action involving psychiatric care is the failure to reasonably protect patients from harming themselves.”<sup>21</sup>

### The Safety Funnel

Adverse event frequency in inpatient psychiatric settings, combined with the threat of punitive actions (eg, regulatory sanctions, litigation), places pressure on inpatient psychiatric staff and administrators to prioritize **managing risks of dangerousness** over other therapeutic needs of patients (ie, characteristics and features of treatment that promote healing and recovery). For example, because hospitalized patients have attempted or completed suicide with shoelaces or belts in the past, inpatient psychiatric facilities may then develop policies restricting all patients from having these items.<sup>22</sup> In response to patients drinking hand sanitizer to become intoxicated, staff members have restricted access to or removed hand sanitizer in psychiatric units to prevent further

ingestion of these products.<sup>23,24</sup> After investigating a psychiatric facility in Colorado for assaults on staff, among other unsafe work conditions, the Occupational Safety and Health Administration cited several workplace hazards in 2019 and suggested abatement methods, including redesigning nursing stations so that patients cannot access these workstations or items for weapons, such as “hole punchers, staplers, telephones, cords, pens, computers, computer peripherals, and other items.”<sup>20,25</sup> Due to security and legal concerns, psychiatric units around the world have installed video surveillance to monitor or record patients and staff on these units.<sup>26</sup> As one article about nursing in these environments noted: “Safety is not merely a consideration or goal, but the highest value.”<sup>27</sup>

Clinical staff and administrators in these settings should remain aware of the need to balance the risks of dangerousness in inpatient psychiatric facilities with the risks of creating dehumanizing and sterile environments that do not support recovery for patients with severe psychiatric needs. For instance, if a patient attempts strangulation with a privacy curtain in a shared room with a roommate, removing all curtains from shared patient rooms without any sort of replacement would entail considerable privacy drawbacks for patients sharing rooms<sup>28</sup>; nevertheless, it is difficult to measure loss of privacy associated with these types of changes. Similarly, if a patient uses exercise equipment to assault a peer or staff, removing all exercise equipment from patients could have deleterious effects on patients who rely on exercise for their mental and broader well-being.

Many safety measures in inpatient psychiatry, from locked doors to the sight of seclusion rooms, may frighten patients<sup>27</sup>—to such an extent that some former patients have described themselves as “survivors” of inpatient psychiatric care.<sup>29</sup> Patients might experience considerable distress when they lose access to personal belongings or even basic privacy. And while hospitals may remove access to phones, cameras, and other devices that can compromise patient privacy,<sup>30</sup> less is often done to mitigate the risk of privacy breaches when staff discuss patients’ personal history and mental health treatment in shared rooms and spaces.<sup>28</sup>

### Equity

Therapeutic features of the built environment include the physical resources, structures, policies, and care for patients that provide the physical and emotional space for patients to access therapies to improve mental health and general well-being.<sup>31,32</sup> However, features of the built environment may become so centered around safety that they hardly resemble the therapeutic spaces they were conceived to be, with several implications for health equity. Research suggests that **racially and ethnically oppressed persons** are often more likely to enter the health care system through “coercive agencies,”<sup>33</sup> such as the juvenile justice system, child welfare system, and involuntary hospitalization, than their White counterparts.<sup>34</sup> Racially and ethnically oppressed patients are also at a greater risk of being placed in restraints in hospital settings, even when they do not differ from White patients in terms of histories of violence or number of violent acts committed.<sup>35,36,37</sup> These findings are significant, given that racially and ethnically oppressed groups are also overrepresented in a number of criminal justice settings.<sup>38,39,40,41</sup> Extreme safety measures in inpatient psychiatry may include bleak sterile environments, artificial lighting, limited windows, limited privacy, lack of access to personal belongings, and even bolted down beds in rooms with concrete or padded walls; as a result, some psychiatric facilities may resemble carceral settings more than hospital settings. When marginalized individuals are brought to hospitals by law



enforcement and then enter inpatient psychiatric settings where safety and prevention are prioritized over all else, the similarities to carceral environments may contribute to their mistrust, trauma, and retraumatization.<sup>42</sup>

### Paths Forward

People involved in the design and operation of inpatient psychiatric settings, including clinical staff, hospital administrators, and policy makers, face considerable pressures to reduce the dangerousness of these environments; nevertheless, they must also remain committed to supporting the dignity and recovery of patients hospitalized in these settings. The Table lists different levels of decision making and examples of specific actions to balance **safety, dignity, and recovery** in inpatient psychiatric units. In particular, partnering with people with lived experience, such as by inviting current or former patients and their families to participate in design and policy making efforts related to inpatient psychiatric care, can integrate into the decision-making process a range of diverse voices and perspectives that can speak to the potential implications of proposed changes.

**Table.** Strategies for Balancing Safety, Dignity, and Recovery in Inpatient Psychiatric Settings

Decision-making sphere	Strategies
Clinical staff	<ul style="list-style-type: none"> <li>• Help clearly explain safety measures to patients.</li> <li>• Train incoming colleagues about safety measures, the reasons behind these measures, and how to implement them in a respectful manner with patients.</li> <li>• Regularly review the need for restrictions imposed on specific individuals (eg, visitors) or unit-wide policies (eg, taking shoelaces, restricting access to electronic devices).</li> <li>• Provide feedback to hospital leadership about the built environment, particularly how new changes have affected staff or patients.</li> </ul>
Hospital policy	<ul style="list-style-type: none"> <li>• Regularly solicit feedback from inpatient psychiatric staff and existing patients about the built environment and ways to improve the experience for patients and staff.</li> <li>• Include people with lived experience, such as patients and families, on committees and oversight boards that provide input on the design and operation of these units.</li> <li>• Minimize the presence of weapons in these environments, while providing training and adequate staffing levels for managing disruptive behavior.<sup>43</sup></li> <li>• Collect data on safety measures implemented at the hospital level and associated outcomes, such as rates of self-harm and violence and patient and staff perceptions of safety measures.<sup>13,16</sup></li> </ul>
Regulatory frameworks	<ul style="list-style-type: none"> <li>• Delineate and protect patients' basic rights when patients are hospitalized on inpatient psychiatric units (eg, access to visitors, phones, private conversation), as modeled, for example, by the Patients' Bill of Rights in the 1980 Mental Health Systems Act.<sup>44</sup></li> <li>• Regularly review and update these rights; for example, access to mail may no longer be as relevant to patients as access to electronic devices.<sup>30</sup></li> <li>• Solicit perspectives of people who have experienced hospitalization and worked in inpatient psychiatric units to guide policy making for these environments.</li> <li>• Integrate trauma-informed practices into accreditation and licensing requirements.<sup>45</sup></li> </ul>

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#### Justice and DEI

- Recruit and retain staff from ethnically, racially, and culturally diverse backgrounds and incorporate cultural brokering in the care of patients in acute psychiatric settings.
  - Consider how the features of the built environment might affect individuals who have less agency.<sup>45</sup>
  - Recognize the similarities between extreme safety measures in inpatient psychiatry and carceral settings, including the potential for contributing to or exacerbating trauma experienced by hospitalized patients.<sup>42</sup>
  - Incorporate perspectives of individuals from diverse backgrounds in design and policy-making processes.
- 

Abbreviation: DEI, diversity, equity, and inclusion.

To guide these efforts, leaders should draw on measured outcomes related to the design and operation of psychiatric facilities to inform evidence-based practices in these environments. Too often, the care of psychiatric patients in inpatient psychiatric facilities is based more on convention and tradition than research or outcomes.<sup>46</sup> Nevertheless, more data collection related to safety measures in inpatient psychiatric settings, including outcomes related to adverse events, as well as patient privacy, dignity, and equity, can potentially help facilities balance the risks of dangerousness and the risks of placing patients in dehumanizing environments.<sup>13,16,46</sup> For example, the US Department of Veterans Affairs developed a Mental Health Environment of Care Checklist, which included architectural changes to improve inpatient safety, that a 2016 study reported was associated with long-term declines in inpatient suicides.<sup>47</sup> However, the brief report did not include additional measures of patient, visitor, and staff perceptions of these changes. Similarly, researchers in Sweden studied design features to reduce violence in psychiatric wards, including not only increased safety measures (eg, designs to facilitate observation) but also stress reduction measures for patients (eg, access to gardens, nature window views, designs for low social density).<sup>48</sup> The authors found that these measures were associated with a decreased proportion of patients receiving medication injections for aggression, but the study did not include additional measures of patient or staff perceptions of these features.<sup>48</sup>

#### Conclusion

Inpatient psychiatric environments are meant to be places of healing but can also entail risks to the safety and privacy of patients and staff who inhabit these environments. Avoiding the safety funnel is not easy or straightforward, as adverse events in these settings can be traumatic, frightening, and even life-altering. Self-harm, violence, and other adverse safety incidents can occur in other health care settings, such as emergency departments, general medical floors, and intensive care units. Nevertheless, patients and staff should not have to trade their dignity for safety when entering health care environments, including inpatient psychiatric units. Recognizing and addressing the safety funnel is essential for creating inpatient psychiatric facilities where inhabitants can feel not only safe and secure but also human.

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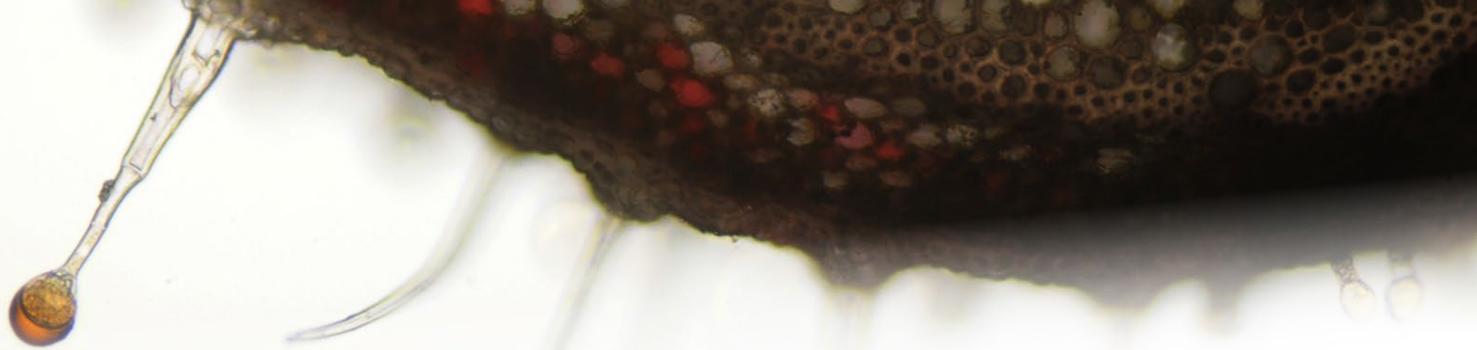
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## AMA Journal of Ethics®

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### HISTORY OF MEDICINE: PEER-REVIEWED ARTICLE

#### What Does the History of Inpatient Psychiatric Unit Design Tell Us About Balancing Safety and Healing for Patients With Suicidal Behaviors?

Alice J. Liu, David S. Im, MD, and Laura D. Hirshbein, MD, PhD

##### Abstract

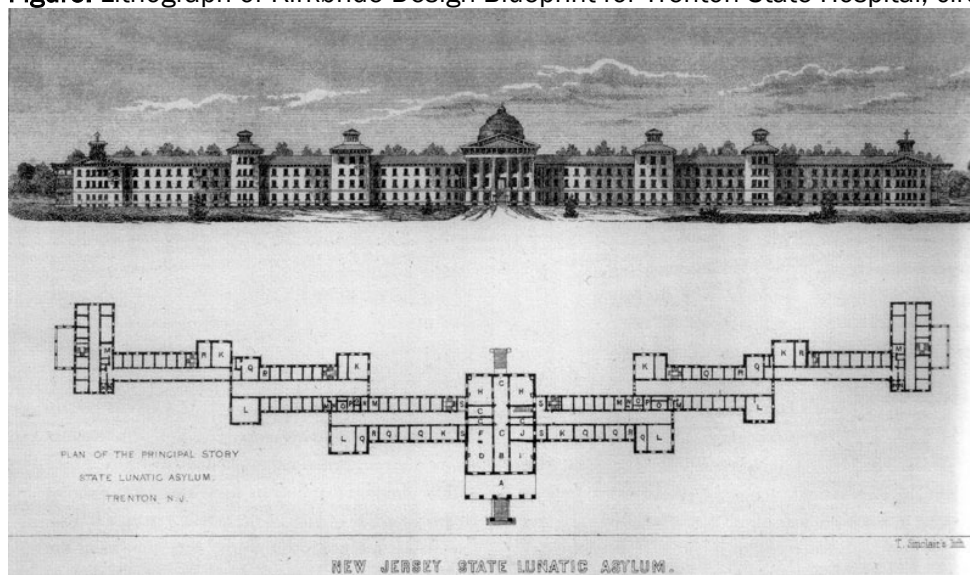
Since the Joint Commission shifted its focus to suicide mitigation strategy implementation in behavioral health units in 2007, examining modern design trends in historical context is more clinically and ethically important than ever. This article considers architectural evolutions in how health care organizations have used structure and space designs to balance safety and healing when housing patients who are suicidal.

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##### History of Psychiatric Inpatient Unit Design

An intimate history of psychiatry and architectural design has been forgotten with the advent of modern psychiatric treatment and medications. However, the 19th century saw the emergence of psychiatry as a medical specialty and tremendous growth of and investment in asylums for those with mental illness.<sup>1,2</sup> Psychiatrists during this period relied on specially designed asylums not merely to house patients but as a core part of treatment.<sup>1</sup> It was believed that 70% to 90% of individuals with psychiatric conditions were curable, provided they left home to receive treatment in purposefully structured asylums.<sup>1</sup> Daylight and ventilation were prioritized in building design, with the first few asylums focused on having corridors with rooms on one side and a shared indoor walkway on the other side.<sup>1</sup> In comparison to the more economical option of having corridors with rooms on both sides, these single-loaded corridors allowed fresh air and light to freely pass from the exterior of the building to the patient room. The Kirkbride, or linear, plan quickly became the exemplary model for asylum design.<sup>3</sup> It was composed of a series of small, interconnected buildings arranged in a shallow V (see Figure), which granted all patients an unhindered outside view of the natural landscape as well as ventilation. However, its layout inadvertently became associated with patient hierarchy, with the loudest and most troublesome patients allocated to the building's outskirts and further removed from physician care.<sup>1</sup>

**Figure.** Lithograph of Kirkbride Design Blueprint for Trenton State Hospital, circa 1848



Note: Follows principles of Kirkbride plan by including short, interconnected buildings featured in a V shape.

### **Contemporary Shifts Toward Emphasis on Architecture**

Fast forward to our modern era. While the pages of psychiatry journals were once filled with a focus on buildings, psychiatric treatment now is centered on medications.<sup>4</sup> However, the renewed influence of architectural design on psychiatry is apparent in 2 competing goals of care.

*Reducing risk.* The Joint Commission (TJC)—which started regulating psychiatric hospitals on the same basis as medical ones in the 1990s<sup>5</sup>—began to focus on environmental threats to patient safety in 2007, when it declared a National Patient Safety Goal of preventing suicides on inpatient units,<sup>6</sup> given the widely cited statistic of 1500 inpatient suicides per year in the United States.<sup>7</sup> This statistic was initially published in the American Psychiatric Association (APA) 2003 clinical practice guidelines, with the further remark that one-third of suicides occurred despite one-on-one patient observation or 15-minute checks.<sup>7</sup> In response, psychiatric hospitals adhering to the new TJC guidelines were required to make large design changes to mitigate suicide risk.

The widely cited 1500 inpatient suicides per year statistic remained undisputed until an in-depth investigation published in a TJC journal revealed that the actual number of inpatient suicides ranged from 48.5 to 64.9 per year, vastly lower than the previously suggested 1500.<sup>8</sup> It appears that the original figure was an estimate without any basis in actual data, and yet it has had a profound effect on regulatory policy. Furthermore, it has been well documented that significantly more suicides occur following discharge from inpatient psychiatric hospitalization than during hospitalization.<sup>8</sup> This information forces us to reconsider at what cost to the health care system and patients we are changing built environments on the mistaken assumption that suicide risk mitigation should be prioritized over other design goals.

*Healing power of the environment.* In the last few decades, there has been a renewed interest in the impact of general hospital design on patient outcomes across all medical specialties. Ulrich's transformative paper, published in 1984, asserted that post-



cholecystectomy patients staying in rooms with window views of nature had a shorter average length of stay than those in windowless rooms.<sup>9</sup> Similar associations between patient outcomes and room design can be found in the psychiatric literature. One study found that less anxiety medication was dispensed by nurses on a psychiatric unit when realistic nature artwork was hung on the wall than when abstract or no art pieces were displayed.<sup>10</sup> Similarly, an intensive care unit study evaluating the benefit of daylight for delirium found that delirious patients in rooms with windows had fewer behavioral episodes warranting antipsychotics than those in windowless rooms.<sup>11</sup>

While the effect of architectural design on mental health deserves further study, we know the significance of this relationship extends beyond hospital walls. Encouraging findings have emerged from studies evaluating the association between physical environment factors and behavioral outcomes. For example, a systematic review of the relationships among urban green space, violence, and crime revealed that though the results were mixed, “more evidence support[ed] the positive impact of green space on violence and crime, indicating great potential for green space to shape health-promoting environments.”<sup>12</sup> It is important to note that the relationship between architecture and health outcomes is likely not confined to the effects of one or two design variables. Instead, it is the **creation of a built environment** focused on room layout, furniture, interior design, and wayfinding that produces therapeutic spaces.

### **Conflicting Priorities**

While the general rekindled interest in the relationship between hospital design and patient outcomes is encouraging, with respect to the design of psychiatric facilities, there is a tug of war between proponents of creating a healing environment and proponents of minimizing suicide risk. It is difficult to discern whether these 2 priorities are mutually exclusive or can be equally, effectively, and concomitantly addressed with thoughtful design. Given that hanging is the predominant method of suicide in the inpatient setting, TJC has prioritized mitigating ligature risk in its suicide safety standards.<sup>8</sup> However, there has been widespread uncertainty regarding the implementation of these vague guidelines and the cost of renovations. The requirement for hospitals to be as ligature free as possible has been accompanied by minimal instruction from TJC on how to implement this standard in the physical space, and implementation has been further impeded by a limited number of design furniture vendors for behavioral wards. The APA found that, in 2017, 23 facilities reported paying between \$6 million and \$100 million for ligature-risk citations, and 14 hospitals had been forced to reduce their number of psychiatric beds.<sup>13</sup> Thus, facilities have been cited for issues related to suicide risk and pressured to make changes that are not feasible due to physical barriers and cost, despite TJC surveyors having limited evidence to inform their practices. While there have been attempts to reduce suicide rates using mental health checklists, the impact of these checklists is unclear, given the small number of completed suicides on inpatient psychiatric units.<sup>14</sup> As such, it has become common practice for medical directors of psychiatric facilities to hire consultants to inspect hospitals before official TJC surveys to interpret how these ambiguous guidelines apply to their physical spaces. An example of one such consultation occurred on our adult inpatient psychiatric unit, where a piano and uncaulked paintings in the common space were identified as potential ligature risks.

Psychiatric wards differ from general medical units in their use of public spaces to provide opportunities for positive social engagement.<sup>15</sup> It is well established that the quality of staff-patient and patient-patient social interactions can enrich a patient's

experience on psychiatric wards and create a less stigmatizing social environment.<sup>15</sup> Key design features—including a homelike environment with a diversity of communal spaces, open nursing spaces, and mobile furniture that can be arranged in small, flexible groupings—have been shown to promote positive interactions.<sup>16</sup> Outdoor public spaces with **access to nature** can also elevate patient physical and mental well-being.<sup>17</sup> In contrast, a poorly designed environment void of stimuli and comfort can limit cognitive function and contribute to patients feeling stigmatized due to their struggles with mental health.<sup>15,18</sup> This distinction between well and poorly designed environments becomes important especially when consultants advise removing communal objects (such as the piano in the example above) or adjusting furniture in public spaces without consideration of how design elements contribute to the healing and building of a larger community. This trade-off between safety and healing is also apparent in modern behavioral health furniture, which is generally designed to minimize safety risks rather than to promote aesthetics, comfort, or mobility.

Of note, the safety-healing trade-off is most apparent in public spaces, as 90% of inpatient suicides occur in private spaces, including the bedroom, bathroom, closet, and shower.<sup>8</sup> Given the burden of suicides in private spaces, it would be worthwhile to consider how suicide risk mitigation strategies, along with staff-to-patient ratio, should differ in public and private spaces. Standardized suicide prevention guidelines could be developed that consider characteristics of a unit's physical space, with relatively greater emphasis on risk mitigation in private spaces in the least intrusive manner possible. Where renovation or new construction of inpatient psychiatric units is considered, thoughtful design would ideally foster the creation of healing spaces in both private and public areas while minimizing safety risks.

### **Balancing Safety and Healing**

In addition to implementing design elements to mitigate suicide risk in inpatient psychiatric units, organizations (both health care and accreditation), researchers, and clinicians should also keep in mind the potential of **architectural design to create healing spaces**. TJC guidelines have largely narrowed the focus to interventions on the built environment that theoretically minimize acute suicide risk. However, these interventions not only lack empirical support but also prioritize risk management over healing. To balance the promotion of therapeutic spaces with reduction of safety risks, TJC guidelines for psychiatric hospitals could be modified to distinguish between public and private spaces based on the different hazards associated with each location. As mentioned, research has shown that suicides occur predominantly in private spaces; aggression, inappropriate behavior, and falls occur in both private and public spaces.<sup>19</sup> Thus, TJC ligature risk-based guidelines could focus on private spaces while TJC supervision-based guidelines (eg, for clear views of communal spaces and corridors from the central nursing area) could focus on public spaces. However, it is essential to recognize that adverse incidents can often be reduced or prevented with environmental adaptations geared toward healing. Designing public spaces with the intent of reducing noise and stress from crowding (eg, movable furniture) or offering positive distractions (eg, nature art) can reduce incidents of aggressive behavior.<sup>20</sup> The physical environment is also a known contributor to falls, with documented risk factors that include poor nighttime lighting, uneven floors, and spaces that limit visual observation.<sup>21</sup> Thus, design interventions for public spaces that provide clear views, reduce overstimulation, promote engagement (eg, via diversity of communal areas with movable seating), and offer positive distraction (via nature artwork, windows with nature views, and ample daylight) better align with the therapeutic value of recovery and could still mitigate fall

risks in contradistinction to design interventions for private spaces, which largely focus on structural ligature risk-reducing interventions. Such design elements have been shown to contribute to positive healing in psychiatric patients.<sup>17,20,22</sup> Instead of enforcing stringent ligature risk regulations in private and public spaces, TJC should consider partnering with health care organizations and behavioral health units in revising current guidelines to strengthen the therapeutic qualities of spaces.

As former National Institute of Mental Health director Thomas Insel has pointed out, there is substantially more to healing from mental illness than is incorporated in our current practice.<sup>23</sup> We must remember that treating patients' underlying mental illness and providing them with tools to cope with distressing emotions and adverse circumstances are the most effective methods in suicide prevention.<sup>24</sup> Health care organizations contemplating restructuring of their behavioral unit should consider incorporating known therapeutic design elements—privacy, sound reduction, daylight, environmental complexity, ventilation, color, and nature—while also incorporating opportunities for clinicians to observe patients (eg, open nursing units) to help maintain patient autonomy.<sup>17,22</sup> Instead of seeing the environment as something patients need protection from, we should regard physical spaces as another nonpharmacological strategy to add to our tool kit for the prevention and treatment of psychiatric conditions.

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# AMA Journal of Ethics®

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## ART OF MEDICINE

### How Better Architecture of Health Care Structures and Spaces Can Help Avoid Iatrogenic Harm

Sudhiksha Srinivasan, MArch

#### Abstract

This series of digital drawings considers how design influences patients' experiences.

#### Architecture and Well-Being

Often overlooked but key factors in health care structures' and spaces' **designs** include seating, lighting, sound, doors, windows, walls, and corridors.

*Seating.* Patients generally want more interaction with their clinicians, but a high volume of patients constrains clinicians' time and can limit their opportunities to meaningfully engage patients during clinical encounters. Wall-mounted seating might encourage some clinicians to sit, perhaps prompting some patients to perceive that they are getting their clinicians more focused attention, if not more of their time.

*Lighting.* Intense light impedes patient recovery and strains caregivers.<sup>1</sup> Diversified lighting zones enable selective illumination and allow individuals control over light levels.

*Sound.* Alarms disrupt rest, compromise many patients' recoveries, and can overwhelm both patients and clinicians.<sup>2</sup> Acoustic panels on walls or furniture can help redirect sound waves and curb excess noise.

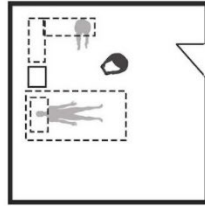
*Doors.* Doors influence experiences of privacy and mobility. Thin-aperture doors offer more privacy by limiting visual access. Wide-aperture doors enhance visual access and mobility but can compromise privacy.

*Windows.* Biophilic design significantly influences patient recovery.<sup>3</sup> Rooms without windows prolong length of stay and impede recovery by **depriving patients of natural light and scenery.**

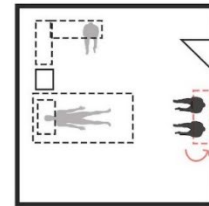
*Walls.* Interactive audio-visual walls can transform a room's landscape. Interactive or still images can be projected onto the walls, and lighting and sound can be individually controlled

*Corridors.* Cluttered hospital corridors can hinder movement, impede navigation, and cause collisions. Thicker corridor walls allow for alcoves, where equipment can be stowed or compact sinks can be installed.

**Figure 1.** *A Space for Doctors to Sit*



Patients seek reassurance, but limited doctor time due to high case volume restricts extensive interaction.

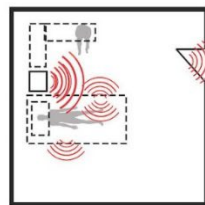


Wall-mounted seating cultivates the perception of extended doctor-patient interaction, despite the limited time.

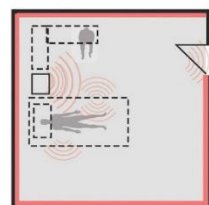
## Media

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**Figure 2.** *Alarm Fatigue*



Alarm fatigue disrupts patient rest, hampers recovery, exhausts doctors, and inundates rooms with sensor noises.

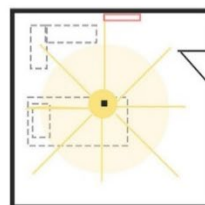


Optimal acoustical panels redirect sound waves, aiding patient recovery by reducing noise disturbance.

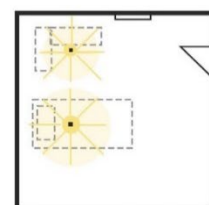
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**Figure 3.** *Lighting*



Single harsh light in wards hampers patient recovery and disrupts caregivers.

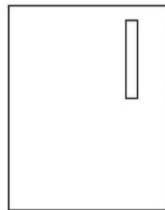
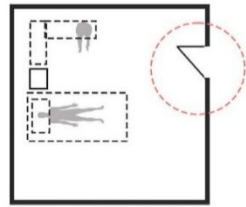


Varied lighting zones provide undisturbed patient recovery and caregiver rest with selective illumination.

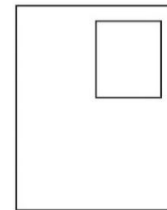
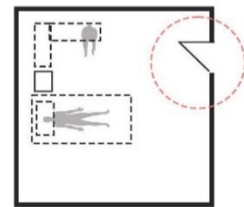
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Adobe Photoshop.

**Figure 4. Dilemma of Doors**



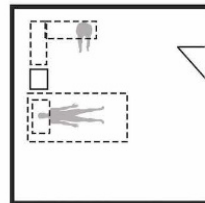
Thin-aperture doors offer enhanced privacy but reduce visual access by limiting potential for improved mobility.



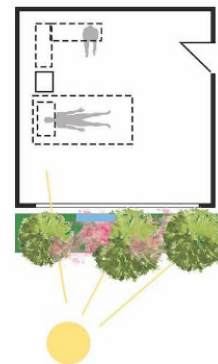
Wide-aperture doors enhance visual access for improved mobility but compromise privacy.

**Media**  
Adobe Photoshop.

**Figure 5. Effect of Biophilic Design**



A lack of windows in rooms hampers recovery, prolonging stays by limiting access to natural light and landscape views.

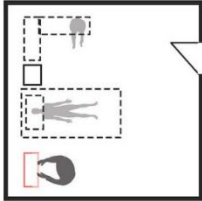


Rooms with windows accelerate recovery and shorten stays by providing access to natural light and scenic views.

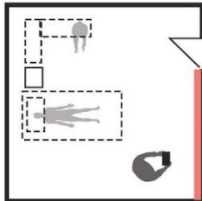
**Media**  
Adobe Photoshop.



**Figure 6. Elements of PLAY in Rooms**



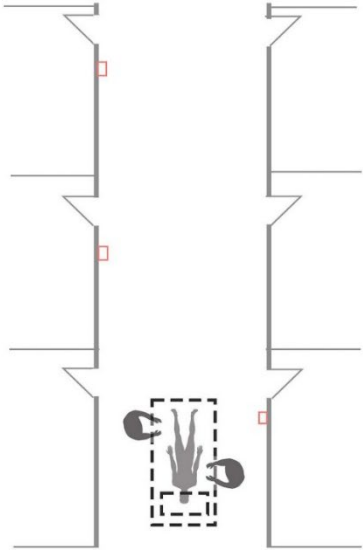
Corner-placed computers and verbal recovery updates are not optimal for information delivery.



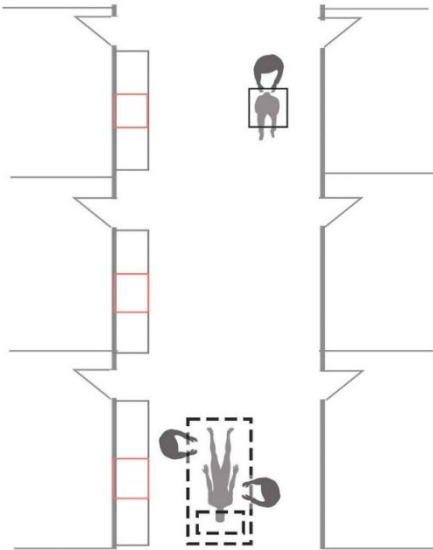
An interactive A/V wall in your room displays your reports as infographics and landscapes when there are no windows and allows lighting control and family video call access – empowering your environment.

**Media**  
Adobe Photoshop.

**Figure 7. Sinks Instead of Sanitizing**



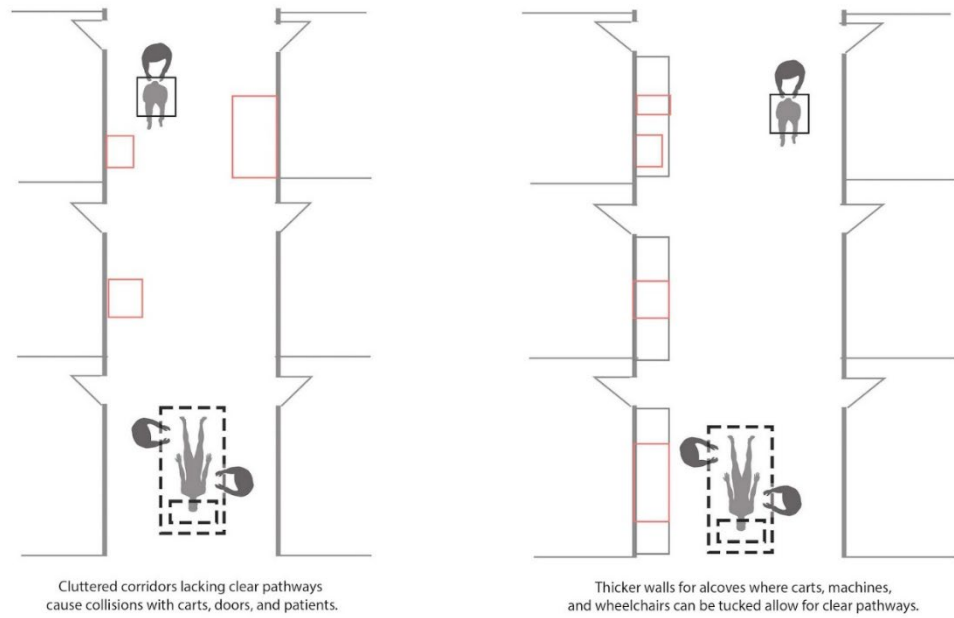
Relying solely on sanitizer pods outside wards isn't sufficient for doctors to eliminate all infections.



Compact sinks in thicker wall alcoves offer infection control without obstructing pathways for doctors.

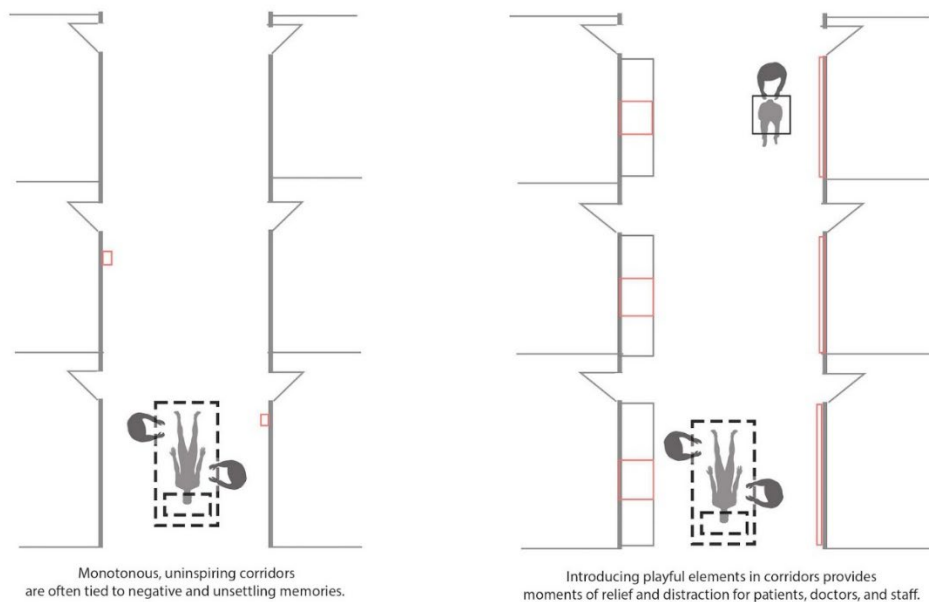
**Media**  
Adobe Photoshop.

**Figure 8. Alleviating Corridor Crashes**



**Media**  
Adobe Photoshop.

**Figure 9. Element of PLAY in Corridors**



**Media**  
Adobe Photoshop.

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## AMA Journal of Ethics®

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### VIEWPOINT

#### Virtual Eye Contact

Christy A. Rentmeester, PhD

##### Abstract

This article draws on architectural analogies and popular culture to consider ethically and clinically important characterizations of causation and nonarbitrariness. This investigation also suggests similarities between intention and design.

##### Correlation and Causation

Did you know that sex could not be publicly discussed in the Soviet Union?<sup>1</sup>

Me, neither. Without knowledge of this factoid, it's hard to appreciate the cultural importance of what happened in 1987 when a television network in Finland broadcast the randy French series, *Emmanuelle*. Viewable in some areas<sup>1</sup> of Estonia (a Soviet state until 1991), episodes were allegedly so hot that “[n]ine months later the birth rate in Estonia spiked to an all-time high.”<sup>2</sup> Another more well-known source suggests that accounts of a “skyrocketed” birth rate were “probably exaggerated,”<sup>3</sup> but it does not express much caution about mistaking correlation for causation. With Estonian independence foreseeable by some, though, many factors could have generated parental enthusiasm about raising a child in a country soon to be free from Soviet rule.

##### Design and Intention

As in this historical example about roles healthy doubt can play in rooting out logically tenuous causation claims, we can apply a similarly questioning stance to causation attributions in health care, especially when describing relationships between health care settings' **designs and patients' outcomes**. The architect Stefan Lundin has explored these relationships in psychiatric settings. In my view, his work has interesting and important ethical relevance because we tend to think about the moral psychological phenomenon of *intention* similarly to how we think about structural and spatial *design* of places we inhabit. One article by Lundin about safety among inpatients with mental illness poses that designs' importance comes not only from what they cause or patient outcomes with which they are correlated, but from the fact that they are “not arbitrary.”<sup>4</sup> What might this mean ethically in health care?

If there is an upshot from Lundin's work that matters to health care ethics, one seems to be that designs thoughtful and well-considered enough to express a plurality of

stakeholders' interests promote safety among patients and caregivers in psychiatric units. Lundin states that a patient's sense of control is key to keeping them safe.<sup>4</sup> This is, he suggests, because **making patients feel heard** diminishes their stress. Patients' stress reduction has design value not because it informs the physical or spatial architecture of a care setting, but because it influences how the care environment is inhabited by clinicians and patients. Inclusion is a lived ethical value intrinsic to how we intend our interactions with others to proceed. Intentions are moral psychological formations that express our motivations to act; they express how we design and define our characters over time in each action we are moved to do in each moment.

Yet our most fraught interactions illustrate that how we express our intentions must respond to external factors beyond our control and so, sometimes, only imperfectly influence our actions. Our intentions are not equally, perfectly, or completely expressible in our actions in all circumstances. Perhaps a contrast is helpful for explanation.

In moral psychological terms, *if an intention is arbitrary*, it is not grounded in one's perception of a reason to act. An action can still have ethical value (positive or negative) because of its consequences, but it has little-to-no value in expressing an agent's character if it has no explanatory force about their intention or motivation. One might say this is one reason some criminal legal proceedings invest so much time in exploring what an action expresses, if anything, about the intention (*mens rea* in legal language) of the agent who committed the action. By contrast, ethically speaking, *an intention is nonarbitrary* if it has explanatory force about an action; even if that action does not go as planned, we might ask the agent, *What did you mean? What were you thinking? What motivated you?* In other words, even when an action does not carry out, or express, an agent's intention well, an agent's action can still have ethical value for the agent's character if it expresses their intention, even if incompletely. (This is one reason why our expressions of regret or disappointment about an action that didn't express an intention well can also have ethical significance; a statement like *This isn't what I wanted to happen, and this is what I mean to happen* can matter ethically, particularly if you're affected by the action that didn't express the agent's intention well.

### **Virtual Eye Contact**

An example is from the world of video conferencing, in which moral psychological links between our intentions and our actions can be disrupted—by user errors, poor connection, poor reception, or accidents of context (eg, transmission delays)—if not severed completely. These external factors can make video call interactions more than just technically fraught, especially if someone on a video call is upset. If you've ever tried to make good on a humanitarian impulse to be empathic and emotionally intelligent with someone visibly upset on a video call, you might identify with what I found on video calls to be a confusing irony: you have to look at *the camera* on your device in order to create the impression for the person you're trying to help that you're looking at *them*. I'm not even sure whether virtual eye contact is possible. Yet, trying to do it for someone who would need eye contact in person somehow seems consistent with our "better angels"<sup>5</sup> moral intuitions and, thus, seems to have ethical value.

Of course, looking directly at the camera on your device means you are *not* looking directly at the person's image on your screen, which isn't even really them, but a representation of them. Facilitating your interlocutor's feeling that you are looking into their eyes—what many of us can do easily and quickly in person—to try to make them feel seen, heard, or understood requires diverting focus from their eyes in their image on

your screen to the camera on your device. I don't know whether this counts as virtual eye contact, but, even if it does, a source of trouble is that you can't focus intently or simultaneously on both your device's camera and on your interlocutor's onscreen image, so your ability to modify your actions, expressions, and speech according to their affective cues is compromised by specific actions you need to perform in order to express your intention to connect with them.

In video calls in which you strive to keep virtual eye contact with an interlocutor you think might be helped by it, you simply have to live with the uncertainty that you might miss some key affective cues. If the affective clues you miss are critical ones, your actions might be received and perceived by your interlocutor very differently than you intend, and perhaps badly. Disjunctions between intention and action are always a risk, and this risk is exacerbated online. It doesn't always make us feel better about the disjunctions between intentions and actions that external circumstances force us to navigate them. But, thankfully, intention and design need not be perfect in execution in order to have ethical and, according to Lundin, clinical value. They just need to be nonarbitrary to be important to who we want to be for ourselves and for each other.

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