



D<sup>3</sup>

*The Intersection of  
Diagnosis, Dignity and Design  
for Mental and Behavioral Health  
Communities in Crisis*

**A Glimpse Ahead - Preview Research and  
Findings D3 will be published summer of 2022**

# BEHAVIORAL HEALTH THOUGHT LEADERS



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IDD Provider Capacity Building*

*.....designing with  
passion and emphasis  
toward safe, therapeutic  
and restorative care  
environments...*

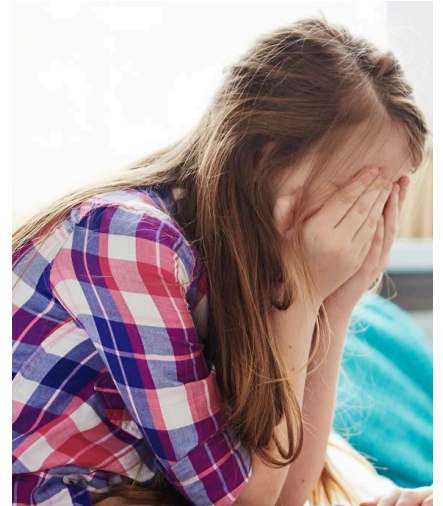




# D<sup>3</sup> - Diagnosis, Dignity and Design

*The Intersection of Diagnosis, Dignity and Design  
for Mental and Behavioral Health*

*Translating into Safe, Therapeutic and  
Restorative Environments of Care.*





# Defining Crisis

*A crisis exists when individual skills and resources are not adequate to deal with a situation AND the ability to cope is overwhelmed.*

- Crisis triggers can be:
  - Biological,
  - Psychological
  - Social
    - *Usually, a combination of the three.*





# Why This Work is Important

- 20% of U.S. population meet diagnostic criteria for a mental illness each year
  - Likely underreported and closer to 25%+
  - Depression is leading cause of disability age 15-44
- Over 20 million adults met SUD criteria





# Diagnostic Criteria (MI)


Different mental illnesses have different diagnostic criteria. In general, mental illness is diagnosed based on a combination of symptoms, duration of symptoms, and functional impairment.

- **Diagnostic and Statistical Manual of Mental Disorders (DSM-5)**
  - Published by the American Psychiatric Association
  - Used by mental health professionals to diagnose a wide range of mental health conditions






# Diagnostic Criteria (MI)

- *Depression*
    - **Depressed** mood most of the day, nearly every day
    - Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day
    - Significant weight loss when not dieting or weight gain, or decrease or increase in appetite nearly every day
    - **Insomnia** or hypersomnia nearly every day
    - Psychomotor **agitation** or retardation nearly every day
    - **Fatigue** or loss of energy nearly every day
    - Feelings of **worthlessness** or excessive or inappropriate **guilt** nearly every day
    - Diminished ability to think or concentrate, or indecisiveness, nearly every day
    - Recurrent thoughts of death, recurrent **suicidal ideation** without a specific plan, or a suicide attempt or specific plan for committing suicide
- 



# Diagnostic Criteria (SMI)

Serious Mental Illness (SMI) is defined as having, at any time during the past year, a diagnosable mental, behavior, or emotional disorder that causes serious functional impairment that substantially interferes with or limits one or more major life activities. *(NIDA, 2021)*


- Includes major depression, schizophrenia, bipolar disorder, and other mental disorders that cause impairment
  - Around 1 in 4 individuals with SMI also have an SUD.
- 






# Diagnostic Criteria (SUD)

A substance use disorder (SUD) is a chronic and relapsing brain disease characterized by an impaired ability to control one's use of a substance, despite its harmful consequences.

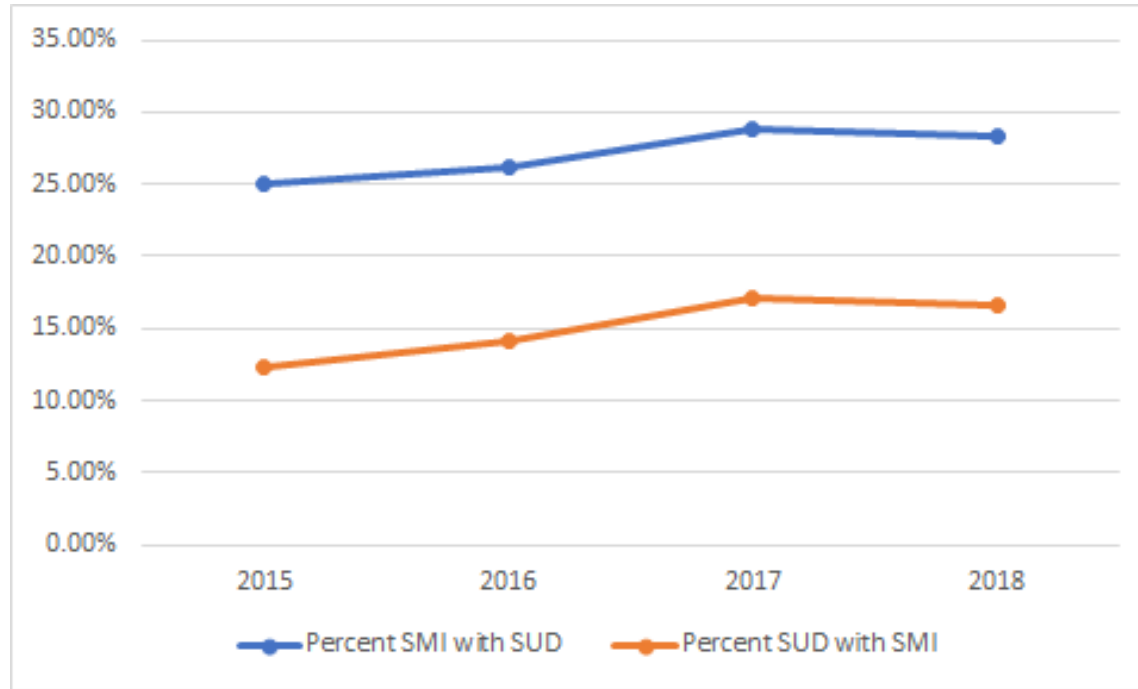
- The term “substance use disorder” replaced the terms “substance abuse” and “substance dependence” in the DSM-5
  - As an example, Alcohol Use Disorder can be diagnosed as mild, moderate, or severe. The number of symptoms present determines the distinction between mild, moderate, or severe
- 



# Diagnostic Criteria (SUD)

- *Alcohol Use Disorder*
    - The DSM-5 lists 11 possible symptoms of Alcohol Use Disorder
    - Examples include failure to perform responsibilities due to substance use, a physiological tolerance to the substance, cravings for the substance, and failing to stop use despite multiple attempts to quit.
    - To be diagnosed with mild Alcohol Use disorder,
    - an individual must possess **two to three** of the 11 symptoms.
    - To be diagnosed with moderate Alcohol Use disorder an individual must possess **four to five** of the 11 symptoms.
    - To be diagnosed with severe Alcohol Use disorder, an individual must possess **six or more** of the 11 symptoms
- 

# Crisis Confusion




- Co-morbidity and Common Characteristics



# Crisis Response & Stabilization



# Traditional Crisis Response

- Call 911
  - EMS or Police respond
  - Transport to Emergency Department or Jail
    - Long Wait Times
  - Inpatient Psych Care or Community
- 



# Ideal Crisis Response

- Call 988
  - *80% resolved (100 → 20)*
- Mobile Crisis Teams respond
  - *70% resolved (20 → 6)*
- Transport to Crisis Center
  - Little to No Wait Time





# 988 Roll-out

- *Important to note that 988 will launch July 2022*
- Without an effective crisis system, 988 will create:
  - Increased demand on emergency departments
  - Worsen existing problems like jail admissions and psychiatric boarding





# Crisis Centers

”Short-term and stabilization services in a home-like, non-hospital environment” *(SAMHSA, 2020)*

- Two Primary Components:
  - Temporary Observation Unit
    - **≤ 24-hour stabilization**
  - Extended Observation Unit
    - **5 – 7 day stabilization**







# Crisis Centers


- **Key Features**
  - 24/7/365 Operation
  - “No Wrong Door” Access
    - First Responder Priority*
  - Warm Hand-off
  - Level of Care Assessment
  - Discharge Planning at Admission
  - Community Collaboration





# Temporary Observation

- **Key Functions**

- Assessment & Stabilization
  - Determination Appropriate Level of Care
  - Psychiatric Eval (Risk & Meds)
    - Psychiatrist or Psychiatric Nurse Practitioner
  - Brief medical screening
    - Registered nurse
  - SUD Screening and Psychosocial
    - Licensed clinician
  - Discharge Planning
    - Bachelor's level clinician
- 




# Extended Observation

- **Key Functions**
    - Assessment
    - Diagnosis
    - Observation and engagement
    - Individual and group therapy
    - Skills training
    - Prescribing and monitoring of psychotropic medication
    - Referral and linkage to community resources
- 



# Important to Note

- Mental Health / Substance Use Specific
  - Exclusionary Criteria
  - Medical Clearance
  - Must include Community Collaborative
- 

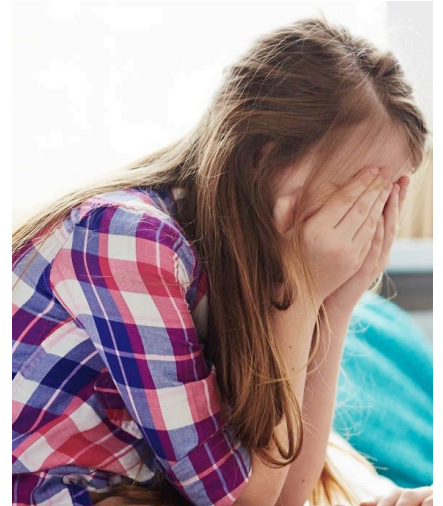


# A Tale of Two Systems

# D<sup>3</sup> - Diagnosis, Dignity and Design


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# Behavioral Health Design Guide

January 2022



## BEHAVIORAL HEALTH DESIGN GUIDE

Formerly:  
Design Guide for the Built Environment of Behavioral Health Facilities

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Provisionally Published by:  
National Association of Psychiatric Health Systems (NAPHS), 2003-2014  
Faculty (designated as Institute), 1997-2014

November 2020 Behavioral Health Design Guide Baseline Page - 18

**b. Door Hardware** – Hardware on doors that connect to a higher level of Risk shall have hardware suitable for the higher level of risk.

i. **Double-Acting Continuous Hinges**<sup>111</sup> are preferred and can be used on patient room-to-corridor doors to counteract barricading without the hazard presented by pivot hinges. These continuous hinges can be paired with full-height emergency stops<sup>112</sup> that lock in place and can be easily unlocked to allow the door to swing into the corridor.

ii. **Geared-Type Single-Acting Continuous Hinges**<sup>113</sup> are a solution for retrofit frame conditions at doors that have will pass through and normally locked doors because they minimize possible attachment points. These hinges are available from various manufacturers with a hospital "factory installed closed-sloped top" and continuous tip<sup>114</sup> (factory installed closed-sloped top) and continuous tip of hinges to create this slope is strongly discouraged because that often exposes voids that may be used as a hinge attachment points.

Geared continuous hinges do provide significant pinch points between the two leaves of the hinge when an door is closed. If this is not an acceptable risk to an organization, double acting continuous hinges that do not have this pinch point<sup>115</sup> can be provided.

iii. **Wicket Doors**<sup>116</sup> use single acting continuous hinges with hospital tips for the main door and the center portion is mounted on a continuous hinge with hospital tip (or concealed) hinge and secured with a deadbolt lock that has no visible hardware on the room side of the door. Care should be taken with the detail of the edge of the smaller panel so that a crack is not provided that can be seen through and is smoke tight if required.

iv. **Unequal Pair of Double Egress Doors** – both doors may be mounted on single acting continuous geared hinges with hospital tips. The lock-set can be the same as any other single-acting door. If the mullion is not provided, a deadlock with concealed bolts that engage the head of the door frame (and possibly the floor) is needed for the smaller inactive leaf. This deadlock is similar to item #143b except that it is preferred to not






November 2020 Behavioral Health Design Guide Baseline Page - 19

have any visible hardware on the room side of the door. If the mullion is provided, a deadbolt that does not have any exposed hardware on the inside can be used to secure the door into the mullion.

v. **Closers** – See Level II

vi. **Lock-sets** – Use of some type of ligature-resistant lock-set is recommended for all door handles in patient-accessible areas. A lock-set handle can be used for ligature attachment in three ways: pulling down, pulling up and over the top of the door, using both the inside and outside handles (transverse). The latchbolt itself has even been used successfully as an attachment point and some companies offer a tapered bolt that it makes it easier to open a locked door by using a small piece of this. The downside to the tapered bolt is that it makes the strike plate can be a ligature attachment point; for this reason, a box should always be provided behind the strike plate. In our opinion, the perfect solution for this dilemma does not exist at this time. Several of the better options are discussed below.

- **Lock-sets with a Lever Handle**<sup>118</sup> – These effectively reduce the level of risk of up and down pressure but are susceptible to transverse attachment. The lever should move freely in both directions when locked to reduce ligature attachment risks. This type of handle is more typical (less institutional) in appearance and operation than other choices. Both of these qualities are very desirable in items that patients will touch and are very typical. However, lever handles may be susceptible to transverse attachment as mentioned above.
- **Crescent Handle Locksets**<sup>119</sup> – This type of lock-set has a lever handle and thumb turn that are ligature-resistant and may meet ADA requirements. It is available with a handle that can be mounted in either horizontal or vertical position and allows the user's hand to easily slip off the free end.
- **Push/Pull Hardware** – This type of door handle is available with a flush push pad on one side and a ligature-resistant pull handle on the other.<sup>120</sup>

This document is intended to represent leading current practices, in the opinion of the authors. It does not represent minimum acceptable conditions or establish a legal "standard of care" that facilities are required to follow.

Behavioral Health Design Guide Baseline Page - 20

c. **Seating** - Furniture used in behavioral health facilities is preferred to be easily cleaned, easily reupholstered, very sturdy, and as heavy as possible to minimize the likelihood of patients throwing chairs, tables, etc. Where indicated by the Safety Risk Assessment, furniture is suggested to be securely anchored in place or weighted to resist stacking or tipping of furniture and breaking into items that can be used as weapons.<sup>121</sup> Upholstered lounge chairs with polyethylene rotationally molded<sup>122</sup> and sand-cast<sup>123</sup> furniture are generally preferred. An alternative is a sand-cast organization should select furniture that is intended.

Seating is needed (e.g., dining and activity lounge chairs) that are light polypropylene chairs<sup>124</sup> that resist spills are preferred. An alternative is a chair that is partially filled with sand (or otherwise) to make it difficult to throw or use as a weapon.

Lounge areas may have specially designed seating that are designed for patients and with very durable materials.

Seating should be sooting and fire retardant. Seating should be specially designed seating that should be taken to realize that higher risk areas of a unit to be designed risks being created. Furniture should have






November 2020 Behavioral Health Design Guide Page - 21

**01 00 00 – General**

**01 00 01 – Trash Receptacle Liner**

1a. Trash receptacle liner – paper  
**Sani-Inners**  
Wisconsin Converting  
Green Bay, WI  
920-593-8297  
[www.wisconsinconverting.com](http://www.wisconsinconverting.com)

1c. Trash receptacle liner – paper  
**Psych-Select-Bag™**  
Dano Group  
Stamford, CT  
800-348-3266  
[www.danogrp.com](http://www.danogrp.com)

**07 00 00 – Thermal and Moisture Protection**

**07 92 00 – Joint Sealants**

10a. Sound and Smoke Seals – Breakaway  
**Cush 'N' Seal w/breakaway anti-ligature option**  
Door and Hardware Systems, Inc.  
Rochester, NY  
585-235-8543  
[www.dhcs.com](http://www.dhcs.com)

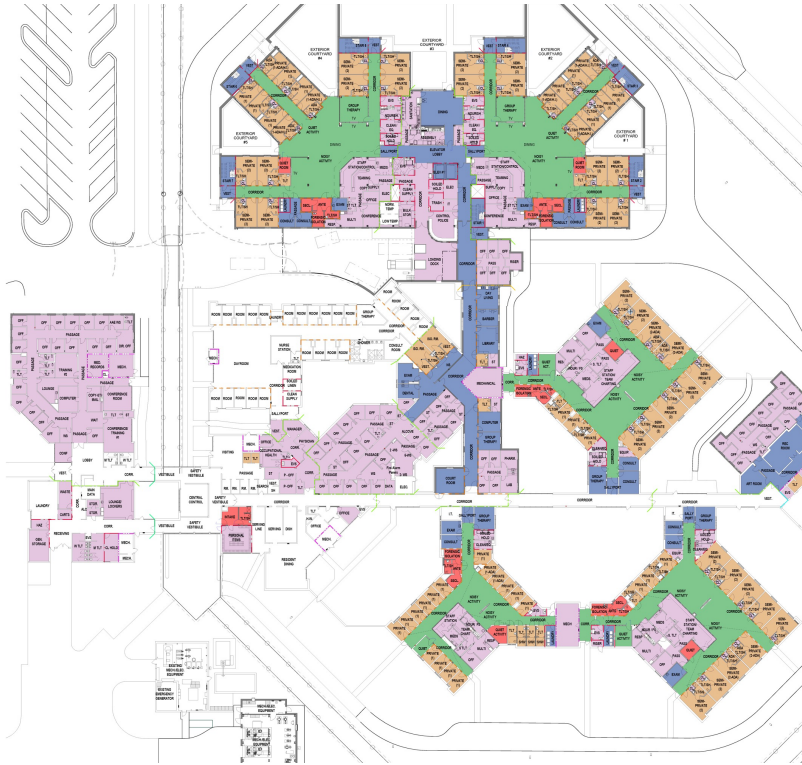
10b. Sound and smoke seals – breakaway  
**Ligature-resistant Zag option**  
Zero International – Allegion  
Indianapolis, IN  
877-871-7011  
[www.zerointernational.com](http://www.zerointernational.com)

10c. Sound and smoke/fire seals






# Patient and Staff Safety



Resource: Alabama Department of Mental Health – Forensic Facility

- LEVEL I
- LEVEL II
- LEVEL III
- LEVEL IV
- LEVEL V

## Environmental Safety Risk Assessment

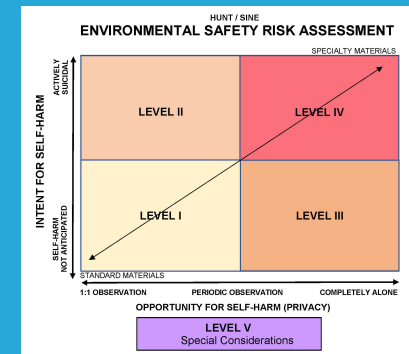
*Level I: Areas where patients are not allowed.*

*Level II: Areas behind self-closing and self-locking doors where patients are highly supervised and not left alone, such as counseling rooms, activity rooms, interview rooms, group rooms as well as corridors that do not contain objects that patients can use for climbing and where staff are regularly present.*

*Level III: Areas that are not behind self-closing and self-locking doors where patients may spend time with minimal supervision, such as lounges, day rooms and corridors where staff are not regularly present. Open nurse stations should be considered under this Level*

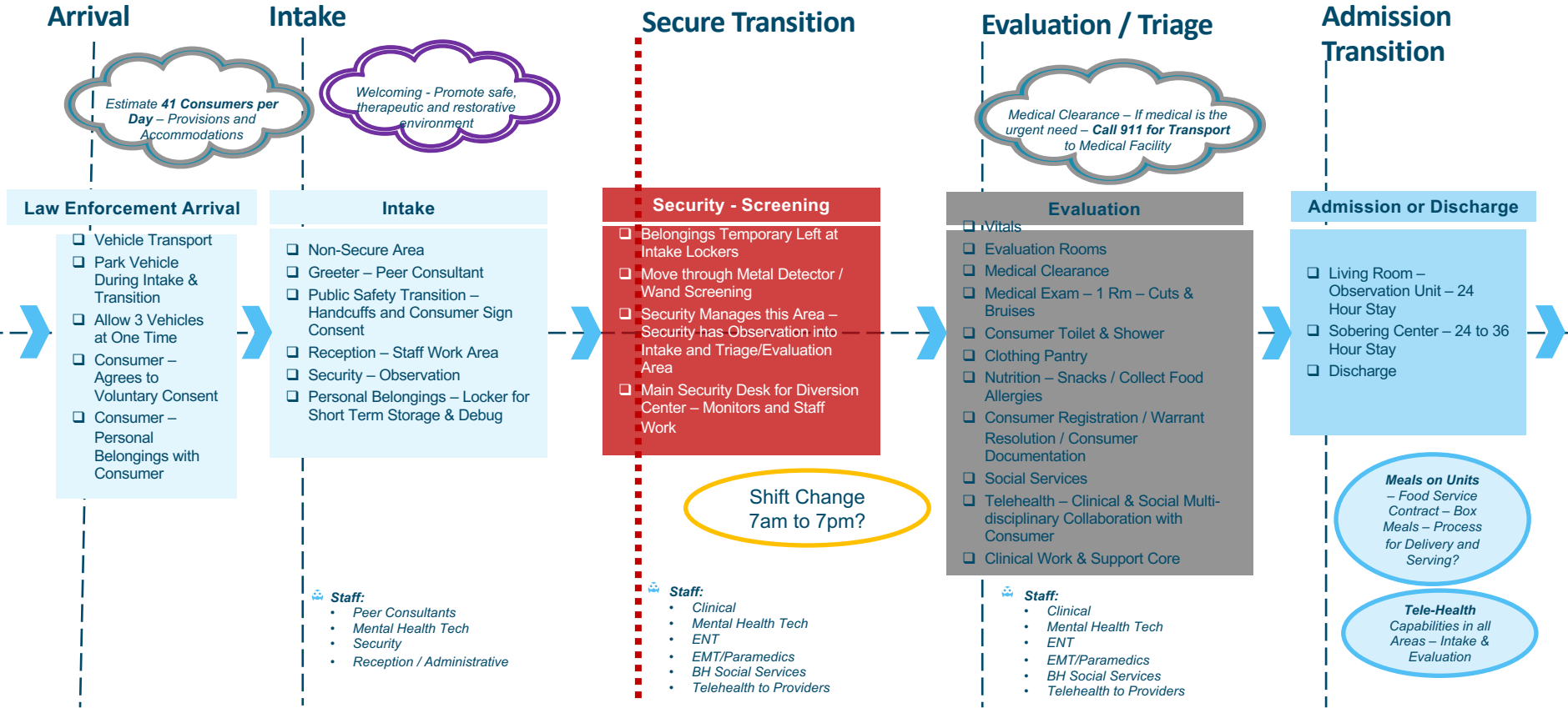
*Level IV: Areas where patients spend a great deal of time alone with minimal or no supervision, such as patient rooms (semi-private and private) and patient toilets.*

*Level V: Areas where staff interact with newly admitted patients who present potential unknown risks or where patients may be in highly agitated condition. Due to these conditions, these areas fall outside the parameters of the risk map and require special considerations for patient (and staff) safety. Such areas include seclusion rooms and admission rooms.*





# Crisis Diversion Center – Arrival Sequence through Admission into Unit or Discharge



Example One Segment for Work Session to Define Patient and Staff Flow

## EXPERIENTIAL MAPPING – “DAY IN THE LIFE”

# Living Room Peer Support Model & Extended Stay - Space Needs

## Evaluation / Assessment

- Front Walk-Ins
- Public Service Vehicle Entrance
- Evaluation / Medical Exam
- Secure Hold
- Consumer Toilet/Shower

## Living Room – 24 Hour Stay

- Open Consumer Environment
- Recliner Chair Patient Stations
- Private Patient Room – 10%
- Consumer Toilet / Shower – 1:6
- Consumer Laundry
- Consultation Rooms – Tele-Communications
- Medical Exam / Vitals Daily
- Group Therapy
- Peer Consultation Office
- Social Soft Seating – Television Area
- Nutrition Bar – Snacks, Drinks, Ice
- Dining – Tables for Meals
- Visitation & Family Consultation?

## Staff Work:

- Open Work
- Secure Work – Head Down
- Team Planning
- Staff Lounge, Toilet, Lockers
- Medication
- Clean Supply & Linen
- Soil Hold
- Housekeeping
- Offices – Administration, Social Services, Case Mgt, Etc.

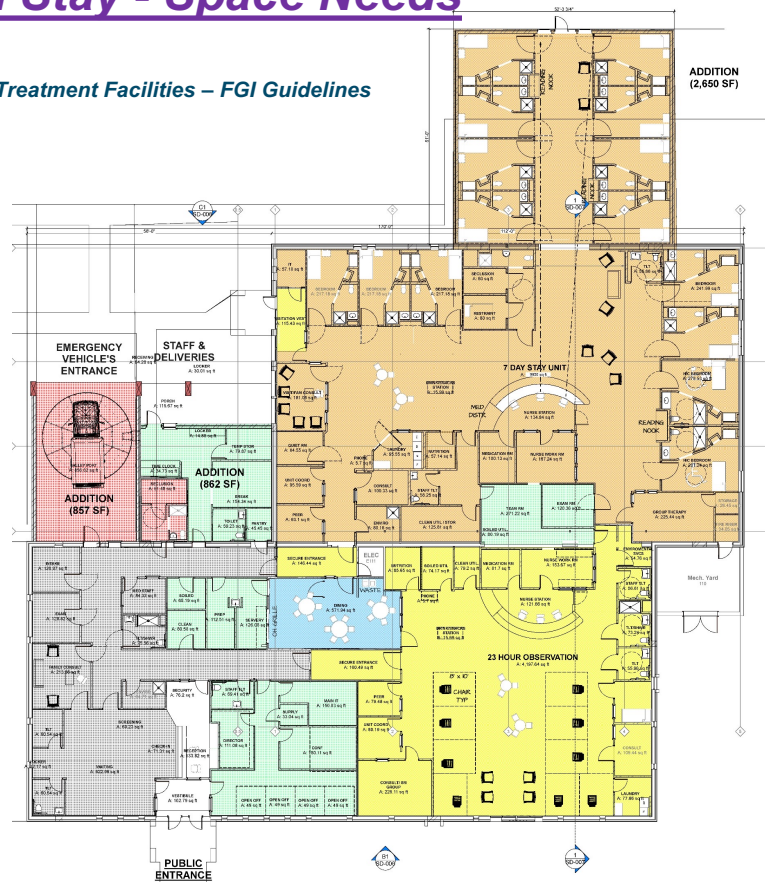
## Outpatient Occupancy and Residential Treatment Facilities – FGI Guidelines

## Extended Stay

- Private Patient Room – Gender Separate
- Consumer Toilet / Shower – 1:6
- Consumer Laundry
- Consultation Rooms – Tele-Communications
- Medical Exam / Vitals Daily
- Group Therapy
- Peer Consultation Office
- Social Activity Soft Seating – Television Area
- Nutrition Bar – Snacks, Drinks, Ice
- Dining – Tables for Meals
- Visitation & Family Consultation

## Professional Staff:

- Peer Consultates
- Social Services
- Case Managers
- Mental Health Techs
- Clinical – RNs, Providers
- Security



Resource: [Alabama Department of Mental Health](#)

## Crisis Center Examples

# Warm Handoff



*Dedicated Law Enforcement Entrance with secure gated sallyport and Touchdown Area for Officers with Transition to Crisis Center Staff*

*Consider Dignity of Consumer / Client*

*Dedicated Space for Warm Handoff – Not a Transition in the Corridor or Vestibule*



# Living Room Model Peer Resources



*The Living Room Peer Support Model (LRPSM) use of certified peer support workers and peer volunteers in providing the following services within a drop-in setting:*

- *de-escalation during crisis,*
- *short term goal setting,*
- *safety plan development,*
- *teaching coping skills,*
- *connecting with community and hospital resources,*
- *medical and behavioral health system navigation,*
- *job search & employment preparation,*
- *supportive coaching and more.....*

*Resource: Oriana House, Cuyahoga County Diversion Center and University of North Carolina Transitional Care Unit, Chapel Hill*

# Therapeutic Milieu



Open Design to Facilitate Continuous Observation, Social Interaction, Flexibility and Choices



Resource: *Connections Health Solutions, Margie Balfour, MD, PhD and Oklahoma City Crisis Center, ODMHSAS*

# Basic Physiological & Social Services

Nutrition, Shower, Laundry, Medication Adjustments, Community Resources, Rest, etc.



*Resources:  
Oriana House, Cuyahoga County  
Diversion Center,  
Mind Springs Colorado, and  
University of North Carolina  
Transitional Care Unit, Chapel Hill*





What is important to you?  
What do you need to know?





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