Managing behavioral issues in inpatient medical settings

Vizient Patient Safety Organization safety tool kit

September 2018

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Background

Comorbid medical and mental health conditions such as substance use and suicidal or aggressive behaviors are prevalent in inpatient medical units and the emergency department (ED). Almost 40 percent of patients in inpatient medical units suffer from comorbid mental illnesses and these patients have worse clinical outcomes, longer stays and higher costs.[1-5] Caring for these patients is stressful and challenging, and staff are often ill-equipped to manage their needs.[5-7] In addition, risk of injury from on-the-job assaults and violent acts is nearly four times higher for health care workers than for employees in other industries.[8] Factors such as care providers' lack of knowledge, training or support, lack of confidence in their skills, and anxiety or fear can compromise the quality of care for patients with behavioral issues. Other challenges include environmental safety factors and the stigma that is often attached to these patients.[6,9]

Assessment: Vizient PSO data analysis

The Vizient® Patient Safety Organization (PSO) conducted a retrospective review of behavior-related event reports submitted from January 2017 through March 2018. Four percent of all reported events were behavioral events. In non–behavioral (i.e., medical) health care settings, disruptive and assaultive behaviors and possession of contraband or unauthorized objects were the most common types of behavioral events reported (Table 1). Males were more often involved in behavioral events in medical settings than females (54 percent vs. 37 percent); the same was true for behavioral care settings.

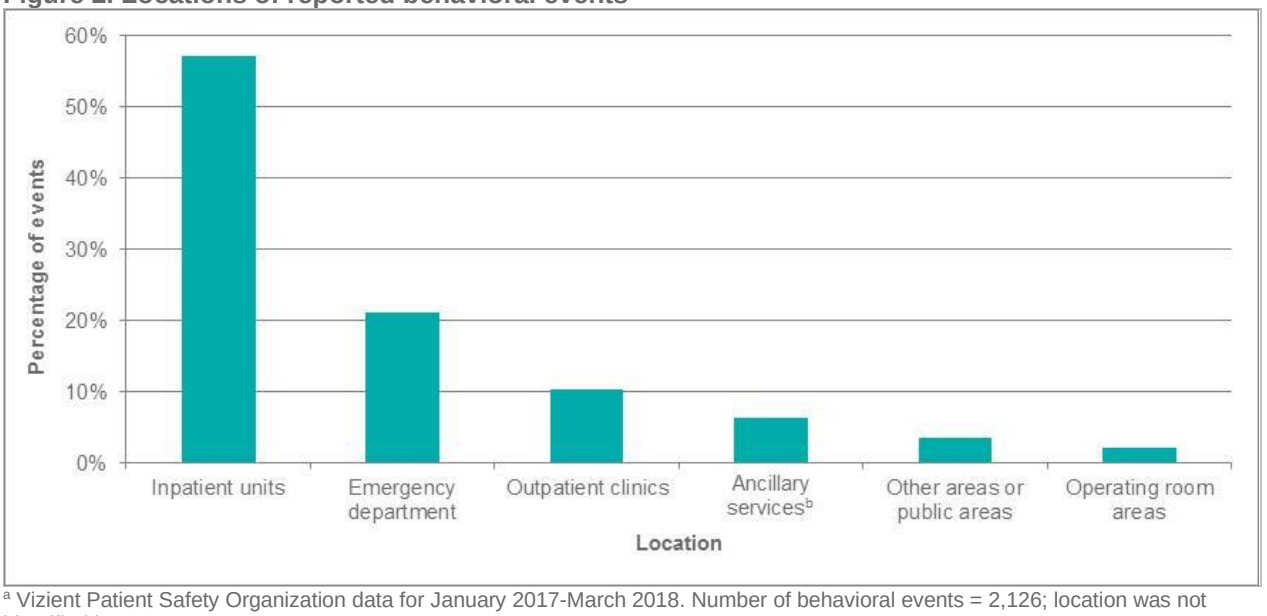
The majority (57 percent) of behavioral events were reported in inpatient medical units (Figure 2). Of these, medical-surgical units (24 percent), critical care units (8 percent), and specialty units such as oncology, rehabilitation, cardiac and neurology units reported the most behavioral events. More than 20 percent of behavioral events were reported as occurring in the emergency department and 10 percent in outpatient clinics.

Table 1. Rates of behavioral event types[a]

Event type	Percentage of behavioral events
Disruptive behavior	31
Other behavioral event	27
Assault	10
Possession of contraband/unauthorized objects	10
Self-harm or injury	7
Refusal of therapy	6
Threat by patient	4
Destruction of property	2
Suicide or suicide attempt	2
Restraint-related injury/death	2
Sexual assault/rape	1
Consensual sexual activity	0.2

[a] Vizient Patient Safety Organization data for January 2017-March 2018. Number of events = 2,725.

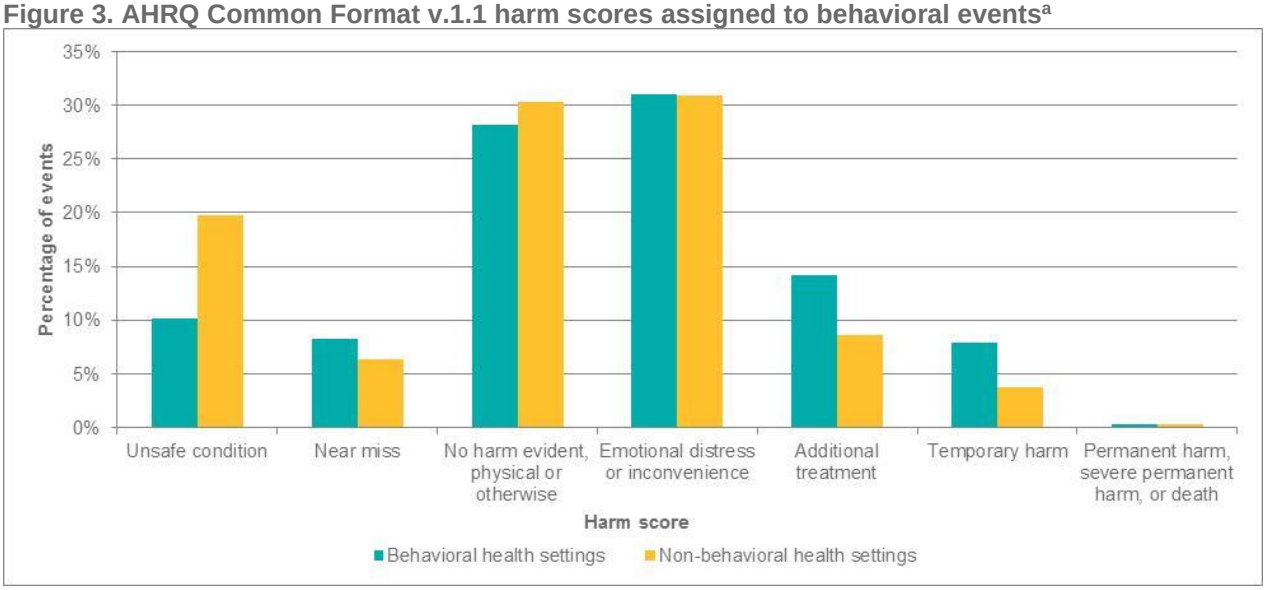
Figure 2. Locations of reported behavioral events[a]



[a] Vizient Patient Safety Organization data for January 2017-March 2018. Number of behavioral events = 2,126; location was not identified in 599 events.
[b] Ancillary services include radiology, rehabilitation, diagnostic, cardiovascular, respiratory, laboratory, pharmacy, etc.

Of the behavior-related events that occurred in non–behavioral health areas, 12 percent resulted in additional treatment or temporary harm and 0.3 percent in permanent harm or death, compared with 22 percent and 0.3 percent, respectively, of the events that occurred in behavioral health settings (Figure 3). In medical settings, the events that resulted in serious harm or death were suicide-related.

Figure 3. AHRQ Common Format v.1.1 harm scores assigned to behavioral events[a]



[a] Vizient Patient Safety Organization data for January 2017-March 2018. Number of events in non-behavioral health settings = 2,725; number of events in behavioral health settings = 670.
Abbreviation: AHRQ = Agency for Healthcare Research and Quality.

Assaultive behavior

There were 269 events categorized as assaultive behavior, but additional mentions of patient assaults were found in reports in other behavior-related event categories. The most common locations reporting assaults were the ED (24 percent), medical and surgical units (21 percent), critical care units (10 percent), and neurology and neurosurgery units (4 percent). The reported assaults were primarily committed by patients against staff or other patients. Some events involved allegations by patients of staff abuse or were assaults by patients of their visitors. Some of the reports of aggressive behavior involved patients with diagnosed psychiatric disorders; in others the patients were suffering from delirium, dementia or substance use, or had a history of violence.

Assault victims were most often punched, slapped, kicked, pushed, thrown, bitten, choked, spat at, fondled or struck with an item. In some cases, the event reporter stated that there was no warning that the patient was going to strike out. In others, the patient attempted to grab an officer's weapon or the patient or the patient's spouse pulled out a knife or other weapon and either threatened or attacked a patient or clinician. Forty-five percent of assaults caused emotional distress and 20 percent required additional treatment or caused temporary harm. Physical harm described in events included pain, bleeding, bruises, swelling, abrasions, scratches, lacerations, bites, punctures and head injuries. Males committed assault more often than females (54 percent vs 30 percent; in the remaining 16 percent of cases the offender's sex was not reported. Fifty-nine percent of assaulters were between the ages of 18 and 65 years, 18 percent were over 65, and 6 percent were children or adolescents; in the remaining, the assaulter's age was not reported.

Contraband or unauthorized articles

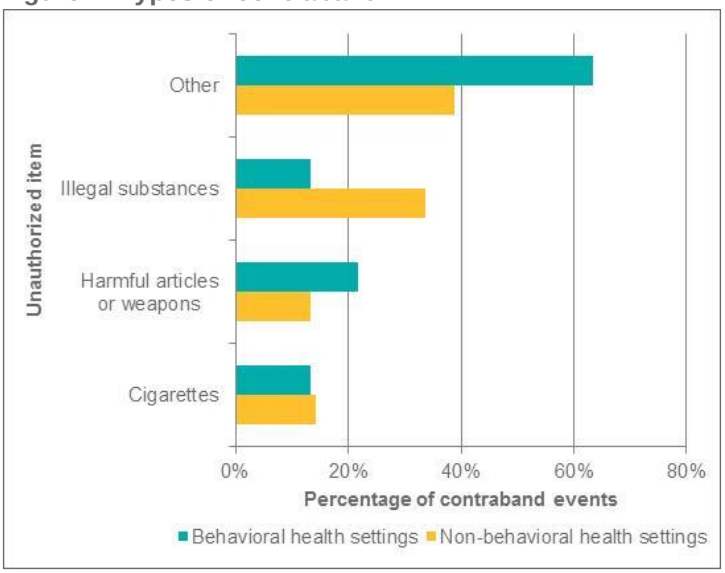
Ten percent of reported behavioral events involved possession of contraband or unauthorized articles. Contraband in these cases was categorized as "other" (39 percent), illegal substances (34 percent), cigarettes (14 percent), and harmful articles or weapons (13 percent). Illegal drugs were reported more often in medical than in behavioral health care settings (Figure 4). Review of the narrative event descriptions revealed that in most of the 255 contraband events that occurred in medical settings, patients brought in and used or tried to use illegal drugs or alcohol or had bottles of unauthorized pills during their hospital stay. Some events involved illegal substances or drug paraphernalia discovered after visitors had left.

The types of illegal drugs discovered by nursing staff included morphine, heroin, methadone, cocaine, marijuana, propane and other unidentified pills, powders or liquids, as well as drug paraphernalia. In most cases, the patients either attempted to or did ingest, snort or inject the drugs via their own syringes or their existing intravenous lines. Some of the patients had a known history of substance use disorder and were more closely monitored; others were caught in the act. In some cases, visitors brought the drugs hidden in

clever places (e.g., fast food). In a number of cases, the patient involved had a sudden change in condition and was found unresponsive, hypotensive, or lethargic. When indicated, emergency medical care such as an opioid antagonist was administered and a rapid response team called.

Other contraband-related events involved patients who had sharps or weapons such as knives, blades or guns. Sometimes patients informed staff they had weapons and handed them over, but in other cases either the sharps or weapons were found in the possession of a violent or suicidal patient, or the patient lashed out at staff with the weapon. In some cases the organization had preventive measures in place but procedures were not followed by staff. For example, alarms from the metal detector were assumed to be false alarms, allowing patients to go through with weapons in their possession.

Figure 4. Types of contraband[a]



[a] Vizient Patient Safety Organization data for January 2017-March 2018. Number of events in non-behavioral health settings = 255; number of events in behavioral health settings = 60.

Suicide-related behavior

Suicide is one of the five most common sentinel events reported to The Joint Commission. Suicide rates in the U.S. have risen nearly 30 percent over the past two decades.[10] Fifty suicide-related events in medical settings — including suicidal ideation, suicide attempts and completed suicides — were reported to the Vizient PSO. Forty-seven percent of these events were reported by inpatient medical units, 35 percent by the ED, and 20 percent by non–behavioral health outpatient settings (e.g., clinics, home health). Suicide attempts or completions that resulted in permanent harm or death were reported more often in medical settings than in behavioral health settings. Among older adults, suicide-related events were more common in medical than in behavioral health settings. Findings from other studies on suicides in general medical hospitals show that the patients involved in these events are more likely to be older, married and employed than those in psychiatric settings.[11]

Sixteen percent of these suicide-related events were “near-miss” situations, such as suicidal ideations discovered during a medical visit, patients caught preparing to act on their suicide plans, or unsafe environments (e.g., patients had harmful articles in their possession or were discharged to a home where

there was a gun). The majority of suicide-related events reached the patient but 49 percent of these either resulted in no harm or caused only emotional distress. Twenty percent required additional treatment or caused temporary harm and 14 percent caused permanent harm or death. Patients most often attempted suicide by means of strangulation or hanging, mostly with cords from equipment in their rooms, sheets, belts or clothing. Other methods included overdosing on medication, using a firearm, jumping in front of moving vehicle and cutting.

The contributing factors reported for suicide-related events were inadequate assessment, observation or care planning; environmental safety issues; and discharge of patients to home without adequate support or with an inadequate level of care. Cases of serious attempts or completed suicides in the ED or on medical units involved inadequate observation of suicidal patients who had access to areas with ligature points or equipment with cords or tubing that posed a safety risk. Some suicidal patients attempted to strangle or hang themselves even while a one-on-one monitor was in the same room or just outside the bathroom. Patients were able to attempt suicide in cases where body or belonging inspections were not conducted or were inadequate or where constant supervision was not maintained in the ED or medical units. Some patients committed suicide, or attempted suicide and returned to the ED, at the time of or shortly after discharge. In these cases, the care planning was reported to be inadequate based on the patients' risk factors and resources were lacking.

Leading practice recommendations

The following leading practice recommendations for managing behavioral issues in inpatient medical settings were developed by Vizient with the guidance of a multidisciplinary team of clinical experts (Appendix A).

- Establish proactive processes for screening, assessment and ongoing management of patients with behavioral issues.
- Identify and mitigate environmental safety hazards, conditions and situations that can lead to violence, suicide or self-harm and set policies and procedures to address the safety of the immediate environment for patients at risk of harm to themselves or others.
- Create a multidisciplinary behavioral emergency response plan.
- Conduct education and training programs on managing behavioral issues based on staff members' roles and responsibilities.

Proactive screening, assessment and management

- Conduct screening of patients on admission to medical units for history of mental illness, substance abuse, suicide or violence, and for current symptoms that should trigger further assessment and interventions based on the patient's needs.
- Incorporate a proactive process for psychiatric consultation and collaboration among interprofessional colleagues to improve care for patients with comorbid medical and mental health conditions.
  - A proactive psychiatric consultation team, also known as a behavioral intervention team (BIT), is typically composed of an attending psychiatrist, a social worker and a clinical nurse specialist (CNS).[4,12] The BIT identifies and addresses patients who have comorbid mental health issues early in the hospital stay and has been shown to result in shorter hospital stays, reduced need for one-on-one staff monitoring and restraints, and lower costs. The educational and collaborative nature of the process also improves staff satisfaction on medical units. Rather than reacting to requests by the medical team for psychiatric consultation when symptoms fully manifest, the BIT proactively screens patients on medical units and identifies treatment needs to improve the effectiveness and efficiency of medical care and aftercare planning.[4,5,12-14]
  - The goals of the proactive psychiatric consultation team or BIT include:
    - Early identification and intervention for patients with comorbid medical and mental health or substance use disorders to improve their physical care and recovery.[12]
    - Education, interprofessional collaboration and support from psychiatric experts to assist clinicians in managing behavioral health patients in medical settings through formal or informal ("curbside") psychiatric consultation.[4,7,12]
    - Coordination of care and disposition for patients who require behavioral health hospitalization or services and referrals after discharge from the medical unit.[4,12]

Suicidal ideation

Establish procedures to help clinical staff identify patients at risk of suicide, guide interventions, and facilitate referral and follow-up after discharge.[15,16]

- Review the Joint Commission *Sentinel Event Alert* on detecting and treating suicidal ideation in all settings.[15]
- Review each patient's personal and family medical history for risk factors and screen all patients for suicidal ideation, using a brief, standardized, evidence-based screening tool such as the Columbia-Suicide Severity Rating Scale (C-SSRS), Patient Health Questionnaire-2 (PHQ-2) or Patient Health Questionnaire-9 (PHQ-9), or Suicidal Behaviors Questionnaire-Revised (SBQ-R). Also visit the Suicide Prevention Resource Center to find a consensus guide for EDs and the ED Patient Safety Screener and

ED Secondary Screener.[15]

- Reassess when changes occur in a patient's clinical status at transfer and prior to discharge and when psychosocial stressors occur such as worsening of physical health or receipt of a poor prognosis.[11,15,17,18]
- Take immediate action to provide a safe environment by checking for and removing unsafe items brought in by patients and visitors and in the environment.[15,18]
- Develop a standardized process and checklist for conducting environmental safety checks and managing belongings brought in by visitors, and educate staff on the process.
- Assign a continuous one-on-one monitor in acute situations and when warranted based on further evaluation by a mental health professional. Review its necessity regularly (e.g., every 12-24 hours).[15,18]
- Coordinate treatment recommendations among providers, with the patient's permission.[15]
- Educate staff on the importance of maintaining continuous observation and good communication between providers, and developing a therapeutic alliance with the suicidal patient. Gaps in observation and others' negative perceptions of patients' behavior are potential risk factors for suicide in the hospital.[18]
- Educate the patient and family members on the warning signs of suicide and available resources (e.g., National Suicide Prevention Lifeline, local crisis and peer support contacts). Direct them to remove common means of suicide — medications, chemicals, guns — and to discontinue the use of alcohol and illegal drugs.[15] Provide trigger locks for guns.
- Establish a comprehensive network of behavioral health, primary care and community resources and referrals to ensure continuity of care for individuals at risk for suicide.[16,19]
- For additional information, see the section of this tool kit on environmental safety for the suicidal patient and education and the Vizient PSO paper, "An Analysis of Suicide-related Events."

Agitation and aggression

- Develop a comprehensive violence prevention program that is supported by leadership and includes[8]:
  - A commitment to violence prevention and employee involvement in the prevention program.
  - A culture that has zero tolerance for aggressive behavior.
  - A workplace risk assessment to identify hazards, conditions, operations and situations that can lead to violence and evaluate the effectiveness of existing security measures. The assessment should include tracking and analyzing reports of violence, conducting staff surveys and evaluating workplace security.
  - Tools and practices designed in response to the findings of the workplace analysis, such as:
    - Alarm systems, handheld alarms, portable phones or radios, personal communication badges
    - Metal detectors, security cameras, safety-focused environmental design
    - Computer and signage alerts for patients with a history of violence

- A formal violence prevention training program and program evaluation, which includes trauma-informed principles[20] and a proactive approach to prevention.
- Procedures for reporting and responding to episodes of violence, including debriefings and counseling for employees involved in threatening and violent situations (e.g., employee assistance program).
- For additional information, see the Vizient summary of violence prevention strategies.

- Develop processes to proactively assess and address the causes of agitation and aggression such as delirium, dementia, alcohol or drug withdrawal and neurological issues.[21]

Delirium

- Recognize, prevent and manage delirium in hospital patients.
- Proactively identify patients at high risk for in-hospital delirium (e.g., Mini-Cog Screening Tool).
- Use a standardized tool to identify delirium (e.g., Confusion Assessment Method [CAM][22] or Delirium Symptom Interview) and the severity of delirium (e.g., Confusion Assessment Method-Severity).
- Identify and treat the underlying causes of delirium and provide supportive care.
- Implement multicomponent interventions to prevent delirium including[23-25]:
  - Promoting good quality of sleep at night and discouraging sleeping during the day.
  - Minimizing environmental noise and providing good lighting and natural light.
  - Ensuring adequate nutrition and hydration.
  - Avoiding use of physical restraints.
  - Ensuring that patients wear their eyeglasses or hearing aids.
  - Encouraging early mobilization after surgery and increasing activity; using physical or occupational therapy.
  - Reorienting the patient to time, place and situation, and reducing psychological stress.
  - Providing cognitive stimulation; using trained volunteers to talk about past and current events, assist with eating, drinking and exercise, and facilitate activities such as playing cards.
  - Educating family and friends to visit often and to reorient the patient as needed; bring in personal items from home such as pictures, glasses, hearing aids and dentures; and encourage activity as permitted. (Niche Need to Know for Patients and Families: Delirium)
  - Administering medication based on the patient's needs; avoiding use of drugs that can bring on delirium such as benzodiazepines (unless for withdrawal) and anticholinergics; and avoiding oversedation.

Substance use withdrawal

- Identify and treat patients who are in drug or alcohol withdrawal early using evidence-based protocols to prevent adverse outcomes and reduce patients' agitation and the risk of aggression toward others.

- Use a standardized alcohol withdrawal treatment protocol with symptom-triggered dosing (e.g., revised Clinical Institute Withdrawal Assessment of Alcohol Scale [CIWA-Ar]) to improve management and outcomes. The protocol should focus on the goals of reducing restraint use, transfers to intensive care, and the incidence of delirium tremens.[26]

Environmental safety

- Identify environmental safety risks in nonpsychiatric hospital settings (e.g., medical inpatient units, ED, intensive care unit) where patients with psychiatric conditions may receive care.[27]
- Follow Centers for Medicare & Medicaid Services (CMS) guidelines for providing care in a safe setting.
  - CMS memorandum summary: Clarification of ligature risk policy
  - CMS manual system: A-0144, : Revisions to State Operations Manual (SOM) Appendix A: Survey Protocol, Regulations and Interpretive Guidelines for Hospitals (Rev. 176, Issued: 12-29-17, Effective: 12-29-17, Implementation: 12-29-17); §482.13(c)(2)[27]
  - Vizient webinar recording: Behavioral Health: CMS Clarification of Ligature Risk
- Conduct an environmental risk assessment appropriate to the specific care environment and patient population. The assessment may include items that pose risks of harm to self or others.
  - A ligature risk (point) includes items or areas to which a cord, rope or other material for the purpose of hanging or strangulation can be attached, such as shower rails, coat hooks, pipes and radiators, bedsteads, window and door frames, ceiling fittings, handles, hinges and closures.
  - Other safety risks include but are not limited to furniture or objects that can be easily moved or thrown; sharp objects; plastic bags (e.g., garbage); medical tubing or cords (e.g., oxygen tubing, call light cords), equipment used to check vital signs or administer intravenous fluids; glass (e.g., breakable windows); accessible light fixtures; non–tamper-proof screws; unattended medications or chemicals; and areas with poor staff visibility.[27]
  - The items outlined in the checklist developed for Department of Veterans Affairs hospitals: VA National Center for Patient Safety: Mental Health Environment of Care Checklist.[28]
- Designate rooms in the ED and medical units that provide additional safety (e.g., ligature-resistant features; sharps, glass and medications made inaccessible). For patients who are at risk of harming themselves or others, implement mitigation strategies for any ligature risks that cannot be permanently corrected.
- Identify and protect patients at risk of intentionally harming themselves or others.[27]
  - Mitigate safety risks in the patient's immediate environment.[26]
  - Develop an environmental assessment checklist and establish policies and procedures that define who is responsible for completion of the checklist and when it should be completed (e.g., in advance

of the patient's arrival if behavioral issues are known, shift-to-shift, and after visitors leave).
  - Remove sharp objects or equipment that patients could use to harm themselves or others from the room or area when they are not needed to provide medical care.[27]
  - Implement safety measures such as one-on-one monitoring with continuous visual observation or video surveillance by trained staff, depending on the level of risk and medical equipment needs.[27]
  - Develop clearly defined policies and procedures with criteria for evaluating the need for continuous visual observation by a one-on-one monitor, video surveillance or close observation based on the patient's risk. Ensure that all members of the treatment team are aware of their roles and responsibilities.
- Develop policies and procedures for body and belonging inspections to prevent patients at risk of harming themselves or others from bringing in potentially harmful items or illegal substances. Involve your legal counsel in review of the policy and procedure.
- Check the patient's body and belongings and secure any unsafe items, medications and illegal substances.
- Develop policies and procedures to determine when staff should check items brought by visitors for harmful, unauthorized or illegal items or substances before they enter a patient's room and for securing these items.
- Consider the use of lockers where visitors can self-check their own belongings.
- Consider using clear, tamper-evident bags to store patients' belongings to reassure patients that their belongings are being safely stored.
- Consider restricting food brought in from outside the hospital that is not commercially prepared and in a sealed container to prevent the entry of illegal substances.
- Develop visual cues for patients at risk that are readily viewable by staff.
  - Identify readmitted patients who have a history of violence in the electronic medical record (e.g., by displaying a banner in the record).
  - Display signage near the patient's room to alert staff entering the room to the risk.
- Structure the medical record to include readily accessible behavioral notes and plans of care that can be easily viewed by the multidisciplinary care team and used in coordinating care with outpatient providers.
- Emergency department resource: Tips for Providing Safe Structure for Adult Behavioral Health Patients.[29]

Behavioral emergency response plan

- Develop a systemwide, coordinated approach to emergency management of behavioral issues in medical settings to enhance patient care and promote workplace safety by minimizing violence.
- Collaborate with interdisciplinary stakeholders to develop a plan to leverage existing resources to manage behavioral issues based on the organization's needs.[19]
- Consider developing a consultative resource or team with expertise in managing behavioral issues and de-escalation. Behavioral emergency response teams (BERTs) — modeled after the rapid response team that addresses medical deterioration — have been shown to reduce assaults and restraint use and improve staff satisfaction, support, collaboration and education. The BERT includes multiple disciplines and performs the following[21,30-33]:
  - Collaborates in a safety huddle with the primary care team and assesses the patient, situation and level of threat.
  - Recommends interventions and resources needed to maintain safety.
  - Models effective communication and de-escalation techniques.
  - Holds a debriefing with the primary team after a response and develops a treatment plan.
  - Facilitates follow-up to evaluate the effectiveness of the treatment plan and modify it if indicated.
  - Collects data in a standardized debrief format.
- Develop a process for ongoing evaluation of patients with behavioral issues and support of medical staff such as[34]:
  - Rounding by a designated psychiatric liaison
  - Rounding protocols for high-risk areas or patents that includes security
  - Curbside consultations
- Engage families in providing patient support when warranted.

Education and training

- Develop an education and training program on the management of behavioral issues including mental illness, substance use, suicide and violence for employees who interact with patients, including clinicians, supervisors, support staff, one-on-one monitors and security personnel. In addition, educate auxiliary staff such as receptionists and dietary, housekeeping, and maintenance staff on safety procedures. Involve patient advisors in developing the program and educating staff and patients.
- Ensure that the appropriate level of education and training is provided based the employee's role and responsibilities in patient care as well as the level and type of patient risk in the employee's specific care area.[27]
- Ensure that one-on-one monitors, who play a key role in ensuring patients' safety, receive more extensive

training. Consider creating a specific role and title with competencies that address education and training on psychiatric management, de-escalation, environmental safety, personal protection and emergency response.

- Provide in-service education and training at initial orientation and annually that includes[8,16]:
  - Review of related policies and procedures
  - Employees' roles and responsibilities in screening, assessing and intervening when behavioral issues are identified, including evaluating and addressing environmental safety
  - Risk factors for and early warning signs of behavioral problems
  - How to speak to patients and families with respect and empathy in all interactions
  - Nonconfrontational, nonviolent crisis intervention techniques for de-escalating violent situations or dealing with hostile visitors (CPI'S Top 10 De-escalation Tips[34])
  - Personal safety strategies such as assessing the environment for safety, remaining vigilant and having an exit strategy
  - Standard emergency response action procedures including use of emergency devices and how and when to call for an emergency response
  - Safe use of restraints
  - Procedures for reporting and self-care after an incident
- Certify your organizational trainers in a nonviolent crisis intervention program and identify unit champions.
- Incorporate additional learning modalities such as simulation training and conduct mock behavioral emergency scenario training with bedside and ancillary staff.[21]
- Promote a culture of safety and encourage reporting of incidents of aggression.

Business case for change

- Elicit leadership support for improving care for patients with comorbid medical and behavioral health conditions and providing a safe environment for staff.
  - Share data on workplace safety, injuries and adverse events with leaders and hospital boards.
  - Use findings from the literature and member case studies to support the business case for change.
  - Have staff and patients present their stories of behavioral issues via video or in person.

Measure processes and outcomes

Collect baseline and ongoing process data such as:

- Number of emergency response team activations and details about the incidents, including:
  - Patient demographics and diagnosis
  - Location and reason for activation

  - Factors contributing to the behavior
  - Intervention and outcome
  - Time spent dealing with the situation[21,33]
- Compliance with policies and procedures governing one-on-one monitors and environmental safety.
- Percentage of staff who received training on managing behavioral issues and ensuring environmental safety.

Collect baseline and ongoing data on outcome measures including:

- Patient assaults and homicide attempts on staff, other patients and visitors (frequency, type and level of harm).[21]
- Patient suicide attempts (frequency, type and level of harm).
- Rates of employee injuries (e.g., number of injuries per 100 full-time workers) resulting from patient behavioral issues, and their associated costs (cost of injury, claims paid, and days away from work, restricted or transferred).[21,33]
- Use of one-on-one monitors to manage behavioral issues.[13]
- Use of restraints to manage behavioral issues on medical units.[30]
- Length of stay.[4,12-14]
- 30-day readmission rates.[12,13]
- Potential denied days.[12]
- Delays in transfer of medical patients to inpatient psychiatry units due to unavailability of beds.[12,14]
- Staff satisfaction with education and training.[21]
- Staff feedback on the impact of interventions, including[4,12,21,30]:
  - Effectiveness of the intervention and recommendations for improvement
  - Level of comfort in caring for patients with behavioral issues
  - Job satisfaction
  - Safety culture
- Patient satisfaction
- Number of reports of workplace violence.
- Number of discharges against medical advice and elopements.
- Number of reports involving contraband

For more information, contact Tammy Williams or Ellen Flynn.

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