

Creating Sanctuary: Reducing Violence in a Maximum Security Forensic Psychiatric Hospital Unit



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During this past year, the Management and Treatment Unit, (MTU), Mendota Mental Health Institute, (MMHI), in Madison, Wisconsin, put their theory as well as the APNA recommendations regarding reducing violence to the test. MTU is the most secure maximum security unit in the state's mental health system. The most acutely aggressive patients receiving mental health services from the state are admitted to MTU. Accordingly, the care providers are constantly grappling with questions involving restrictive measures as well as the threat of injury from aggressive patients. In a concerted effort to reduce violence, the MTU treatment team implemented several significant changes during the last year. Consistent with the APNA recommendations, the MTU treatment team incorporated programming that has included a focus on early, consistent interventions; introduced enhancements to the milieu to increase calmness; and developed working relationships and partnerships between care providers and patients (Delacey, 2000). The underlying hope in utilizing these measures was as predicted by APNA, an overall decrease in violence as evidenced by reductions in patient violence-related injuries, use of restrictive measures, emergency codes, emergency interventions teams, (EIT), and formal complaints from the patient. Utilizing approaches consistent with their motto of "Protect, Respect and Connect;" you will learn how the treatment team efforts have, indeed, resulted in a positive impact on the MTU.

Setting

MMHI is a psychiatric hospital providing mental health services to patients with complex psychiatric illnesses. It is operated by the Division of Mental Health and Substance Abuse Services within the Wisconsin Department of Health Services. The average daily population at MMHI is around 250 and is consistently at or above 95% capacity. MTU, a 14 bed all male adult unit, is one of four maximum-security units and is the most secure of those 4 units. MMHI is accredited under the Joint Commission hospital standards. However, the maximum security units are not certified by the Centers for Medicare and Medicaid Services (CMS), due to the use of Security Night Lock, which is allowed by State law. Security Night Lock at MTU is the only unit that by law- can have patient room doors locked at night for safety. All patients are assessed every 15 minutes, 24 hours a day. The doors can be unlocked on AM & PM shifts and are locked at night. All other areas are less restrictive units and doors are not locked at night- unless there are specific MD orders.

MTU provides treatment to the most acutely aggressive civil and forensic patients in need of maximum security. These patients have diagnoses that include major mental illnesses, personality disorders, alcohol and other drugs of abuse (AODA) and medical illness. Most have legal issues as well. Patients come to MTU from the community, jails, prisons, other facilities, or other MMHI units because they have been violent in less restrictive settings. Like MMHI, MTU is consistently full. The MTU treatment team consists of a Nurse Manager, Nurse Clinician, Psychiatrist, Psychologist, Social Worker, Certified Occupational Therapy Assistants, and Psychiatric Care Technicians.

Initial Analysis

Focusing on environment structure, early intervention, and patient relationships were pivotal, however, this team had to take programming to another level. It required understanding that for change to be meaningful, it would mean affecting culture. Melanie Sears reminds us in her book, *Choose Your Words: Harnessing the Power of Compassionate Communication to Heal and Connect* that "When we become conscious of our communication and develop choice in how we think and react, then we change our world." (Sears, 2007) Keeping this in mind, it was clear that simply changing the way we would relate to

each other would not be enough. We would also have to consider our thinking, feelings, and beliefs about violence, safety, and change. In August 2007, the MTU treatment team began to look at ways to revise its programming with the goal of reducing violence. Revisions to programming could not be made without first considering patient and care provider ideas related to: 1) care provider and patient knowledge base including their beliefs, attitudes, feelings and fears about what constitutes violence; 2) beliefs about the possibility of change in the amount of violence and benefits of such change; 3) current team approach to managing behaviors and preventing violence; and 4) current and potential barriers to implementing programming to reduce violence.

Care provider and consumer knowledge base about what constitutes violence

Care providers' beliefs regarding what they considered violence and what they did not consider violence varied significantly from one care provider to another. Many of the care providers, as well as the patients, held the belief that violence only included a direct threat or an act of physical aggression. In large part, the definition related to how the particular care provider "felt" (i.e., threatened or not) in response to a particular behavior, rather than on the patients behavior itself.

Beliefs about the possibility of reducing violence

Many of the common beliefs initially held by care providers and patients were in direct conflict with a belief that violence on the unit could be reduced. These included the belief that violence was a part of their job and that it was not reasonable to expect a reduction in restrictive measures. Furthermore, there was a belief among some care providers that increasing expectations regarding patient's behaviors would lead to an increase in acting out or aggressive behavior. Patients' views regarding the reduction of violence on the unit were also sought. Some patients appeared fearful of the idea of reducing violence, stating "But this is the only unit where we can come to and it is OK to be violent. Where else could we go?" Patients' belief in the possibility of change was also not promising. One patient offered the following observation: "You're crazy if you think this will change; this is maximum security. It is not possible."

Current team approach to manage behaviors and prevent violence

Along with security night lock previously mentioned, MTU has a "level system" providing clear limits and predictable consequences for specified behaviors. In addition, given the unit's unique role, MTU has a specialized management/security tool available, specifically Individual Emergency Response Plans, (IERP's). The IERP was developed for patients who meet very clear criteria including, but not limited to, a history of aggression that has not responded to treatment. If an IERP is in place and a patient is exhibiting behaviors that have led to aggression in the past a patient's door can be locked. In addition, when out in the general unit patients may be out in protective assistive devices (PAD's), ambulatory restraints until the predecessor behaviors are no longer present. Predecessor to aggression here means those behaviors that the patient presents that will lead to physical aggression. For example: if a certain patient begins to pace, it is a documented predecessor to aggression for him. So instead of waiting for the physical aggression, we can intervene and exit the patient from the area when he begins pacing. Not every patient placed on MTU qualifies for an IERP. For those who do not qualify for an IERP but display behaviors that present a danger to themselves or others, seclusion is also an option.

Barriers to Change

Care providers came to rely heavily on the IERPs to manage potentially aggressive behaviors. Because the Patients on IERP's had not previously responded to treatment interventions to reduce violence, the possibility of reducing violence beyond what was already provided through the IERP was viewed with skepticism. As a result, there was a belief that a certain level of violence on the unit was inevitable if more restrictive measures were not used.

1. Early Intervention Through Use of De-escalation Plans

- Anger, fear and frustration can lead to violence and each calls for a specific approach.(Stokowski, 2007) In order to provide better tools for early intervention, de-escalation plans were introduced and incorporated into patient treatment plans. A de-escalation plan is the behavioral component of the treatment plan that identifies triggers to stressors that could lead to violence; early warning signs of increasing stress; self-calming interventions; threatening behaviors; and interventions care providers will use

when threatening behaviors are presented. (Riemer, Corwith, 2007) To increase chance of success, the plan is written in partnership with the patient, if he is able to participate. The goal of the plan is to proactively intervene and defuse early warning signs of increasing stress before the need to react to the presentation of violent or potentially violent behaviors.

- The National Institute for Occupational Safety and Health (NIOSH) states that “although not every incident of violence can be prevented, many can and the severity of injuries sustained by employees can be reduced” (NIOSH, 1996). To that extent, specific self-calming intervention options for managing stressors are included in each patient's de-escalation plan. Self-calming interventions include taking alone time, listening to music, reading, exercising, utilizing relaxation exercises, using stress balls, talking with staff or taking a PRN medication. If a patient is unable to self calm utilizing the identified alternatives, the expectation is that the patient removes himself from the area, independently or with one verbal prompt by staff. Prior to re-entering the area, a debriefing with staff is expected in order to assess recovery and ability to re-enter the location safely.
- In addition to working with patients to develop their own de-escalation plans, educational groups teaching and reinforcing healthy ways to manage emotions through self-calming rather than through violence are regularly offered. Self-calming interventions taught in these groups include diaphragmatic breathing, grounding, meditation and progressive relaxation exercises. Care providers also participated in these groups in order to role model the techniques and encourage their use when situations arise. With everyone practicing the self-calming techniques in groups, patients come to view the MTU treatment team members as partners in their recovery journey.

2. **Promoting Milieu Calmness**

- Given the clearly defined level system and availability of IERPs on MTU, there was already a great deal of structure. Nonetheless, confusion and inconsistency with implementing the unit rules was a source of team conflict. Though rules are intended to help create a safe environment, inconsistent interpretation and enforcement of unit rules can instead cause conflict between care providers and patients as well as between treatment team members. The level of conflict in turn adds to unit acuity. Addressing inconsistencies, conflict and confusion surrounding the unit rules became one of the team's major priorities. The team began by defining and clarifying each rule as a team in order to increase consistency with enforcement. One of the most significant rules in need of clarification was MTU's “zero tolerance” for violence policy. As previously discussed, there was no common understanding of what violence was. Without a common understanding of violence, there was no way that zero tolerance could be consistently enforced.
- **Defining Violence**
 - It appeared that, in general, both care providers and patients considered only actual physical violence or direct threats of physical violence to be violence. It was far less likely that either the care providers or the patients considered passive and nonverbal violence to be actual violence. In a book by Marshall Rosenberg, Ph.D., *Nonviolent Communication: a language of life*, Arun Gandhi contends “passive violence fuels the fire of physical violence” (Rosenberg, 2006). Indeed, it was not uncommon for a patient who was new to the unit to claim he had no history of violence as he has never been physically aggressive against anyone; however, that same patient would repeatedly be observed provoking and agitating his peers who in turn would be aggressive. To improve the consistency on the unit, and to help care providers intervene early before physical violence is displayed, violence in all forms was clearly defined as any behavior that increased the acuity of the unit's environment and threatens sanctuary and that definition was implemented.

3. **Building a Working Relationship/Partnership with Consumers**

- Understanding the possible causes of violent behavior and giving care providers and patient's additional tools to address situations in a non-violent way were the next critical

steps for promoting calmness. In her book, *Humanizing Health Care with Nonviolent Communication: A guide to revitalizing the Health Care Industry in America*, Melanie Sears describes how unmet needs can lead to violence: “Consumers often act out in violent ways trying to get their needs met because they do not understand what their own needs are and have no tools for meeting these needs in healthier ways” (Sears, 2006). Non-violent Communication (NVC), based on the teaching of Marshall Rosenberg, Ph.D., delineates steps that individuals can use in any setting to help get their needs met through respect, empathy and compassion rather than through violence. The NVC steps include observation without judgment, identifying feelings and needs, and then making a request without demands (Rosenberg, 2006). NVC skill training was provided first to care providers. The treatment team practiced the skills by using them in team meetings. Subsequently, regular treatment groups focusing on NVC were included in the unit’s programming. In the beginning the groups were held weekly, then increased to two times per week, and finally integrated and reinforced in other unit groups as well. Care providers were present in the treatment groups to actively participate and assist in providing education and practice with patients. This sent the message that everyone as a member of this community was responsible for their part in helping to create a safe culture, by expressing and getting needs met without use of violence.

- After adding de-escalation plans for each patient, providing education for self-calming and coping skills, clarifying unit rules, defining violence and providing several weeks of NVC skills groups, the unit began to calm. Patients and care providers reported feeling safer and began to comment that a violence-free unit might be possible. The time had come to introduce the idea of sanctuary and establish everyone’s roles and responsibilities in protecting sanctuary through trauma-informed care training.

Trauma-Informed Care

It is impossible to address violence without also addressing trauma and its effects. It is imperative that care providers and patients understand the relationship between the cycles of violence and trauma. Sandra Bloom’s Sanctuary Model is “a method for creating a trauma-informed, trauma-sensitive culture for promoting healing and recovery without solely relying on 1:1 interventions. The model is a concept of safety that encompasses physical, psychological, social and moral safety and then expects that everyone in the environment—from the leader to the newest client, adhere to the policy of nonviolence as a member of the community” (Bloom, 2008). The idea of sanctuary was first introduced in our NVC Skills group after reading about Promoting Awareness, Victim Empowerment, (PAVE), an organization that provides education and awareness about safety and nonviolence. After learning about the educational projects suggested by PAVE, the project chosen for MTU was a bulletin board project. Within this project, the concepts of the PAVE project, Nonviolent Communication and sanctuary based on Sandra Bloom’s Sanctuary Model, were combined. During the group, patients and staff engaged in a discussion of what a sanctuary would look and feel like and as a result, a list of the qualities of a sanctuary was developed. Initially, the overall feeling in the room was that sanctuary was not possible on a maximum security unit. After completing the list, and comparing it to the list from the Sanctuary Model as defined by Sandra Bloom, the affect of the group drastically changed. The group was speechless and surprised discover that, with the recent changes made, MTU already had many of the qualities of a sanctuary. Patients were amazed to realize that they were actually helping to create a sanctuary of their own. After processing the information as a group, everyone was invited to dedicate themselves to protecting this sanctuary that they had a hand in creating. With construction paper and markers, patients and care providers traced their hands on the paper, cut them out and wrote their names on the hands. The paper hands were then placed on a larger bulletin board under the heading “Hands and Words Are Not for Hurting. Working Together Towards a Violent Free MTU.” The sanctuary project, as shown in Figure 1 below, is displayed next to the NVC process of communication in the large day room on MTU to help remind us that even in maximum security forensics, sanctuary is not impossible. It is a reminder of the possibilities for hope and recovery when we are able to get our needs met respectfully and peacefully without the need for violence.

Figure 1: The Bulletin Board on MTU that combines the concepts of the PAVE project Nonviolent Communication and the Sanctuary Model.



“THESE HANDS AND WORDS ARE NOT FOR HURTING.
WORKING TOGETHER TOWARDS A VIOLENT FREE MTU”

Protecting Sanctuary

Within the concept of sanctuary is the expectation that all patients and care providers on MTU are to participate in creating and preserving the sanctuary of the unit. Along with the visual reminder displayed prominently in the day room, the concept of sanctuary was explicitly incorporated into the MTU Policies and Procedures. Including sanctuary in the unit's policies helped care providers and patients recognize that protecting sanctuary is not just a concept, but an expectation. Patients and care providers protect sanctuary using a variety of tools including participating with developing their own de-escalation plans, learning and enhancing cognitive, emotional regulation, coping, problem solving, communication and conflict resolution skills. In addition, promotion of healthy relationships by practicing pro-social skills, respecting rights and boundaries of others, extending empathy and compassion to others, using NVC skills to get needs met without violence, and exiting the environment if unable to calm themselves are also expectations. Weekly community meetings in the form of NVC Problem Solving Meetings have been added to the unit schedule. In these community meetings, patients and care providers come together to discuss issues that have come up during the week, clarify unit expectations, and problem solve concerns together as a team. Education is provided using role play of difficult situations to demonstrate how to resolve conflicts using NVC skills along with practice of emotional regulation skills. Members also take time to express empathy, give gratitude, and celebrate successes together as a community. During one community meeting, patients discussed an incident that threatened their sanctuary the evening before. A patient on the unit escalated. This escalation normally results in very physical and hands on intervention with this individual. Staff intervened very early and was able to defuse without hands on. As patients and care providers processed their observations, feelings, and needs, there was an exchange of empathy between care providers and patients. Patients expressed appreciation to care providers for their efforts at respectful and early intervention. Care providers expressed appreciation to patients for their efforts to help preserve sanctuary by clearing the area quickly. This connection between care provider and the patient contributes to supporting a relationship that is a partnership in working towards MTU's number one goal of a violence-free environment.

The more compassion we have for ourselves, the more compassion we have for others (Sears, 2006). Care providers also have several new tools for protecting sanctuary. As Jean Clarke has said, "A person's needs are best met by people whose needs are met" (Pitonyak, 2008). Keeping this in mind, and given the fact that it is not uncommon for staff to develop secondary traumatic stress symptoms because of their work, routine debriefings were implemented for care providers each shift. These debriefings assist care providers to process and disengage from the day's events before going home. They are able to discuss their observations, feelings, needs, and problem-solve concerns about the shifts events as team. In addition, they also take time to express gratitude and celebrate what went well during their shift.

The treatment team also developed a code phrase to help protect sanctuary. "You have a phone call" is a gentle prompt given without judgment to help a care provider disengage and take a few minutes away from the situation to regroup. The team then comes together as soon as possible in order to process as a team the observations leading up to the prompt being given, the feelings, needs, and any requests around the situation that occurred. The treatment team members have come to appreciate the code phrase as an additional tool to support and communicate with each other without judgments when disagreements arise.

Results

In the past year (from August 2007 to July 2008), through the many initiatives introduced, MTU has experienced a change in culture from one within which violence was tacitly, if not openly, accepted as the norm to one within which zero tolerance for violence is consistently enforced. Anecdotally, both patients and care providers say that they feel safer as well as more relaxed, and heard and respected. Indeed, the data bear this out showing fewer injuries from patient aggression; a reduction in the use of restrictive measures; a decrease in the use of code calls and emergency intervention teams (EIT), to deal with escalating situations; and fewer patient grievances. Table 1 shows the data for the year prior to the changes (2006-2007) and the year while the changes were being implemented (2007-2008).

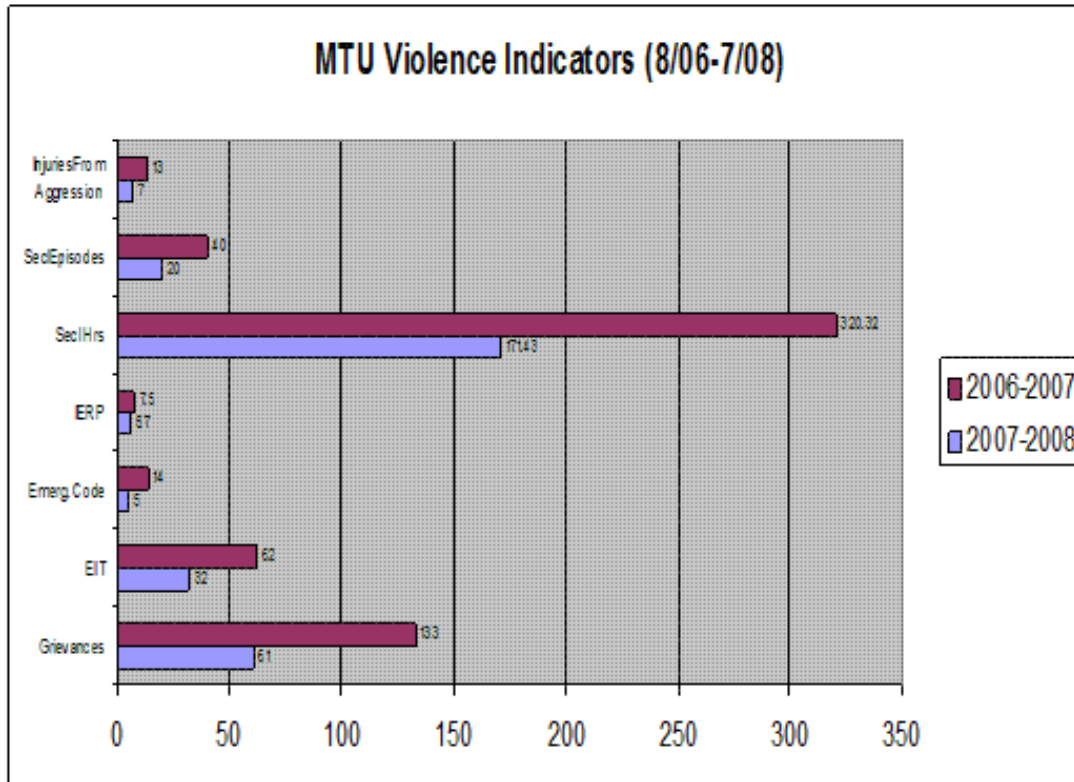


Table 1: MTU Violence indicators all show a reduction in 2007-2008 as compared to 2006-2007.

Given that MTU provides treatment for patients with a history of aggression, injuries caused by patient aggression have not been uncommon.

As recognized from the outset, a goal for many psychiatric hospitals is the reduction of restrictive measures. MTU is no exception. An important distinction on MTU is that, as previously discussed, it has both emergency seclusion as well as "Individual Emergency Response Plans" (IERPs) to assist with aggressive or potentially aggressive patients. IERPs allow for door lock or ambulatory restraint devices when a patient is displaying identified predecessor behaviors that cannot be defused using the patient's de-escalation plan. Despite the availability of this additional restrictive measure, reducing the use of restrictive measures both emergency seclusion and IERPs is an important and continuous goal on MTU. Accordingly, we were pleased to note a significant reduction in the use of both seclusions and IERPs. The number of seclusion episodes reduced from 40 to 20, a 50% reduction. The total number of hours that patients were secluded reduced from 320.32 to 171.43, a 46% reduction. Likewise, the number of patients per day who had an IERP applied reduced from 7.5 to 5.7 a 24% reduction.

As in probably all mental health facilities, there are mechanisms for unit care providers to get assistance from additional care providers off the unit when a violent or potentially violent situation develops. At MMHI, two frequently used mechanisms are "Codes," in which an overhead page is called for care providers from other units to respond immediately, and Emergency Intervention Teams, (EITs), in which security gathers a team of specially trained care providers and security officers suit up in protective equipment and respond. During the past year, the unit's use of codes and EITs decreased significantly. Specifically, the number of codes called to MTU reduced by 64% from fourteen to five. Similarly, the number of EIT calls reduced by 48% from 62 to 32. The decreased reliance on additional assistance suggests decreased unit acuity as well as increased confidence among unit care providers in their ability to effectively handle situations without calling for additional resources off the unit. It is also important to note that the number of Codes and EITs declined despite the fact that patients were being managed with less reliance on restrictive measures.

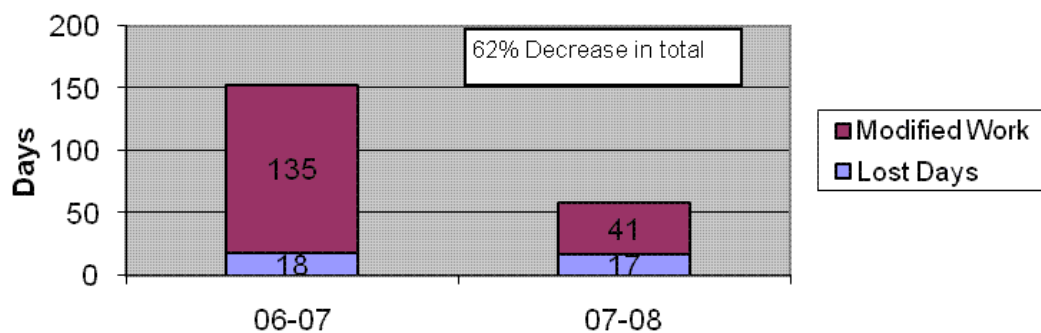
On a maximum security unit, rules and structure are needed to keep both the patient and the care providers safe. Given conflicts over the rules as well as how and when the rules are applied, grievances against care providers are not uncommon in maximum security settings. During this past year, strong emphasis has been placed on enforcing unit policies consistently; facilitating communication; promoting trust between care providers and patients; and resolving conflict without unnecessary delay. Both patients and care providers have learned and practiced getting their needs met respectfully. The number of patient grievances reflects these changes: 54% fewer formal complaints were filed with the client rights office during this past year, down from 133 to 61.

Patient and care provider satisfaction surveys were recently distributed. Both patients (n = 10) and care providers (n = 10) who responded reported feeling safe on the unit. On a scale of 1-3 with 3 being "very safe," patients were asked how safe they felt. The average rating was 2.5 indicating reasonably strong feelings of safety among patients. Notably, when looking at responses from a patient who had been on MTU prior to the changes, 67% stated they felt safer now compared with before the changes were made. Care providers were also asked how safe they felt. With a range of 1 to 5, 5 being "very safe," the average score was 4.5. Accordingly, both care providers and patients are reporting they feel safe on MTU, the unit treating the most acutely aggressive patients in the State's mental health system.

Along with a 50% reduction in violence-related injuries for care providers, staff also had a reduction in loss from work including a 62% reduction in the number of light duty days required with a reduction from 135 days from 2006-2007 to 41 days in 2007-2008 as reflected in table 2 below.

Table 2: MTU shows a reduction in lost days and days of modified duty
In 07-08 as compared to 06-07 (prior to changes in MTU programming.)

Number of Lost Days and Days of Modified Duty Due to Staff Injuries Resulting from Patient Violence



Implications for Forensic Nursing

These results are perhaps the result of adding consistency to structure, early and proactive intervention, and enhancing the quality relationships between the care provider and the patient. A clear definition of all forms of violence, impact of violence, effects of trauma even in just witnessing violence, and alternatives to violence must be provided for patients to be successful in emotional self regulation. In addition, ongoing education in areas of problem solving, conflict resolution, communication skills, and trauma-informed care and a clear expectation of a zero tolerance for any form of violence by all members of the community is imperative. Care provider needs cannot be ignored while assuring patients' needs are met. We must be clear that care providers have the same right to sanctuary that patients do. Patients and care providers must be willing to partner towards the same goal of recovery and wellness without violence.

Conclusion

Patients and staff report an increase in feelings of safety, communication, and continuity of care since the revision of MTU programming. MTU continues to work towards creating a trauma-sensitive unit that promotes recovery and wellness. Principles of recovery, trauma-sensitivity, and sanctuary have been added to the MTU unit rules. This is proof that when a group of patients and care providers come together to work towards a common goal of creating a violence-free unit, the results are not surprising. Many of the key changes begin and end with one key premise: Patients and care providers expect to be free from violence, even on a maximum security unit. To make this concept a reality, it is important that neither care providers nor patients be given permission to normalize behaviors that are considered violent and that zero tolerance for all forms violence is enforced consistently. In addition to ongoing education, care providers and patients must be provided with an array of tools to help create and maintain an environment of non-violence. De-escalation plans, trauma-informed care, self-calming techniques and enhanced communication skills through NVC. Give patients a strong foundation with which to work as partners in their recovery. These tools, combined with a clear vision of a safe and secure unit, they see that care providers are working with them towards a common goal, rather than merely enforcing rules over them. The MTU treatment team through their mission statement, "Protect, Respect and Connect" have partnered with patients to succeed in changing the culture of MTU by creating a sanctuary where recovery is possible, from a place where violence was once believed acceptable; a sanctuary in, of all places, the most maximum security forensic unit in the state of Wisconsin.

- References

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Ms. Riemer is a Board Certified Psychiatric Mental Health Nurse, Legal Nurse Consultant, and Certified Traumatologist. Ms. Riemer has worked with children, adolescents, and adults, in shelters with women & child victims of domestic and intimate partner violence (IPV). Voted as Wisconsin Nurse of the Year in 2000, she is an active member of the American Psychiatric Nursing Association (APNA), and the International Association of Forensic Nursing (IAFN). She has served on the 2007 APNA Seclusion/Restraint (S/R) Task Force and on the 2008 APNA Workplace Violence (WPV) Task Force, and is currently serving on The Trauma-Informed Care Advisory Committee for the State of Wisconsin. A published author in the IAFN News Letter: On The Edge in 2007, she detailed her treatment team's experience reducing violence by greater than 90% over a 3 year period in a medium security forensics unit, significantly reducing the need for more restrictive interventions. Ms. Riemer is able to explain how recovery focused interventions in a trauma-informed, trauma sensitive environment helps to promote recovery, and the importance of partnering with patients to create sanctuary and learn how to get their needs met safely.