COUNTY OF MILWAUKEE
Inter-Office Communication

**DATE:** January 11, 2011

**TO:** Supervisor Michael Mayo, Chairman - Milwaukee County Board of Supervisors

**FROM:** Geri Lyday, Interim Director, Department of Health and Human Services

**SUBJECT:** **INFORMATIONAL REPORT FROM THE INTERIM DIRECTOR OF THE DEPARTMENT OF HEALTH & HUMAN SERVICES REGARDING A FOLLOW-UP REPORT REGARDING MIXED-GENDER PATIENT CARE UNITS AT THE BEHAVIORAL HEALTH DIVISION**

**Issue**

On April 14, 2010, the department received a referral from Supervisor Peggy West, Chairperson for the Health & Human Needs Committee, requesting a report from the Behavioral Health Division (BHD) on mixed-gender units for the acute psychiatric inpatient unit. The BHD Administrator assigned medical staff the responsibility to conduct a study and literature review, consistent with Joint Commission expectation that the medical staff have a leadership role in enhancing the quality of care, treatment and service, and patient safety.

On June 16, 2010, a preliminary report from the BHD Gender Unit Work Group was presented to the committee. The conclusion was that the mixed-gender acute inpatient units utilized by BHD are the norm among public psychiatric hospital systems in Wisconsin and have been the standard model for inpatient psychiatric treatment for decades. Any revision to the existing practice at BHD of mixed-gender units must look carefully at implications for safety, patient satisfaction and choice and therapeutic benefit. For these reasons, the Gender Unit Work Group recommended that BHD do a detailed study to more thoroughly evaluate the various options to ensure a safe inpatient unit environment. The work group presented an update to the committee in September and is now returning with a follow-up report that specifically addresses the current practice of mixed-gender units at BHD.

**Discussion**

The follow-up report from the BHD medical staff makes several recommendations important to the discussion of mixed-gender units. Specifically, the Gender Unit Work Group recommends a configuration of the four Acute Adult Inpatient units that would create a 12-bed Intensive Treatment Unit (ITU) that is expected to be predominantly male; a combined Women's-Option/Med-Psych Treatment Unit; and two mixed-gender General Treatment Units. More information about these recommended units, the rationale, and supporting documentation is included in the attached *Milwaukee County BHD follow-up report to the BHD Administrator: Mixed-Gender Units*, submitted by the Gender Unit Work Group.

**Recommendation**

This is an informational report. No action is necessary.

Respectfully submitted:

Geri L. Lyday

Geri Lyday, Interim Director
Department of Health & Human Services

Attachment

cc: County Executive Lee Holloway
Renee Booker, Director – DAS
Allison Rozek, Analyst – DAS
Jennifer Collins, Analyst – County Board
Jodi Mapp, Committee Clerk – County Board

MILWAUKEE COUNTY BEHAVIORAL HEALTH DIVISION

# FOLLOW-UP REPORT TO BHD ADMINISTRATOR:

# MIXED - GENDER UNITS

***Submitted by the***

***GENDER UNIT WORK GROUP***

**December 1, 2010**

## EXECUTIVE SUMMARY

### Introduction

On June 16, 2010, the *Preliminary Report to BHD Administrator: Mixed-Gender Units (May 22, 2010)* was presented to the Milwaukee County Committee on Health and Human Needs. The Committee had requested a report from the Behavioral Health Division (BHD) on mixed-gender units for acute psychiatric inpatients. A Gender Unit Work Group conducted a comprehensive international literature review on mixed and single-gender units, obtained information from Wisconsin public psychiatric hospitals, reviewed BHD incident and inpatient consumer satisfaction data and explored the history of mixed-gender units, prevalence, patient perceptions and staff attitudes. The report concluded that the mixed-gender Acute Adult Inpatient units utilized by BHD are the norm and have been the standard model for inpatient psychiatric treatment for many decades. The Work Group recommended before there is any revision to the existing practice of mixed-gender units at BHD that a more detailed evaluation be done of the various gender unit options, while continuing the current practices in place to minimize risk and ensure a safe, therapeutic unit environment. This Follow-Up Report details the comprehensive study conducted by the Gender Unit Work Group of the current practice of mixed-gender acute units at BHD, specifically in the context of patient sexual safety.

### Methods

To this aim, the study involved four phases. We administered semi-structured questionnaires to BHD Acute Adult inpatients to assess their perceptions of safety on the current mixed units as well as preferences for single-gender units. We surveyed BHD staff working on the Acute Adult inpatient units on their perceptions of patient sexual safety on the units, effectiveness of current safety practices and attitudes toward gender unit options. We communicated with other public psychiatric hospitals regarding the gender configuration of their acute adult units. We obtained input from community stakeholders on male and female patients residing on the same and single-gender units and on recommendations to improve quality of care in the acute hospital.

## Results

**BHD Patient Perceptions.** Most of the 130 patient respondents reported feeling somewhat or very safe on a mixed-gender unit. More than 90% of male patient respondents and nearly 84% of female respondents felt somewhat or very safe with men and women on the same unit. The majority of them explained that their feeling safe related to positive interpersonal interactions and denial of concerns about aggression. The small percentage of men and women patients who felt unsafe on a mixed-gender unit was concerned about safety from aggression. Respondents indicated that they would feel safer on a mixed-gender unit with improved interpersonal interactions and with unit and security staff presence, behavior and monitoring. Almost 50% of male and female patient respondents did not prefer to be on a same-gender unit. The primary reason cited for this finding was the perceived value of interpersonal interactions between patients and the negative impact a single gender unit would have on these interactions. A secondary, less predominant, reason was the potential for more aggression on an all-male or all-female unit. Only 15% of male patient and 29% of female patient respondents indicated that they would prefer a same-gender unit if it were available. The women who did prefer an all-female unit cited the positive impact of female-to-female interpersonal interactions, and did cite concerns about male aggression on a mixed-gender unit. Thirty percent of both male and female respondents were unsure of their preference for a same-gender unit. but commented on the mainly positive features of interpersonal interactions with both men and women on a unit.

Only one-quarter of the total of male and female patient respondents indicated that they would feel safer on a same-gender unit. A higher percentage of men would feel less safe (38%) than more safe (23%) on an all-male unit. The men who said they would feel less safe on a same-gender unit were mostly focused on the potential for aggression. Male respondents who gave reasons for feeling safer on a same-gender unit cited interpersonal benefits. A slightly higher percentage of women responded that they would feel less safe (32%) than more safe (29%) on an all-female unit. Women who said they would feel less safe on a same-gender unit were mostly focused on the potential for interpersonal conflict between women. Those who responded that they would feel safer on a same-gender unit cited safety from aggression and expected improvements in interpersonal interactions.

Women did not express a definitive preference for a women's-only lounge to be made available on the unit. Of the women who were opposed (39%) to a women's-only lounge, the majority of their reasons cited an expected negative impact on interpersonal interactions. The remainder of their comments cited expected verbal and physical aggression between women. Of the women who would prefer (32%) that there be a women's-only lounge on the unit, most reasons centered on an expected benefit in their interpersonal interactions and shared communication with other women. Only a few comments referenced a vague feeling that they would feel safer.

**BHD Inpatient Staff Perceptions.** More than 60% of the 82 staff respondents thought that men and women patients are somewhat or very sexually safe residing on the same unit. Nearly 40% of staff respondents think men and women patients are somewhat or very sexual unsafe residing on the same unit. Staff respondents' sexual safety concerns for both men and women on the same unit were related to the individual's vulnerability to sexual harassment, intimidation, exploitation and/or abuse, and also to the unit configuration, staffing pattern and patient mix. Staff respondents identified that both men and women raised sexual safety concerns about vulnerability to sexual harassment and intimidation; being concerned about personal boundary violations; and general (nonsexual) safety concerns. Nearly half of staff respondents said that men usually expressed no sexual safety concerns, and nearly one-quarter said women did not raise any sexual safety concerns.

Current practices were predominantly rated by staff respondents as being somewhat effective for ensuring the sexual safety of patients on the unit. Locked community bathrooms and the unit zone surveillance system were the highest rated practices with more than 40% of staff respondents rating them as very effective. Cross shift communication of special risk patients, the separation of bedroom hallways for men and women, and behavior observation for special risks were other practices rated by about one-third of staff as being very effective. In regard to other suggestions to improve sexual safety on the mixed-gender units, the largest percentage (32%) of staff respondents suggested an improved staffing pattern. Additional suggestions included better supervision and training of staff, better teamwork and hospital configuration of patient mix.

Nearly half of staff respondents thought it would be somewhat or very helpful for managing sexual safety on the units for BHD to develop plans for an all-women's unit. This group of respondents thought that this would reduce or eliminate sexual harassment and contact and could better serve the subset of women with sexual abuse and trauma issues. Unsure or neutral respondents cited the benefit of patients being able to interact and learn from the opposite sex on mixed-gender units and were concerned about not being able to control or prevent all sexual contact, including same-gender activity. Those not viewing the unit as being helpful were also concerned about same-gender sexual activity and felt that patients need to function in a normalizing environment similar to the community. Nearly half of staff respondents thought it would be somewhat or very helpful for managing sexual safety on the units for BHD to develop plans for an all-men's unit. Respondents thought that this could particularly help high-risk men from taking advantage of vulnerable females and provide a safer, less violent environment for the rest of the patient population. Those respondents that were unsure or not in favor of an all-men's unit cited concerns about the unit being more violent than a mixed-gender unit, that vulnerable males may be abused, and same-gender sexual behavior.

Only about one-quarter of staff respondents were in favor of a women-only lounge, citing it as a safe and secure place for women to go to when feeling threatened. Those staff respondents not in favor or unsure indicated that inappropriate sexual behavior occurs in places other than lounge areas, and that the area would require close monitoring by staff. Most staff respondents were unsure or did not think that having a men-only lounge on a mixed-gender unit would improve sexual safety. They indicated that inappropriate sexual behavior occurs in places other than lounge areas, and the area would require close monitoring by staff. Only one-fifth of staff respondents were in favor of a men-only lounge.

As for staff preference for type of unit work assignment, nearly half of staff respondents would not prefer to work on an all-women's unit. Primarily this was due to their concerns about having to deal with stressful demands, and secondarily their viewing the benefits of a mixed-gender recovery environment that reflects the community to which patients will return. Similarly, most staff respondents did not prefer or were neutral or unsure about working on an all-men's unit due to the potential for aggression and violence. Most staff respondents preferred to work on a mixed-gender unit due to the variety of patient needs and personalities of this arrangement, and the benefits of the current mixed-gender recovery environment that reflects the community

**Public Psychiatric Hospital Practices.** Information from 9 Midwest public psychiatric hospitals with civil acute units revealed that none of them have single-gender civil acute units and most stated that their units have been coed for as long as they can remember. Of the hospitals that also have formally-designated state forensic units, some of these units are single-gender, some all-male and some all-female. Practices some hospitals use for patients identified at increased risk for dangerous behaviors include heightened levels of observation and monitoring to reduce opportunity for acting out, as well as a psychiatric intensive care unit to manage particularly violent or high-risk patients.

**Community Stakeholder Input.** A total of 216 community stakeholders shared a variety of responses about having male and female patients residing on the same acute adult inpatient units, as well as thoughts about having patients reside on all-male and all-female acute inpatient units. Nearly half of respondents offered comments citing advantages of mixed-gender units, and slightly more than a half cited reasons against such an arrangements. Consumers and families tended to be more favorable in their opinions of men and women on the same units, whereas advocates and "other" type respondents were more skewed in their focus on disadvantages as compared to advantages. The advantages of mixed-gender units fell into the two main content categories of *Therapeutic Recovery Environment* (beneficial effect on interpersonal interactions and treatment milieu, and practice standards) and *Quality of Care & Patient-Centered Treatment* (core issues of quality of care, staffing/supervision and screening/treating of most dangerous/vulnerable). Disadvantages of mixed-gender units fell into two main categories of *Therapeutic Recovery Environment* (negative impact on interpersonal interactions and treatment milieu) and *Vulnerability, Trauma and Patient Mix* (impact on safety, potential for harassment, abuse and re-traumatization of women and patient mix of vulnerable and dangerous).

With respect to having patients reside on all-male or all-female units, approximately two-thirds of respondents shared benefits of gender segregation and one-third focused predominantly on disadvantages. The advantages of single-gender units fell into the same two main categories as did the disadvantages of mixed units: *Therapeutic Recovery Environment* and *Vulnerability, Trauma and Patient Mix*. Likewise, responses focusing on disadvantages of single-gender units fell into the same two main categories as did the advantages of mixed units: *Therapeutic Recovery Environment* and *Patient-Centered Treatment.*

## Conclusions

The results of the study indicate that when it comes to the issue of mixed and single-gender units, it is not about one answer but rather it is a process. There are reasons for and reasons against each option. BHD inpatients, hospital staff and community stakeholders, including consumers, are all of varying opinions and preferences. Of interest among all respondent types, regardless of their opinion about unit gender mix, is the recurrent theme that gender should not be the primary factor in determining best placement, and that quality of care and recovery focus will not be adequately addressed by resort to single-sex segregation. Other factors, such as severity of illness and risk of violence and vulnerability, are equally important, if not more so, in creating a safe and therapeutic inpatient environment. The Gender Unit Work Group concludes that segregation by gender of all BHD Acute Adult Inpatient units is too indiscriminate and compartmentalized an approach. We propose a configuration of the adult units that offers a blended model that is more thoughtful, flexible and pragmatic.

## Recommendations

The Gender Unit Work Group recommends a configuration of the four Acute Adult Inpatient units that would create a 12-bed ***Intensive Treatment Unit (ITU)*** that is expected to be predominantly male, a combined ***Women's-Option/Med-Psych Treatment Unit*** and two mixed-gender ***General Treatment Units.*** The ***Intensive Treatment Unit*** would be designated for patients with high risk for aggression and violence, including sexual acting out. The ITU can be presumed to be predominantly, if not always, all male. Most women with aggression can usually be managed in the general population with enhanced monitoring. The ITU concept will need to be further developed, but the Work Group is united in its stand that the intention is not that the unit be a "secure" unit (all BHD acute units are secure and locked), a "forensic" unit (BHD has no such formally designated forensic services or specialty) or a "detention" unit (BHD is not a correctional facility). The ITU <u>must</u> have reduced beds. We recommend the ITU have a capacity of 12 beds. The implication is that BHD would have to reduce its overall Acute Adult Inpatient bed capacity by 12 to a total of 84 beds. The benefit of the ITU is that it achieves separation, from the general patients, of predominantly those male patients with higher violence potential. Such separation addresses the main safety concerns of staff and patients, especially vulnerable male patients and many female patients. The concerns of women patients, however, are more complex due to higher rates of trauma and may not be fully resolved by segregation of high-risk men. For this reason, the Work Group recommends that one unit be designated as a combined ***Women's-Option/Med-Psych Treatment Unit.*** The unit would consist of the small number of vulnerable geriatric and complicated medical-psychiatric patients whom BHD serves, with the majority remainder of beds prioritized for female patients at heightened risk of vulnerability to inappropriate sexual behavior, abuse and violence. Assignment would be per medical staff assessment and/or patient choice, depending on clinical safety needs and bed availability. With a new overall Acute Adult Inpatient bed capacity of 84 beds, the female beds on this unit (Women's-Option and Med-Psych) could conceivably accommodate more than half of the total estimated adult female patients at any given time. The remaining two units would be mixed-gender ***General Adult Treatment Units*** with separate bedroom hallways as is currently the case. The separation of those patients with highest violence and vulnerability potential would, hopefully, allow these units to better serve the general population in a therapeutically-focused milieu.

The Work Group believes that the proposed configuration offers a more individualized, needs-based and trauma informed care approach than simple division by gender. The model addresses many of the concerns of BHD staff, inpatients, community consumers and other stakeholders as well as coheres with accepted practices of public psychiatric hospitals. Aside from requiring a 12-bed reduction in Acute Adult capacity, the recommendation is feasible and offers flexibility with census management. It addresses gender-based safety concerns while affirming the current improvement practices in place. This recommendation of the Gender Unit Work Group is advisory to the BHD Administrator. Should it receive endorsement, a detailed planning process will need to be undertaken, addressing considerations in three areas of: Human Resources, Program Development and Physical Environment Audit. The estimated timeline for implementation of this unit configuration recommendation is during Quarter 3 of 2011 (July to September). Regardless of the final decision, BHD shall continue its current practices, policies and guidelines in place to maintain a safe, therapeutic unit environment.

MILWAUKEE COUNTY BEHAVIORAL HEALTH DIVISION

# FOLLOW-UP REPORT TO BHD ADMINISTRATOR:

# MIXED - GENDER UNITS

## December 1, 2010

***Submitted By The***

***GENDER UNIT WORK GROUP***

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# INTRODUCTION

On June 16, 2010, the *Preliminary Report to BHD Administrator: Mixed-Gender Units (May 22, 2010)* was presented to the Milwaukee Committee on Health and Human Needs. The Committee had requested a report from the Behavioral Health Division (BHD) on mixed-gender units for acute psychiatric inpatients. A Gender Unit Work Group was formed, under Medical Staff leadership, to examine the issue of mixed-gender units. The Work Group conducted a comprehensive international literature review on mixed and single-gender units, obtained information on units in Wisconsin public psychiatric hospitals and reviewed BHD incident and inpatient consumer satisfaction data. The report explored the history of mixed-gender units, their prevalence, patient perceptions and staff attitudes.

The report concluded that the mixed-gender Acute Adult Inpatient units utilized by BHD are the norm among public psychiatric hospitals in Wisconsin and have been the standard model for inpatient psychiatric treatment for many decades. An extensive literature search failed to identify any published articles in the United States (U.S.) on the issue of mixed and single-gender units. Similarly, there is little research in the U.S. on whether female inpatients consider gender segregation to be either desirable or likely to contribute to their sense of safety. In the United Kingdom where the topic of single-sex accommodation has received much attention, there is little empirical research comparing single-sex and mixed-sex units. Available studies are small in size, the settings variable and generalizability limited across other systems and cultures. The views of their female patients and staff are more complex and reflect concern about overall safety that may not be wholly resolved by the introduction of single-sex units. An informed, aware and safe unit milieu depends on many factors beyond patient gender mix – among them, staff sensitivity and training, monitoring and environmental design. There are different ways that psychiatric hospitals here and across the country protect patient safety, including sexual safety.

Any revision to the existing practice of mixed-gender units at BHD must look carefully at assumptions regarding safety, choice, patient satisfaction and therapeutic benefit. For these reasons, the Work Group recommended a more detailed evaluation by BHD of the various gender unit options, while in the interim continuing the current practices put in place to minimize risk and ensure a safe, therapeutic unit environment. The Committee on Health and Human Needs endorsed this recommendation for further study by BHD of mixed-gender units.

This Follow-Up Report details the study conducted by the Gender Unit Work Group. The aims of the study were to: assess BHD inpatient perceptions of safety on the current units and preferences for gender composition; assess BHD staff perceptions of patient sexual safety on current units, effectiveness of current safety practices and attitudes towards gender unit options; attempt to identify public psychiatric inpatient facilities who have single-gender units and communicate with them regarding their experience; and obtain input from community stakeholders on recommendations to improve quality of care on acute inpatient units, including thoughts about gender composition.

The original Gender Unit Work Group reconvened on July 21, 2010 and members re-evaluated their continued participation in the next phase of the study. Additional members were nominated to represent consumers, direct care acute unit nursing staff, acute inpatient management, rehabilitative services and program evaluation and research. The Gender Unit Work Group met for 14 sessions (approximately 3 times a month) between July 28 and December 1, 2010 for over

28 hours, in addition to numerous times outside of meetings to design measures and procedures, compile results and analyze findings. A note about language: the terms single-gender and mixed-gender are used in this report to describe the types of units, though respondents may have used similar interchangeable terms of same-sex or mixed-sex. A number of terms are often used to refer to consumers of mental health services. This report uses the term *patient* to refer to a person receiving treatment in an acute inpatient unit, consistent with language for persons admitted to a general hospital and understandable to the public.

## METHODS

### Participants and Procedures

**BHD Acute Inpatient Survey.** A semi-structured questionnaire was administered to patients hospitalized on the Acute Adult psychiatric units between August 16 and September 10, 2010. The sample was drawn from the four Acute Adult inpatient units with a total patient capacity of 96 and approximately 184 admissions per month. All patients consecutively admitted to these units over this four-week period were eligible to participate in the survey after having been in the hospital for a minimum of one day. Patients considered by the primary unit RN to be too ill or acutely dangerous that day to participate were approached at a later date when more stable. Patients were limited to one survey per episode of hospital stay; if a patient was re-hospitalized during the survey period, they were eligible to do the survey again. Patients were interviewed on the unit using a semi-structured questionnaire. The two interviewers were independent of the patient's clinical treatment team and BHD management. One interviewer was the BHD Client Rights Specialist. The other interviewer was a part-time staff member from Vital Voices, a mental health advocacy organization with extensive experience conducting interviews of consumers of mental health services. Both interviewers had years of experiences working with persons with serious mental illness and conducting patient interviews and surveys. Each interviewer assumed primary responsibility for two units.

A semi-structured questionnaire was developed specifically for this study to obtain the opinion of BHD Acute Adult inpatients about men and women being on the same unit here (see Appendix A for copy of the survey tool). The questionnaire consisted of three main questions with objective ratings asked of both male and female patients, and then a fourth question for female patients only. Each objective question was followed by an open-ended question asking the patient to explain more in a narrative response. One question had an additional open-ended follow-up item. The questions were developed by the Work Group with careful attention to non-leading language and avoidance of intrusive questions about personal experiences that could provoke emotional distress. The three main questions asked whether patients: (1) preferred to be on an [*same gender as pt.*] all-men's/all-women's unit if it were available ("No" "Unsure/Doesn't Matter" "Yes") and then to explain why; (2) how they feel with men and women patients on the same unit ("Very Unsafe" "Somewhat Unsafe" "Somewhat Safe" "Very Safe") and to explain why and say what would make them feel safer; and (3) how they would feel if there were [*same gender as pt.*] all men/women patients on the unit ("Less Safe" "No Difference" "More Safe") and to explain why. The fourth question for women only asked whether they (4) would prefer there to be a <u>women-only</u> patient lounge available on the unit ("No" "Unsure/Doesn't Matter" "Yes") and to explain why.

Interviewers were trained on the patient questionnaire by the Work Group Chair. Interviewers approached eligible patients individually, explained the purpose of the survey and that participation was voluntary and would not influence the services they receive. The questionnaire was administered in a semi-private location on the unit. The interviewer entered the date of the survey, patient's date of admission, age, gender, race/ethnicity and acute unit. The Interviewer read each objective question and response choices to the patient, and then circled the patient's response. The interviewer asked the follow-up open-ended questions and recorded the patient's narrative answer verbatim.

**BHD Acute Adult Inpatient Staff Survey.** *An Acute Adult Inpatient Staff Survey: Patient Sexual Safety* was distributed to all clinical staff working in the Acute Adult Inpatient program, either as their regular assignment or as pool/float staff. The purpose of the survey was to obtain staff's opinions specifically about the sexual safety of men and women patients residing on the same acute units here, as this was the main charge of the Work Group. For the purposes of the survey, *sexual safety* was defined as referring to preventing and managing sexual behavior between patients – including sexual contact, harassment, exploitation, intimidation and assault. The survey was printed on special paper to prevent photocopying and individuals submitting more than one survey. Surveys were delivered to staff mailboxes in sealed blue envelopes with staff name on envelope label but no staff-identifying information on the survey tool itself. Staff was assured that their answers were confidential. Work Group members briefed unit clinical treatment teams on the purpose of the survey and encouraged their participation. The surveys were distributed to 236 Acute Adult Inpatient staff, consisting of approximately 24 Medical Staff (MD- psychiatrists and physical care doctors, PhD-psychologists, APNP-advanced practice nurse prescribers), 22 Social Work/Rehabilitative Services (social workers, occupational therapists, music therapists), 104 Registered Nurses (unit, float, pool, nursing program coordinators, administrative resources), 76 Certified Nursing Assistants (unit, float, pool), 7 Peer Specialists, 3 Dieticians and 1 Chaplain. Of the RN and CNA staff, approximately 76 were pool or float. Surveys were disseminated on September 16 with due date of September 30, 2010.

The Acute Adult Inpatient Staff survey consisted of ten main items, nine of them questions with objective ratings followed by one or more open-ended follow-up questions requiring a narrative response. The remaining one item was solely an open-ended question giving staff an opportunity to make other suggestions to improve the sexual safety of men and women patients residing on the units (see Appendix B for copy of survey tool). The first item asked staff their opinion as to how sexually safe men and women patients are residing on the same unit in our hospital, followed by a series of items about what sexual safety concerns they have for patients and what concerns patients themselves have raised. Next, staff was asked to rate the effectiveness of 11 current practices for ensuring the sexual safety of patients on the unit, then followed by recommendations to improve them as well as any other suggestions to improve the sexual safety of men and women residing on the same units. Lastly, staff opinions were obtained on possible future strategies to improve unit safety for men and women, specifically developing plans for an all-women's unit, all-men's unit, and women-only and men-only lounges on the mixed-gender units. Staff was also asked to rate their preferences for working on all-women's, all-men's and mixed-gender units. Demographic/descriptive data recorded included gender, position, years of employment at BHD and years of employment in Acute Adult Inpatient.

**Public Psychiatric Hospital Information.** An attempt was made to locate other public psychiatric facilities with single-gender acute units and communicate with them regarding their experience. The search was narrowed to facilities in states from the Midwest geographic region and close to a major metropolitan area. The only state included outside of the Midwest was Pennsylvania. Names of public psychiatric hospitals were obtained from the web sites of the National Association of State Mental Health Program Directors, the National Association of County Behavioral Health and Developmental Disability Directors and state departments of mental health. An effort was made to select those hospitals that appeared to have or might reasonably have a civil acute unit (versus medium/long-term stay civil units or forensic units). An email letter was developed describing the BHD Acute Adult Inpatient Service (# of beds, median and mean lengths of stay), the study we had undertaken of whether to continue to use mixed-gender units and a desire to communicate with public adult psychiatric hospitals that currently have, or had within the last 5 years, single-gender units. The hospital was asked to contact the Chair of the Work Group if they had relevant experiences they were willing to share with us about the gender configuration of their acute adult units. The email letter was sent to the hospital's chief clinical officer, chief operating officer, or administrator as identified by the site or by phone contact with the facility. The email letter was sent to a total of 24 public psychiatric facilities in the states of Illinois, Minnesota, Missouri, Michigan, Ohio and Pennsylvania. Except for one county-operated hospital, all other facilities were state-operated psychiatric hospitals and regional treatment centers.

**Community Stakeholder Input.** Community stakeholders (i.e., consumers, family members, behavioral health providers, advocates and other interested parties) were invited to provide input relevant to BHD's evaluation of the current practice of mixed-gender acute adult inpatient units and recommendations to enhance the quality of care in the acute hospital. Thoughts and opinions were requested specifically about men and women patients residing on the same acute inpatient units at BHD and having patients reside on all-male and all-female acute inpatient units at BHD. Respondents were asked to identify themselves as either a consumer/patient, family member, provider, advocate or other. They were asked to answer the two questions on the attached form and send their response by postal or email address to the BHD Manager of Community and Employee Outreach. The request for input was distributed on November 9 with deadline of November 17 (subsequently extended to November 19) and sent to relevant community stakeholders via organizational network lists of BHD as well as Disability Rights Wisconsin.

**Data Analysis**

Quantitative data from the inpatient and staff surveys were analyzed using SPSS (Statistical Package for the Social Sciences). Narrative answers from BHD inpatients, BHD staff and community stakeholders to the open-ended questionnaire items were analyzed using a content analysis descriptive approach. The content analysis was conducted by hand and involved grouping responses into categories and, for some items, counting the responses. The most formal content analysis was applied to the BHD inpatient survey and BHD inpatient staff survey question #3 because of the relevant and direct experience of these participants to the study questions at hand. The content analysis began with one judge sorting the verbatim responses into main content categories that occurred to her and writing a brief definition of the category. The preliminary categories and definitions were then presented to several members of the Work Group or the entire Work Group for them to sort the same set of responses without seeing the judge's results. They compared notes, discussed responses on which they disagreed and resolved differences. Based on this process, categories were added or deleted/combined and clearer definitions formulated.

# RESULTS

## BHD Acute Adult Patient Survey

**Characteristics of Participants.** One hundred thirty patients participated in the study. Of those 130, 74 (56.9%) were men and 56 (43.1%) were women. This gender breakdown very closely mirrors the latest BHD figures for Acute Adult Inpatient admissions of 59.8% men and 40.2% women (data from 01/01/2009 through 10/31/2010), slightly over-representing women. Fifty-nine were African American (45.4%), 58 White/Caucasian (44.6%), 5 Hispanic/Latino (3.8%), 1 Native American (0.8%) and 7 Other (5.4%). Average age was 40.9 years (median 41.5, range 18 -81 years). Median length of stay in the hospital at time of survey was 6.0 days (overall BHD Acute Adult Inpatient median LOS = 7.0 days). Thus, patients were surveyed after having been reasonably exposed to the inpatient unit and sufficiently stable in their treatment to provide informed opinions to the survey questions. Participation was representative of all 4 units and reflected slight differences in their admissions (43A – 26.2%; 43B - 18.5%; 43C – 25.4% and 43D – 30.0%).

**Content Analysis and Main Patient Themes.** A summary of all main patient content themes of responses to the open-ended follow-up items is contained in Appendix A. The main content theme categories and definitions are presented in Table 1.

Table 1. *Main Patient Content Themes*

| ***SAFETY FROM AGGRESSION*** | ***INTERPERSONAL INTERACTION*** |
|---|---|
| ❖ Concern about or experience of:<br>o Verbal aggression<br>o Physical Aggression<br>o Sexual behavior<br>o *Safety* issues<br>❖ Includes either *presence* or *denial* of concern about any safety issues | ❖ Quality and mix of opportunities for patient interpersonal interactions, including:<br>o Communication, sharing<br>o Cooperation, respect<br>o Socialization<br>o Emotional or social attributes<br>❖ Includes either *positive* or *negative* interpersonal effects and expectations |
| ***UNIT AND SECURITY STAFF*** | ***SELF ADVOCACY*** |
| ❖ Unit or security staff presence and behavior | ❖ Feeling of confidence or ability to manage, advocate for or protect self |
| ***OTHER*** | |
| ❖ Irrelevant to question<br>❖ Does not belong to available theme categories | |

**Perceptions of Safety on Mixed-Gender Units.** Patient perceptions of how safe they feel with men and women patients on the same unit are reflected in their responses to Question 2a. of the survey (see Table 2).

Table 2. *Patient Feelings of Safety with Men and Women Patients on Same Unit*

| **2. How do you feel with men and women patients on the same unit?** | | | | | | |
|---|---|---|---|---|---|---|
| | MALES (n=74) | | FEMALES (n=56) | | TOTAL (n=130) | |
| | N | % | N | % | N | % |
| Very Unsafe | 5 | 6.8 | 6 | 10.7 | 11 | 8.5 |
| Somewhat Unsafe | 2 | 2.7 | 3 | 5.4 | 5 | 3.8 |
| Somewhat Safe | 15 | 20.3 | 14 | 25.0 | 29 | 22.3 |
| Very Safe | 52 | 70.3 | 33 | 58.9 | 85 | 65.4 |
| **2a. Respondents' explanation of 'why'** | | | | | | |
| | MALES | | FEMALES | | TOTAL | |
| **Somewhat / Very Unsafe** | N | % | N | % | N | % |
| Safety from aggression | 6 | 100.0 | 6 | 85.7 | 12 | 92.3 |
| Interpersonal interaction | 0 | 0.0 | 1 | 14.3 | 1 | 7.7 |
| Unit & security staff | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 |
| Self advocacy | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 |
| **Somewhat / Very Safe** | | | | | | |
| Safety from aggression | 9 | 21.4 | 18 | 39.1 | 27 | 30.7 |
| Interpersonal interaction | 20 | 47.6 | 19 | 41.3 | 39 | 44.3 |
| Unit & security staff | 8 | 19.0 | 6 | 13.0 | 14 | 15.9 |
| Self advocacy | 5 | 11.9 | 3 | 6.5 | 8 | 9.1 |

- Over 90% of the men felt somewhat or very safe with men and women patients on the same unit. For these men, their comments centered primarily (48%) on potentially beneficial interpersonal interactions, and additionally (21%) on denial of aggression as a concern, with a few fearing there would be more fights with all men. Almost a fifth of the comments (19%) focused on how unit and security staff contributed to their feelings of safety. Another 12% of the men who felt safe gave as the reason their confidence in their ability to advocate for their own safety.

- Slightly less than 10% of men felt somewhat or very unsafe with men and women on the same unit. All of their explanations were concerned with the potential for aggression.

- Nearly 84% of women felt somewhat or very safe with men and women patients on the same unit. For these women, 41% of the reasons had to do with the positive interpersonal experience of having men on the unit. An additional 39% of the reasons why women felt safe centered primarily on feelings of safety from aggression. Another 20% gave reasons for their feeling of safety having to do with unit and security staff and confidence in their own self-advocacy skills.

- Approximately 16% of women felt somewhat or very unsafe with men and women patients on the same unit. Their reasons were primarily (86%) concerns about safety from aggression.

- Almost 88% of all patients said they felt somewhat or very safe with men and women on the same unit. The majority of them mentioned reasons related to positive interpersonal interactions and denial of concerns about aggression. Among these patients who reported feeling safe, a few mentioned unpleasant interpersonal experiences or safety concerns involving the opposite gender. The small percentage (12%) of patients who felt somewhat or very unsafe with men and women patients on the same unit cited primarily concern about potential for aggression.

As for what would make patients feel safer on the mixed-gender units, their suggestions fell into three main themes centering on improved interpersonal interactions, unit and security staff and reliance on self advocacy (see Table 3).

Table 3. *Patient Suggestions to Increase Feeling of Safety*

| **2b. How do you feel with men and women patients on the same unit? What would make you feel safer?** | | | | | | |
|---|---|---|---|---|---|---|
| | MALES (n=74) | | FEMALES (n=56) | | TOTAL (n=130) | |
| | N | % | N | % | N | % |
| Very Unsafe | 5 | 6.8 | 6 | 10.7 | 11 | 8.5 |
| Somewhat Unsafe | 2 | 2.7 | 3 | 5.4 | 5 | 3.8 |
| Somewhat Safe | 15 | 20.3 | 14 | 25.0 | 29 | 22.3 |
| Very Safe | 52 | 70.3 | 33 | 58.9 | 85 | 65.4 |
| ***Respondents' explanation of 'What would make you feel safer?'*** | | | | | | |
| | MALES | | FEMALES | | TOTAL | |
| **Somewhat / Very Unsafe** | N | % | N | % | N | % |
| Interpersonal interaction | 2 | 28.6 | 6 | 66.7 | 8 | 50.0 |
| Unit and security staff | 2 | 28.6 | 2 | 22.2 | 4 | 25.0 |
| Self advocacy | 1 | 14.3 | 0 | 0.0 | 1 | 6.3 |
| Other | 2 | 28.6 | 1 | 11.1 | 3 | 18.8 |
| **Somewhat / Very Safe** | | | | | | |
| Interpersonal interaction | 7 | 11.3 | 8 | 14.3 | 15 | 12.7 |
| Unit and security staff | 41 | 66.1 | 32 | 57.1 | 73 | 61.9 |
| Self advocacy | 7 | 11.3 | 6 | 10.7 | 13 | 11.0 |
| Other | 7 | 11.3 | 10 | 17.9 | 17 | 14.4 |

- For the 10% of men who felt unsafe on a mixed-gender unit, no single factor stood out that would make them feel safer, with the few comments offered spanning interpersonal interactions, unit and security staff and self advocacy.

- For the more than 90% of men who felt safe on a mixed-gender unit, 66% of their suggestions for what would make them feel safer centered on unit and security staff presence, behavior and monitoring. Other factors identified that would make them feel safer were evenly split between improved interpersonal relations (11.3%) and reliance on self-advocacy and protection (11.3%).

- For the approximately 16% of women who felt unsafe on a mixed-gender unit, suggestions as to what would make them feel safer clustered mostly (67%) around improvements in overall interpersonal interactions, with just a few suggestions about unit and security staff.

- For the almost 84% of women who felt safe on a mixed-gender unit, their suggestions for what would make them feel even safer centered primarily (57%) on unit and security staff presence, behavior and monitoring. Other factors identified that would make them feel safer included a mixture of comments regarding interpersonal interaction (14.3%) and reliance on self-advocacy and management (10.7%).

- For the 12% of patients overall who felt unsafe on a mixed-gender unit, factors they identified that would make them feel safer included improved interpersonal interactions (50%) and, to a lesser extent, unit and security staff (25%). For the 88% of patients who reported feeling safe on a mixed-gender unit, nearly 62% of their suggestions as to what would make them feel safer focused on unit and security staff presence. This pattern was consistent for both men and women patients.

**Preferences For and Attitudes About Single-Gender Units.** On the question of preference to be on an all-men's/all-women's unit if it were available, almost 50% of male and female respondents did not prefer to be on a single-gender unit and about 30% were unsure of their preference. Results are presented in Table 4.

Table 4. *Patient Preferences for Single-Gender Units*

**1. Would you prefer to be on an all-men's / all-women's unit if it were available? Explain why.**

| | MALES (n=74) | | FEMALES (n=56) | | TOTAL (n=130) | |
|---|---|---|---|---|---|---|
| | N | % | N | % | N | % |
| No | 41 | 55.4 | 23 | 41.1 | 64 | 49.2 |
| Unsure / Doesn't Matter | 22 | 29.7 | 17 | 30.4 | 39 | 30.0 |
| Yes | 11 | 14.9 | 16 | 28.6 | 27 | 20.8 |

| | MALES | | FEMALES | | TOTAL | |
|---|---|---|---|---|---|---|
| **No** | N | % | N | % | N | % |
| Safety from aggression | 6 | 14.6 | 3 | 9.7 | 9 | 12.5 |
| Interpersonal interaction | 35 | 85.4 | 28 | 90.3 | 63 | 87.5 |
| **Unsure / Doesn't Matter** | | | | | | |
| Safety from aggression | 5 | 38.5 | 1 | 7.7 | 6 | 23.1 |
| Interpersonal interaction | 8 | 61.5 | 12 | 92.3 | 20 | 76.9 |
| **Yes** | | | | | | |
| Safety from aggression | 0 | 0.0 | 7 | 38.9 | 7 | 35.0 |
| Interpersonal interaction | 2 | 100.0 | 11 | 61.1 | 13 | 65.0 |

- More than half of the men (55%) did not prefer to be on an all-men's unit. More than 85% of the explanations for this preference cited the negative impact it would have on interpersonal interactions with other patients. Less than 15% of the reasons related to safety from aggression.

- Almost 30% of men were unsure or felt it did not matter but cited mainly positive features of interpersonal interactions when a unit has both men and women.

- Less than 15% of men preferred to be on an all-men's unit and only two explanations were given related to interpersonal interactions.

- More than 40% of women did not prefer to be on an all-women's unit. Over 90% of the reasons related to positive interpersonal interactions with men and women on the same unit and expectation of negative interactions if there were only women. The remaining reasons why women do not prefer to be on an all-women's unit had to do with concerns about potential aggression with other women on the unit.

- Approximately 30% of women were unsure or felt it did not matter. However, their comments mentioned mostly positive expectations for interpersonal interactions and minimized concerns and problems with men on the unit.

- Almost 29% of women preferred to be on an all-women's unit. More than 60% of their explanations cited an expected positive impact all women would have on interpersonal interactions. Almost 39% of explanations for why these women preferred an all-women's unit centered on concerns about male aggression.

- Almost 50 % of men and women did not prefer to be on a same-gender unit. Another 30% were unsure or said it did not matter, whereas 20% said they would prefer to be on a unit with same-gender patients. All three groups cited reasons that overwhelmingly (>81%) had to do with the effect they thought a same-gender unit would have on the quality of interpersonal interactions with each other. The remaining reasons were related to safety from aggression.

As for how safe patients thought they would feel if there were all single-gender patients on the same unit, only about 25% of both male and female patients indicated they would feel safer. Complete results are in Table 5.

Table 5. *Patient Expectations of Safety on Single-Gender Units*

| 3. How would you feel if there were all men / all women patients on the same unit? Explain why. | | | | | | |
|---|---|---|---|---|---|---|
| | MALES (n=74) | | FEMALES (n=56) | | TOTAL (n=130) | |
| | N | % | N | % | N | % |
| Less Safe | 28 | 37.8 | 18 | 32.1 | 46 | 35.4 |
| No Difference | 29 | 39.2 | 22 | 39.3 | 51 | 39.2 |
| More Safe | 17 | 23.0 | 16 | 28.6 | 33 | 25.4 |

| 3a. Respondents' explanation of "why" | | | | | | |
|---|---|---|---|---|---|---|
| | MALES | | FEMALES | | TOTAL | |
| **Less Safe** | N | % | N | % | N | % |
| Safety from aggression | 22 | 78.6 | 7 | 33.3 | 29 | 59.2 |
| Interpersonal interaction | 6 | 21.4 | 14 | 66.7 | 20 | 40.8 |
| **No Difference** | | | | | | |
| Safety from aggression | 4 | 26.7 | 8 | 44.4 | 12 | 36.4 |
| Interpersonal interaction | 11 | 73.3 | 10 | 55.6 | 21 | 63.6 |
| **More Safe** | | | | | | |
| Safety from aggression | 3 | 33.3 | 7 | 53.8 | 10 | 45.5 |
| Interpersonal interaction | 6 | 66.7 | 6 | 46.2 | 12 | 54.5 |

- Slightly less than 40% of men said they would feel less safe if there were all men on the unit. Just fewer than 80% of their reasons focused on concerns about safety from aggression, including serious fights.

- Approximately 40% of men felt there would be no difference for them being on a unit with all men patients because they recognize the potential for people to get along.

- More than 20% of men felt they would be safer on a unit with all men due to the expected quality of the interpersonal interactions.

- Slightly less than a third of the women said they would feel less safe on an all-women's unit. Approximately two-thirds of their reasons cited concern about increased interpersonal conflict with all women and one-third of the reasons related to the potential for physical aggression.

- Slightly less than 40% of women said there would be no difference for them being on a unit with all women patients. The majority of comments cited positive effects on interpersonal interactions with men and women together and a minimization of concerns about potential for aggression.

- Slightly less than 30% of women said they would feel safer being on a unit with all women patients. The two main reasons were safety from aggression and expected improvement in interpersonal interactions.

- Overall, about 40% of men and women felt that being on a same-gender unit would make no difference to them in terms of safety. Slightly more than a third said that they would feel less safe, whereas a fourth of all patients said they would feel safer. {This response pattern held true for both men and women pts. However, a slightly higher % of men than women expected to feel less safe on a same-gender unit, and a slightly higher % of women than men expected to feel more safe on a same-gender unit.}

**Women's Preferences for Women-Only Lounge.** Women were split in their preference for a women-only lounge on the unit and the majority of reasons for and against focused on the expected effect on interpersonal interactions rather than safety (see Table 6 for results).

Table 6. *Women Patient Preferences for Women-Only Lounge*

| **4. Women only: Would you prefer there to be a women-only patient lounge available on the unit? Explain why.** | | |
|---|---|---|
| | *N* | % |
| No | 22 | *39.3* |
| Unsure / Doesn't Matter | 16 | 28.6 |
| Yes | 18 | 32.1 |
| | | |
| **4a. Women respondents' explanation of 'why'** | | |
| | *N* | % |
| **No** | | |
| Safety from aggression | 5 | 20.0 |
| Interpersonal interaction | 20 | 80.0 |
| **Unsure / Doesn't Matter** | | |
| Safety from aggression | 1 | 14.3 |
| Interpersonal interaction | 6 | 85.7 |
| **Yes** | | |
| Safety from aggression | 4 | 22.2 |
| Interpersonal interaction | 14 | 77.8 |

- Women were split in their preference for a women-only lounge on the unit, with 39% saying no, 32% saying yes and 29% being unsure or neutral.

- Of women who were opposed to a women-only lounge, 80% of their reasons cited an expected negative impact on interpersonal interactions and 20% of the comments cited expected verbal and physical aggression between women.

- Of women who said they would prefer a women-only lounge, the vast majority (77.8%) of their reasons centered on an expected benefit in their interpersonal interactions and shared communication with other women. Only a few comments referenced a vague feeling that they would feel safer.

- Of interest, all of the comments by the unsure or neutral group of women emphasized no problems with the current arrangement of a shared lounge with men on the unit.

**BHD Acute Adult Inpatient Staff Survey**

**Characteristics of Participants.** A total of 82 staff participated in the survey, a 34.6% return rate. Though lower than hoped for, this response rate is not unusual for this type of survey and is a more than adequate sample size for analysis. Of those staff who responded, 22 (27.2%) were male and 59 (72.8%) female. Breakdown of response by position and (% of total sample) was medical staff 11 (13.9%), social work/rehab services 8 (10.1%), registered nurse 38 (48.1%), certified nursing assistant 15 (19.0%), peer specialists 4 (5.1%) and other 3 (3.8%). Mean years of employment at BHD was 9.7 years with mean years of employment in Acute Adult Inpatient 7.8 years.

**Content Analysis and Main Themes.** A summary of main content themes of responses to the open-ended items is contained in Appendix B.

**Staff Perceptions of Patient Sexual Safety on Mixed-Gender Units.** More than half of staff respondents think that men and women patients are somewhat sexually safe residing on the same unit. An additional 9 % think they are very safe (total for somewhat and very sexually safe = 60.5%). Almost 40% of staff respondents think that men and women patients are somewhat (27%) or very (12%) unsafe residing on the same unit. Please see Table 7.

Table 7. *Staff Perceptions of Patient Sexual Safety*

| 1. HOW SEXUALLY SAFE DO YOU THINK MEN AND WOMEN PATIENTS ARE RESIDING ON THE SAME UNIT IN OUR HOSPITAL? | | |
|---|---|---|
| | N | % |
| Very Unsafe | 10 | 12.3 |
| Somewhat Unsafe | 22 | 27.2 |
| Somewhat Safe | 42 | 51.9 |
| Very Safe | 7 | 8.6 |
| Total | 81 | 100.0 |

Asked about specific safety concerns they have for women patients on the unit, staff respondents indicated that most (53%) of their concerns for women patients' sexual safety were related to the women's vulnerability to sexual harassment, intimidation, exploitation and/or abuse. Staff also noted that the unit configuration, staffing pattern, and patient mix contributed to their sexual safety concerns for women on the unit. Additionally, staff respondents identified concerns about women initiating or provoking sexual activity. As for sexual safety concerns they have for men patients on the unit, staff respondents indicated that most (46%) of their concerns for men patients' sexual safety also were related to some men being vulnerable to sexual harassment, intimidation, exploitation and/or abuse. Of note, 14% of staff responses indicated they had no sexual safety concerns for men patients. Staff respondents identified concerns about men initiating or provoking sexual activity. Staff also noted that the unit configuration, staffing pattern, and patient mix contributed to their sexual safety concerns for men on the unit.

With respect to sexual safety concerns that women patients have raised with them, of staff who responded, 33% reported women raising concerns about vulnerability to sexual harassment and intimidation. Almost 29% cited women being concerned about personal boundary violations, with another 12% of comments saying that women have raised general (nonsexual) safety concerns. Almost 22% of staff respondents reported women not having raised any sexual safety concerns. As for sexual safety concerns raised by men patients, of staff who responded, 30% reported men raising concerns about vulnerability to sexual harassment and intimidation. Almost 12% cited men being concerned about personal boundary violations, with another 9% of comments saying that men have raised general (nonsexual) safety concerns. Another 46% of staff said that men usually expressed no sexual safety concerns.

**Effectiveness of Current Sexual Safety Practices.** Current practices were predominantly rated by staff respondents as being somewhat effective (approximately 3.0) for ensuring the sexual safety of patients on the unit (see Table 8) Locked community bathrooms and the unit zone surveillance system were the highest rated practices with more than 40% of staff respondents rating them as very effective. Cross shift communication of special risk patients, the separation of bedroom hallways for men and women, and behavior observation for special risks were other practices rated by about one-third of staff as being very effective.

Table 8. *Staff Rating of Effectiveness of Current Practices*

| 2. HOW WOULD YOU RATE THE EFFECTIVENESS OF THESE CURRENT PRACTICES FOR ENSURING THE SEXUAL SAFETY OF PATIENTS ON THE UNIT? * | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| CURRENT PRACTICES | Scale Avg.** Rank Ordered | Very Ineffective | | Somewhat Ineffective | | Somewhat Effective | | Very Effective | |
| | | N | % | N | % | N | % | N | % |
| **Locked Community Bathrooms** | 3.2 | 3 | 4.1 | 9 | 12.3 | 30 | 41.1 | 31 | 42.5 |
| **Unit Zone Surveillance** system | 3.1 | 7 | 10.1 | 9 | 13.0 | 21 | 30.4 | 32 | 46.4 |
| **Cross Shift** communication of special risk patients | 3.1 | 4 | 6.0 | 7 | 10.4 | 35 | 52.2 | 21 | 31.3 |
| **Bedroom Hallways** separate for M & W; no bed assignment beyond fire doors for W | 3.0 | 6 | 8.3 | 10 | 13.9 | 32 | 44.4 | 24 | 33.3 |
| **Behavior Observation** monitoring for special risks | 2.9 | 7 | 9.3 | 12 | 16.0 | 32 | 42.7 | 24 | 32.0 |
| **Therapeutic Groups** | 2.9 | 4 | 6.0 | 13 | 19.4 | 31 | 46.3 | 19 | 28.4 |
| **Overall Effectiveness** of current practices | 2.9 | 7 | 9.5 | 11 | 14.9 | 40 | 54.1 | 16 | 21.6 |
| **Recovery Planning** special risks, treatment obj., interventions | 2.9 | 4 | 5.8 | 15 | 21.7 | 37 | 53.6 | 13 | 18.8 |
| **Morning Report** with both treatment teams represented | 2.8 | 9 | 14.5 | 5 | 8.1 | 36 | 58.1 | 12 | 19.4 |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Assessments** by PCS and Inpatient MD/PhD of special risks | 2.8 | 8 | 11.4 | 12 | 17.1 | 35 | 50.0 | 15 | 21.4 |
| **Patient Education** on sexual contact policy | 2.8 | 4 | 5.7 | 15 | 21.4 | 42 | 60.0 | 9 | 12.9 |
| **Electronic Video Monitoring** of unit | 2.7 | 10 | 18.9 | 10 | 18.9 | 20 | 37.7 | 13 | 24.5 |

*Instructions for this survey question directed respondents to leave blank any items for which they did not have experience. Total number of respondents for each item was between 53 and 75 (total surveys received = 82).

** Response Scale: 1 = very ineffective / 2 = somewhat ineffective
3 = somewhat effective / 4 = very effective

For current practices rated as ineffective, staff was asked for recommendations to improve them (see Appendix B for complete list). Staff suggested that the unit zone surveillance was a very good idea and would work even better if staffed adequately and with better monitoring of CNA performance. Patient education on the no sexual contact policy, though well intended, was often inconsistent and of little benefit for patients with impulse control issues. Some staff commented that higher risk patients seem to get around unit safety nets.

In addition to the current safety practices, staff was asked for any other suggestions to improve the sexual safety of men and women residing on the same unit (see Table 9).

Table 9. *Staff Suggestions to Improve Sexual Safety*

| **3. WHAT OTHER SUGGESTIONS DO YOU HAVE TO IMPROVE THE *SEXUAL SAFETY* OF MEN AND WOMEN RESIDING ON THE SAME UNIT?** | | |
|---|---|---|
| **Suggestion Category** | **N** | **%** |
| Staffing pattern (e.g. adequacy & composition of staff for monitoring & duties) | 26 | 31.7 |
| Staff performance (e.g. staff supervision, training, and teamwork) | 20 | 24.4 |
| Hospital configuration for patient mix (e.g. based on gender, risk, acuity, etc.) | 15 | 18.3 |
| Clinical interventions (i.e. clinical strategies for intervening with patients) | 11 | 13.4 |
| Unit environment modification (i.e. modifications to existing unit physical environment and practices) | 10 | 12.2 |
| Total | 82 | 100.0 |

Nearly one-third (32%) of suggestions from staff indicated that an improved staffing pattern (e.g. adequacy and composition of staff for monitoring duties) would contribute to the sexual safety of men and women residing on the same unit. Nearly another quarter (24%) suggested better supervision and training of staff and better teamwork would improve the sexual safety of men and women residing on the same unit. Additional staff respondent suggestions for improving sexual safety included the hospital configuration for the mix of patients; increasing the use of clinical intervention strategies regarding sexual issues and behavior; and modifying the existing unit physical environment.

**Attitudes and Preferences for Single-Gender Units.** Table 10 presents staff opinions on the helpfulness for managing sexual safety for BHD to develop plans for an all-women's unit.

Table 10. *Staff Opinions about an All-Women's Unit*

| 4. HOW HELPFUL DO YOU THINK IT WOULD BE FOR MANAGING SEXUAL SAFETY ON THE UNITS FOR BHD TO DEVELOP PLANS FOR AN ALL-WOMEN'S UNIT? | | |
|---|---|---|
| | N | % |
| Not at all helpful | 10 | 12.5 |
| Not very helpful | 10 | 12.5 |
| Neutral / Unsure | 22 | 27.5 |
| Somewhat helpful | 15 | 18.8 |
| Very helpful | 23 | 28.8 |
| Total | 80 | 100.0 |

Nearly half (48%) of staff respondents thought it would be somewhat or very helpful for managing sexual safety on the units for BHD to develop plans for an all-women's unit. These respondents thought that this would promote the women on the unit feeling safer and reduce or eliminate sexual harassment and contact. Staff also thought an all-women unit could better serve the subset of women with sexual abuse and trauma issues. Slightly more than a quarter (28%) of staff were neutral or unsure whether an all-women's unit would be helpful primarily due to not being able to control or prevent all sexual contact, including same-gender activity. Additionally, staff cited the benefit of patients being able to interact and learn from the opposite sex on mixed-gender units. Another quarter of staff respondents thought that an all-women's unit would be not very or not at all helpful due to the possibility of same-gender sexual activity and that patients need to function in a normalizing environment similar to the community.

Table 11 presents staff opinions on the helpfulness of BHD developing plans for an all-men's unit. Nearly half (49%) of staff respondents thought it would be somewhat or very helpful for

Table 11. *Staff Opinions about an All-Men's Unit*

| 5. HOW HELPFUL DO YOU THINK IT WOULD BE FOR MANAGING SEXUAL SAFETY ON THE UNITS FOR BHD TO DEVELOP PLANS FOR AN ALL-MEN'S UNIT? | | |
|---|---|---|
| | N | % |
| Not at all helpful | 12 | 15.2 |
| Not very helpful | 8 | 10.1 |
| Neutral / Unsure | 20 | 25.3 |
| Somewhat helpful | 14 | 17.7 |
| Very helpful | 25 | 31.6 |
| Total | 79 | 100.0 |

managing sexual safety on the units for BHD to develop plans for an all-men's unit. Respondents thought that this could help particularly high-risk men from taking advantage of vulnerable females and provide a safer, less violent environment for the rest of the patient population. Those staff respondents who were unsure (25%) cited concerns that this might shift the risk of sexual behavior toward vulnerable male patients, and that an all-male unit may be more violent than a mixed-gender unit. Another quarter of respondents thought that an all-men's unit would not be very or at all helpful, and also cited concerns about same-gender sexual behavior and the abuse of vulnerable males.

**Preference for Unit Work Assignment.** Most staff respondents would not prefer or were neutral or unsure about working on a single-gender unit if BHD had one, with more staff respondents preferring to work on an all-men's unit rather than an all-women's unit See Tables 12 and 13). Nearly half (48%) of staff respondents would not prefer to work on an all-women's

Table 12. *Staff Preferences to Work on All-Women's Unit*

| **6. WOULD YOU PREFER TO WORK ON AN ALL-WOMEN'S UNIT, IF BHD HAD ONE?** | | |
|---|---|---|
| | N | % |
| No | 37 | 48.1 |
| Neutral / Unsure | 29 | 37.7 |
| Yes | 11 | 14.3 |
| Total | 77 | 100.0 |

unit if BHD developed one. Their reasons were primarily concerned with the stressful demands and problems they would have to deal with from hostile, moody, and threatening women. They also cited the benefits of the current mixed-gender recovery environment that reflects the community to which patients will return. Male staff respondents were also concerned about the potential for false accusations of sexual advances. Almost 38% of staff respondents were neutral or unsure about working on an all-women's unit. The few reasons provided by the 14% of staff respondents who preferred to work on an all women's unit referenced wanting to feel safe and to be there for all patients.

Table 13. *Staff Preferences to Work on an All-Men's Unit*

| **7. WOULD YOU PREFER TO WORK ON AN ALL-MEN'S UNIT, IF BHD HAD ONE?** | | |
|---|---|---|
| | N | % |
| No | 33 | 42.9 |
| Neutral / Unsure | 26 | 33.8 |
| Yes | 18 | 23.4 |
| Total | 77 | 100.0 |

Most staff respondents did not prefer (43%) or were neutral or unsure (34%) about working on an all-men's unit. The primary reasons cited were concerns about anger and the potential for aggression and violence. They also cited the benefits of the current mixed-gender recovery environment that reflects the community to which patients will return. Nearly a quarter (23%) of staff respondents would prefer to work on an all-men's unit due to either their personal preference or their belief that men are easier to handle and deal with.

Table 14. *Staff Preferences to Work on Mixed-Gender Unit*

| **8. WOULD YOU PREFER TO WORK ON A MIXED-GENDER UNIT (MEN & WOMEN), LIKE BHD HAS NOW?** | | |
|---|---|---|
| | N | % |
| No | 5 | 6.6 |
| Neutral / Unsure | 28 | 36.8 |
| Yes | 43 | 56.6 |
| Total | 76 | 100.0 |

Most (57%) staff respondents preferred to work on a mixed-gender unit like BHD has now (see Table 14). Most reasons for this preference had to do with the variety of patient needs and personalities of this arrangement, and the benefits of the current mixed-gender recovery environment that reflects the community to which patients will return. Approximately 37% of respondents were neutral or unsure but cited the benefits of the current mixed-gender recovery environment for interpersonal interactions.

**Attitude on Single-Gender Lounges.** Most staff respondents were unsure or did not think that having single-gender lounges on mixed-gender units would improve sexual safety (Tables 15, 16). Approximately 40% of staff respondents did not think that having a women-only patient

Table 15. *Staff Attitude about Women-Only Patient Lounge*

| 9. DO YOU THINK THAT HAVING A WOMEN-ONLY PATIENT LOUNGE ON A MIXED-GENDER UNIT WOULD IMPROVE SEXUAL SAFETY? | | |
|---|---|---|
| | N | % |
| No | 31 | 39.7 |
| Neutral / Unsure | 26 | 33.3 |
| Yes | 21 | 26.9 |
| Total | 78 | 100.0 |

lounge on a mixed-gender unit would improve sexual safety. Another third of respondents were neutral or unsure. The primary reasons why these two groups of respondents did not think it would improve sexual safety were focused on their observation that inappropriate sexual behavior occurs in places other than lounge areas, and that the area would require close monitoring by staff. Slightly more than a quarter of staff respondents were in favor of a women-only lounge as a safe and secure place for women to go to when feeling threatened.

With respect to a men-only patient lounge, approximately 45% of staff respondents did not think

Table 16. *Staff Attitude about Men-Only Lounge*

| 10. DO YOU THINK THAT HAVING A MEN-ONLY PATIENT LOUNGE ON A MIXED-GENDER UNIT WOULD IMPROVE SEXUAL SAFETY? | | |
|---|---|---|
| | N | % |
| No | 35 | 44.9 |
| Neutral / Unsure | 27 | 34.6 |
| Yes | 16 | 20.5 |
| Total | 78 | 100.0 |

that having a men-only patient lounge on a mixed-gender unit would improve sexual safety. Approximately another third of respondents were neutral or unsure. The primary reasons why these two groups of respondents did not think it would improve sexual safety were focused on their observation that inappropriate sexual behavior occurs in places other than lounge areas, and that the area would require close monitoring by staff. Only 20% of respondents were in favor of a men-only lounge and provided few reasons.

**Public Psychiatric Hospital Findings.**

Ten of the 24 public psychiatric hospitals that were contacted responded to the email inquiry. Of the 10 replies, all but 1 have civil acute units at their facility; the civil units at the 1 other facility that replied has an average length of stay of 5 years and, therefore, cannot be considered to be acute. Of the 9 public hospital respondents, none of them have single-gender civil acute units and most stated that their units have been coed for as long as they can remember. Of the hospitals that also have formally-designated state forensic units, some of these units are single-gender, some all-male and some all-female. Some of the hospitals shared that patients identified at increased risk for dangerous behaviors are on a heightened level of observation and monitoring to reduce opportunity for acting out. Some of the hospitals operate a psychiatric intensive care unit to manage particularly violent or high-risk patients that, though not intended or designated as such, tends to be predominantly male.

## Community Stakeholder Input

**Characteristics of Respondents.** Input was obtained from community stakeholders regarding the practice of having male and female patients residing on the same acute adult inpatient units, as well as thoughts about having patients reside on all-male and all-female acute inpatient units. Input was received from 216 respondents. The self-identified breakdown was: Consumer 112 (51.9%), Family 8 (3.7%), Provider 35 (16.2%), Advocate 37 (17.1%) and Other (e.g., human service, corrections, law enforcement) 24 (11.1%). Some individuals checked more than 1 box. The reply was counted in the order of respondent type above to try to reflect those respondent types more likely to have had direct experience with acute psychiatric inpatient services and operations. Because this respondent classification is approximate, findings are summarized for the total group of respondents, with any trend differences between respondent types informally noted.

**Content Analysis and Main Categories.** The responses to each of the two questions posed were sorted into those citing primarily advantages of mixed and single-gender unit arrangements, and those citing primarily disadvantages. The advantage and disadvantage groups of comments were then further divided into major content categories based on the main ideas expressed in those comments. Included in the content tables are responses illustrating those main ideas. The questions asked for respondents' thoughts about, not necessarily mutually exclusive preference for, the two types of gender-unit accommodations. Indeed, a number of respondents who offered positive comments about single-gender accommodation also offered positive comments about mixed-gender accommodation. It is important to interpret the summary of opinions with caution due to limitations associated with the collecting of this input. The information was obtained through an open invitation for input, not based on systematic sampling procedures.

**Opinions about Mixed-Gender Units.** With respect to the first question on men and women patients residing on the same acute inpatient units, approximately 47% of respondents cited predominantly advantages, and approximately 53% cited predominantly disadvantages. The respondents who were noted to emphasize more advantages over disadvantages of mixed-gender units tended to be consumers and families. Advocates and other respondents were more skewed in their focus on disadvantages as compared to advantages.

Comments citing <u>advantages</u> of mixed-gender units fell into the two main categories of *Therapeutic Recovery Environment* and *Quality of Care & Patient-Centered Treatment*. A third category was comprised of *Nonspecific* positive comments. The categories and illustrative responses are summarized in Table 17 below.

Table 17. *Community Input on Advantages of Mixed-Gender Units*

| **THERAPEUTIC RECOVERY ENVIRONMENT**<br>❖ **Quality of interpersonal interactions**<br>❖ **Impact on overall treatment milieu**<br>❖ **Practice standards and availability** | **QUALITY OF CARE & PATIENT-CENTERED TREATMENT**<br>❖ **Focus on safety and quality of care**<br>❖ **Role of staff, supervision and training**<br>❖ **Screening and treatment for vulnerability/risk** |
|---|---|
| • Healthy environment realistic to everyday interaction; should be reflective of society; hospital experiences should mimic the community and help patients cope with the real world they will return to | • Question whether mixed gender is really the core cause of problems vs. interrelated issues of adequate staffing, skills and prevention of violence in general; violence is usually related to staffing, observation of and interaction with patients and absence of a recovery focus; main concern is safety and gender mix doesn't matter – people can be violent against their same sex, too |
| • Should have opportunity to learn from men and women, share experiences; healthier and promotes recovery | • Segregation by gender doesn't fix the problem or promote resilience – the problem is staffing, supervision, programming; better and easier as long as enough trained staff to oversee the unit; with proper supervision, the practice is quite acceptable as long as potential for violence is not high – anyone displaying questionable behavior toward others is removed or closely supervised |
| • Adults who are not a threat should have access to the least restrictive and most integrated treatment environment; been on coed inpatient units before and had no problems as long as there is supervision | • If use trauma-informed care as a standard, it won't matter how we house patients – needs of patients should be indicators of units to be placed on, no one size fits all in recovery; appropriately assign patients to units for benefit of treatment, not just restriction of freedom |
| • Better to be in a natural setting, not prison-like, when in a crisis | • Issue is not gender but protecting people who are vulnerable or have aggressive behavior that hampers safety or recovery; need better screening and keeping more vulnerable or potentially dangerous patients under closer care; more appropriate to place by acuity; patients should be housed by severity of behavior – men assault men and women, women; put people who are scaring others in their own unit and help them get better |
| • Standard of care for most hospitals as long as adequate supervision; realistic approach with screening and monitoring processes; refer to best practices for guidance and determining beds for inpatient facilities | • Don't base decisions on people's opinions but on research, site data and careful analysis – treatment of people with mental illness is not any less worthy |
| **NONSPECIFIC**<br>❖ **Brief, general comments** | |
| • Good idea, nothing wrong with it | |

Comments citing <u>disadvantages</u> of mixed-gender units fell into two main categories of *Therapeutic Recovery Environment* and *Vulnerability, Trauma and Patient Mix*. A third category was comprised of *Nonspecific* negative comments. These categories and illustrative responses are summarized in Table 18 below.

Table 18. *Community Input on Disadvantages of Mixed-Gender Units*

| **THERAPEUTIC RECOVERY ENVIRONMENT**<br>❖ **Quality of interpersonal interactions**<br>❖ **Impact on overall treatment milieu**<br>❖ **Practice standards and availability** | **VULNERABILITY, TRAUMA & PATIENT MIX**<br>❖ **Impact on overall experience of safety**<br>❖ **Potential for harassment, abuse and victimization of women**<br>❖ **Patient mix of vulnerable and dangerous** |
|---|---|
| • Can focus on recovery more; coed atmosphere counterproductive due to distractions of the opposite sex ; focus should be on behavioral issues not socialization during hospital stay; causes problems relationship-wise<br><br>• Opposite sex can add stress to a difficult situation; people need to be away from opposite sex to heal<br><br>• Possible fears of opposite sex that would affect rehabilitation, competition for attention and detract from treatment; would reduce further anxiety at a time of crisis and limit potential for manipulation; puts patients in uncomfortable position not conducive to recovery<br><br>• Taking individuals with mental illness and putting them with dangerous people creates tension and hostility; interferes with sense of privacy, security and therapeutic outcomes<br><br>• Behavior may be improved on mixed-wards but staff needs to help individuals make competent choices among treatment alternatives | • Too much risk of inappropriate behavior; patients of opposite sex may lack appropriate boundaries or are not supervised closely enough and adds to stress and possible sexual contact or abuse; patients will feel safer; dangerous situation; so no one gets hurt; potential for manipulation and intimidation by opposite sex; bad idea safety-wise<br><br>• Experiencing mental illness is difficult enough, why add element of sexuality to the mix, tempt individuals with little impulse control over behavior and make work of staff more difficult; too much access to inappropriate behavior regardless of how well supervised<br><br>• Unsafe/uncalming environment for those already in vulnerable state, especially females; women more vulnerable and at increased risk of harm from harassment, discomfort, abuse, assault; men give the women reason to feel unsafe<br><br>• Patients are very sick and many women are already traumatized; higher proportion of females who have been physically or sexually assaulted by men and they should feel secure to facilitate treatment; could be possible with enough staff to supervise but reservation mixing vulnerable people and women with issues of past abuse who could be victimized by men on the same unit<br><br>• Shouldn't put dangerous patients together with vulnerable of both genders – creates environment likely to result in sexual and physical assaults; females and vulnerable males feel safer in less triggering environment – separate hypersexual males from both sexes; women may be victims of sexual abuse or domestic violence and can be uncomfortable - men with histories of these crimes need to be separated |
| **NONSPECIFIC**<br>❖ **Brief, general comments** | |
| • Bad idea, oppose/no; should be separate; trouble waiting to happen | |

**Opinions about Single-Gender Units.** With respect to the second question on having patients reside on all-male or all-female units, approximately 66% of respondents cited predominantly advantages, and approximately 34% cited predominantly disadvantages. Comments citing advantages of single-gender units fell into the two main categories of *Therapeutic Recovery Environment* and *Vulnerability, Trauma and Patient Mix.* A third category was comprised of *Nonspecific positive* comments. The categories and illustrative responses are summarized in Table 19 below.

Table 19. *Community Input on Advantages of Single-Gender Units*

| **THERAPEUTIC RECOVERY ENVIRONMENT**<br>❖ **Quality of interpersonal interactions**<br>❖ **Impact on overall treatment milieu**<br>❖ **Practice standards and availability** | **VULNERABILITY, TRAUMA & PATIENT MIX**<br>❖ **Impact on overall experience of safety**<br>❖ **Potential for harassment, abuse and victimization of women**<br>**Patient mix of vulnerable and dangerous** |
|---|---|
| • Though isn't normal to segregate sexes during the recovery process, seems safe and smart; fine, if helps individuals focus on their recovery; less distraction; less stressful for healing; men and women will feel more comfortable and the recovery process more successful; should be working on their issues, getting well; less interference with therapy<br><br>• May find it easier to relate to same sex; so women won't have their therapy interrupted by men; decreased anxiety and some women may not be comfortable residing with the opposite sex due to privacy and space<br><br>• Could be beneficial and offered as an option based on patient preference and staff to create sense of security and patient-centered care; wouldn't have an issue with them but should be based on consumer preference then staff; some patients do fine on mixed units and some better on single-gender – ideally hospital could maybe have both types to give patients and caregivers options; mixed gender not an issue but some clients are easily manipulated or intimidated by opposite sex and may have better therapeutic stay on separate units | • Much safer; safest situation for women; protects patients and staff more effectively; female clients will feel safer with all women and have less paranoia about men<br><br>• Avoids vulnerable people being taken advantage of; decreases potential for victimization between residents; segregation eliminates possibility of male on female sexual assaults<br><br>• Some have been abused by opposite sex and have triggers; men won't be tempted; would make men and women who have been harassed by opposite sex feel safer; because of trauma, important for women who feel safer on all-female unit<br><br>• Fine if facility can't have good screening system; first choice but problem is with severity and sufficient staff; may be circumstances that warrant mixed units though at times same-sex facilities must be mandated by staff for good of patient; hopefully, safer treatment option for men and women who are vulnerable and limited in judgment and impulse control<br><br>• For particular patients whose history makes it unsafe for them to be in an environment with the opposite sex, placement on a same-gender unit may be indicated based on professional evaluation; violent patients should be kept as separate as possible from all other patients |
| **NONSPECIFIC**<br>❖ **Brief, general comments** | |
| • Makes sense; if feasible, better option; would be fine, too; would be a good change | |

Comments citing disadvantages of single-gender units fell into two main categories of *Therapeutic Recovery Environment* and *Patient-Centered Treatment*. A third category was comprised of *Nonspecific* negative comments. These categories and illustrative responses are summarized in Table 20 below.

Table 20. *Community Input on Disadvantages of Single-Gender Units*

| **THERAPEUTIC RECOVERY ENVIRONMENT**<br>❖ **Quality of interpersonal interactions**<br>❖ **Impact on overall treatment milieu**<br>❖ **Practice standards and availability** | **QUALITY OF CARE & PATIENT-CENTERED TREATMENT**<br>❖ **Focus on safety and quality of care**<br>❖ **Role of staff, supervision and training**<br>❖ **Screening and treatment for vulnerability/risk** |
|---|---|
| • Provides degree of safety while under care but doesn't reflect society and may create false security; limits experiences to share with each other and should only be by choice; can be therapeutic for men and women to be with each other; makes little sense to restrict sexes from learning from one another if goal is to reintegrate back into society; we're grown adults and should be with other people, male or female; while such units may put people at ease over safety concerns, they will tend to increase tension and hostility less prevalent on mixed units and can be counterproductive<br><br>• Makes mental health recovery place more like a jail, prison-like setting; can be viewed as a move to corrections approach versus focusing more on person-centered, trauma-informed care<br><br>• Archaic, based on other hospitals familiar with and where coed works out fine<br><br>• Not conducive to reducing stigma; should be based on competent research and data informed judgments, not on what's popular with the public or press; problems are likely not related to gender issue – though makes for great media and political scrutiny<br><br>• Not necessary for the general population – violence can occur on same-sex units as well and having a recovery focus would contribute more to a healing, safe environment in the long run than segregation<br><br>**NONSPECIFIC**<br>❖ **Brief, general comments**<br><br>• Not good idea; like coed better but would be fine; not much benefit; fine but not necessary | • Wouldn't focus on gender segregation – create a respectful environment, segregate troublemakers; problem isn't mixing patients of different gender but quality of care- that should come first<br><br>• Issue isn't keeping people separate but supervision, trained staff and better screening to keep vulnerable/potentially dangerous people under closer care; staff need to care more and walk around to see what's going on<br><br>• Treat people for their problems, not demographics, and if people can't behave acceptably among peers, they should be treated on separate units with staff to meet their special needs; no segregation of men and women – find a place for people who are most destructive instead; important to do what's best for individualized patients – one may be comfortable on mixed unit and would be nice if another with trauma had a choice<br><br>• More appropriate response is to isolate high risk male patients from women rather than remove women to separate unit – conveys that sexual aggression is related to individual high-risk men and reduces stigma of being on a women-only unit; gender mix doesn't matter, male to male and female to female can be just as unsafe or violent<br><br>• This approach can be used for setting up units with increased supervision of patients at greater risk for violence; better to segregate patients by degree of potential for violence with increased supervision; segregation of all patients is not needed; don't see this as an issue of male-female but rather as predatory and vulnerable, regardless of sex |

# DISCUSSION

The purpose of this study was to conduct a detailed evaluation of the current practice of mixed-gender units at BHD, specifically in the context of patient sexual safety. To this aim, the study assessed BHD inpatient perceptions of safety on the current mixed units as well as preferences for single-gender units; examined BHD staff perceptions of patient sexual safety on the inpatient units, effectiveness of current safety practices and attitudes toward gender unit options; communicated with other public psychiatric hospitals regarding the gender configuration of their acute adult units; and obtained input from community stakeholders on male and female patients residing on the same and single-gender units, and recommendations to improve quality of care in the acute hospital.

**BHD Patient Perceptions**

Most of both male and female patient respondents reported feeling somewhat or very safe on a mixed-gender unit. The majority of them explained that their feeling safe related to positive interpersonal interactions and denial of concerns about aggression. Almost 88% of all patient respondents reported that they felt somewhat or very safe with men and women patients on the same unit. More than 90% of male patient respondents felt somewhat or very safe with males and females on the same unit. Nearly 84% of women felt somewhat or very safe with male and female patients on the same unit. The predominant explanation provided by male respondents for feeling safe centered on potentially beneficial interpersonal interactions and denying aggression was a concern, although some respondents did fear there would be more fights on an all-male unit. They also cited that unit and security staff and their own self-advocacy contributed to their feeling safe. The predominant explanation provided by female respondents feeling safe focused on the positive interpersonal interactions of having male patients on the unit and feelings of being safe from aggression. These women also cited that unit and security staff and their own self-advocacy contributed to their feeling of being safe on the unit. The small percentage of men and women patients who felt unsafe on a mixed-gender unit was concerned about safety from aggression.

Respondents indicated that they would feel safer on a mixed-gender unit with improved interpersonal interactions and with unit and security staff presence, behavior and monitoring. For male patient respondents, most indicated that what would make them feel safer was concerned with unit and security staff presence, behavior and monitoring. For women patient respondents, most indicated what would make them feel safer were improvements in overall interpersonal interactions and unit and security staff presence, behavior and monitoring.

Almost 50% of male and female patient respondents did not prefer to be on a same-gender unit. The primary reason cited for this finding was the perceived value of interpersonal interactions between patients and the negative impact a single gender unit would have on these interactions. A secondary, less predominant, reason was the potential for more aggression on an all-male or all-female unit. Only 15% of male patient and 29% of female patient respondents indicated that they would prefer a same-gender unit if it were available. The women who did prefer an all-female unit cited the positive impact of female-to-female interpersonal interactions, and did cite concerns about male aggression on a mixed-gender unit. Thirty percent of both male and female respondents were unsure of their preference for a same-gender unit. Of note, however, were their explanatory comments that cited mainly positive features of interpersonal interactions with both men and women on a unit.

Only one-quarter of the total of male and female patient respondents indicated that they would feel safer on a same-gender unit. A higher percentage of men would feel less safe (38%) than more safe (23%) on an all-male unit. The men who said they would feel less safe on a same-gender unit were mostly focused on the potential for aggression. Male respondents who gave reasons for feeling safer on a same-gender unit cited interpersonal benefits. A slightly higher percentage of women responded that they would feel less safe (32%) than more safe (29%) on an all-female unit. Women who said they would feel less safe on a same-gender unit were mostly focused on the potential for interpersonal conflict between women. Those who responded that they would feel safer on a same-gender unit cited safety from aggression and expected improvements in interpersonal interactions.

Women did not express a definitive preference for a women's-only lounge to be made available on the unit. Of the women who were opposed (39%) to a women's-only lounge, the majority of their reasons cited an expected negative impact on interpersonal interactions. The remainder of their comments cited expected verbal and physical aggression between women. Of the women who would prefer (32%) that there be a women's-only lounge on the unit, most reasons centered on an expected benefit in their interpersonal interactions and shared communication with other women. Only a few comments referenced a vague feeling that they would feel safer. The comments by the unsure or neutral group (29%) of women emphasized no problems with the current arrangement of a shared lounge with men on the unit.

**BHD Inpatient Staff Perceptions**

Most staff respondents thought that men and women patients are somewhat or very sexually safe residing on the same unit. More than 60% of staff responding to the survey thinks that men and women patients are somewhat (52%) or very (9%) sexually safe residing on the same unit. Nearly 40% of staff respondents think that men and women patients are somewhat (27%) or very (12%) sexually unsafe residing on the same unit. Staff respondents' sexual safety concerns for both men and women residing on the same unit were related to the individual's vulnerability to sexual harassment, intimidation, exploitation and/or abuse, and the unit configuration, staffing pattern, and patient mix. Staff respondents indicated that most (53%) of their concerns for women patients' sexual safety were related to the women's vulnerability to sexual harassment, intimidation, exploitation and/or abuse. Staff also noted that the unit configuration, staffing pattern, and patient mix contributed to their sexual safety concerns for women on the unit, and identified concerns about women initiating or provoking sexual activity. Staff respondents indicated that most (46%) of their concerns for men patients' sexual safety were related to some men being vulnerable to sexual harassment, intimidation, exploitation and/or abuse. Staff also noted that the unit configuration, staffing pattern, and patient mix contributed to their sexual safety concerns for men on the unit, and identified concerns about men initiating or provoking sexual activity. Staff respondents identified that both men and women raised sexual safety concerns about vulnerability to sexual harassment and intimidation; being concerned about personal boundary violations; and general (nonsexual) safety concerns. Nearly half of staff respondents said that men usually expressed no sexual safety concerns, and nearly one-quarter said women did not raise any sexual safety concerns.

Current practices were predominantly rated by staff respondents as being somewhat effective for ensuring the sexual safety of patients on the unit. Locked community bathrooms and the unit zone surveillance system were the highest rated practices with more than 40% of staff respondents rating them as very effective. Cross shift communication of special risk patients, the separation of bedroom hallways for men and women, and behavior observation for special risks were other practices rated by about one-third of staff as being very effective. In regard to other suggestions to improve sexual safety on the mixed-gender units, the largest percentage (32%) of staff respondents suggested an improved staffing pattern. Additional suggestions included better supervision and training of staff, better teamwork and hospital configuration of patient mix.

Nearly half of staff respondents thought it would be somewhat or very helpful for managing sexual safety on the units for BHD to develop plans for an all-women's unit. This group of respondents thought that this would reduce or eliminate sexual harassment and contact and could better serve the subset of women with sexual abuse and trauma issues. Unsure or neutral respondents cited the benefit of patients being able to interact and learn from the opposite sex on mixed-gender units and were concerned about not being able to control or prevent all sexual contact, including same-gender activity. Those not viewing the unit as being helpful were also concerned about same-gender sexual activity and felt that patients need to function in a normalizing environment similar to the community. Nearly half of staff respondents thought it would be somewhat or very helpful for managing sexual safety on the units for BHD to develop plans for an all-men's unit. Respondents thought that this could particularly help high-risk men from taking advantage of vulnerable females and provide a safer, less violent environment for the rest of the patient population. Those respondents that were unsure or not in favor of an all-men's unit cited concerns about the unit being more violent than a mixed-gender unit, that vulnerable males may be abused, and same-gender sexual behavior.

Only about one-quarter of staff respondents were in favor of a women-only lounge, citing it as a safe and secure place for women to go to when feeling threatened. Those staff respondents not in favor or unsure indicated that inappropriate sexual behavior occurs in places other than lounge areas, and that the area would require close monitoring by staff. Most staff respondents were unsure or did not think that having a men-only lounge on a mixed-gender unit would improve sexual safety. They indicated that inappropriate sexual behavior occurs in places other than lounge areas, and the area would require close monitoring by staff. Only one-fifth of staff respondents were in favor of a men-only lounge.

As for staff preference for type of unit work assignment, nearly half of staff respondents would not prefer to work on an all-women's unit. Primarily this was due to their concerns about having to deal with stressful demands, and secondarily their viewing the benefits of a mixed-gender recovery environment that reflects the community to which patients will return. Similarly, most staff respondents did not prefer or were neutral or unsure about working on an all-men's unit due to the potential for aggression and violence. Most staff respondents preferred to work on a mixed-gender unit due to the variety of patient needs and personalities of this arrangement, and the benefits of the current mixed-gender recovery environment that reflects the community.

**Public Psychiatric Hospital Practices**

Information from 9 Midwest public psychiatric hospitals with civil acute units revealed that none of them have single-gender civil acute units and most stated that their units have been coed for as long as they can remember. Of the hospitals that also have formally-designated state forensic units, some of these units are single-gender, some all-male and some all-female. Practices some hospitals use for patients identified at increased risk for dangerous behaviors include heightened levels of observation and monitoring to reduce opportunity for acting out, as well as a psychiatric intensive care unit to manage particularly violent or high-risk patients.

**Community Stakeholder Input**

Community stakeholders shared a variety of responses about having male and female patients residing on the same acute adult inpatient units, as well as thoughts about having patients reside on all-male and all-female acute inpatient units. This wide range of opinions is to be expected as some respondents are more likely to have direct experience with BHD acute inpatient services and/or acute hospital operations, whereas those groups of respondents extending further into the community have more a indirect and varied information base. Nearly half of respondents offered comments citing advantages of mixed-gender units, and slightly more than a half cited reasons against such an arrangements. Consumers and families tended to be more favorable in their opinions of men and women on the same units, whereas advocates and "other" type respondents were more skewed in their focus on disadvantages as compared to advantages. The advantages of mixed-gender units fell into the two main content categories of *Therapeutic Recovery Environment* (beneficial effect on interpersonal interactions and treatment milieu, and practice standards) and *Quality of Care & Patient-Centered Treatment* (core issues of quality of care, staffing/supervision and screening/treating of most dangerous/vulnerable). Disadvantages of mixed-gender units fell into two main categories of *Therapeutic Recovery Environment* (negative impact on interpersonal interactions and treatment milieu) and *Vulnerability, Trauma and Patient Mix* (impact on safety, potential for harassment, abuse and re-traumatization of women and patient mix of vulnerable and dangerous).

With respect to having patients reside on all-male or all-female units, approximately two-thirds of respondents shared benefits of gender segregation and one-third focused predominantly on disadvantages. The advantages of single-gender units fell into the same two main categories, described above, as did the disadvantages of mixed units: *Therapeutic Recovery Environment* and *Vulnerability, Trauma and Patient Mix*. Likewise, responses focusing on disadvantages of single-gender units fell into the same two main categories, described above, as did the advantages of mixed units: *Therapeutic Recovery Environment* and *Patient-Centered Treatment*. Of interest is that a number of respondents, including consumers, regardless of their opinions about unit gender mix, argued that gender should not be the primary factor taken into consideration in determining placement, and that quality of care and recovery focus will not be adequately addressed by resort to single-sex segregation. Other factors, such as severity of illness and risk of violence, are equally if not more important in creating a safe and therapeutic environment.

## LIMITATIONS

This study is limited by the sample of respondents who participated in the various phases. BHD inpatients were sampled over a restricted period of one month and were self-selected. Their opinions may not be necessarily representative of all BHD acute inpatients. Participants may have felt unwilling to appear critical of care while in the hospital. BHD staff respondents were self-selecting and the generalizability of their opinions is limited by the overall response rate. In addition, participants might have had particular concerns around issues of patient sexual safety and gender configuration of acute units. The findings on single-gender units at public psychiatric hospitals represent the practices of those facilities that responded. It is unknown if those who did not respond failed to do so because they had no experience with single-gender units to share, or due to other customary reasons. The process of obtaining input from community stakeholders was an open request for opinions and was not based on systematic sampling procedures. As such, the opinions only represent those individuals who chose to respond and may not be representative of community stakeholders in Milwaukee County as a whole. Additionally, it is unknown to what extent those who provided opinions have knowledge of the operation of the BHD acute inpatient units, or psychiatric inpatient units in general, and whether they have more or less favorable perceptions of the services provided on these units. For example, some comments indicated that the respondent had erroneous assumptions about the acute inpatient units (e.g., units could be single-gender and patients meet in a coed TV room and dining room; male and female patients shouldn't live together but have opportunity to interact at coed social and recreational activities).

## RECOMMENDATIONS

Based on this extensive study, The Gender Unit Work Group recommends a configuration of the 4 Acute Adult Inpatient Units that would create a 12-bed ***Intensive Treatment Unit (ITU)*** that is expected to be predominantly male, a combined ***Women's-Option/Med-Psych Treatment Unit***, and 2 remaining mixed-gender units designated as ***General Acute Treatment Units***. The new configuration of the Acute Adult Inpatient units and bed capacity would be as follows:

| ACUTE ADULT UNIT CONFIGURATION | |
|---|---|
| • Intensive Treatment Unit (ITU) | 12 beds |
| • Women's-Option/Med-Psych Treatment Unit | 24 beds |
| • General Acute Treatment Unit | 24 beds |
| • General Acute Treatment Unit | 24 beds |
| NEW CAPACITY | 84 beds |

### Unit Configuration Model

The ***Intensive Treatment Unit*** would be designated for patients with high risk for aggression and violence, including sexual acting out. The ITU can be presumed to be predominantly, if not always, all male. Most women with elevated risk of violence can usually be managed in the general population with enhanced monitoring. Though the ITU concept will need to be further developed, the Work Group is firm in its stand that the unit not be considered nor referred to as a "secure" unit [all BHD acute units are secure and locked], a "forensic" unit [BHD has no formally designated forensic services or specialty nor is it in a position to add such] or a "detention" unit [BHD is not a correctional facility]. The ITU <u>must</u> have reduced beds, as is the practice in other hospitals with such units. We recommend the ITU have a capacity of 12 beds. <u>The implication is that BHD would have to be prepared to reduce its overall Acute Adult Inpatient bed capacity by 12 beds to a total of 84 beds</u>. The benefit of the ITU is that it achieves separation, from the general acute patients, of predominantly those male patients with higher violence potential. This separation addresses the main safety concerns of staff and patients, especially vulnerable male patients and most female patients.

The needs of women patients, however, are more complex due to higher rates of trauma and may not be fully resolved by segregation of high-risk men. For this reason, the Work Group recommends that one unit be designated as a combined ***Women's-Option/Med-Psych Treatment Unit***. One of the current adult units has historically been partly dedicated to treating geropsychiatric patients and younger patients with complex medical-psychiatric disorders. BHD Acute Adult Inpatient admission data from 2009 – 2010 YTD were reviewed using an age cut-off of 60 and older (though not "geriatric" it errs on side of caution to allow for younger med-psych patients). At any given time, there are approximately 9 "geriatric/med-psych" patients on this unit. Per BHD current acute inpatient gender breakdown (59.8% male and 40.2% female), this equates to 5-6 men and 3-4 women. With a unit capacity of 24, this leaves 15 beds that are anticipated to be available as Women's-Option beds. These beds would be prioritized for female patients at heightened risk of vulnerability to inappropriate sexual behavior, abuse and violence. Assignment would be based on medical staff assessment or patient choice, depending on clinical safety needs and bed availability. Though there will be a minority of generally older male patients on this unit, the anticipated risk is lower and can be planned for. With a new overall bed capacity of 84 beds, the female beds on this unit (Women's-Option plus Med-Psych beds) would equate to more than half of the total estimated adult female inpatient beds.

The remaining two units would be mixed-gender ***General Adult Treatment Units***, with separate bedroom hallways for male and female patients as is currently the case. The separation of those patients with highest potential risks of both violence and vulnerability would, hopefully, allow these units to better serve the general patient population in a normalizing, therapeutically focused milieu which many patients value.

**Rationale**

Segregation and mixing of genders is not an all or nothing approach. It is not about one answer. It is a process. There are reasons for and reasons against each option. To some, segregation by gender of all of the units seems to be the obvious choice. However, the Work Group was unanimous in its conclusion that, though appearing progressive on the face of it, this approach is compartmentalized and rigid. The proposed configuration offers a blended model that covers the main bases in a thoughtful, flexible and pragmatic way. It is not one-size-fits-all. It offers a more individualized, needs-based, trauma informed care approach than simple division by gender. A strong impression was given by a number of patients and consumers that a recovery focused, de-stigmatizing and normalizing treatment environment is desirable to them. The model addresses many of the concerns of BHD staff, patients, community consumers, and stakeholders and coheres with accepted practices of public psychiatric hospitals. Other than requiring a 12-bed reduction in overall Acute Adult Inpatient capacity, the recommendation is feasible and offers flexibility with census management. It acknowledges gender-based safety concerns while affirming the current improvement practices already being implemented.

**Next Steps and Implications**

The recommendation of the Gender Unit Work Group is advisory to the BHD Administrator. Should it receive endorsement, the proposal will need to be presented to the full BHD clinical and administrative-finance leadership teams. Then a detailed planning process will need to be undertaken, addressing considerations in three main domains:

1. Human Resource – Determination of staffing composition and pattern of the ITU; staff selection (preference is for selection by skill versus seniority) and labor union issues; Medical Staff recruitment to fill vacant acute inpatient positions
2. Program Development – Development of model for ITU and Women's-Option units, admission/transfer criteria, programming needs, staff training
3. Physical Environment/Operations – Plans for reduction in bed capacity and census management, physical environment audit of proposed ITU unit location and completion of any necessary environmental modifications

To allow for the planning required, the estimated timeline for implementation of the unit configuration recommendation is during the Quarter 3 of 2011 (July to September). Regardless of the final decision, BHD shall continue the current practices, policies and guidelines in place to maintain a safe, therapeutic unit environment. Patient risk assessment, interdisciplinary treatment planning and effective patient monitoring processes are essential components. Staff supervision and active patient intervention are recognized as factors that can contribute to reduction of violence of all types. Peer specialists and client rights specialists provide essential advocacy services to help represent patient interests and support dignity, respect and autonomy.

## ACKNOWLEDGEMENTS

We would like to thank Desirine Vann, BHD Client Rights Specialist, and Carol Knabe of Vital Voices, a mental health advocacy organization, for their invaluable assistance administering the BHD inpatient semi-structured questionnaires and attaining such an excellent response from our patients. Special thanks to Sue Clark, Executive Director of Vital Voices, for her generous allocation of staff resources in support of this study. Thank you to Barbara Beckert of Disability Rights Wisconsin for her help disseminating the BHD request for input to community stakeholder groups. The Chair of this study wishes to acknowledge the members of the Gender Unit Work Group for their commitment and devotion of many hours to this project outside of their regular work assignments. Special appreciation is extended to Dr. David Jaet for his valuable assistance with survey construction, statistical analysis and interpretation of results.

# APPENDIX A

*Contents*

I. BHD Acute Inpatient Questionnaire – *Acute Adult Inpatient Gender Unit Preference Survey*

II. Content Analysis of Male and Female Patient Responses to Open-Ended Items

# ACUTE ADULT INPATIENT
# GENDER UNIT PREFERENCE SURVEY

We would like to know your opinion about men and women being on the same unit here. Your answers are confidential and will not influence the services you receive.

| | | | |
|---|---|---|---|
| **Date of Survey:** ____/____/**2010** | | **Date of Admission:** ____/____/**2010** | |
| **Gender:** ____ **Male** ____ **Female** | | **Race/Ethnicity (check one):** | |
| **Age:** ____ **years** | | ____ **African American** | ____ **White/Caucasian** |
| **Acute Unit** ____ **43A** ____ **43B** | | ____ **Hispanic/Latino** | ____ **Native American** |
| ____ **43C** ____ **43D** | | ____ **Asian/Pacific Islander** | ____ **Other** |

| | | NO | UNSURE/ DOESN'T MATTER | YES |
|---|---|---|---|---|
| 1. | Would you prefer to be on an [*say same gender as pt.*] all-men's/all-women's unit if it were available? | 1 | 2 | 3 |

➢ 1a. Explain why.

| | | VERY UNSAFE | SOMEWHAT UNSAFE | SOMEWHAT SAFE | VERY SAFE |
|---|---|---|---|---|---|
| 2. | How do you feel with men and women patients on the same unit? | 1 | 2 | 3 | 4 |

➢ 2a. Explain why.

➢ 2b. What would make you feel safer?

| | | LESS SAFE | NO DIFFERENCE | MORE SAFE |
|---|---|---|---|---|
| 3. | How would you feel if there were all [*say same gender as pt.*] men/women patients on the unit? | 1 | 2 | 3 |

➢ 3 a. Explain why.

**<u>THE NEXT QUESTION IS FOR WOMEN ONLY</u>:**

| | | NO | UNSURE/ DOESN'T MATTER | YES |
|---|---|---|---|---|
| 4. | Would you prefer there to be a <u>women-only</u> patient lounge available on the unit? | 1 | 2 | 3 |

➢ 4a. Explain why.

**THANK YOU FOR COMPLETING THIS SURVEY!**

| Question 1. Would you prefer to be on an all-men's unit if it were available? (1a.) Explain why. | | |
|---|---|---|
| **NO** | **UNSURE/DOESN'T MATTER** | **YES** |
| **SAFETY FROM AGGRESSION** | | |
| • Less fights if mixed – 2<br>• M would kill and fight each other – 2<br>• Some M are homosexual so would not make us safe<br>• Don't feel comfortable around a lot of guys | • W touching other people too much<br>• Could be sedated and clothes half off and lead to charges of indecent exposure<br>• M trying to mess with the girls<br>• Because what's going on in the media, pt had sex with a W and had a baby<br>• Staff should be watching what's going on so pts are safe | |
| **INTERPERSONAL INTERACTION** | | |
| • Want to be around M and W – 7<br>• W give a different point of view, can learn from them – 3<br>• In real world, have to deal with multiple genders – 2<br>• Integration of M and W facilitates healing<br>• Meet new people, socialization – 5<br>• Different people to talk to – 5<br>• Like to see variety of people on unit – 3<br>• W have soft touch, more understanding<br>• Like to see a smiling face<br>• Get along better with W<br>• Pts need help<br>• Keep to myself<br>• M are rude<br>• Pick up bad habits<br>• Don't want to look at all M all day<br>• Boring | • Nice to have a mix of cultures<br>• Like to be around different people<br>• Nice to see a pretty face – 2<br>• People need to get along – 2<br>• W are trouble - 2 | • Everyone would have their own space<br>• Don't feel appreciated |
| **OTHER** | | |
| | | • Get mixed emotions<br>• Poison in food |

<table>
<tr><th colspan="3">Question 1. Would you prefer to be on an all-women's unit if it were available? (1a.) Explain why.</th></tr>
<tr><th>NO</th><th>UNSURE/DOESN'T MATTER</th><th>YES</th></tr>
<tr><th colspan="3">SAFETY FROM AGGRESSION</th></tr>
<tr><td>• There haven't been any problems sexually with M and W on the unit<br>• W would just fight<br>• Because W are always arguing over hair products</td><td>• M are not going into W's rooms, so I don't have fears about my safety</td><td>• Men try to intimidate W<br>• Sometime I feel safer when I'm around all W<br>• Because you have to watch what you're wearing with all M around<br>• M act out more – I was called a derogatory name this morning by a M<br>• M might swear at us or hurt us<br>• Because M might want to have sex, sometimes it makes me nervous to be around M<br>• Lot of interactions between the sexes, at times disruptive to safety and treatment</td></tr>
<tr><th colspan="3">INTERPERSONAL INTERACTION</th></tr>
<tr><td>• Good to meet new, different people, I like a variety of people – 5<br>• Would like to meet M and W, prefer M and W, been with M and W all my life – 7<br>• Like having input/talking to both genders, hearing M talk and interacting with them – 4<br>• You need to talk to M and give each other feedback, can teach each other lessons - 2<br>• Don't get along with W very often, W can't get along with each other – 3<br>• W are catty, get into "he said she said" kind of talk, are too bitchy when they get together as a group, are not as nice to each other as they should be, would nag at each other and try to control – 5<br>• They think they know everything and talk too much<br>• W like to form cliques</td><td>• I like to see different people very day, like to see a mixture of people – 2<br>• We're all human and should be around each other and get along, as along as we all get along – 2<br>• We're all treated the same and here for the same reason<br>• I can get along with anybody, I'm flexible – 2<br>• I don't let M bother me most of the time<br>• I haven't had any problem with anyone here<br>• Doesn't matter, I'm a little old lady<br>• W are louder than M<br>• All the hospitals I've been in have M and W on the same unit so I can't compare to anything else</td><td>• Feels better with all W, personally like W better than M – 2<br>• Get along better with W than M – 3<br>• W are easier going, fun – 2<br>• W have a lot in common, could talk about our children and women's issues<br>• More privacy with just W<br>• Lot of interaction between the sexes, at times it's healthy<br>• M are devils</td></tr>
<tr><th colspan="3">OTHER</th></tr>
<tr><td>• Cause M and W wouldn't get along</td><td></td><td>• Because I can change without M being around<br>• Neither, I'd like to go home</td></tr>
</table>

| Question 2. How do you feel with men and women patients on the same unit? (2a.) Explain why. | |
|---|---|
| **VERY UNSAFE/SOMEWHAT UNSAFE** | **SOMEWHAT SAFE/VERY SAFE** |
| **SAFETY FROM AGGRESSION** | |
| • Would be a fight – 3<br>• Some W touching people all the time<br>• Other people can get into arguments<br>• Pts sometimes pour coffee on another pt | • Some M make me feel safe<br>• No one gets hurt, no fighting or killing<br>• W usually not violent, though some can be<br>• Never know when someone's going to snap – 2<br>• Would be lots of fights with all M, More M will be trouble other pts try to start fights – 3<br>• Pt threw coffee on me |
| **INTERPERSONAL INTERACTION** | |
| | • M and W get along, communicate – 6<br>• We can talk it out – 3<br>• + Here to get help, focus<br>• W tell what they see<br>• Depends on people on the unit and attitudes<br>• Both M and W can be moody<br>• W over-exaggerate more than M, like to fuss – 2<br>• Some W approach you<br>• Some W have a bad attitude |
| **UNIT AND SECURITY STAFF** | |
| | • Because of social worker and nurses<br>• Staff watch people<br>• Feel protected by CNAs<br>• Security on unit<br>• Staff and security act fast if pts get aggressive and loud; staff able to handle any problems – 2<br>• Staff are busy and sometimes can't get to us right away<br>• Staff tease pts too much |
| **SELF ADVOCACY** | |
| | • I walk away, don't argue with people<br>• I know how to separate myself from people - 2<br>• I'm a huge guy |

| Question 2. How do you feel with men and women patients on the same unit? (2a.) Explain why. | |
|---|---|
| **VERY UNSAFE/SOMEWHAT UNSAFE** | **SOMEWHAT SAFE/VERY SAFE** |
| **SAFETY FROM AGGRESSION** | |
| • When it's all girls, I feel safer<br>• M and W like to fight each other<br>• M are devils<br>• Besides being called a name this morning, some of the M try to go down the W's hallway<br>• Because people are yelling for help at night and I don't know what's happening to them<br>• There's people here doing things to me that make me feel like they don't want to be around me – both pts and staff | • M don't try to do anything to the W on the unit; don't have problems with the M, haven't shown themselves to be predators towards me; no one tried to come in my room and there's a no-touch policy – 3<br>• No one would touch me, no pt would touch each other<br>• I haven't seen any violence since I've been here; no one has tried to do anything bad - 2<br>• M would take notice if a W was being mistreated and would do something about it; the M will defend us W, being around M makes me feel safe – 3<br>• Because when W try to get in a fight, the M pts will try to help break it up<br>• A W could punch me for no reason as could a M<br>• I feel threatened by some of the M – 2<br>• Sometime, depending on the person there's been sexual contact in the past<br>• Some of the W make me feel unsafe also, if they are aggressive or intimidating<br>• I get scared sometime<br>• Depending on their illness, all W on the unit would make me feel safe<br>• The W would protect me |
| **INTERPERSONAL INTERACTION** | |
| • Because of different age groups; young people should be together and old people with each other because young try to get you caught up in their issues or to do things for them | • M and W need to get along with each other – 2<br>• M and W get along better<br>• Used to being around M and W – 2<br>• We should have different kind of people from all over, never know how they will respond to you – 2<br>• The M don't bother me, they are not mean, I don't have any problems, M are nicer to W here than on the street – 5<br>• M will watch over W, we have each other's back – 2<br>• M always like to talk to the W, we can work together – 2<br>• Don't know the other people very well, matter of meeting them, talking and making friends<br>• I get along with anyone but need younger pts on unit<br>• Sometime think people are my friend but they're not, so feel somewhat safe |
| **UNIT AND SECURITY STAFF** | |
| | • If you have a problem, you can tell the nurse and they take of it<br>• Staff manages behavior by redirecting people as needed<br>• Staff have everything under control and there's security staff to help if necessary<br>• It's improved since CNAs are sitting in different areas of the<br>• Pts who need to be watched are supervised more carefully<br>• People are always walking around |
| **SELF ADVOCACY** | |
| | • I feel safe with anyone – 2<br>• I will stand up for my rights |
| **OTHER** | |
| • I don't like being here - 2 | |

| Question 2. How do you feel with men and women patients on the same unit? (2b.) What would make you feel safer? | |
|---|---|
| **VERY UNSAFE/SOMEWHAT UNSAFE** | **SOMEWHAT SAFE/VERY SAFE** |
| **UNIT AND SECURITY STAFF** | |
| • Security<br>• Nobody make me feel safer | • Security – 19<br>• Staff – 11<br>• The Zone – 3<br>• Staff need to get their act together, do their jobs – 6<br>• Don't trust security – 2 |
| **INTERPERSONAL INTERACTION** | |
| • More M - 2 | • Respect and boundaries, caring, if patients could get along – 2<br>• Family and friends - 3<br>• No threats<br>• If people wouldn't steal |
| **SELF ADVOCACY** | |
| • I will make myself feel safe | • I know how to protect myself – 3<br>• Myself - 2<br>• I feel safe already – 2 |
| **OTHER** | |
| • Sheriff<br>• No poison | • In my own house, not in hospital with strangers – 2<br>• Access to personal belongings, music<br>• Good environment<br>• Sheriff<br>• God<br>• Contact with Social Security Office because of concern about my benefits |

| Question 2. How do you feel with men and women patients on the same unit? (2b.) What would make you feel safer? | |
|---|---|
| **VERY UNSAFE/SOMEWHAT UNSAFE** | **SOMEWHAT SAFE/VERY SAFE** |
| **UNIT AND SECURITY STAFF** | |
| • Security<br>• Staff could help people get along | • Staff, my nurse, doctors – 12<br>• Security – 12<br>• CNA<br>• Should have more than 1 CNA on each unit per shift to take care of the M<br>• Make certain staff give me the right medication so I can get well<br>• Staff should pay more attention to the pts, people who are more sick – 2<br>• I'd feel better if they'd control the noise; I feel threatened when people yell, staff should have them in their room<br>• If staff would treat us the way they want to be treated, with more respect<br>• Sometime staff makes us feel invisible when we go to the desk, they ignore us when we have important questions |
| **INTERPERSONAL INTERACTION** | |
| • If people wouldn't get angry and swear<br>• People respecting their elders<br>• If M and W have separate units; that M are out of my life – 2<br>• More people who are here to get professional help<br>• Curtains dividing the rooms so no one is watching you and you have some privacy to heal<br>• I couldn't get out of my room this morning and that makes me uncomfortable | • No issue with the M<br>• I need to get to know people better<br>• Family - 2<br>• W friends<br>• Mixing of genders is an issue at times<br>• The M, not staff; Feel the pts will help me instead of staff - 2 |
| **SELF ADVOCACY** | |
| | • Myself – 2<br>• Take my medications on time – 2<br>• They can talk to me but not touch me, touching my hand would be OK<br>• Mind my own business |
| **OTHER** | |
| • Sheriff and police | • Cops - 2<br>• I feel safe now - 3<br>• A cleaner environment<br>• God<br>• Nothing – 3 |

| Question 3. How would you feel if there were all men patients on the unit? (3a.) Explain why. | | |
|---|---|---|
| **LESS SAFE** | **NO DIFFERENCE** | **MORE SAFE** |
| | **SAFETY FROM AGGRESSION** | |
| • Fights, someone will get killed – 18<br>• Sexual assaults, M get "funny" ideas– 3<br>• M like to start trouble | • I wouldn't feel threatened - 3<br>• Mixed feeling – men carry weapons | • No one would touch you<br>• I can defend myself<br>• M don't start arguments like W |
| | **INTERPERSONAL INTERACTION** | |
| • Enjoy W's company; wouldn't have emotional help from W, more compassionate – 2<br>• M have hidden agendas, don't trust them<br>• I have nothing to offer a M<br>• Would feel like prison<br>• Would need more activities to keep M calm | • I get along with everyone – 4<br>• Both M and W can get along – 2<br>• I walk away from drama - 2<br>• Everyone's docile<br>• What matters is if someone cares<br>• All are strangers anyway | • More comfortable<br>• Could get to know each other and do things together<br>• M are more reliable<br>• M are more protective<br>• Women are nosy, they watch everything that goes on<br>• Prefer M and W |
| | **OTHER** | |
| | | • No poison |

| Question 3. How would you feel if there were all women patients on the unit? (3a.) Explain why. | | |
|---|---|---|
| **LESS SAFE** | **NO DIFFERENCE** | **MORE SAFE** |
| | **SAFETY FROM AGGRESSION** | |
| • They like to fight and scream at each other; lot of W get into cat brawls; there'd be a lot of bruises on me – 6<br>• When I get around a lot of W, they threaten to hurt me | • M on this unit have not been harmful in any way; I don't feel threatened – 2<br>• We all need help and unit staff or security will intervene if needed – 2<br>• Anyone can have an acting out behavior problem<br>• If a W attacked me, I could handle her<br>• I don't argue with people<br>• Staff knows what they're doing; if anyone acts out they intervene | • W don't fight; not as aggressive as the M; may form cliques but usually don't get violent – 3<br>• No M could hurt me; don't want any M making advances toward me – 2<br>• Don't feel afraid but feels like all W unit would be safer<br>• W protect each other |
| | **INTERPERSONAL INTERACTION** | |
| • Need mixed gender, need the openness of both M and W, all our peers – 2<br>• More tension with all W, too many W get on my nerves, W don't get along very well, they talk about each other or gossip, too many young women get upset about too many things, like doing things better than them – 5<br>• Don't like to be around all W, don't get along with W like I do M – 2<br>• W get bitchy when they get their period – 2<br>• W can be loud and domineering; having M around keeps them somewhat under control – 2<br>• Have less privacy with W around and boundary issues, they think they have the right to invade your personal space | • Wouldn't mind, I like W also – 5<br>• W should participate more, we should stick together but we don't<br>• I don't have to worry about them<br>• M and W are good together; both friendly with me – 2<br>• Some of the M are enjoyable | • All W stick together, we can watch one another – 2<br>• I can try to trust W, it's harder to trust M<br>• Has to do with wearing appropriate clothing when M are around<br>• I keep to myself<br>• Depends on type of illness W has, some are more serious |
| | **OTHER** | |
| • Men are like animals<br>• I will not like it on unit if we share with M | | |

| Question 4. Would you prefer there to be a <u>women-only</u> patient lounge available on the unit? (4a.) Explain why. | | |
|---|---|---|
| **NO** | **UNSURE/DOESN'T MATTER** | **YES** |
| **SAFETY FROM AGGRESSION** | | |
| • W like to argue and M don't<br>• W like to fight; catty girls would get in a fight and staff couldn't get to us to intervene – 2<br>• W are jealous of each other an they want what you've got and they'll try to get it<br>• M might try to protect us from others who try to hurt us | • Don't want to go in any room with someone alone, M or F | • Feel safer with all W in the room; would make me feel more safe; safer if I could go in a room without M and watch TV – 4 |
| **INTERPERSONAL INTERACTION** | | |
| • Need a mixture of M and W; still want to have a conversation with both M and W pts; like to meet different people – 5<br>• Don't like all W; not all W like other W; W don't get along well - 5<br>• Both genders are people; M and W should like each other and be together; OK the way it is – 4<br>• Feels more normal to have M and W around – keep it real, like in the community; healthier environment, like the rest of society and the world; M like to watch TV with us – 3<br>• Most of the M mind their own business<br>• Stupid idea, only so much room on the unit, we should just all get along<br>• If staff is watching the pts, there shouldn't be need for a separate lounge | • I will talk to all W<br>• Works fine the way it is, don't care if M and W are in the same room – I'll talk to either; extra lounge would be a waste of money – 3<br>• Haven't had a problem with any of the M, people have been respectful; There are some nice and interesting M we like to talk to - 2 | • W have more in common and could talk about things that don't concern M; we could talk about different issues, problems with just W; can talk about things that I can not tell M; can talk about personal business - 6<br>• I get along better with W, like to hang out with W better, W are friends – 4<br>• W might want to be alone with no M around – 2<br>• I trust W more than M<br>• Good idea, by trying it they could observe if W liked it |
| **OTHER** | | |
| | | |

# APPENDIX B

*Contents*

# ACUTE ADULT INPATIENT STAFF SURVEY: *PATIENT SEXUAL SAFETY*

The BHD Gender Unit Work Group would like to know your opinions about the ***sexual safety*** of men and women patients residing on the same Acute Inpatient Units here. **For the purposes of this survey, SEXUAL SAFETY refers to preventing and managing sexual behavior between patients – including sexual contact, harassment, exploitation, intimidation and assault.**

**PLEASE RETURN SURVEY TO DR. MARY KAY LUZI -CENTRAL ADMINISTRATION BY SEPTEMBER 30, 2010 via Inter-Office Mail or Placement in Locked Mail Box Outside Administration Suite 1046.** *Your answers are confidential. Only original printed surveys are to be used. Thank you for your time and participation. We value your input.*

**Gender:** _____ **Male** _____ **Female**

**Years of Employment at BHD:** _____ **Years**

**Years of Employment in Acute Adult Inpatient:** _____ **Years**

**Position :**
- ____ **Medical Staff (MD/PhD/APNP)**
- ____ **Social Work/Rehab Services**
- ____ **Registered Nurse**
- ____ **Certified Nursing Assistant**
- ____ **Peer Specialists**
- ____ **Other (e.g., Dietician, Chaplain)**

**CIRCLE THE NUMBER IN THE BOX THAT BEST DESCRIBES YOUR ANSWER**

| | | VERY UNSAFE | SOMEWHAT UNSAFE | SOMEWHAT SAFE | VERY SAFE |
|---|---|---|---|---|---|
| 1. | How sexually safe do you think men and women patients are residing on the same unit in our hospital? | 1 | 2 | 3 | 4 |

- 1a. What sexual safety concerns do you have for <u>women</u> patients on the unit?

- 1b. What sexual safety concerns do you have for <u>men</u> patients on the unit?

- 1c. What sexual safety concerns have <u>women</u> patients raised?

- 1d. What sexual safety concerns have <u>men</u> patients raised?

**** IF YOU HAVE NO EXPERIENCE WITH AN ITEM, LEAVE IT BLANK.**

| 2. | How would you rate the effectiveness of these current practices for ensuring the sexual safety of patients on the unit? | VERY INEFFECTIVE | SOMEWHAT INEFFECTIVE | SOMEWHAT EFFECTIVE | VERY EFFECTIVE |
|---|---|---|---|---|---|
| 2a. | Assessments by PCS & Inpatient MD/PhD of special risks | 1 | 2 | 3 | 4 |
| 2b. | Recovery Planning special risks treatment objectives & interventions | 1 | 2 | 3 | 4 |
| 2c. | Patient Education on sexual contact policy | 1 | 2 | 3 | 4 |
| 2d. | Unit Zone Surveillance system | 1 | 2 | 3 | 4 |
| 2e. | Morning Report with both treatment teams represented | 1 | 2 | 3 | 4 |
| 2f. | Cross Shift communication of special risk patients | 1 | 2 | 3 | 4 |
| 2g. | Behavior Observation monitoring for special risks | 1 | 2 | 3 | 4 |
| 2h. | Bedroom Hallways separate for men & women; no bed assignment beyond fire doors for women | 1 | 2 | 3 | 4 |
| 2i. | Locked Community Bathroom | 1 | 2 | 3 | 4 |
| 2j. | Therapeutic Groups | 1 | 2 | 3 | 4 |
| 2k. | Electronic Video Monitoring of unit | 1 | 2 | 3 | 4 |
| 2*l*. | OVERALL EFFECTIVENESS of current practices | 1 | 2 | 3 | 4 |

- 2 m. For any current practice you rated as ineffective (1 or 2), explain why and your recommendation for improving it. (please list by item #)

| | |
|---|---|
| 3. | What other suggestions do you have to improve the **sexual safety** of men and women residing on the same units? |

| | | NOT AT ALL HELPFUL | NOT VERY HELPFUL | NEUTRAL/ UNSURE | SOMEWHAT HELPFUL | VERY HELPFUL |
|---|---|---|---|---|---|---|
| 4. | How helpful do you think it would be for managing sexual safety on the units for BHD to develop plans for an All-Women's Unit? | 1 | 2 | 3 | 4 | 5 |

- 4a. Explain why.

| | | NOT AT ALL HELPFUL | NOT VERY HELPFUL | NEUTRAL/ UNSURE | SOMEWHAT HELPFUL | VERY HELPFUL |
|---|---|---|---|---|---|---|
| 5. | How helpful do you think it would be for managing sexual safety on the units for BHD to develop plans for an All-Men's Unit? | 1 | 2 | 3 | 4 | 5 |

- 5a. Explain why.

| | | NO | NEUTRAL/ UNSURE | YES |
|---|---|---|---|---|
| 6. | Would you prefer to work on an All-Women's Unit, if BHD had one? | 1 | 2 | 3 |

- 6a. Explain why.

| | | NO | NEUTRAL/ UNSURE | YES |
|---|---|---|---|---|
| 7. | Would you prefer to work on an All-Men's Unit, if BHD had one? | 1 | 2 | 3 |

- 7a. Explain why.

| | | NO | NEUTRAL/ UNSURE | YES |
|---|---|---|---|---|
| 8. | Would you prefer to work on a Mixed-Gender Unit (men & women), like BHD has now? | 1 | 2 | 3 |

- 8a. Explain why.

| | | NO | NEUTRAL/ UNSURE | YES |
|---|---|---|---|---|
| 9. | Do you think that having a Women-Only Patient Lounge on a Mixed-Gender Unit would improve sexual safety? | 1 | 2 | 3 |

- 9a. Explain why.

| | | NO | NEUTRAL/ UNSURE | YES |
|---|---|---|---|---|
| 10. | Do you think that having a Men-Only Patient Lounge on a Mixed-Gender Unit would improve sexual safety? | 1 | 2 | 3 |

- 10a. Explain why.

**PLEASE RETURN SURVEY TO: DR. MARY KAY LUZI – CENTRAL ADMINISTRATION BY SEPTEMBER 30, 2010. THANK YOU AGAIN FOR YOUR PARTICIPATION!**

**1a. What sexual safety concerns do you have for <u>women</u> patients on the unit?** ***(92 comments)***

| Vulnerability to Sexual Harassment, Intimidation, Exploitation, Abuse *(53.3%)* |
|---|
| • Being approached by others making sexual advances, being propositioned, verbally harassed, intimidated (7)<br>• W who are mentally retarded/cognitive impaired are vulnerable, lack capacity to say no (6) – (e.g., slower functioning W taken advantage of for cigarettes, food, provisions; vulnerable to sexually aggressive M)<br>• MI/psychotic state who otherwise wouldn't consent in normal state of mind (8) – (e.g., acute psychiatric pts, esp. manic, can be very unpredictable and impulsive and harassment esp. is difficult to prevent; due to mental illness, sexually preoccupied; afraid of the M and might consent to sex from fear of harm)<br>• W with trauma histories are very vulnerable to sexual predators and those sexually inappropriate due to power issues with M (3)<br>• Potential for sexual assault (5)<br>• Potential for sexual abuse (2)<br>• Being inappropriately touched (3) (e.g. unwanted touching difficult to stop in common areas of unit)<br>• Sexually inappropriate behavior (4)<br>• Sexually explicit comments<br>• Being victimized<br>• Inability to effectively manage hypersexual males with history of violence<br>• Exploitation by some M<br>• Violent M seducing W for sex, preying on the vulnerable ones (2)<br>• Sexually aggressive M pursuing pt on unit and trying to get contact information after discharge<br>• Being trapped in room with sexually aggressive M<br>• Not being assertive or able to advocate for self<br>• STDs, pregnancy, birth control<br>• Age and physical limitations (e.g., elderly, dementia) |
| **Propensity to Initiate or Provoke Sexual Behavior *(8.7%)*** |
| • Due to decompensation, sexually provocative behaviors themselves, can be sly in hiding actions (2)<br>• They get too close to the M and incidences do occur<br>• Not always the M – some W tell me he looks so fine, I can just grab him and hold him forever<br>• Roommates with bisexual W<br>• W who prey on both sexes<br>• W sought out by M pts more often than not are active willing participants and will take steps to set up meetings together<br>• When M and W are hypersexual, they look for partners and find many willing ones; rape is one thing but keeping people from being sexual when they're impulsive and sexually charged is different |
| **Hospital Unit Configuration and Patient Mix *(18.5%)*** |
| • M sexual predators routinely housed on same unit in close proximity to vulnerable F pts (6)<br>• When sexual predator/violent pt on unit, need extra milieu management to keep genders separate; though q 15 beh checks, takes only 1 minute to abuse someone (3)<br>• Keeping W on their side of the unit (2)<br>• Putting W in the M hall unless on 1:1 (2)<br>• Pts being placed in M hallway due to no female hall beds (2)<br>• M pts wandering into W room to use bathroom and W are exposed, vulnerable<br>• In rooms by self at night |

| **Staffing Pattern** ***(9.8%)*** **(Adequacy and composition of staff for monitoring & duties)** |
| --- |
| • Inadequate staffing – short staffing, decreased ability to monitor all pts (8)<br>• Units are safe with the zones, but only if there is staff to do it |
| **Staff Performance** ***(3.3%)*** **(Team work, staff supervision and training)** |
| • Verbally redirecting W pt who's sexually inappropriate and ask for help from RN and nothing's done<br>• Staff not paying attention or believing it's happening<br>• Knowing pt's history and potential to engage in sexual behaviors |
| **Minimal to No Problems** ***(6.5%)*** |
| • None to little (4)<br>• I feel W are now safe on the unit<br>• OK with proper supervision & security |

**1b. What sexual safety concerns do you have for <u>men</u> patients on the unit?** ***(84 comments)***

| **Vulnerability to Sexual Harassment, Intimidation, Exploitation, Abuse** ***(46.4%)*** |
| --- |
| • Sexual predator s may focus on vulnerable M, psychotic M (4)<br>• Mixing developmentally disabled with general population (4) (e.g., cognitive or emotionally impaired M with sexually aggressive M)<br>• M & W can be abused the same way because of mental illness (3)<br>• Vulnerable M being targeted for physical abuse by aggressive M (4)<br>• Being approached by M & F making sexual advances, propositioning, harassing (4)<br>• Exploitation by some M & F (2)<br>• Sexual assault (4)<br>• Being sexually touched by M pts (2)<br>• Being sexually touched by F pts<br>• Being victimized<br>• M with trauma histories who will not receive care they need if there are sexual predators on the unit (2)<br>• At disadvantage because often neglected fact that they may fall victim to other M and are unlikely to report or protect self (2)<br>• Acute psychiatric pts, esp. manic can be very unpredictable and impulsive, and harassment difficult to prevent<br>• If put in room with M who's sexually active that could cause problems even with 15 min checks (2)<br>• Often accused of sexual advances that may or may not be true due to manipulative W<br>• Age and physical limitation differences<br>• STDs |

| Propensity to Initiate or Provoke Sexual Behavior *(11.9%)* |
|---|
| • Sexually enticing W (3)<br>• Due to decompensation, engaging in sexually provocative behaviors themselves<br>• M who prey on both sexes (2) – (e.g., many M have potential for soliciting sex from other M as well as W<br>• Sexually inappropriate behaviors (2)<br>• Some talk sexual and I tell them this is a hospital and is not tolerated here<br>• M get too close to the W and incidents occur |
| **Hospital Unit Configuration and Patient Mix *(11.9%)*** |
| • Keep M on one side of the unit (2)<br>• When M are in the F hall unless on 1:1<br>• If they are roommates with bisexual M or sexually aggressive M (2)<br>• W wandering in M's rooms<br>• Even large M complain of safety concerns when violent pts on the unit – assaultive/repeat antisocial pts shouldn't mix with regular population (2)<br>• Predatory clients can be identified and should be segregated on a special unit<br>• Prison separation causes same sex sex |
| **Staffing Pattern *(13.1%)***<br>**(Adequacy and composition of staff for monitoring & duties)** |
| • Inadequate staff, short staffing for monitoring (6)<br>• Less need for monitoring because no risk of pregnancy<br>• Residents are monitored much much more and units are truly safer – if had staff for zones, will work perfect (2)<br>• Need more security on units<br>• Psych techs |
| **Staff Performance *(2.4%)***<br>**(Team work, staff supervision and training)** |
| • Assessment of M behaviors/indicators during peer contacts so not "lost in crowd"<br>• That rounds are done |
| **Minimal to No Problems *(14.3%)*** |
| • None (12) |

**1c. What sexual safety concerns have women patients raised?** ***(87 comments)***

| General Safety Concerns *(11.5%)* |
|---|
| • Personal safety, keeping them safe (3)<br>• Feeling unsafe with M pts on unit (2)<br>• Feeling unsafe at night in their rooms<br>• Some concerned with loud, chaotic ward (2)<br>• Asking to have door locked at night<br>• General safety concerns by vulnerable F |
| **Personal Boundary Violations** *(28.7%)* |
| • Room intrusions (9) – (e.g., M coming into their bedrooms when they are asleep or in shower)<br>• Inappropriate, unwanted touching (4)<br>• They flirt (2)<br>• M following them (3) (e.g., talking, smiling, asking for phone numbers)<br>• Personal space violations (4) (e.g., M getting too close to them and brushing up against them)<br>• "stalking" on unit – no private space to go, don't feel safe in room (2)<br>• Not liking the way M or W talk or look at them |
| **Sexual Harassment, Intimidation, Exploitation, Behavior, Contact** *(33.3%)* |
| • M harassing them, intimidating (6)<br>• Trying to solicit sex (5)<br>• Sexual remarks from M (3) (e.g., take your shirt off)<br>• Alleging sexual assault (rarely) or nonconsensual sex (3)<br>• M showing unwanted sexual interest in them (2)<br>• Hypersexual roommates (2)<br>• Being vulnerable to abuse and sexual behavior<br>• M flashing genitals and suggestive language (2)<br>• Fear of hypersexual M who are also violent<br>• Concerns come up after the fact is done<br>• Some W tell me how they've been sexually molested by family and when a M comes up and starts talking, the F freaks out and says he wants to have sex and I have to explain that he does not want to harm you<br>• Fear or rape concerns – all have been product of psychosis<br>• Propositioning by W |
| **Hospital Unit Configuration and Patient Mix** *(4.6%)* |
| • Keep W on one side of unit<br>• Wandering to M's side when not watched closely<br>• Don't want to be in M hallway when no bed in F hall<br>• Some don't care and some want to be on F side only and their own room |
| **Minimal to No Problems** *(21.8%)* |
| • None (18)<br>• They don't talk about it |

## 1d. What sexual safety concerns have <u>men</u> patients raised? *(76 comments)*

| General Safety Concerns *(9.2%)* |
|---|
| • Fear of peer, reported threats (2)<br>• Fear of violent M (2)<br>• Don't feel safe on unit<br>• Noise on the unit<br>• Not liking the way M or W look at them or talk to them |
| **Personal Boundary Violations** *(11.8%)* |
| • Afraid of certain M peers coming in their room (3)<br>• W wandering in their room (2)<br>• W following them around the unit<br>• Intrusiveness of other pts<br>• They flirt<br>• On 3rd shift, some say this W came into my room and I couldn't get her out, she wouldn't leave |
| **Sexual Harassment, Intimidation, Exploitation, Behavior, Contact** *(30.3%)* |
| • Complaints about M peer making sexual comments or advances to them (5)<br>• Extremely rarely have M made allegation of sexual assault by another M (3)<br>• Sexually preoccupied with aggressive M peers<br>• Unwanted touching by M (2)<br>• Propositioned by F peers (2)<br>• Being harassed, targeted (2)<br>• Afraid of peers they perceive as gay, bisexual (2)<br>• Being touched by W<br>• Being recipient unwanted sexual advances and feeling unsafe<br>• When they have sexual behavior issues<br>• They sometimes expose self<br>• Being accused<br>• Concerns come up after the fact is done |
| **Hospital Unit Configuration and Patient Mix** *(2.6%)* |
| • Wander to F side when not watched closely<br>• Keep M on one side of the unit |
| **Minimal to No Problems** *(46.0%)* |
| • None, usually no complaint (34)<br>• They don't talk about it |

## 2m. For any current practice you rated as <u>ineffective</u>, explain why and your recommendation for improving it.

### 2a. <u>Assessments</u> by PCS & Inpatient MD/PhD of special risks

- PCS MDs go overboard in initial monitoring orders; assessment of sexual risks done improperly and not relevant per pt (2)
- Unit Drs go a little overboard with monitoring ½ pts on unit without any history
- PCS not aware of case mix on unit
- Don't think Drs listen enough to RN/CNA and try to appease pt without taking violence risk into account
- CNAs not notified immediately of behavior risks of pts
- Screen out criminals that belong in jail (Pers. D.O. & malingerers vs. true MI)
- Background checks should be done on pts to identify sexual offenders

### 2b. <u>Recovery Planning</u> special risks treatment objectives & interventions

- Interventions not always followed (2)
- CNAs don't read the charts
- Team doesn't seem to meet with pts as they should
- Useless, record not pt-oriented
- Need to implement Trauma Informed Care

### 2c. <u>Patient Education</u> on sexual contact policy

- Inconsistent and of questionable benefit (10) – e.g., inconsistent, pts are very impulsive and not sure RN really goes over orientation material; only few pts are capable of benefiting; don't believe has any effect with main perpetrators (manic pts); doesn't mean pts will listen if they have sexual issues; pts will still do what they want if not monitored; pts don't retain the unit policy info given them.
- Better sexual education & consequences of sexual attachment

### 2d. <u>Unit Zone Surveillance</u> system

- Would work/be very effective if staffed (5) – e.g., zones will work if each unit has enough staff; frequently understaffed and CNAs pulled; RNs have to fill in and it's a lot of work; if short-staffed, RNs won't help CNAs
- Very good idea but issues with staff performance (7) – e.g., staff is reading, texting, listening to ipods; staff sit at beginning of hallway not halfway down so can see rooms better; staff sit in chairs, sit together and talk; staff not always in zone areas & don't know where pts actually are; with increased CNA expectation could be very effective; if short, RNs won't help CNAs with some duties so they have to leave zones
- Very positive step

### 2e. <u>Morning Report</u> with both treatment teams represented

- Don't follow through, both teams are never together (2)
- CNAs not involved in morning report; were told at least 1 CNA would be but never happened (2)
- Different on each unit – touch & go

### 2f. <u>Cross Shift</u> communication of special risk patients

**2m. For any current practice you rated as <u>ineffective</u>, explain why and your recommendation for improving it.**

| **2g. Behavior Observation monitoring for special risks** | **2h. Bedroom Hallways separate for M&W; no bed assignment beyond fire doors for W** |
| --- | --- |
| • So many pts on behavior checks the importance is diminished, so go to 15 minute rounds (6) – e.g., every pt should be on Q 15 minute checks; not done consistently because not taken seriously – everyone's on them; almost everyone's on 15 min checks for vulnerability and difficult to manage, cumbersome<br>• Staff don't always know where pts are so can't monitor; CNAs sitting & talking, need to walk more (4)<br>• Useless, double CNAs and put security in place | • Halls should be single sex only (3)<br>• If beds are tight, have to go beyond fire doors – 3/room is too crowded<br>• Pts find ways to engage in sexual contact despite |
| **2i. Locked Community Bathroom** | **2j. Therapeutic Groups** |
| • Shouldn't be necessary with the Zone<br>• CNAs don't always lock or pts shut the door<br>• A pt found a way to unlock it<br>• Lack of privacy and M peeing on the toilet would make me crazy | • Many pts don't attend<br>• No groups on evenings & weekends<br>• Nursing groups ineffective<br>• No groups to teach pts how to change their behavior<br>• Other hospitals have good groups, like coping skills, not "coloring"<br>• More training for groups from Education Dept |
| **2k. Electronic Video Monitoring of unit** | **2l. Overall Effectiveness of current practices** |
| • Who does this and how is it implemented? (2)<br>• 1 security officer w/o knowledge of pts and risks monitoring multiple units not as effective as staff stationed in various places on unit who know pts and risks<br>• Not noticed effective use or communication with staff; never seen security guard come during emergency situation that could have been seen on camera – we always call for help (2)<br>• Physical appearance of security would be money better spent<br>• Not in every place – limited space<br>• Electronic ankle monitor for high risk pts from entering designated areas (2) | • Wards frequently understaffed to put these practices in use, incl. Lunch coverage for CNAs (5)<br>• Need correct staff- 4 RNS and psych techs who constantly rove/monitor, not just sit<br>• Many CNAs don't watch – chat on cell phones & travel the building<br>• "Secure unit" for violent/sexually predatory pts (3)<br>• Pts with sexual abuse hx may be predatory and find ways to get around safety nets<br>• Present mix of pts on a given unit can be scary<br>• Focus on very effective practices – separate M&F units (2)<br>• If everyone on all 3 shifts would be on their watch, could prevent most<br>• Staff remains in nursing station for lengthy periods of time |

**3. What other suggestions do you have to improve the sexual safety of men and women residing on the same units?** ***(82 comments)***

| |
|---|
| **STAFFING PATTERN** ***(31.7%)***<br>• **Adequacy of staff**<br>• **Composition of staff for monitoring & duties** |
| • Units fully staffed & consistent monitoring (9)<br>• Unit Zone Surveillance is adequate for monitoring sex (2)<br>• Properly man the zones and will be most effective tool for sexual safety (2)<br>• More CNAs (2)<br>• Better way to measure acuity & ensure correct coverage (2)<br>• More RNs (4) – e.g., 4 RNs for 6 pts each more manageable esp. to cover Zone 2 and CNA breaks, RNs doing CNA work, not job hired to do so they could talk to pts more<br>• More security visible (4) - e.g., to deal with behavior issues therapeutic staff can't monitor while doing other cares<br>• Manager has to be on the unit to make sure CNAs are rounding, not sitting |
| **STAFF PERFORMANCE** ***(24.4%)***<br>• **Team Work**<br>• **Staff Supervision**<br>• **Training** |
| • Better CNA supervision and training on Zones (5) – e.g., enforce zone supervision; make sure CNAs are doing job and roving, not talking on phone, doing word searches; not allowing CNAs on break to visit other units<br>• Increase RN involvement with CNAs (2) – e.g., help CNA when pts need redirecting<br>• Increased supervision of staff (3) – e.g., each staff person doing their job<br>• Close proximity of staff to pts (close monitoring) (2)<br>• Enhance execution of current safeguards (2)<br>• Give all staff immediate report of pt sexual behavior issues<br>• More team work<br>• MDs need to listen to RNs (too permissive and prescribed Viagra in past)<br>• Increase training of staff (2) – e.g., rights of pts to a recovery environment; sexual safety policies<br>• Welcoming attitude and take seriously pts bringing sexual safety concerns to staff |
| **CLINICAL INTERVENTIONS** ***(13.4%)***<br>• **Clinical strategies for intervening with patients** |
| • Increase unit groups & activities (3) – e.g., to decrease boredom; better teaching groups geared to unit population; group and individual therapy to discuss sexual abuse and vulnerability<br>• 1:1s at least until meds in system (2)<br>• RNs to intervene when pts are being sexually inappropriate<br>• Ensure pts know to inform staff if they feel threatened<br>• Remind pts each shift about no sexual contact<br>• Pass restrictions for those with sexual assault histories<br>• Give something to lower libido<br>• Discharge sooner |

| |
|---|
| **UNIT ENVIRONMENT MODIFICATION *(12.2%)***<br>• **Modification to existing unit physical environment and practices** |
| • Separate M-only & F-only hallways (3) – e.g., no exceptions, no 3/room<br>• Door/wall to separate M & F on same unit, with coed groups, meals and supervised social areas (3)<br>• Allowing bedroom door to be locked upon request (2)<br>• Separate lounges<br>• Separate M & F bathrooms |
| **HOSPITAL RECONFIGURATION OF PATIENT MIX *(18.3%)***<br>• **Reconfiguration of patient mix on units based on such variables as gender, risk, acuity, etc.** |
| • All M and all F units (5)<br>• Separate unit for high risk males<br>• Segregate pts with sexual, criminal, antisocial history, violent behavior<br>• "Forensic" unit (2) – e.g., dangerous pts found incompetent to stand trial; should be a hospital & prison<br>• Special unit for dangerous pts (more than average) (3) – e.g., esp. physical assault, but ending coed units not the answer; don't put predators on mixed gender unit<br>• Acute mixed unit for decompensated pts at higher risk<br>• Separate by acuity: MI vs. personality disorder<br>• Segregating sexes not the answer – can still assault same sex |

**4. How helpful do you think it would be for managing sexual safety on the units for BHD to develop plans for an <u>All-Women's Unit</u>?**

| NOT AT ALL HELPFUL/NOT VERY HELPFUL |
| --- |
| • Can still have W to W sex (6)<br>• Pts. Need to function in a normal setting, community environment (3)<br>• W are hypersexual (when noncompliant with meds) and separating units won't help (2)<br>• Anything can happen no matter what and if employees don't do their job<br>• Staff need to carry out plans<br>• More violent environment for pts and staff<br>• Only need all M unit for criminals, sexual offenders, history of assaultive behavior<br>• Opposite sex caregiver could be falsely accused of inappropriate behavior at increased rate |
| **NEUTRAL/UNSURE** |
| • Sexual acts can occur between same sexes (5)<br>• Would prevent some, not all, contact<br>• Life interactions involve M&W; won't give pts chance to interact and learn from opposite sex (2)<br>• Don't believe sexual contact can be controlled in any setting<br>• If aggressive M are on all M unit, can monitor W more easily & not have availability of highly sexualized M<br>• Hypersexuality is dangerous, whether M or F<br>• Fully staffed<br>• Increased security time on units<br>• Trauma informed care is the solution |
| **SOMEWHAT HELPFUL/VERY HELPFUL** |
| • W to W sex still possible, but W would feel safer (5)<br>• Answer to many problems coming up – vulnerable W mixed with M, limits exposure of W to predatory aggressive M (4)<br>• Would reduce/remove M-F contact, assault, harassment (3)<br>• Potential for harassment from those who prefer same sex (2)<br>• Some W have fear of M due to past trauma<br>• W with trauma history are retraumatized as solicited by M for sex<br>• Still sexual issues but no pregnancies<br>• Allow for stabilization in a manic state until less sexually preoccupied<br>• Remove temptation with no M around<br>• Prevents M from undetected access to W<br>• Subset of population (gender identity, sexual abuse) better served by same-sex unit<br>• Effective, easier fewer incidents<br>• Caring staff can better understand and care for gender<br>• Potential problem of W vying for attention, getting restless with each other (2)<br>• But staff can become inattentive in monitoring<br>• Won't need zones but zones are working well<br>• But best to address safety in general |

**5. How helpful do you think it would be for managing sexual safety on the units for BHD to develop plans for an <u>All-Men's Unit</u>? Explain why.**

| NOT AT ALL HELPFUL/NOT VERY HELPFUL |
| --- |
| • M to M sex can still be a problem; vulnerable M can still be abused by M (12)<br>• Concern about increased fighting, safety concerns, violence potential (2)<br>• Need a community environment (2)<br>• Many nurses are small W and may be at increased risk for victimization<br>• Only if staffed with all M<br>• Anything can happen if employees don't do their jobs<br>• Need to monitor all pts.<br>• Not enough CNAs to cover zones |
| **NEUTRAL/UNSURE** |
| • M could sexually assault each other unsure if would shift risk to same sex behavior, vulnerable M could be a target (9)<br>• May be more violent/aggressive than on a coed unit (2)<br>• All pts who are hypersexual are dangerous<br>• Life interactions involve M & F<br>• Staff may be less willing to work there, if mixed with violent pts, could be safety issue for staff (2)<br>• Some M pts. Would still be on units with F pts.<br>• Don't believe sexual contact can be entirely controlled in any setting |
| **SOMEWHAT HELPFUL/VERY HELPFUL** |
| • To separate perpetrators from general pop, from predatory/violent men from preying on vulnerable (5)<br>• Eliminates M-F assault, W would be safer, protects most vulnerable W (3)<br>• Eliminates pregnancy concern (2)<br>• Some M like M, can have sex with each other (2)<br>• Stop the sexual tension between the genders; reduces temptation (2)<br>• But need to focus on <u>overall</u> safety – violence and sexual safety (2)<br>• Zone & monitoring makes M to M sexual contact unlikely<br>• With caring team could better understand needs of that gender<br>• Would require significant staff engagement and use of therapeutic technique<br>• Secure unit for violent high risk men would be safer environment for rest of population<br>• High risk unit with strict behavioral guidelines to protect other pts<br>• Forensic unit for chronic offender<br>• Especially antisocial and sexual predator<br>• Only for violent pts with criminal records and history of violence <u>of any kind</u><br>• But need to separate violent M and W from general population<br>• Must be highly secure for violence as well as sexual contact – security on unit all times, adequate RN/CNA staff<br>• Send criminals to jail, prosecute when they attack staff and pts. |

**6. Would you <u>prefer</u> to work on an All-Women's Unit, if BHD had one? Explain why.**

| NO |
| --- |
| • Don't believe in its principles – to a pt's mental health benefit to be on a mixed unit, current recovery environment more accurately reflects community to which pts will return (4)<br>• Concern about false accusation of sexual advances toward me and other M staff (3)<br>• W can be just as loud, hostile aggressive, threaten other W; worse than M; W can be nasty, lie; cattier and sneakier; too moody (8)<br>• More personality disorders without enough staff to meet needs; too demanding (2)<br>• Not a fan of too many manic W<br>• More problems, too stressful (2)<br>• Array of problems – what if % M vs. F is skewed and single gender units are full?<br>• I enjoy M & F mix and different issues |
| **NEUTRAL/UNSURE** |
| • As M RN would rather not, but would if had to<br>• I have concerns about being falsely accused of abuse<br>• Only if a F older population<br>• Cat fights, more discord between pts per staff who have worked on all F units |
| **Yes** |
| • Because I'm a W, and want to feel safe (2)<br>• I'm here for all pts.<br>• Won't be concerns about sexually inappropriate behavior, though it's not happening now because zones are in place |

7. **Would you <u>prefer</u> to work on an All-Men's Unit, if BHD had one? Explain why.**

| NO |
|---|
| • Don't believe in its principles, to a pt's mental health benefit to be on a mixed unit, more accurately reflects the community to which pts return (4)<br>• I'm a W – too dangerous, I'm too small to protect myself (3)<br>• Too much anger/aggression potential, too violent, danger of violence to staff would be higher (4)<br>• Too little variety (2)<br>• Not if a young M population<br>• Because of my own trauma history<br>• Not much tolerance for sexual comments toward me<br>• Nice way BHD is set up, just need more supervision and training |
| **NEUTRAL/UNSURE** |
| • M might try sexual behavior on F staff<br>• I'm a M RN<br>• They can be mean<br>• Many M pts are protective of F staff<br>• Will have a wide array of problems |
| **Yes** |
| • M are easier to handle and control (3)<br>• Personal preference (2)<br>• Less manic behavior and M seem more respectful to F<br>• Less moody, demanding<br>• Less drama and likelihood of allegation if someone touched me<br>• Better control of unit population to focus on treatment and not policing<br>• As a F, I can talk better to M, reason with them and have them tell me their problems<br>• With the correct staffing and security presence, it would be improved<br>• I'm here for all pts<br>• If you start a high risk unit, I'll work on it |

**8. Would you <u>prefer</u> to work on a Mixed-Gender Unit, like BHD has now? Explain why.**

| NO |
|---|
| • Unsafe |
| **NEUTRAL/UNSURE** |
| • Flexible, I'll work anywhere (2)<br>• System has worked for a long time though has some flaws<br>• Think pts communicate better with mixed genders<br>• Do value interactions between M & W as reflection of "real life"<br>• OK for me, not as safe for pts<br>• Only if trauma informed care is implemented<br>• If predators are separated from the general population |
| **Yes** |
| • Variety (personalities, needs, issues) (7)<br>• Current recovery environment more accurately reflects the environment to which pts will return (4)<br>• Never worked on an inpatient unit with sex segregation – will be like jail, it's about how you monitor<br>• I'm here for all pts<br>• I'm a people person and understand both M & W<br>• Only if properly staffed<br>• To pts mental health benefit to be on mixed unit<br>• Was working until secure M unit closed and violent sociopathic M were integrated onto general units<br>• Would get burned out on all-M or all-F unit<br>• Zones are working<br>• Believe staff is able to manage/separate/protect pts, need to enforce our policies<br>• Easier to work with<br>• Less pt discord<br>• Would work with elderly pts<br>• I like where I am now<br>• OK other than some comments, hand kissing, butt grabbing |

**9. Do you think having a Women-Only Lounge on a Mixed-Gender Unit would improve sexual safety? Explain why.**

| NO |
|---|
| • Most inappropriate sexual behavior occurs in places other than lounge areas, day and night, not just leisure time (4)<br>• If they want to have sex, they'll find a way to do it – they watch staff to find opportunity (3)<br>• M would be jealous, angry and see it as unfair (3)<br>• Sounds discriminating (3)<br>• Lack of space (3)<br>• W have sex with W (2)<br>• Would only increase sexual curiosity toward one another, been seen as another challenge by M pts (2)<br>• Modulating, moderating effect on behavior & emotions with mingling genders<br>• Sexual safety not determined because you have a same sex group<br>• When they decide to get to the other sex, they can be very dangerous<br>• Would still need to monitor<br>• Adequate staff to monitor pts based on acuity<br>• W many times won't use it – sexually preoccupied and want to be near M<br>• Problem is sexual interaction (willing/unwilling) on a mixed unit and it won't solve that<br>• Would help tiny bit but not big difference<br>• Don't need a lounge to hold a gender-specific group<br>• Living quarters separate, common areas mixed<br>• Feel strongly about F-only unit |
| **NEUTRAL/UNSURE** |
| • Would be difficult to keep people separated, would have to closely monitor (3)<br>• Most sexual contact without consent occurs away from lounge<br>• Another thing staff would have to police<br>• Would increase need for more staff<br>• May increase stalking<br>• Not sure if pts would find a way to get away with things<br>• Space concerns<br>• Staff address harassment when it occurs, lounge may help with prevention<br>• Not sure what goal would be<br>• Too isolating for some pts<br>• Not sure would increase safety but would give W sense of comfort and place to relax<br>• Would be a therapeutic benefit<br>• If aggressive M are on their own unit; lounges are in view of staff & pts need to learn to interact in healthy ways |
| **Yes** |
| • Offer W safe place to be on unit when feel threatened (3)<br>• Improve sense of safety, security, place to go and sit (2)<br>• Supplement with a women's group and different trauma topics (2)<br>• Limits sexual contact, innuendo. Flirting between opposite sex pts (2)<br>• Lot of inappropriate behavior happens in the community room<br>• Unstructured time on second shift is higher risk<br>• Zones are working good<br>• May be hard to enforce<br>• May decrease temptations |

**10. Do you think having a <u>Men-Only</u> Lounge on a Mixed-Gender Unit would improve sexual safety? Explain why.**

| NO |
|---|
| • If they want to have sex, they'll find a way to do it, they watch staff to look for opportunity, can be very dangerous (5)<br>• Lack of space (4)<br>• Most inappropriate sexual behavior occurs in places other than lounge areas (2)<br>• Potential sexual predators could bond/plan offenses without W present, and see which peers are weaker (2)<br>• Sounds discriminating (2)<br>• Have M that have sex with M, can prey on other M as well (3)<br>• When you restrict something, they work harder to obtain it; Prefer staff to monitor mixed=gender lounge and be alert to developing relationships<br>• Would only increase sexual curiosity toward one another<br>• Moderating, modulating effect on behavior, emotions with mingling of genders<br>• Adequate staff to monitor pts based on acuity.<br>• Sexual safety is not determined because you have a same sex group<br>• Our job is to monitor changes in inappropriate behavior to return pt to community<br>• Help a tiny bit but not make a big difference<br>• Don't need a lounge to hold a gender-specific group<br>• Would cause anger and hostility with M<br>• Important for pts to interact with both genders as must do in community<br>• Feel strongly about F only unit<br>• Living quarters separate; common areas mixed |
| **NEUTRAL/UNSURE** |
| • Staff addresses harrassment when it occurs; lounge may help with prevention<br>• Another thing staff will have to police<br>• M seem prone to take other means because they're insecure in their sexual identity<br>• Not sure would increase safety but would give M a sense of comfort and place to relax<br>• Need better staff training to improve safety<br>• Not sure if pts would be determined to find a way to get away with things<br>• Would have to monitor closely so W wouldn't enter M lounge (2)<br>• Most sexual contact without consent occurs away from lounge<br>• Too isolating for some pts<br>• If aggressive M are on their own unit; lounges are more in view of staff & pts need to learn to interact in healthy ways |
| **Yes** |
| • Limits sexual contact, innuendoes, flirting between pts of opposite sex (2)<br>• May be hard to enforce<br>• Unstructured time on second shift is higher risk<br>• Zones are working good |