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The Distribution of Staff Time Between Treatment and Security Functions for a Maximum Security Forensic Service: A Preliminary Report

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ABSTRACT: Despite the number of secure psychiatric facilities in operation, there has been little in the literature that discusses the interface between security and treatment. After the establishment of a new maximum security forensic psychiatric facility at Mendota Mental Health Institute, a study of the breakdown of security and treatment duties of clinical staff was undertaken. The authors report the results of this study, and discuss ways in which to improve communications and cooperation between security and clinical staff.

KEYWORDS: psychiatry, jurisprudence, security

There have been a number of studies in the literature that have attempted to measure the amount of staff time necessary to provide adequate clinical care and services based on various clinical characteristics of the patients themselves; this quantity is conventionally known as patient acuity. From a computer-assisted search of the relevant literature [*1-9*], however, it appears that these studies have been done with civil patients; the special security requirements of forensic patients, those who have been committed after having been charged with or convicted of crimes, have not previously been investigated. With the increase in numbers of psychiatric patients being diverted from the civil to the forensic commitment system [*10-12*], more psychiatric facilities are having to deal with the security requirements of forensic patients; it is important to assess the extra duties for staff necessitated by this shift.

In March 1983, the Mendota Mental Health Institute (MMHI) assumed the responsibility for all forensic patients requiring maximum security conditions in Wisconsin. Along with 71

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patients and a completely renovated physical facility, 125 new staff positions (including security as well as clinical staff) were allocated to create 4 maximum security treatment units. The decision was made by the forensic program leadership to assign as many of those positions as possible to clinical staff to allow the maximum amount of treatment programming. This required keeping security staff down to the minimum necessary to monitor physical perimeter security and to provide escorts for patients outside the security perimeter. Implementation of this decision required that clinical staff on the maximum security units be given additional training to carry out duties normally handled by security forces, such as patient censuses, searches, room checks, and physical control over aggressive behavior.

After the four new maximum security units had been established for six months, an acuity study was begun to evaluate staffing needs; we were interested in comparing the staff time requirements on forensic units with those on units treating patients who were clinically similar, but who did not require the same level of security. This report will present our preliminary results for the maximum security units. The results of the full study will be presented in subsequent publications.

Methods

MMHI is a state psychiatric institute providing specialized assessment and treatment to children, adolescents, adults, and geriatric patients as well as to forensic patients. Four units were created in the new maximum security section of the Forensic Program, each designed for a specific purpose: the Forensic Assessment Unit (FAU) is the acute admission unit for the Forensic Program, and is responsible for most of the initial evaluations of patients charged with crimes or transferred from penal facilities for treatment; the Behavioral Treatment Unit (BTU) provides long-term treatment for low-functioning patients with developmental disabilities or psychoses; the Therapeutic Community (TC) provides treatment for high-functioning patients, usually with personality disorders; and the Management Unit (MU) treats the most aggressive patients in the entire state system, both civil and forensic.

Nursing staff (RNs, LPNs, and nursing aides) on the a.m. and p.m. shifts (7 a.m. through 11 p.m.) on each maximum security unit were asked to estimate the amount of time they spent in performing the various duties required of them. These functions were classified by the investigators into Security, Patient Care, Administrative, and Housekeeping categories (Tables 1 to 5). The Security category was defined as duties in addition to those required of staff on a typical closed psychiatric unit that treats involuntary patients. Specialized security duties included sharp counts (keeping track of all sharp objects such as scissors); checking to ensure that screens over all windows were in place and secure; and putting on and taking off Preventive Aggression Devices, leather wrist cuffs attached to belts by adjustable straps, used to restrict the opportunity for very aggressive patients to strike other patients or staff (P.A.D.s).

Clinical staff (physicians, psychologists, social workers, and activity therapists) were not included in the study because they did much of their work outside the wards and were propor-

TABLE 1—*Distribution of staff time.*

	FAU		BTU		TC		MU	
	Hours	%	Hours	%	Hours	%	Hours	%
Security	4.0	19	4.0	19.5	3.7	18.8	8.1	34.9[a]
Patient care	11.5	56	11.9	58.8	10.4	52.9	9.4	40.6
Administration	4.2	21	3.7	18.2	5.0	25.6	4.6	19.8
Housekeeping	0.8	4	0.7	3.5	0.5	2.7	1.1	4.7

[a] $\chi^2 = 7.870$, DF = 3, $P = 0.05$.

TABLE 2—*Security functions.*

Security assignment
Census checks
Locking/unlocking patient doors
Sharp counts
Screen checks
Key counts
Escorting nonstaff on/off unit
Visitor center supervision
Interface with security
Room searches
Shower supervision
Dayroom monitoring
Visitor supervision on unit
P.A.D.S.
Bathroom monitoring
Haircut monitoring

TABLE 3—*Patient care functions.*

Patient requests
Cigarette time
Soup walks
Dining room supervision and escort
Trays on ward
Group escort
Admissions
Escort off ward
Psychiatric intervention
Medications/treatments
Infectious disease control
Seclusion/restraint
1 : 1 observation
Close observation
Patient teaching
Nursing care
Supervision of industrial therapy (I.T.) jobs
Supervision of patient hygiene
Supervision of canteen
Pizza ordering
Mail distribution
Patient snacks

TABLE 4—*Housekeeping.*

Cleaning ward
Laundry/linen
Maintenance

tionately less involved in security and housekeeping functions than were the nursing staff who worked full-time on the wards; night shift staff (11 p.m. through 7 a.m.) were not included because they did not perform many of the duties to be surveyed, and because night staffing was already at an absolute minimum and would not be affected by the results of the study.

Nursing staff were then asked to complete forms listing the time required for each duty on a.m. and p.m. shifts. All staff on three units (BTU, TC, and MU) recorded their activities for

TABLE 5—*Administration.*

Narcotics count
Staff time scheduling
Staff meetings
Charting
Transfers off unit
Return to court
Special staffing
Recording time outs
Patient storage/inventory
Work assignments
Physician orders
Shift reports

21 consecutive days, while 1 randomly selected staff member on FAU recorded activities each day for 3 months. The resulting data were entered into a computer for data analysis and for ultimate use in assignment of nursing coverage.

During the study, an observer (ME) visited each unit at random intervals to make independent time observations as a cross-check to the nursing staff's self reports.

Results

Table 1 demonstrates the distribution of duties on the four units studied. The hours listed are based on two 8-h shifts per day; the totals are greater than 16 h because staff often performed more than one function at a time. Table 6 lists the breakdown of the Security category into component duties, with the actual times for each duty as measured by staff on each maximum security unit listed in minutes per average working day (two 8-h shifts, from 7 a.m. until 11 p.m.). There was no statistically significant difference in distribution of time among three of the four units (FAU, BTU, and TC); the greater amount of time spent in security duties by MU staff (Chi Square = 7.870, degrees of freedom (DF) = 3, $P = 0.05$) and the differences in distribution of time within the Security category are a result of the significantly greater degree of aggressiveness displayed by MU patients, and by the fact that the last four security functions listed in Table 6 are performed only on MU.

TABLE 6—*Security function breakdown (minutes per two 8-h shifts).*

Task	FAU	BTU	TC	MU
Security assignment	96.1	86.5	78.3	50.3
Census checks	5.5	5.8	7.8	6.9
Locking doors	2.0	20.3	0	30.9
Sharp counts	5.5	4.4	8.1	5.0
Screen checks	14.2	14.3	14.4	16.0
Key counts	2.0	3.4	10.7	7.1
Escorting	18.5	9.6	18.4	0
Visitor center	45.0	44.7	48.5	34.0
Security interface	6.9	8.9	13.5	0
Room searches	0	16.8	0	0
Shower supervision	44.3	22.5	22.0	88.6
Dayroom monitoring	0	0	0	103.2
Visitors on unit	0	0	0	20.7
P.A.D.S.	0	0	0	39.7
Bathroom monitoring	0	0	0	25.5
Haircut monitoring	0	0	0	55.0

Discussion

Despite the fact that every state has the responsibility for treating forensic psychiatric patients, as well as civil patients who have been committed under dangerousness criteria, there is little in the literature concerning the relationship between security and treatment functions of the staff who work with this population. What there is suggests that treatment and security are mutually exclusive functions, provided by separate staffs with different training and attitude sets [*13*]. Although there has been some attention in the correctional literature to staffing requirements in secure facilities [*14*], and some discussion of staffing needs in new psychiatric facilities [*15,16*], there has been no previous study of the functions of staff who are responsible for security as well as for the clinical care of patients. Despite the estimates of the nursing staff before the study that security functions took up a large percentage of their time, the results demonstrated that on three of the units, these duties took less than a fifth of staff time. Utilizing treatment staff to perform security functions on the wards permitted us to have more staff trained primarily in treatment, and therefore to provide more extensive clinical programming within the staffing numbers provided by the legislature and to allow the security staff to concentrate solely on providing perimeter security (monitoring gates, video surveillance, and so forth).

In order for this separation of duties to work in practice, it is necessary for the treatment and security staffs to coordinate their efforts. MMHI had addressed this necessity from the inception of the Forensic Program by establishing regular communication between the Forensic Clinical Director and the Director of the Forensic Security Services, both of whom report directly to the Director of Forensic Programs.

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