

### **NVR implementations in residential setting**

The principles of the new authority are focused on structuring authority and presence for authority figures. One of the main benefits of these principles is their flexibility which allows for their application, subject to relevant adjustments, in a variety of fields having to do with juvenile behavior. In this paper I will describe how these principles may be applied in residential settings.

Applying NVR in residential settings poses several interesting challenges. For example - how to perform a sit-in in a ward? Is it possible to use the help of parents whose presence is sometimes barely felt? Other difficulties are the need for an immediate response to a violent incident, as opposed to the "Strike the iron, when it is cold!" principle. In addition, can a model for escalating or helpless parents fit for skilled and professional staff?

More than that, in many cases the attitude of some staff members is that NVR principles are too "soft" to deal with the violent incidents facing them. This tendency to view NVR as "soft" is indeed often prevalent among therapists who note the first part - non-violence - and forget that the active and more significant part of NVR is the "resistance". The components of joint struggle and resistance must be clear enough if we wish to create change in parents as well as therapists/staff in residential setting using this approach.

From the initial training phase the importance of joint resistance actions must be stressed to the staff in order to enhance corporation. It must be clarified for example that indeed in emergency situations they must react immediately and not wait "until the iron is cold," and yet an important part of the training includes understanding of escalating process and presenting means to conduct a non-escalating dialogue.

#### **Minimizing escalating processes**

As well as escalating process are prevailing in home setting, so they are at residential settings, realizing this is the first step in trying to implement NVR. The second step is the recognition that when a staff member is facing escalation by a patient's behavior, s/he should try and act from a state of mind of "I am here as a representative of the ward". The conflict is not a personal one but rather the role of the staff member is to convey a message of "we object to this behavior."

Before adjusting a training to a specific residential setting I usually ask for examples of relevant cases while trying to pinpoint escalating processes. In a trainings (that I will describe later on), the ward's team sent me a verbatim between a team member and a patient. In the training we used it to learn how to minimize escalating process. I will use this example here:

Danny (17) should stay in the ward when the other adolescents are off the ward. According to his treatment plan he has also resting time periods in his room. Danny agreed with this plan

but it is difficult for him to take his rest in his room. The situation described here happened in the evening, when Danny had to be in his room for an hour. After 40 minutes he walks out of his room and approached the nurse.

**Danny:** I want to be out of my room.

**Nurse:** It isn't time yet to leave your room, you still have to stay in your room like you agreed in your program. You have to stay for another 20 minutes in your room.

**Danny:** get out of my way, you fucking bitch. You are nothing.

Then he walked to the nurse, and stood very close...

**Nurse:** please, will you take a few steps back because you intimidate me and I don't feel safe anymore.

Danny took a few steps back, still making provocative remarks and went to his room.

A few minutes later again, he walked out of his room.

**Danny:** I'm not going to my room any more. Get out of my way, you bitch. I'm going to my friend.

He pushed the nurse away with his chest.

**Nurse:** You are provoking and intimidating me, you let me feel really unsafe. You have to go back to your room. If you refuse to go to your room, I'll have to use the alarm, so a lot of people will come to the ward and escort you to your room.

As can be noticed in the example the nurse used long sentences and 20 time "I-You". It is also important to note that it's not an easy situation to be in. Taking into account that Danny was 1.90 cm. tall, I assume that nobody would like to be in her place!

But it is also possible to try and react in a different way. Let us see how:

**Danny:** I want to be out of my room.

**Nurse:** *According to the program there are 20 minutes left for staying in the room. I cannot allow you to leave now.*

**Danny:** get out of my way, you fucking bitch. You are nothing.

Then he walked to the nurse, and stood very close...

**Nurse:** *I don't feel safe now, please step back.*

Danny took a few steps back, still making provocative remarks and went to his room.

A few minutes later again, he walked out of his room.

**Danny:** I'm not going to my room any more. Get out of my way, you bitch. I'm going to my friend.

He pushed the nurse away with his chest.

**Nurse:** *What happened now is a serious violation of the ward's safety. If you will not get to your room I will have no choice but to use the alarm.*

As one can see, the nurse's response is different, although the consequences may remain the same- the message is totally different. In this scenario, the nurse minimizes the "I-you" confrontation while making her position clear as a representative of the ward ("According to

the program"). Her responses are shorter and while in danger ("*I don't feel safe now, please step back*") she also tries to minimize threats while stating "*I will have no choice*".

It is not an easy task to create a non-escalating dialogue in those circumstances but as the use of the NVR approach became more prevalent the staff members began to feel that this approach enables them to expand the repertoire of responses to violent incidents. Conveying a message of "we" as a team, also enhances the team ability to work in NVR terms.

Furthermore, the NVR stance also enabled the staff to bridge one of the most common disputes - between "containing" and "tough" attitudes as a response to violent behavior. The NVR approach enabled the staff to respond in a manner which includes both elements at once. One of the best examples is the sit-in adaptation for residential settings – the SMS.

### **SMS (Silent Message Sending) – The Sit-In version for residential setting**

Applying the Sit-in in residential setting is a central challenge in the implementation of NVR. It is important to understand that the main message conveyed by parents in a Sit-in is: We are present here in the room and control the time and the space. How to convey this message in a ward, where the staff controls the time and the space to begin with? Furthermore the parents are asked to stay in the child's room for about an hour. How can a therapeutic staff which faces frequent emergency situations set aside an hour for a Sit-in? The parents are instructed to sit in the room, a ward staff, for security reasons, is not always able to do that. As a result of these complex constraints, adaptations are made to the Sit-in and in fact, out of recognition of the fundamental change made to the Sit-in, its name was changed to SMS (Silent Message Sending).

In practice two different SMS responses were defined: The Ward SMS (W-sms) and the combined Ward-Parent SMS (C-sms).

**W-sms** - a day after a violent incident, two staff members enters the child's room for about fifteen minutes with another staff member present in the ward. The Sit-in is conducted so that the child is able to leave her/his room but in such a case would meet the third staff member. Instructions are given as to how to conduct a non-escalating dialogue with the child in case s/he should leave, but the two staff members remains in the room. The power of the silence as well as the joint response (in the entrance of two staff members to the room) conveyed the message clearly - we do not accept this behavior in our community! This is the meaning and the power of the SMS. The staff members present at the Sit-in are not necessarily those who witnessed the violent incident and thus the ward-wide message is enhanced.

**C-sms** is a more powerful reaction but also more complex to execute. In C-sms the parents or primary care-givers also joins in the Sit-in. This act lasts longer but has further consequences. Beyond the enhancement of the joint message to the child, the parents are significantly empowered by the ward staff. The parents receive advance instruction on how to act during the Sit-in and this joint action helps in furthering the positive relationship between the parents and the ward. Furthermore, after receiving guidance from the staff, the parents can use this response for similar situations at home - they feel more confident in doing so.

### **NVR in a closed psychiatric ward – Case example**

About four years ago two senior professionals from Amsterdam came on a visit to Israel following a conference by Prof. Omer in Europe. Their intent was to examine whether the non-violent resistance approach can be effectively applied in a closed psychiatric ward. The initial situation that was presented to us was complex and multi-dimensional; from public criticism about excessive use of seclusion rooms to the difficulties the staff has in the daily routine. The ward's team treats adolescents who suffer from a variety of severe disorders including acute psychosis, depression, suicidal behavior etc. The therapeutic staff was diverse (Psychiatrists, Social therapists, Parent counselor, activity coaches etc.) but felt (justifiably) that all difficult cases from other wards were transferred to them. One can understand that the motivation for serving in this ward was rather low, working as a team was not easy and most therapists just wanted their shifts to end. Contacts with parents or primary caregivers were minimal, there was no expectation of cooperation and parents were a negligible factor in formulating the treatment plan.

Three main goals were defined for this project: 1. Reducing the use of seclusion room. 2. Increasing the motivation of staff members to engage in teamwork and 3. Enhancing cooperation with the parents and caregivers.

The project began in 2007 and had four main phases: Basic training in NVR to the ward staff in Amsterdam. Intensive training in Israel for two senior members (the ward director and a psychotherapist)- This training also included the definition of a specific manual for the ward in which adaptations for NVR tools were outlined. E-supervision – that means consultations about implementing NVR for various cases in the ward, presented by the leading team. About a year after the launch of the project we held advance training for two days, which included role-plays that enable the staff to better experience the application of the tools that were developed.

The project yielded rather impressive results. A year after the inception of the project a 50% reduction in the use of seclusion rooms was recorded in response to violent situations. Furthermore, in the ward report it was noted that "NVR was a catalyst for changing the attitude of the team", and in addition "The team, parents and the patients state that the department is perceived as more pleasant".

The use of NVR in the face of rage and violence outbreaks by adolescents hospitalized in a closed psychiatric ward illustrates the capacity of this stance to be effective not only in normative situations but also in extreme acute settings.

However it is important to remember that the persistence as well as the repeated striving for de-escalation was critical to the process of change. Without two years of challenging work by the ward staff it would not have been possible to achieve this impressive result. The ward team members are the real heroes who made the change and I thank them for being able to take part in this remarkable project!