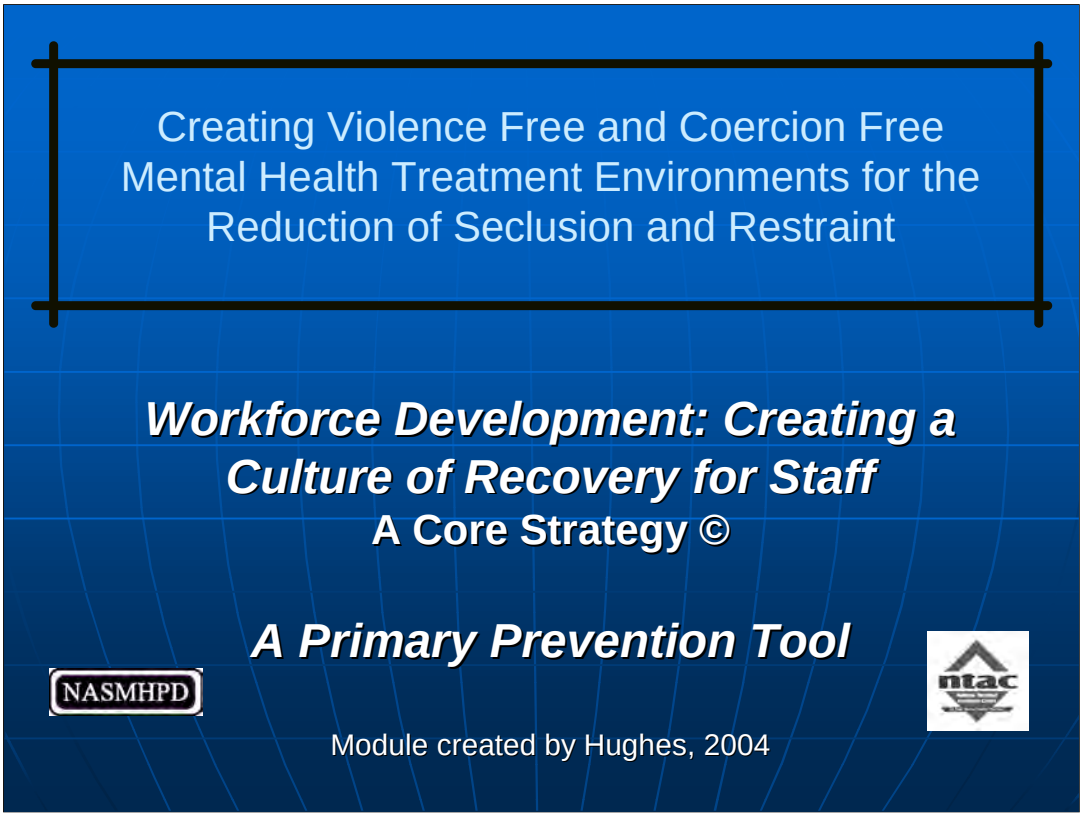

I want to supplement some of what we've been talking about in terms of culture change.

Any work used from this document should be referenced as follows:

"National Executive Training Institute (NETI). (2005). *Training curriculum for reduction of seclusion and restraint. Draft curriculum manual.* Alexandria, VA: National Association of State Mental Health Program Directors (NASMHPD), National Technical Assistance Center for State Mental Health Planning (NTAC)"

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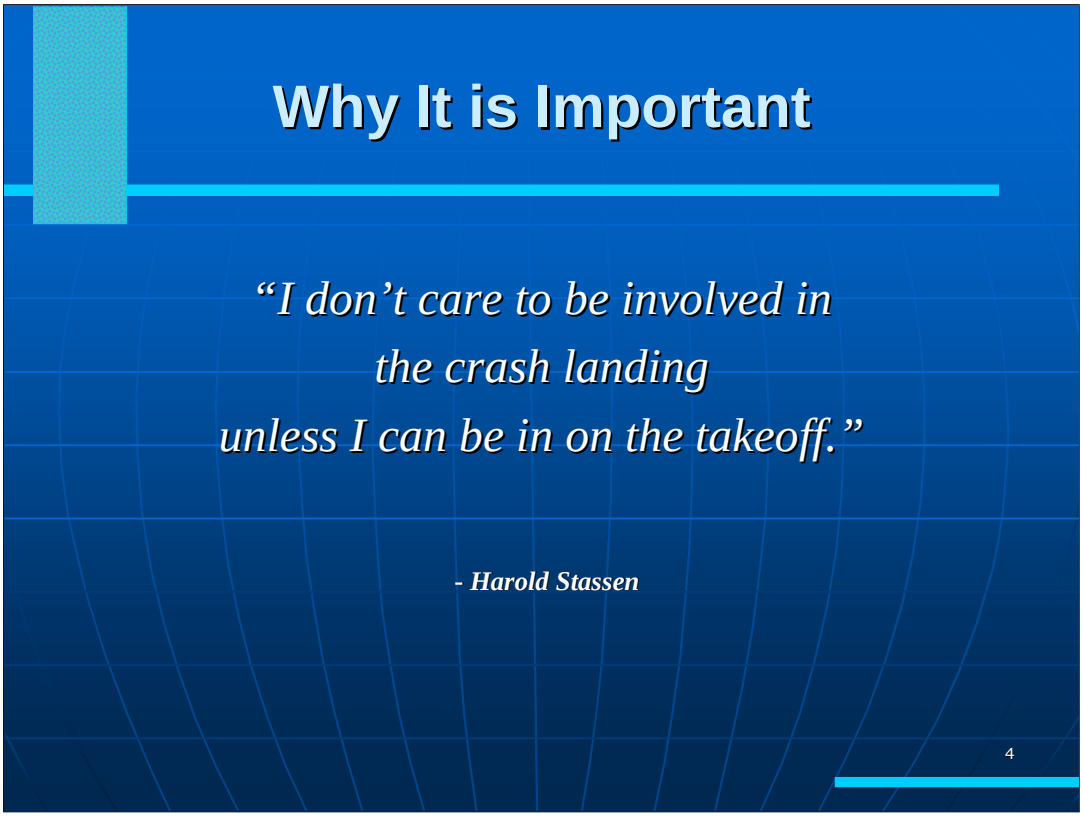
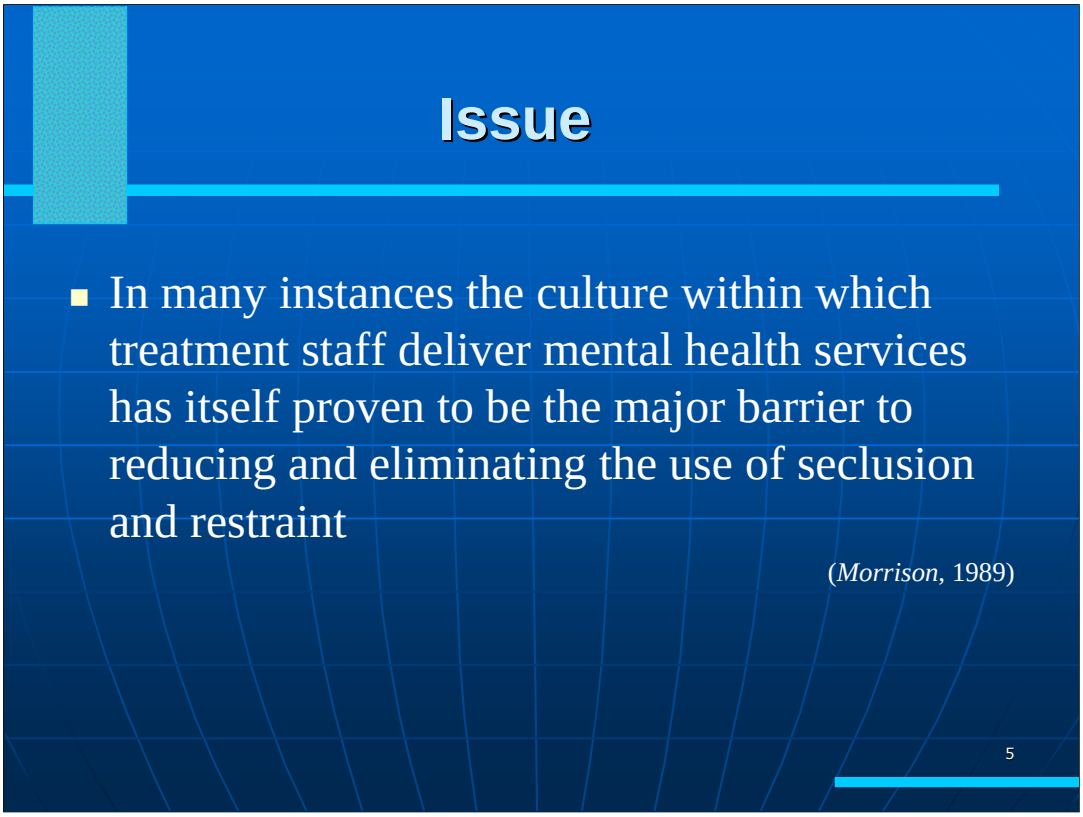
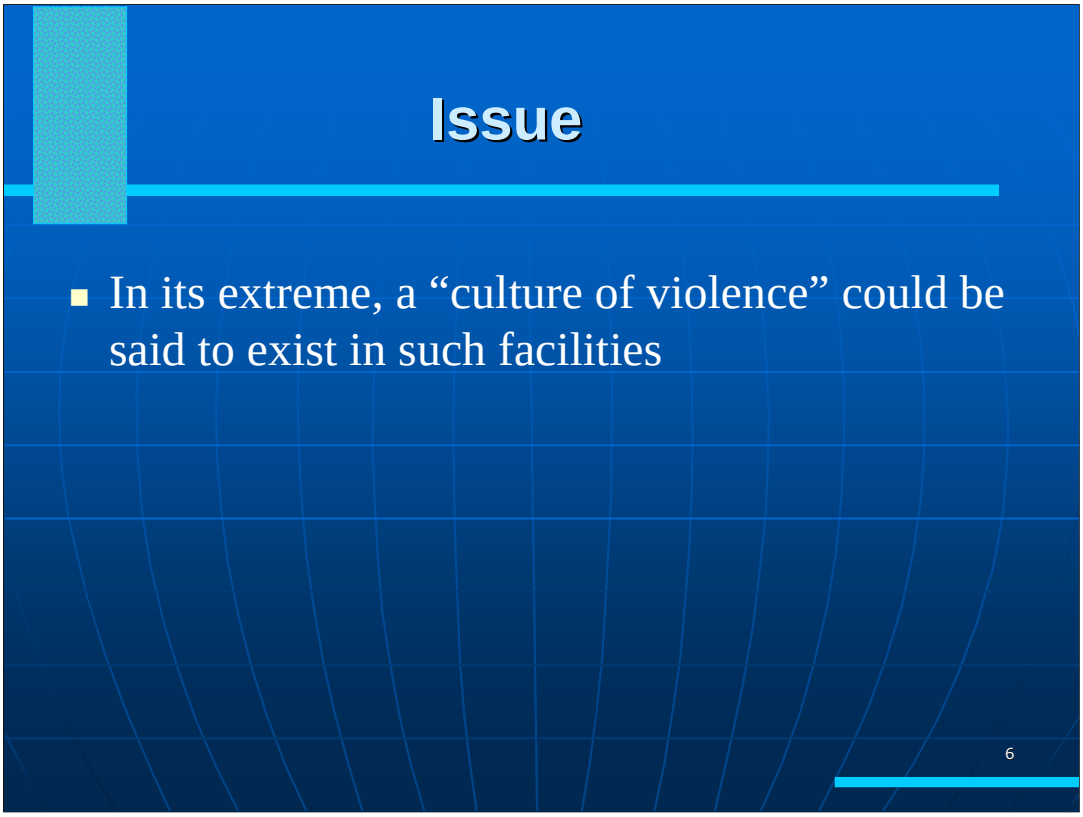


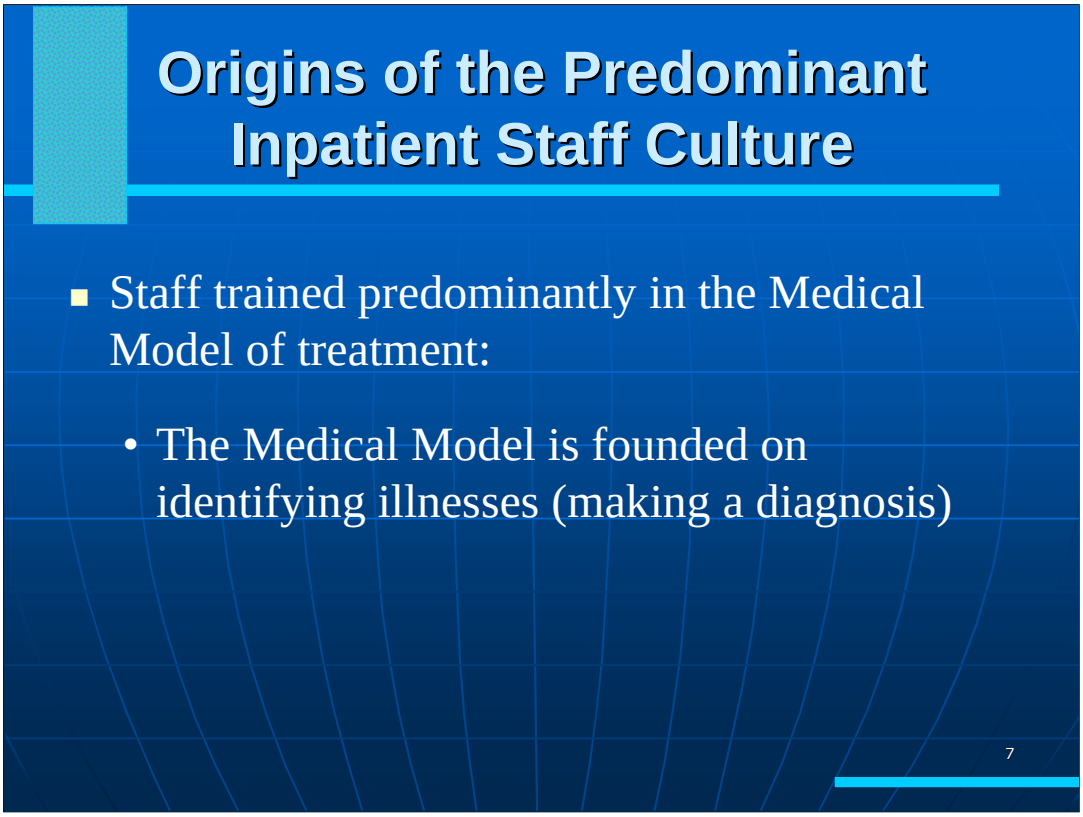
I really like this slide: I don't care to be involved in the crash landing unless I can be in on the takeoff. The take home message is: we have to have everybody on board, from the very start, from the very beginning; everybody has to be on board. If not, it is not going to work. It's just going to fail. My experience is we looked around, we thought we'd done all that we needed to do and then started seeing that on evenings, nights, certain, just certain ones, our seclusion slipping up. We looked further and realized that we had never talked to the psychiatric residents who take call for us. The nights they were on call, they hadn't been informed; they were not on board, which is another issue in terms of a lack of training that is typically provided in many of our professional training programs, whether psychiatry, nursing, psychology or social work.



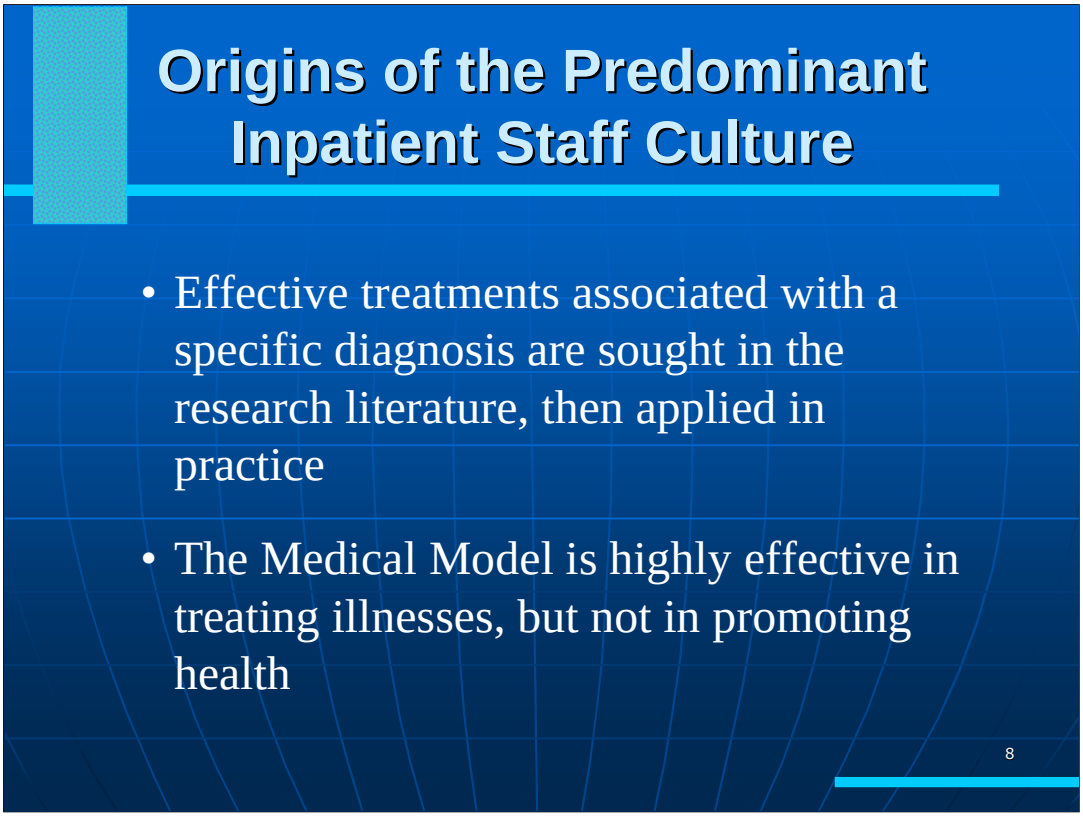
Let's talk about our culture. In many instances, the culture is the problem. The culture we have is the problem and it's the major barrier to reducing the use of seclusion and restraints and other coercive measures. And that's because really we come from a heritage of control. Control to the extent that in many cases we can say that it creates the culture of violence.



And our whole theme is reduction of violence. Reduction in the violence that leads to the use of seclusion and restraint and reduction in the violence that is the use of seclusion and restraint. And why is that? Safety is a major issue. I mean it’s a major issue for everyone working in behavioral health care. I know it’s a major issue for everybody that works directly with those we serve. For those in administrative or supervisory positions it’s a major issue for us because on-unit staff tell us it’s a major issue. What I hear all the time is “we don’t have enough staff. We don’t have enough male staff. The height of the nurse’s station is not high enough; things can happen. We need a management unit for these guys.” The constant issue is safety. “We need more of this; we need more of that in order to be safe” and safety is a major issue for all of us.



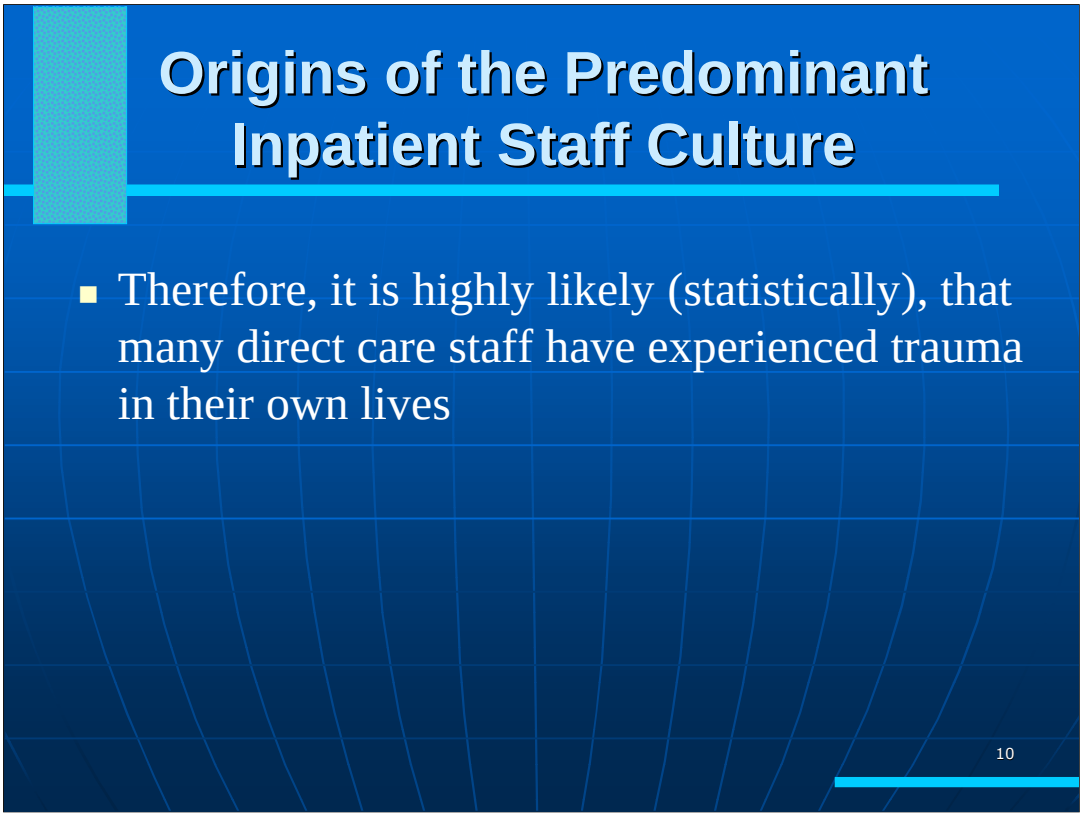
The control issues come from the fact that we have predominantly been trained in all the mental health professions and practiced within a medical model of treatment. The medical model of treatment is excellent.



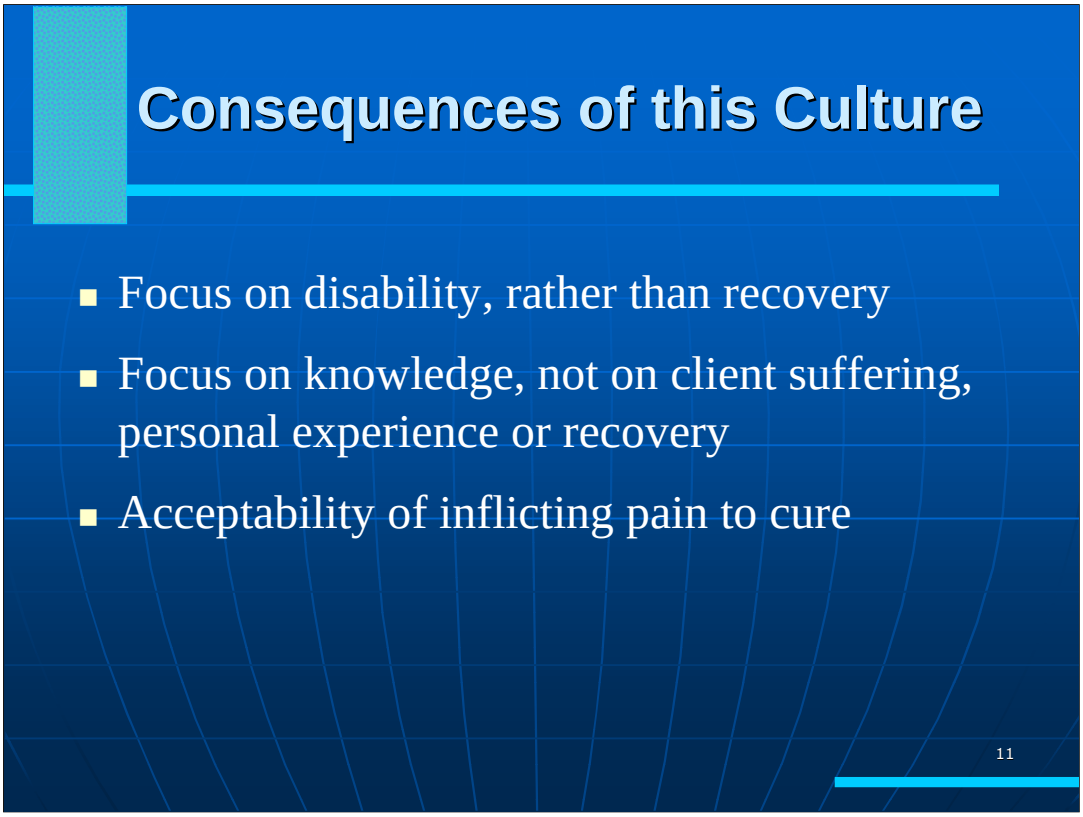
It's very effective in terms of treatments that are associated with known outcomes, based on research. It's highly effective in treating illness but it's not that effective in terms of promoting health because there's a very strict hierarchy there and appropriately so. You have the physician at the top who issues the orders, then you have the nurse who carries out those orders and supervises the aides. It's very appropriate to have that hierarchy for providing medical care. We certainly can't have a mental health tech or a psychologist as I am running around deciding, oh, I think that this person's medications need to be changed so I am going to change them. Or having a mental heatlh tech deciding that a patient does not need their medications today. Decisions regarding medical care must that of a physician and only a physician. The medical treatment consistent with a medical model is totally necessary and I want everyone, especially the physicians in the room before you start throwing rotten fruits and vegetables to understand that; that it is extremely important. But in the business of what we do it is one of several things that have to be done if we're to be successful.. The medications--the wonderful medications that we have--just are fantastic and highly necessary.

However, in addition to medical care we need two other components. One of those is the rehabilitation that we all do and are getting pretty good at consistent with the recovery values. But the third is very important throughout, within our culture and so often has been ignored. It is what I'll call enrichment. It's the relationships. It's what we do everyday in "the normal world" in terms of the interactions with people; the respect, the courtesy, the interactions, the love, the caring that goes on that so often is non-existent in our institutions, whether it's a mental institution, a correctional institution, a children's institution or whatever. So we have this need to control which really works at odds with the need for relationship; where there's a sense of equality, of commonness, as opposed to one which is very highly structured.

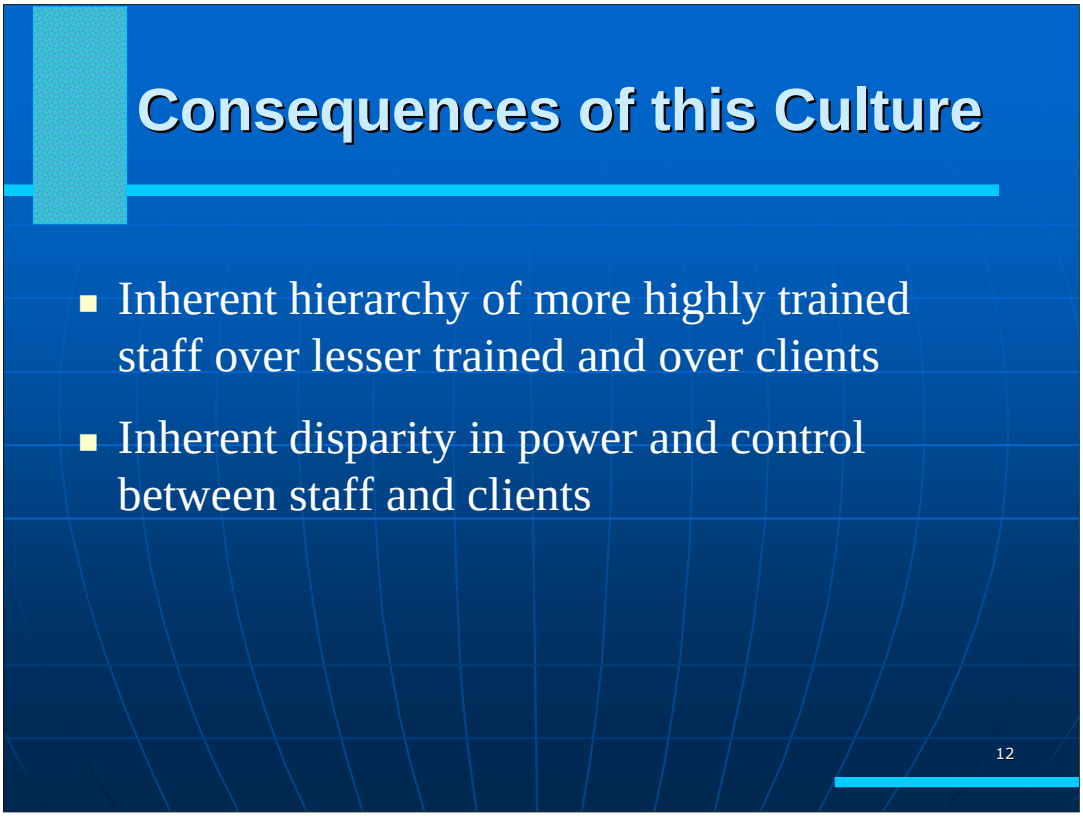
Compounding the control issues is the fact that we come from a society of violence. Keesler identified as far back as 1995, that about 61% of men and 51% of women will experience at least one traumatic event in their lives and that one in four of these people will actually develop some symptoms of PTSD. Now we've talked about trauma in a number of ways and I want to clarify this. Certainly continued sexual or physical abuse is a trauma, but there are many other traumas that we experience; witnessing the loss of a life; witnessing a tragic accident; ending up being mugged or beaten. All of these are traumatic and they affect us whether we're aware of it or not throughout our lives, with or without treatment and we have to be aware of this.



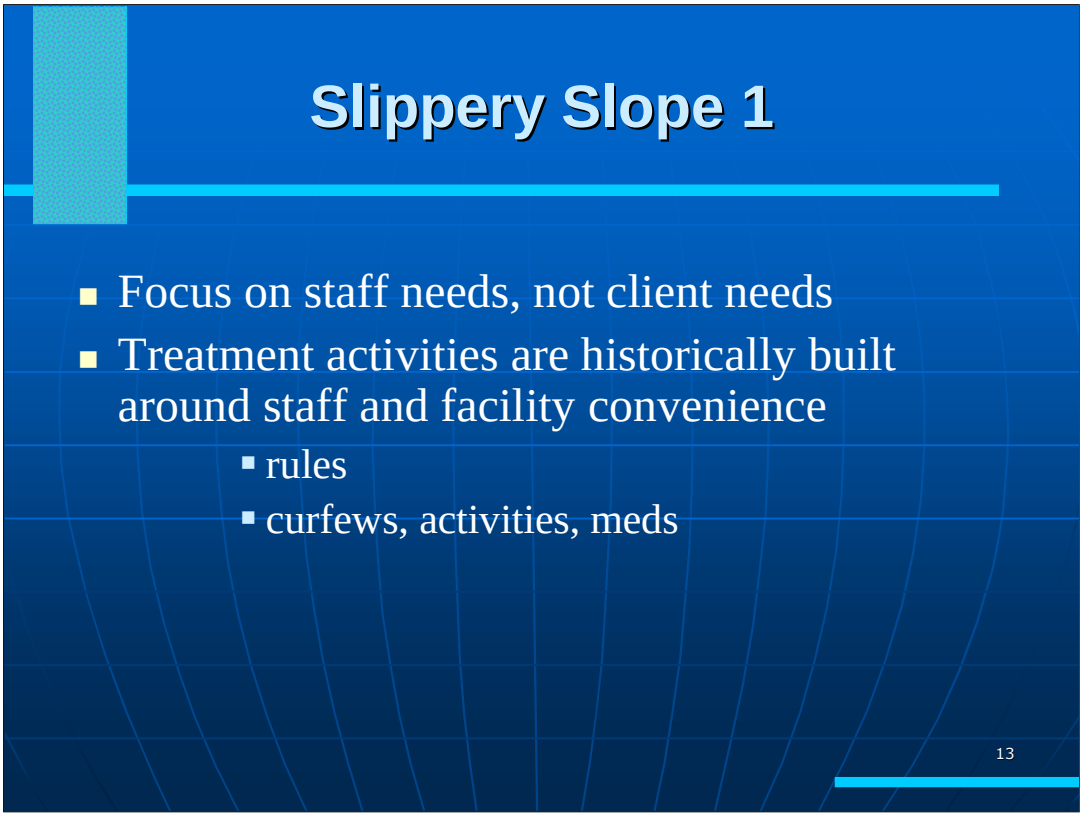
This is a major factor when it comes to dealing with our staff because since we know that many of them most likely have experienced some traumatic event in their lives. We also know that the aftermath of trauma is fear and insecurity which further leads to the need to control the situation. If you're someone who has been mugged, then you certainly want to take control of the situation in terms of which path you and a friend might take. No, we're not going through that dark alley tonight.



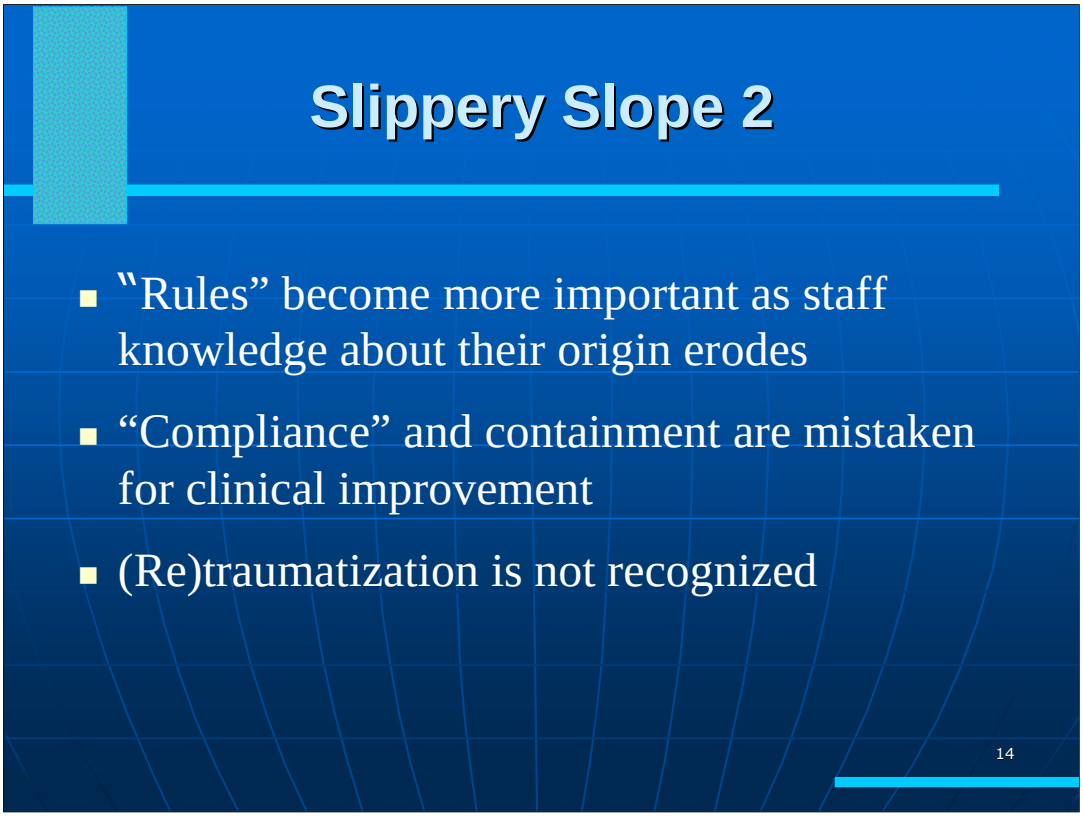
The consequences of this culture is that we tend to focus on disability; what's wrong with the person; what are the symptoms; rather than on the person's ability to recovery. Now keep in mind when I'm talking about this, I'm talking about staff every bit as much as we're talking about those we serve. We're talking about cultural recovery for staff. We tend to focus on the weaknesses of the staff, of our co-workers, rather than focusing on the potential at what can be done. We focus on knowledge; who knows the most, who has the most book learning, etc.; not on the suffering that the staff or the clients may be experiencing due to their trauma histories. And we accept the affliction of pain in order to bring about a cure.



There's also an inherent hierarchy of a more highly trained staff over lesser trained staff and, of course, all staff are in the hierarchy over those we serve. Unfortunately, too often the inherent disparity and power of control of staff over patients is emphasized.

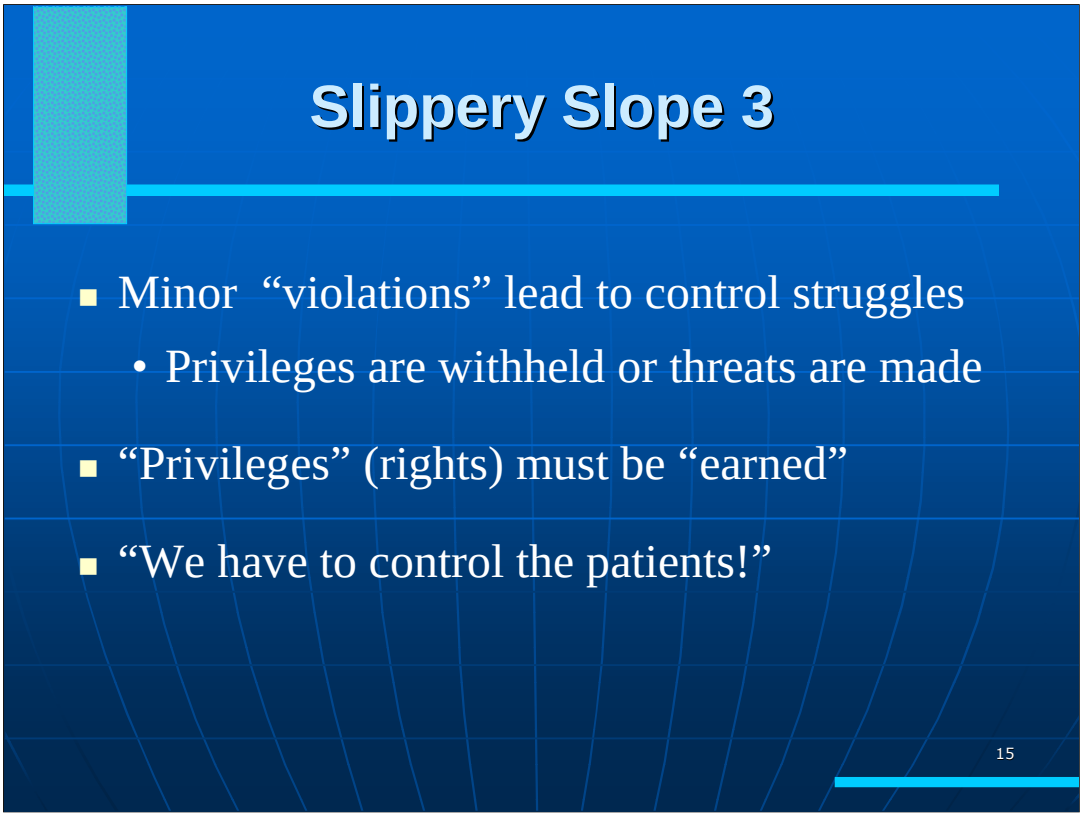


This puts us on a slippery slope, contrary to where we want to be because we tend to focus on staff needs, not on the client needs and our treatment activities are historically built around the staff and conveyances of the facility. I don't know about the practices of those present here but in my setting I have seen a lot of practices that benefited the staff but punished the client. One of the things that I had to fight was the notion that it was fairer to all staff for the clients to get up at 6:00 am because that way the night shift could help with dressing or bathing or whatever needed to go on, so when the day shift came on they didn't have to take care of all that. The problem was you had people up at 6:00 am, dressed, sitting around with nothing to do, just being bored because breakfast was not served until 8:00 So you're asking someone, perhaps with a major mental illness, in a behavioral health setting treatment for that--to sit for 1 ½ hours and do basically nothing until breakfast arrived, all again for the convenience of staff.

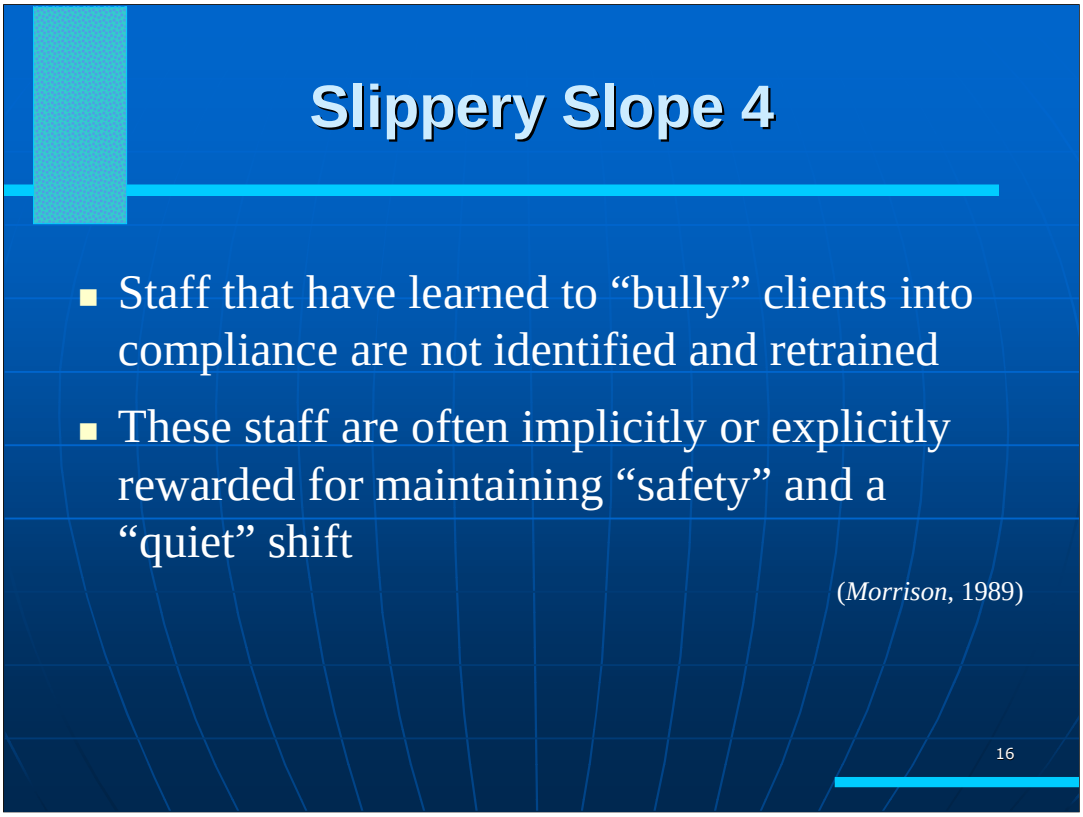


Also in this case, as we've talked about, rules become much more important than staff knowledge. Let me say one thing quickly that I feel strongly about in terms of our heritage. In South Carolina we historically have had two very large institutions, going back to the early 1700's. Huge facilities that at one point held 4,000 people in each place and we had thousands of workers that worked there, probably a couple of thousand across the two hospitals. We just think staffing is bad now. Back then we didn't have nearly the ratios we do now. So every morning like 7:00 am, it looked a lot more like a steel mill than it did a hospital. The only thing missing was the steam whistle on top because you had these masses of people coming to work, getting in line, stamping in time cards, going to their place of duty. And we controlled those places and all the employees through rules. We did not have the systems of supervision that we'd have today. We didn't have the systems of communication. The only means of controlling so many was with policies and rules that were very strictly enforced. If you violated a policy, you got written up, etc. Obviously this philosophy of strict control through rules was passed on to those we served. We ended up, and I saw it, herding people. We herded people to meals. We herded them to showers; we herded them to medications and it was all based on rules. That's part of our heritage that's no longer necessary. We have the technology; we have the staffing; we have the communication to go far beyond that and get away from the heritage of rules.

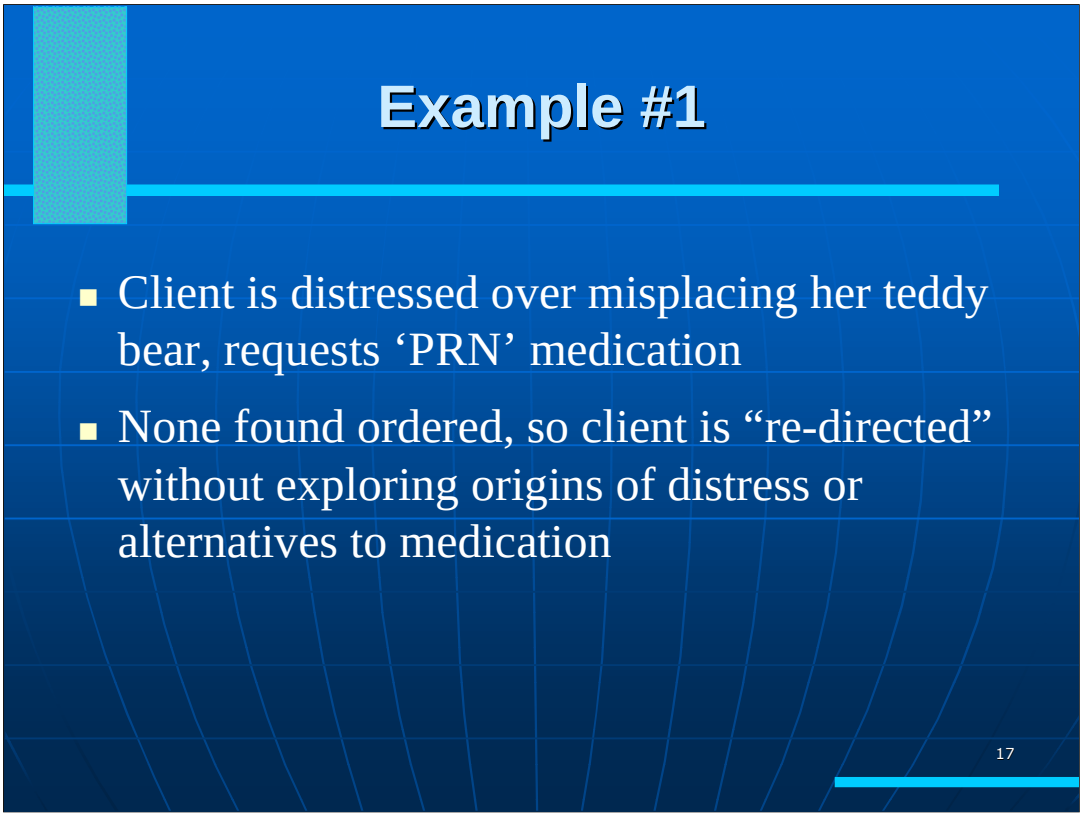
This also led to the mistaken notion that compliance and containment were good things and to the realization that compliance and containment are often mistaken for clinical improvement.



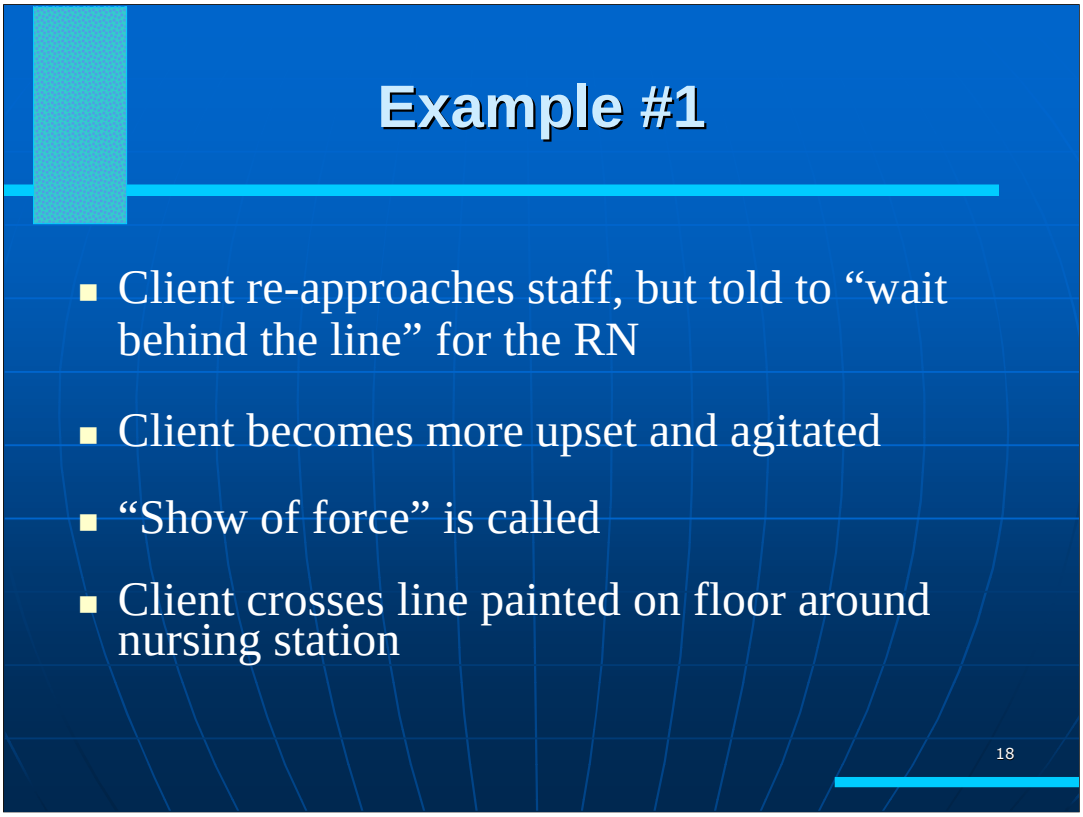
Minor violations lead to control struggles. We withhold privileges or at least threaten to. These privileges must be earned back and all notions that I hear so often from long time workers, we have to control the patients; we have to control the patients. Again, coming from the system that I said was analogous to a steel mill.



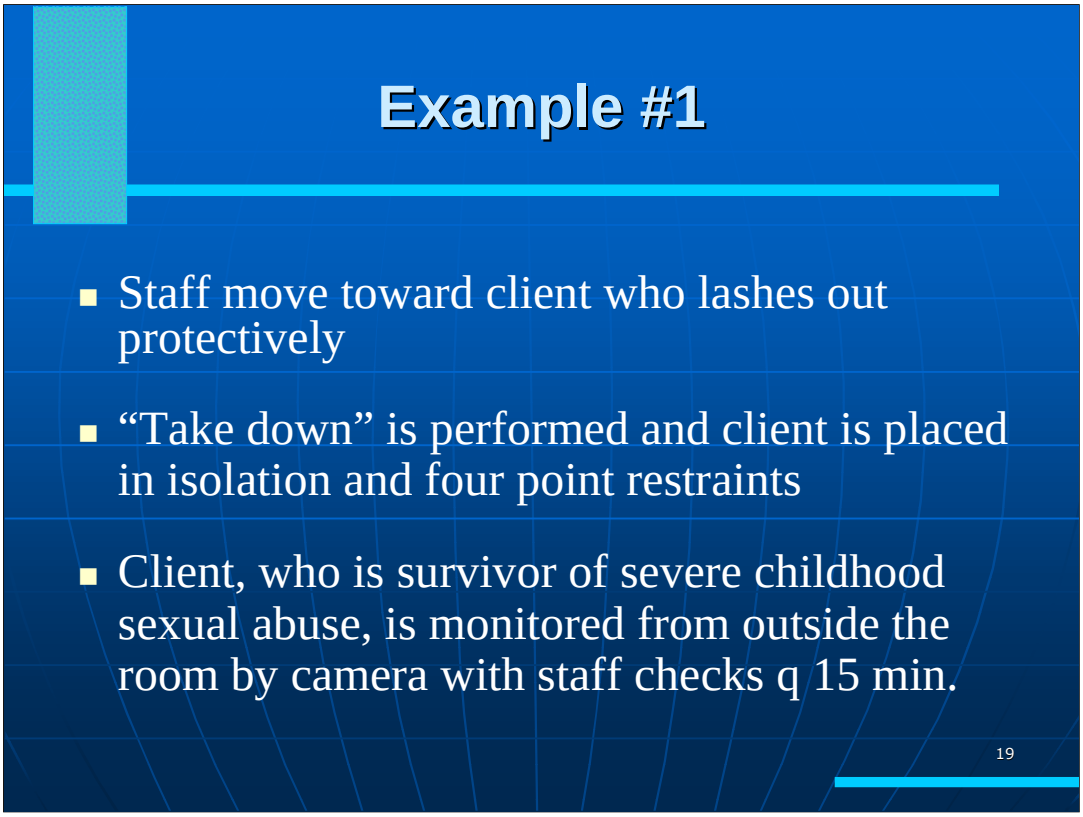
Staff learned to bully compliance in order to keep them under control and these staff are often implicitly or explicitly rewarded for safety and a quiet shift. I know every morning when I get in and I see the 24 hour reports from the hospitals and look over and I say, oh look, there were no seclusions; there were no incidents that occurred in the last 24 hours, this is great. Well, that may not be the case. It may be a very artificial thing that nothing happened because our patient's were being bullied and being controlled, that it was actually mal-adaptive and much less than therapeutic.



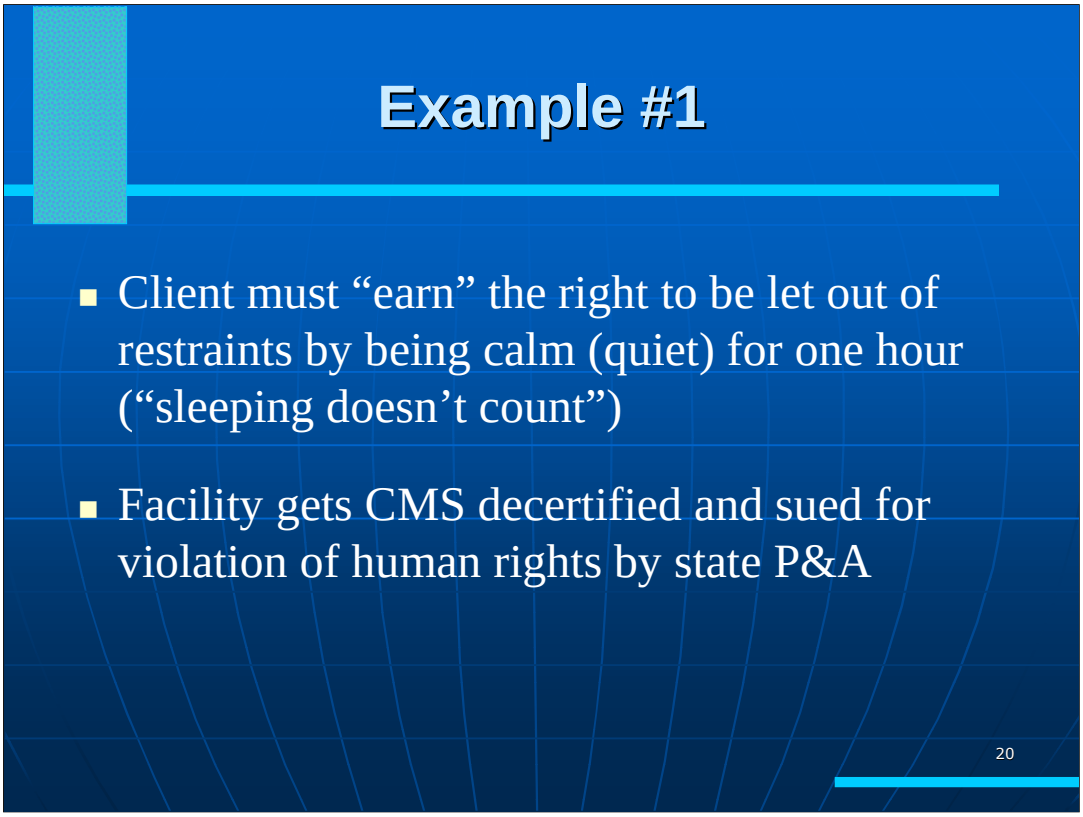
To give you a quick real world example. This is a woman who was in an inpatient unit was distressed because she couldn't find her teddy bear. This was hospital not quite as progressive as many today because she had a PRN order for agitation available or she thought she did. Because she was upset, she asked for a PRN. The nurses found that there wasn't an order so she was "redirected", one of those terms we use that often means "go away," without actually talking to her or finding out what was wrong.



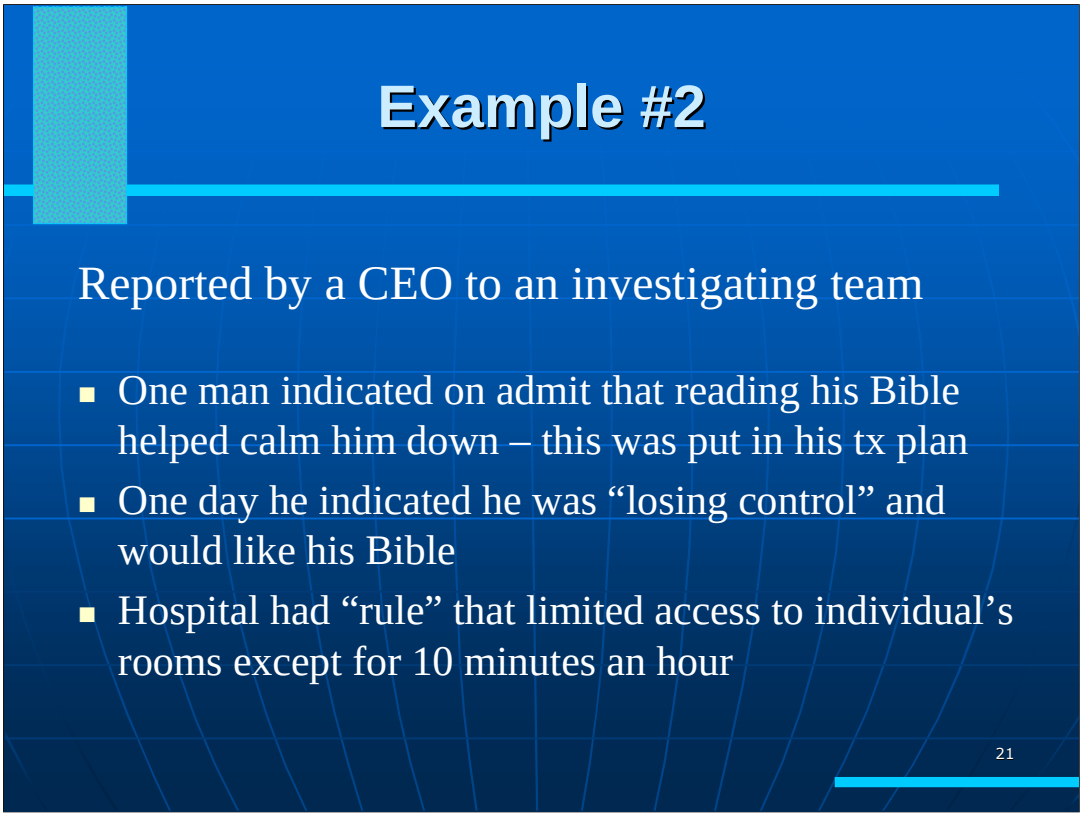
A few minutes later she reapproached the staff, but she was told to wait behind the med line there; she continued to become more and more upset. They called for a show of force. I think that meant call in other staff; call security, etc., which we now know tends to escalate rather than deescalate behavior. She crossed the line on the floor.



Staff stepped toward her; she lashed out protectively; a take down was performed and she was placed in isolation in 4 point restraints. It ends up she was a survivor of severe childhood sexual abuse.



She was kept in the restraint room because she had to earn the right to be let out by being calm; that is quiet for one hour and sleeping didn't count. So she was required to be awake and "calm" for one hour to be released. As a result of this, and again this is a true story, the facility was actually decertified by CMS and sued by the state Protection and Advocacy. This resulted from a culture of control.



Another example with a very different outcome was reported by a hospital CEO to an investigation team. As part of a de-escalation plan conducted upon admission, one man indicated that reading his Bible helped him to calm down when he started to become agitated. One day he felt he was starting to lose control and asked for his Bible. However, the hospital had a rule that limited individuals' access to their rooms to 10 minutes each hour and that time had not arrived.

Example #2 continued

- He was denied and broke 4 windows
- Another staff intervened, got the Bible and he calmed down
- Some staff were upset he wasn't put in restraint
- However, other staff pointed out that if he were home, he would have had access to his Bible and the whole incident would not have occurred
- The hospital changed the rules

(*Jones*, 2002)

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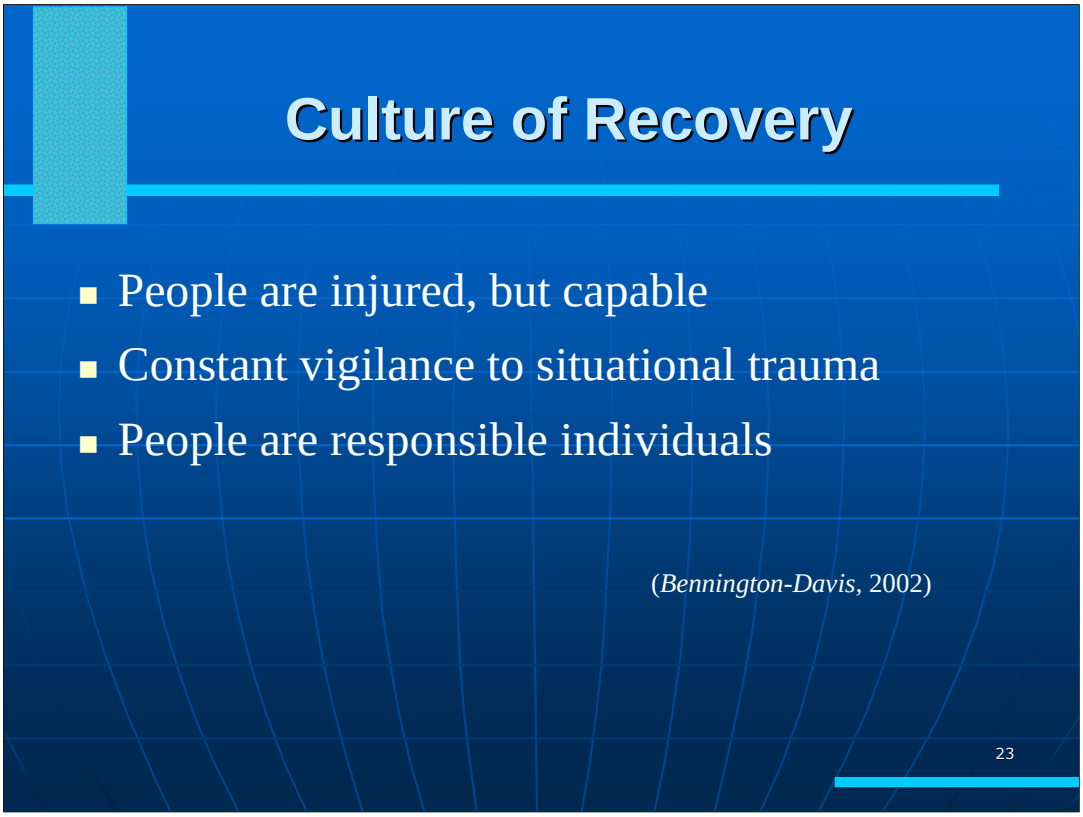
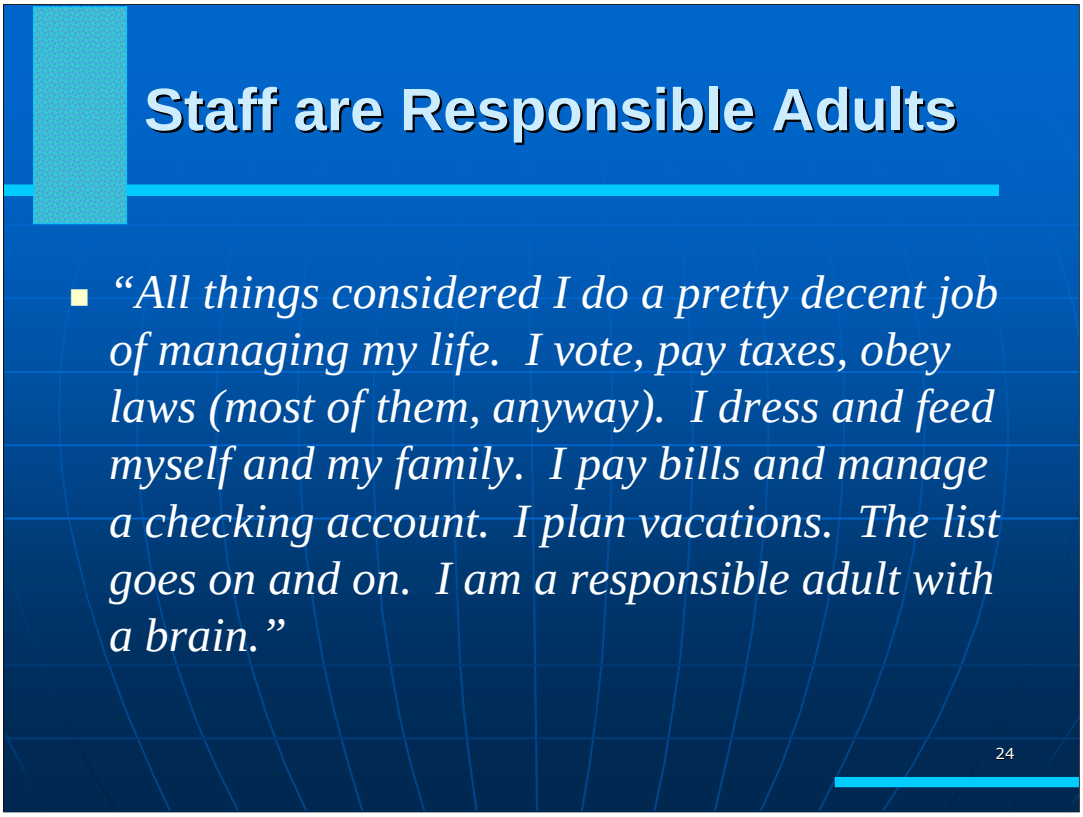
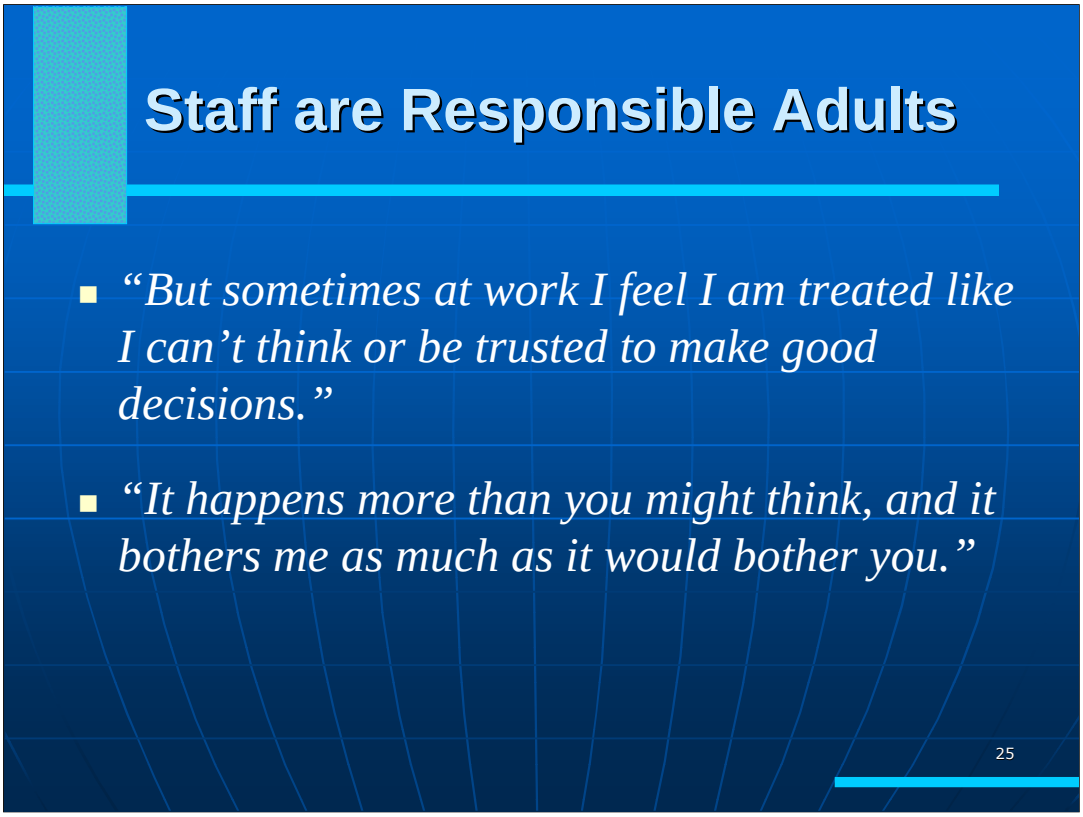
When his request was denied, he became very upset and broke a number of windows. A staff member intervened, got the Bible, and the man immediately calmed down. Some of the staff were upset that this behavior was not punished by placing the man in restraints but others pointed out that if the man were in his own home he would have had free access to his Bible the incident would have never occurred. As a result of this interaction, the hospital changed its rules.



We need to ensure that our culture is changed to one of recovery and apply the values of culture to ourselves and to all staff, as well as to those we serve. We recognize that people are injured. Most of us are injured; we have been wounded at some point in our lives. But we are capable. We need to maintain a constant vigilance to situational trauma and to recognize that people are responsible adults. Virtually all staff at all levels want to do the right thing.

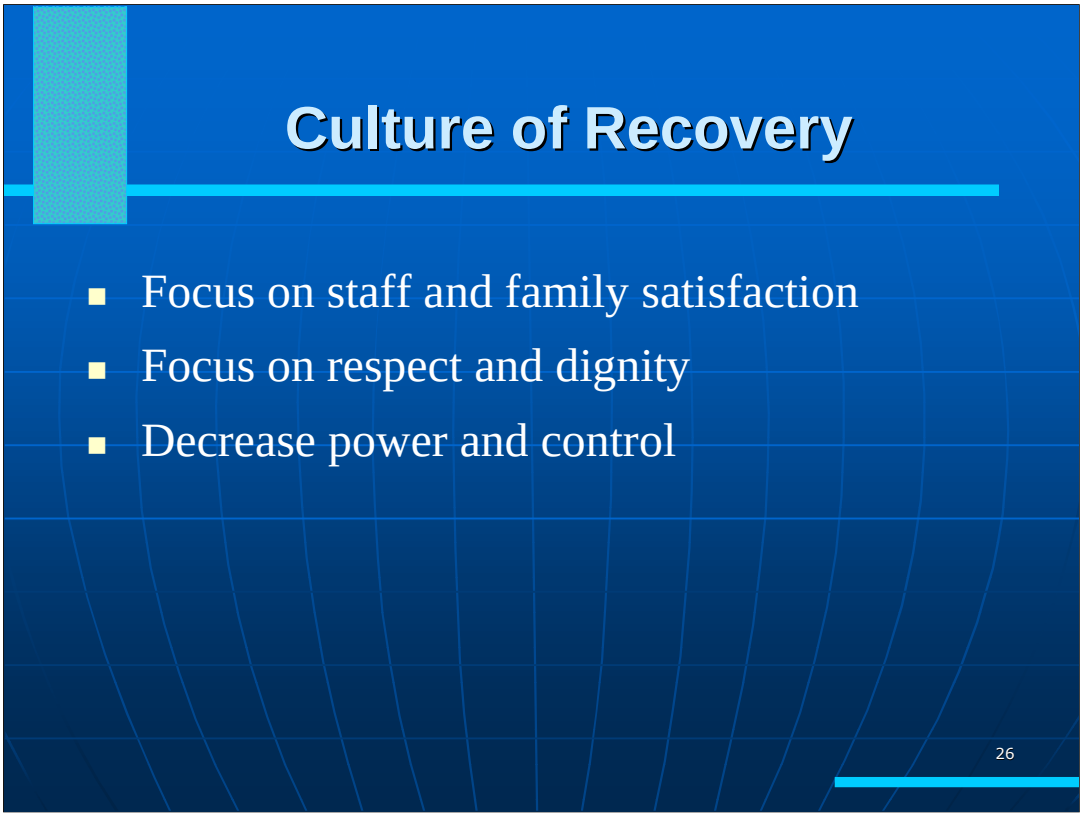


This came several years ago to me in writing from a staff member. "All things considered I do a pretty decent job of managing my life. I vote; pay taxes; obey laws, most of them anyway. I pay bills and manage a checking account. I plan vacations; the list goes on and on. I'm a responsible adult with a brain."



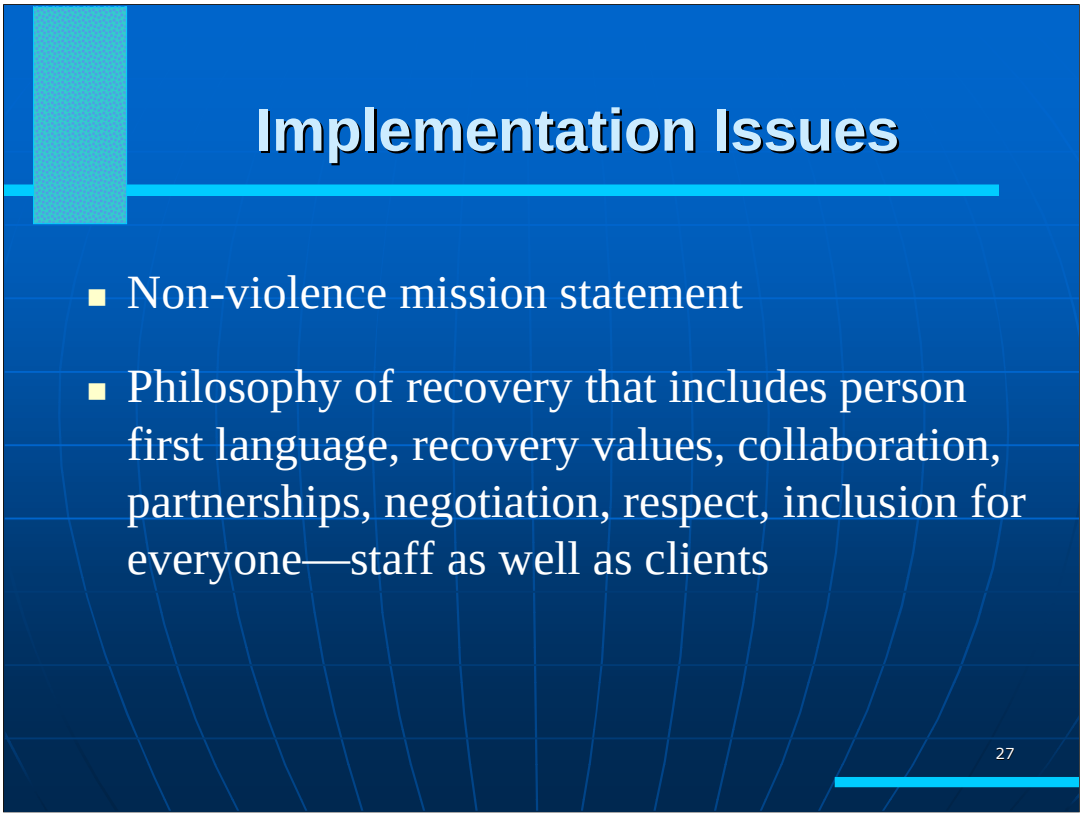
"Sometimes at work I feel I'm treated like I can't think or be trusted to make good decisions. It happens more than you might think and it bothers me as much as it would bother you."

Too often we get what we ask for; we expect so little. Most of you here are too young to remember Dale Carnegie, who I guess he was a real sort of management/ leadership/motivational guru back in the 40's and 50's, but he wrote the book, you may have heard of--*How to Win Friends and Influence People* and conducted leadership training courses. One of the things that he always taught is "give a man a reputation and he will live up or down to it". The bottom line is that we will get what we expect from those with whom we work. If we expect our co-workers, our superiors, our subordinates to be irresponsible, incapable, then that's exactly what we'll get. However, if we expect responsibility, performance, courtesy, respect, and outcomes, that if what we will get.

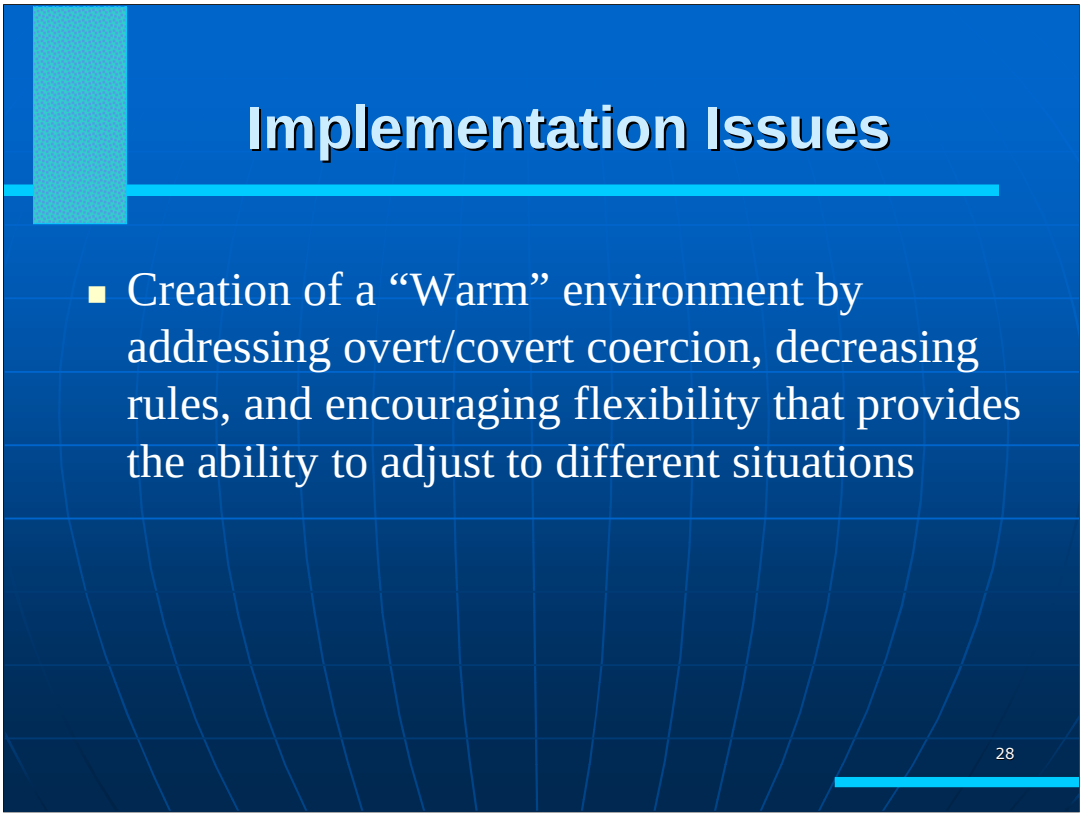


In a culture of recovery, there is focus on staff and family satisfaction. There is the demonstration that we need care a great deal about our staff--all of our staff--and their families and their satisfaction. Life is too short to be in an unhappy job and when you're unhappy, your family is unhappy because you're taking it home with you. I know that is the case for me. My wife knows; she does a lot of therapy with me. But I have an obligation to my family to take happiness home with me and help them be happy and we have an obligation to provide that opportunity for those with whom we work.

In a culture of recovery, we value respect and the dignity of everyone by decreasing power and control.



In implementing this we need to look at our non-violence mission statements and the philosophies that underpin the recovery model. Recovery values in all that we do—person-first language, inclusion, collaboration, partnership, respect—for staff as well as clients.



We are called upon to create a warm environment by addressing all issues of coercion, by decreasing rules and increasing flexibility. When I say a warm environment, what I mean is an environment in which everybody genuinely cares about everybody else. We care about our co-workers; we care about our subordinates; we care about our superiors, but most of all we care about those we serve. We care about their families; we care about other visitors; we care about other people who enter our work lives. We create a warm environment. The beautiful thing about this is that cold people are not comfortable in a warm environment. The people that like strict rules, the high structure, etc., will leave. And I don't know about here but in [South Carolina] there are plenty of places in state government for cold people. The caring, the respect of a warm environment invites and draws in more of the type of people we want.

Implementation

- Four steps:

I. Good Deeds
II. Empowerment
III. Training
IV. Organizational Philosophy/Values

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Implementation

I. “Good Deeds Done with No Expectation of Reciprocity”

- Pizza parties
- Birthday parties
- Christmas – Families Helping Families
- Donuts, etc.

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Implementation

II. Empowerment

- Focus Groups
- Authority to Suspend “Rules”
- Employee Advisory Council
- Self Scheduling
- Self Assignment
- Time Clocks/Accountability

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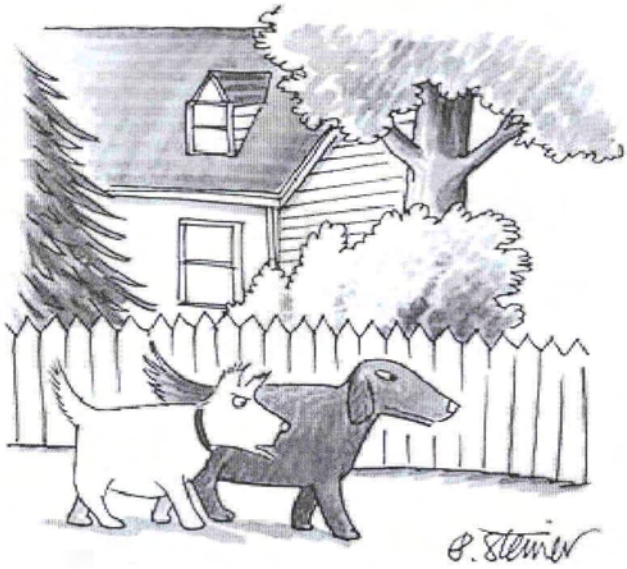


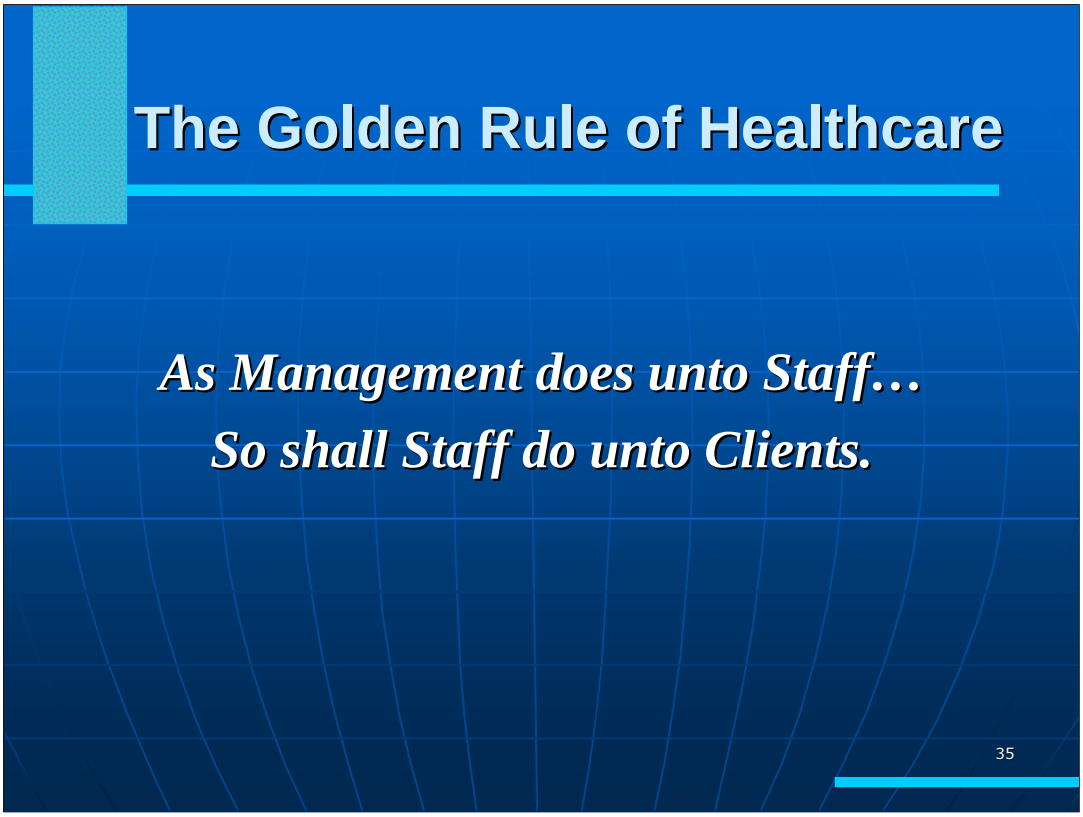
"It's always 'Sit,' 'Stay,' 'Heel'—never 'Think,' 'Innovate,' 'Be yourself.'"

There is too often a lack of recognition and intervention for staff members with histories of trauma. We don't know the histories of those with whom we work. We are not completing trauma assessment as we would for our client's with our co-workers or with our subordinates or superiors. So the only approach that ensures we are sensitive to trauma histories, though not documented, is to that is treat everybody as though they were trauma survivors. Treat everybody like they would like to be treated. Treat everybody with respect and dignity, courtesy. Then we do not have to worry about whether or not the person we are talking with, who we are supervising, or who is supervising us survivor of trauma. We're treating them in a way that we should be treating them anyway and it results in the same end.

Implementation

IV. Organizational Philosophy and Values

- "Preach and Teach"
- The Golden Rule of Healthcare
- Human Resource Development
- Supervisions v. Discipline
- Competency-Based Job Descriptions
- Courtesy and Respect



This is what I call the golden rule of health care and it's actually broader than this, but this is such a truism--as management does unto staff, so shall staff do unto clients. This is a major role for leadership--creating that warm environment and leading by the golden rule of health care. All of us in turn are treating each other with that in mind and we are treating those that we care for and are responsible for in a like manner. Warmth, caring, dignity, respect.

Challenges to Cultural Shift

- Lack of recognition and intervention for staff members with histories of trauma
- Need for intensive staff training
  - Lack of knowledge and tools leads to increased utilization of restraints

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Challenges to Cultural Shift

- Inertia of history (“we always did that”)
- Need for constancy, vigilance, accountability is staff intensive
- Need for setting agency goals and measuring progress

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Supporters of Cultural Shift

- More sophisticated and better trained staff are inherently uncomfortable with control environment
- Mutually agreed-upon treatment goals are easier to reach
- Decreased staff injury and work time loss
- Improved client and staff morale

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Empowerment

- An empowered staff leads to empowered clients
- Share ALL information and planning with everyone
- Create autonomy through boundaries
- Replace the hierarchy with teams

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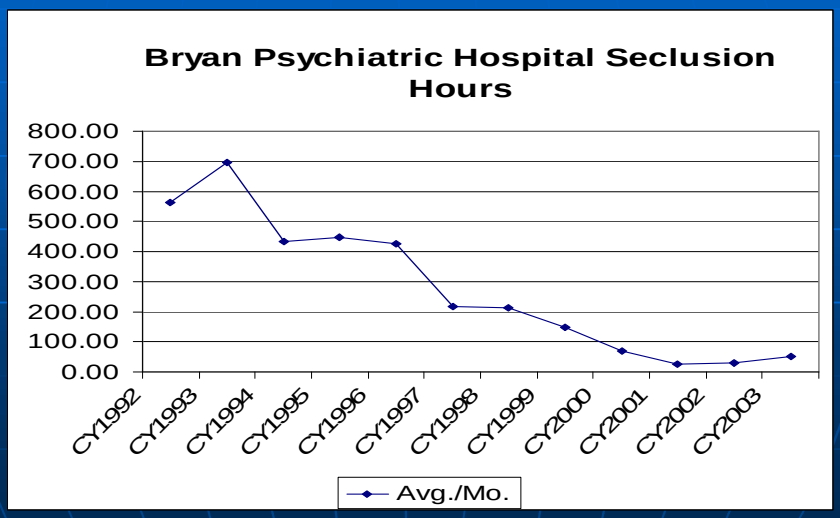
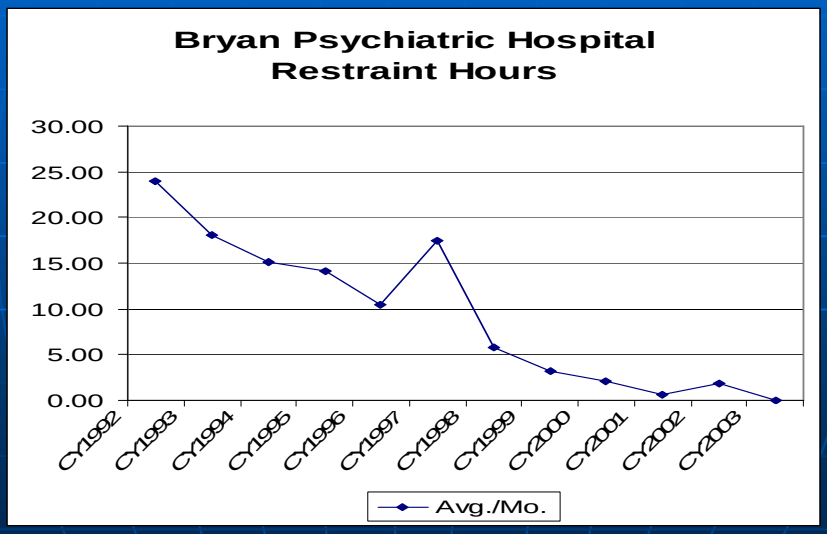
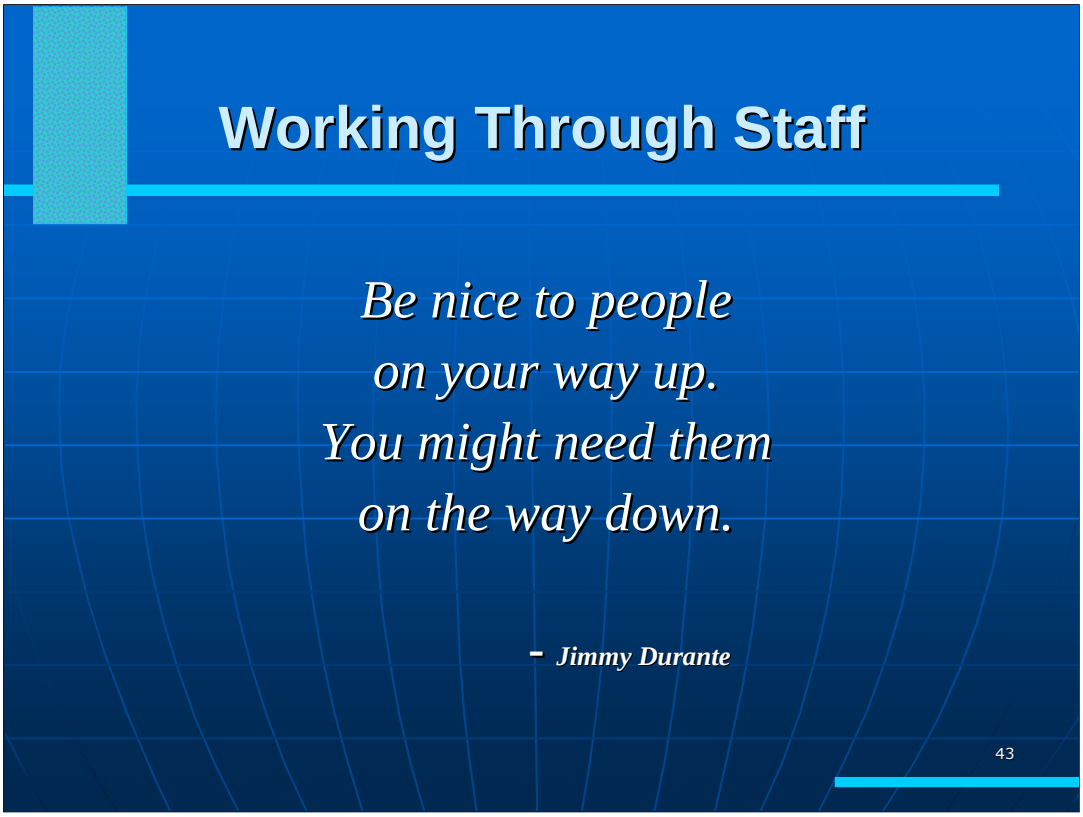
South Carolina Experience



South Carolina Experience



What would a seminar on leadership be without a Stephen Covey quote? "Empowerment is not a program; it's a core condition for quality." It's not something we can mandate; we can't give it, bestow it, grant it, or delegate it. We have to create the condition to develop it.



In the Department of Mental Health in South Carolina we operate by the principle that today you better be nice to everybody because tomorrow the person who is your subordinate may be your boss. We have seen it happen so many times that we have learned our lessons.

Thank you for your time and attention