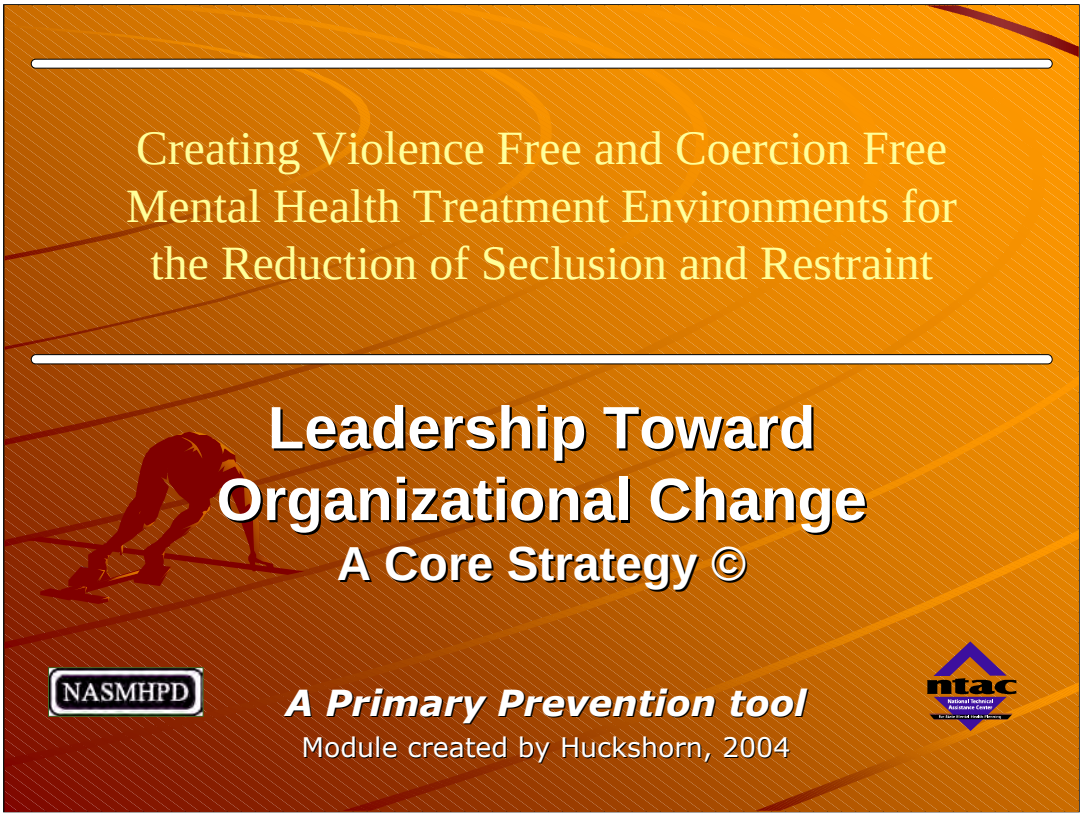

What I'm going to talk to you about is the first core strategy and it's called Leadership Toward Organizational Change. Most of us firmly believe that if any of the core strategies are mandatory, this one is.

When NTAC started looking at the issue of effective leadership in mental health settings we kind of ran into a problem because leadership in the literature, as you know if you have taken any leadership courses, is a big debate and many cases it almost seems very mystical. The literature suggests a multiplicity of theories: that leaders are born, not made; that leaders practice according to the situations they find themselves in, that good leaders use transactions, that good leaders use charisma. So we really didn't know how to approach this originally when we started looking at how to concretize, if you will, what is a leader in terms of creating systemic culture change such as reducing seclusion and restraint. Then we found the literature that Bill Anthony in Boston, and several of his colleagues, had actually started to develop, They have identified what Bill considers the core competencies for leadership and so we borrowed from that and we are going to talk a little bit about fundamental leadership principles with the idea that if you can identify competencies then you can --learn them. So it's not a born but more of a made issue.

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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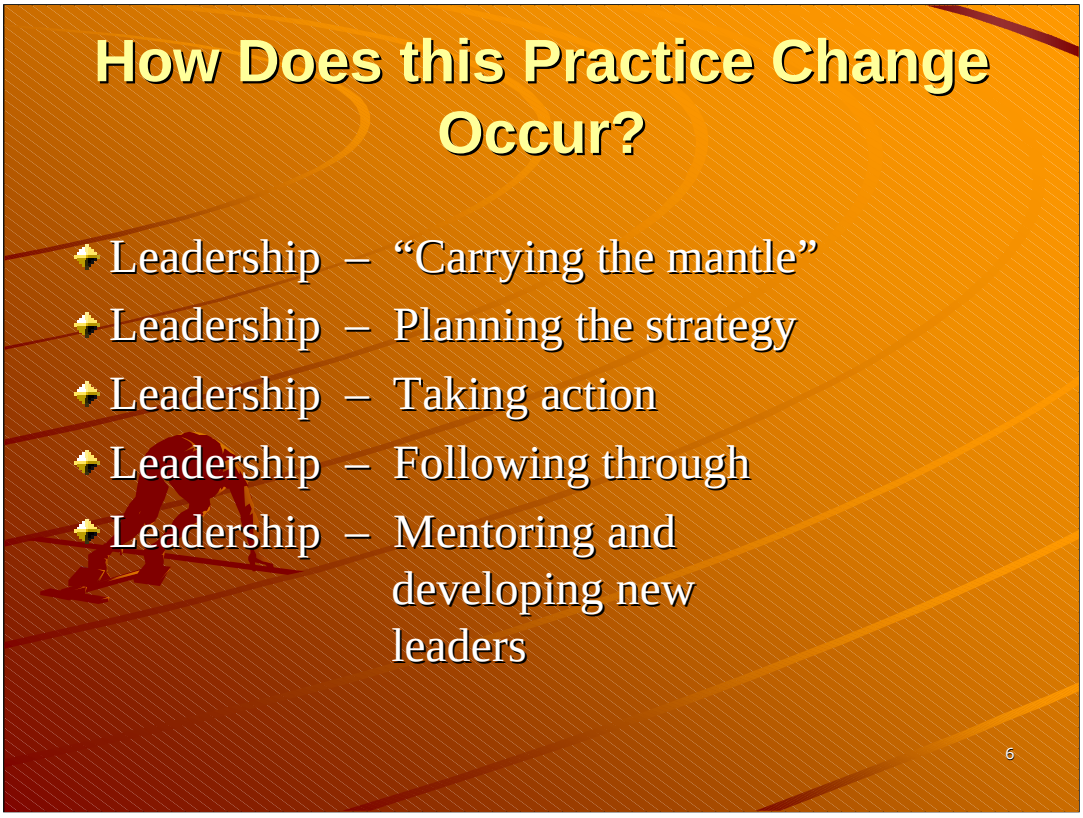
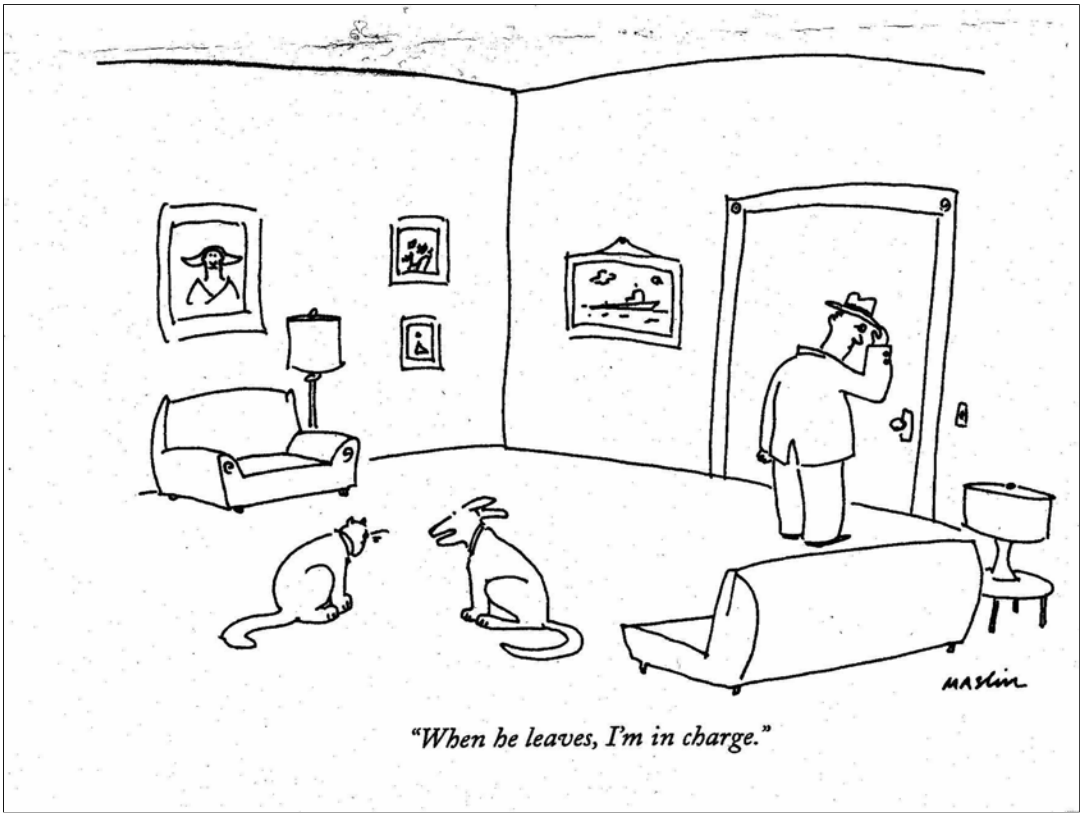
3

This presentation will outline the fundamental role of leadership and core leadership principles as listed here…

Successfully reducing and eventually eliminating the use of seclusion and restraint changes the way we do business; changes the way we view our customers; changes the way we see our own world and requires and results in a major culture change in many of our facilities and programs. This work requires effective leadership.



How does this practice change occur with regard to leaders? Leadership carries the mantle; leadership plans the strategy; leadership takes the actions, especially initially; leadership provides follow through and leadership mentors and develops new leaders and you'll hear us talk about in the training developing seclusion and restraint reduction champions.



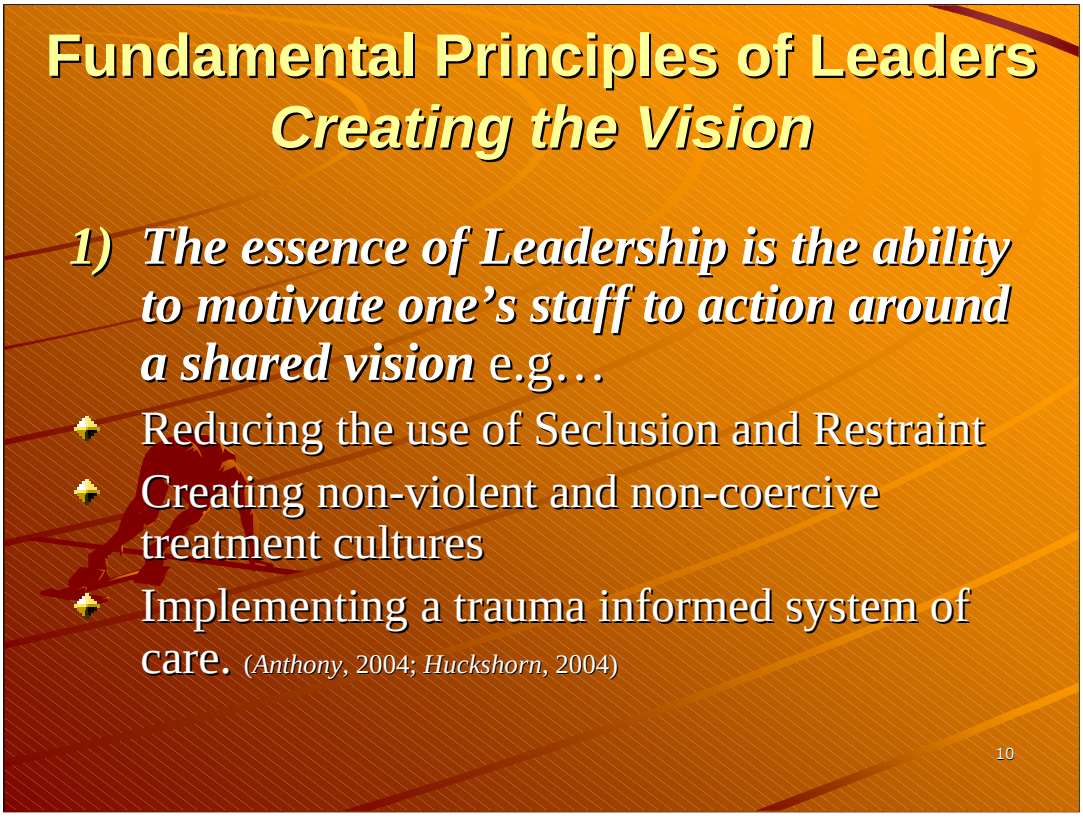
What we mean when we say that is that you are going to take very concerted actions to identify and get on board leaders at all levels, vertical and horizontal, in your staff workforce so that you've got "you" basically recreated on your shifts, all your shifts, every day of the week wherever your folks are working or wherever people are being served. This is what we want to see. When you leave, someone takes the "in charge" approach and has the wherewithal and the pride and the skill set to be able to do that.

The role of leadership, as I said, we think it's the most important component in successful reduction processes. I have personally never seen S/R project that was successful that did not have a very clear and identified leader. These successful projects also demonstrated evidence that the facility staff knew what their role was and why they were doing this work. Only leadership has the authority to make these changes happen. That's a critical piece. Leadership, and I'm talking about executive leadership here, is probably the only group in your facility that has less barriers to get through to make policy changes. A lot of your staff who may have very good ideas have to go through multiple levels of committees and get a lot of consensus before changes are made. Leaders don't have to do this as much. They obviously need to work in getting consensus but they have the power and authority, formal and informal, to do it.

They can make seclusion and restraint a high priority; you can assure for the creation of a plan. You can reduce and eliminate organizational barriers. You can provide or reallocate resources and sometimes we do need to reallocate resources because they're limited. So if you're a leader and you've got everybody asking you for everything, at some point you have to make a decision. In this particular instance it has to be someone who keeps that seclusion and restraint reduction initiative at the highest level of priority and keeps it there through constant change in priorities and all the constant reactive crises that we all face on a day-to-day basis in a setting such as you work.

It also needs to be focused to hold people accountable. Sometimes we go to facilities and we see just a very strong commitment by the leadership to do this work but when you go into the actual units where people are being cared for, the staff are definitely not on board; they really don't know what they're supposed to do, and there's a disconnect between the senior level and the non-licensed staff that are spending the most time, in many cases, with the folks we're serving.

The power of leadership in creating change is within our control. That's another key component of leadership. Part of being a leader is saying I have the power to do this and doing it. Not used effectively, or not used at all, it becomes a major barrier because there really isn't anybody to lead the charge. There are very often and in fact there are several examples in this room that I won't name by name that have started kind of from the grass roots and they have worked very hard over the last year and a half to get the attention of some of their leaders so they can get their state or their facility to this training. It's very hard work. It could happen much more quickly when a leadership can say we're going to do this.



I'm going to go through just a few of the fundamental principles of leadership. The first is creating the vision. The essence of leadership is the ability to motivate one's staff around a shared vision. Reducing the use of seclusion and restraint must be a shared vision. Creating non-violent and non-coercive work places is a shared vision. Implementing a system of care that is trauma informed is another type of shared vision or just going down and making people feel better.

Or just…

"Go down there and make them laugh."

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This is a king trying to create motivation in his staff to go down and make the relatively unhappy people laugh. Sometimes that's what it's about. Just trying to make staff get on board…

Fundamental Principles of Leaders
Creating the Vision

- A shared organizational vision is like a magnet- it attracts to it people with special characteristics.
- Organizational Vision Statements can be pieces of paper *or*
  they can *energize and mobilize* the organization in common cause (*Anthony*, 2004)

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Fundamental principles of leadership in creating the vision is basically knowing what vision statements can do. Vision statements can be pieces of paper or they can energize and mobilize the organization around a shared goal.

Fundamental Principles of Leaders
Creating the Vision

- Vision statements can provide a sense of purpose and meaning to staff, service recipients, families and the community
- Must appeal to reason *and* emotions to be effective (*Anthony*, 2004)
- Must be shared with staff…

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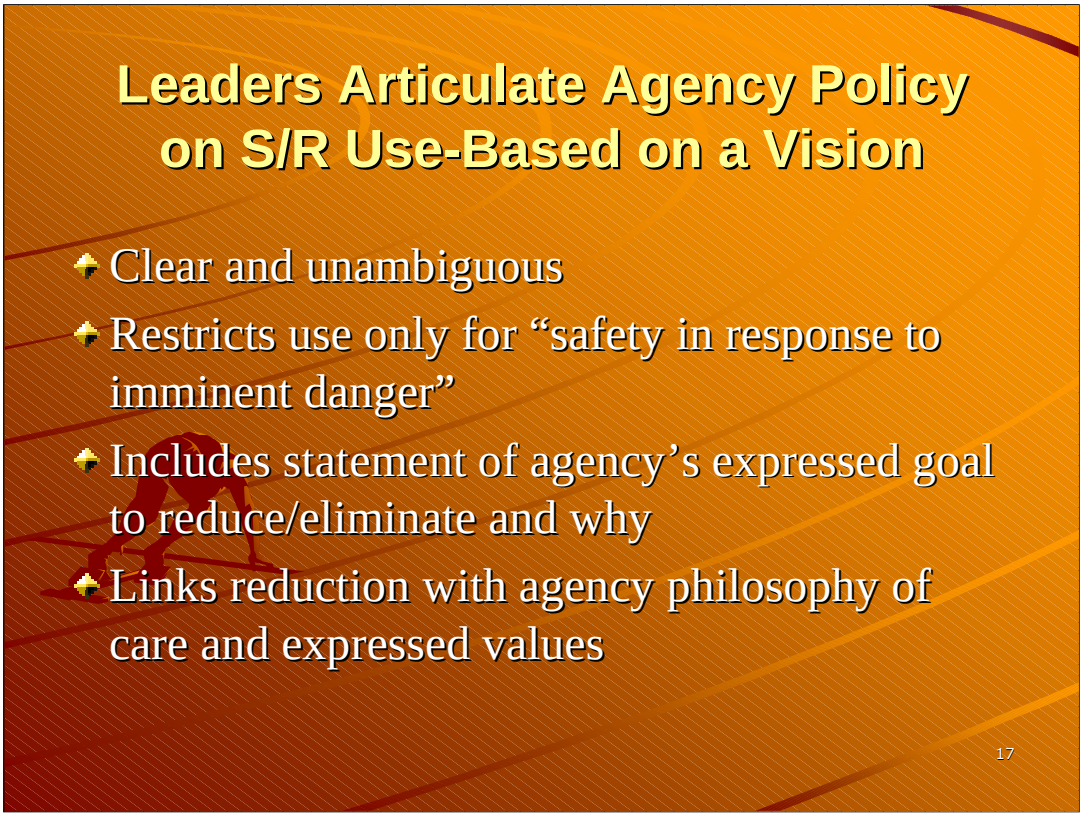
They can provide a sense of purpose and meaning to service recipients, families in the community and of course part of that is bringing in family members, consumers in the community to participate in that visionary process.

Good vision statements must also appeal to emotions and reason to be effective and must be shared with staff. A vision statement that is now typed on pieces of paper or on posters and put around a facility does not make it a vision statement or a mission statement.

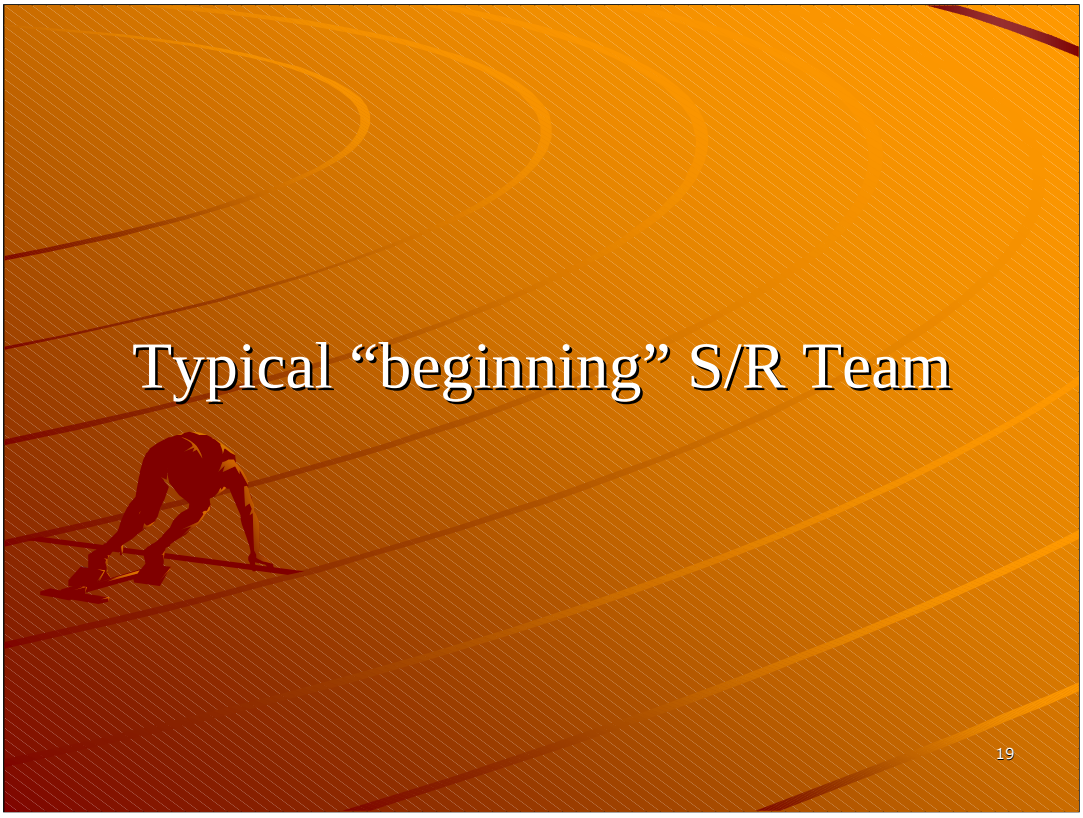
For example, I’m just going to give you a couple of examples here.

"To reduce the use of seclusion and restraint by defining and articulating a mission, philosophy and action plan and then holding people accountable." That would be an example of a possible vision statement. The state of Pennsylvania, the adult mental health side, did this early on and used very strong language where they used seclusion and restraint a treatment failure. NASMHPD, the organization, also did this. They brought the commissioners together and after some long talks and a lot of debate came up with a very strong vision/mission statement also in 1999 and that's on our website. I also believe there are examples of mission and vision statements on the resource manual that you can look at.



A vision statement needs to be articulate, clear and unambiguous. A most important piece in a vision statement on seclusion and restraint is that we articulate that it is a safety intervention, not a therapeutic intervention, and it's only used in response to imminent danger and that you all have the understanding that you have to clearly define what imminent danger is for your staff. Talks about the agency's goal in reducing and links this goal with the overall philosophy of the agency.

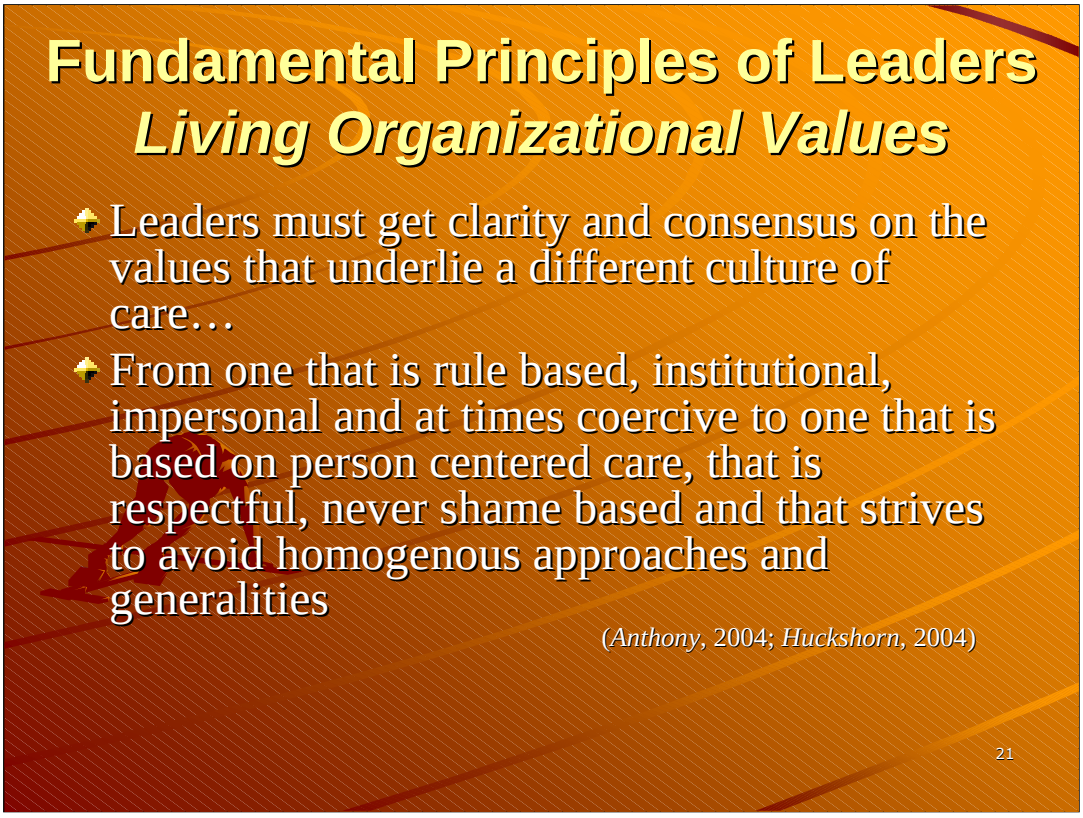
The second leadership principle, or core competency is that leaders "live organizational values." Leaders operationalize their principles in that they create an organizational culture that identifies and tries to live by key values and sometimes this takes time because you have to work on values clarification with the agency staff. Anthony thinks that values are the organizational Velcro that bind vision to operations; define what we say we believe in and what we do on a daily basis and that we must be very clear about values and how those values are interpreted in the daily practice of our staff. Once you can do that then you can start to team build.



This is a typical beginning of a seclusion and restraint team and it brings me to mind with the one that was formed at South Florida State Hospital in 1999-2000 where Kevin Huckshorn and her colleagues started this work and, as she reports, “ we basically had everybody sitting around debating and this turned out to be a big part of the values clarification process.” The group wrestled with “What happens if it doesn’t work? What happens if it does work? What if we get sued? What if it all blows up in our faces? What happens if it works too well? How are we going to generalize it?”

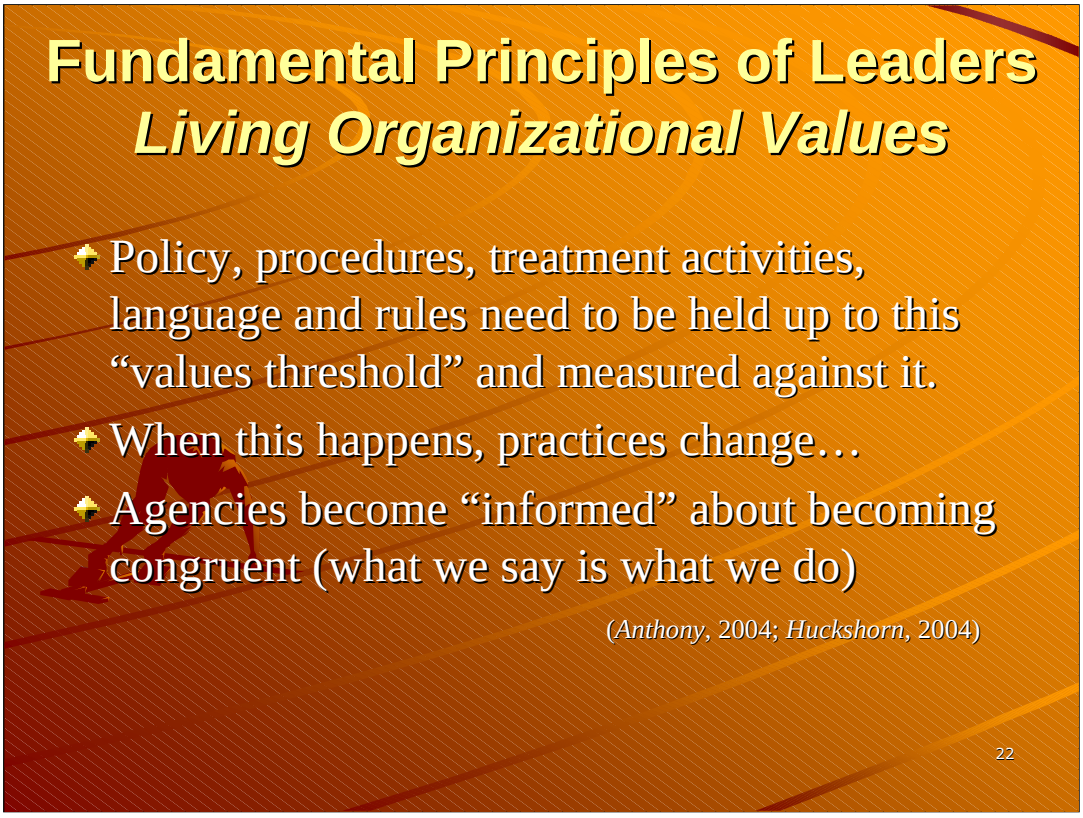
There was an awful lot of discussion about that but what I remember mostly was the CEO of my facility, who was not a clinician, sat in a corner of the room, nodded, smiled, was very supportive and never, ever, ever stopped saying we’re not going to do this anymore to people. We are not going to use seclusion and restraint anymore. It’s not right.


WORRY TANK
What if it doesn't work?
What if it all blows up in our faces?
What if somebody sues?
What happens if it works... all too well?
What happens ten years down the line?
THEN WHAT?



Living organizational values means that leaders must get consensus and clarity on values that underlie a different culture of care and sometimes that also means going back and redoing your values, whatever values that you're living by. Sometimes and what we found a lot is that inpatient mental health treatment programs have become very rule based, institutional, impersonal and because of that at times coercive in an unintentional manner. We know that no one intentionally wants to be coercive but because when you're dealing with large groups of people and things called institutions we start pretty much trying to manage them and us through the use of a lot of institutionally based rules.

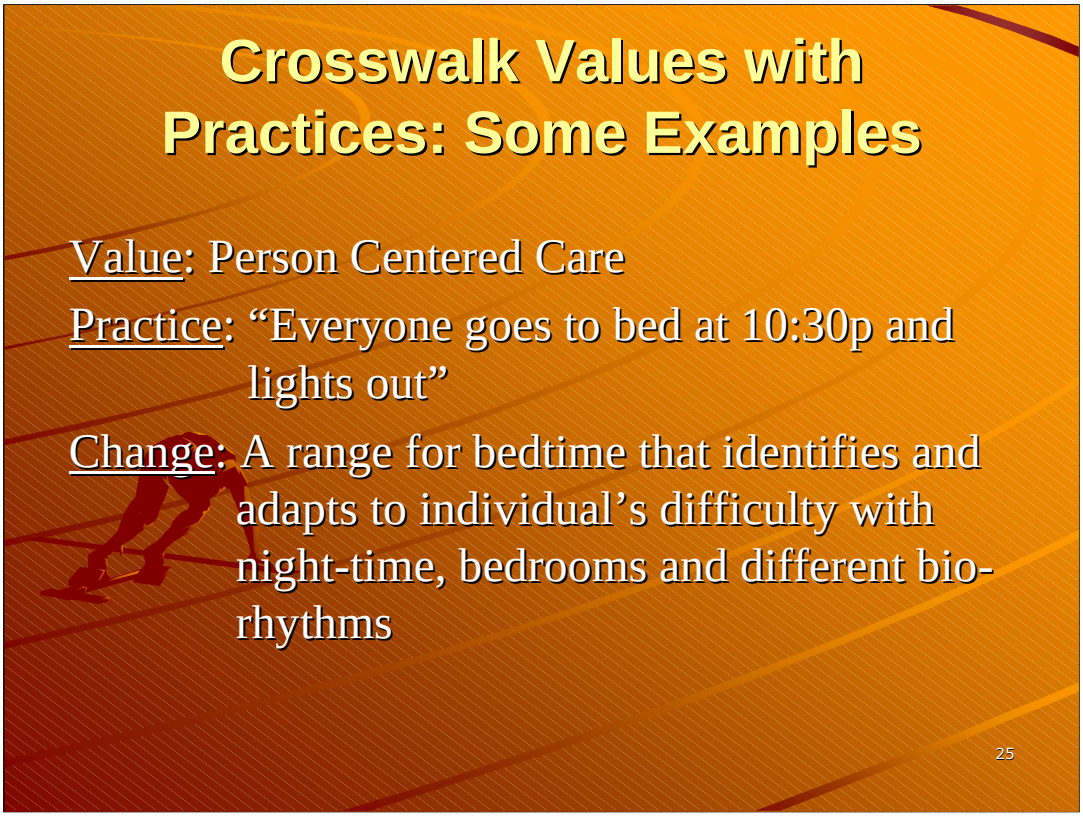
We also have sometimes drifted from our therapeutic treatment activities or whatever our therapeutic treatment philosophy is so that our level system that started out to be a well-run fidelity, honest philosophy has now drifted and has become more shame based or you have staff in front of other or the staff and the people we're serving in large community areas being docked points; being threatened with points being docked. So we'll have to look at those kinds of things when we start talking about values.



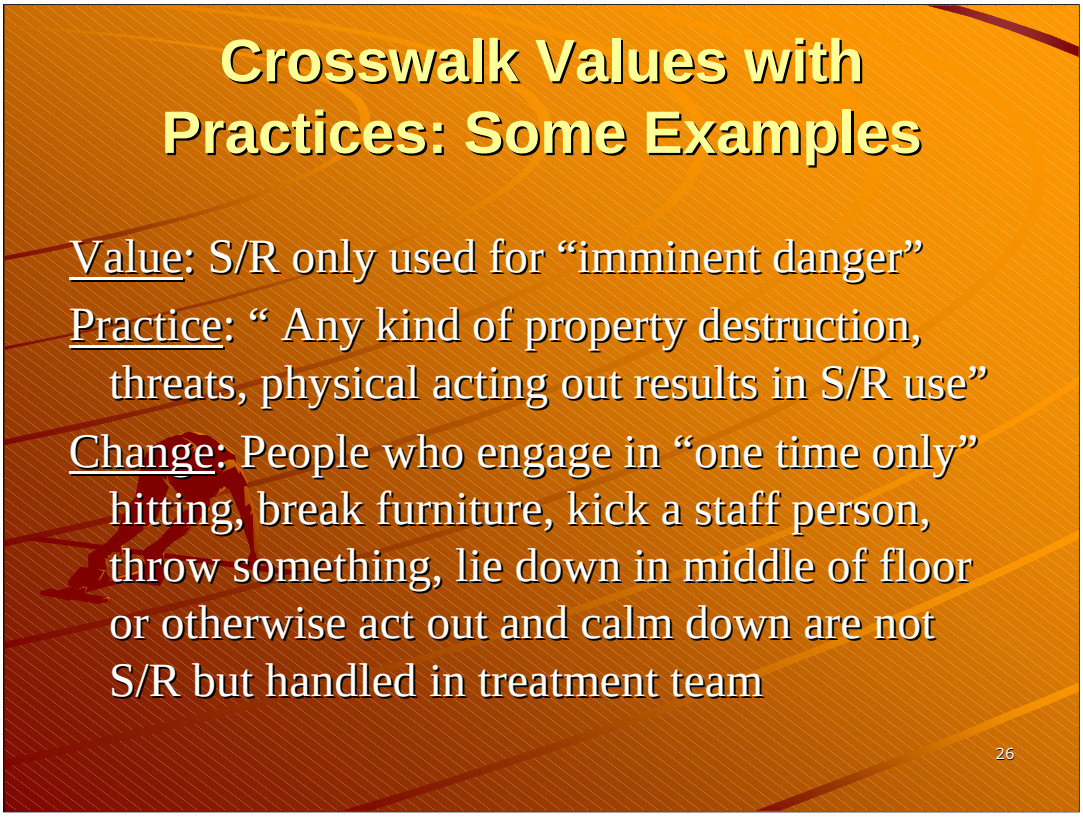
Policy, procedures, all the things we do; treatment activities, language and rules need to be held up against whatever values that you say you espouse. When this happens your practices will start to change, as will some of your policies. It takes a lot of work; it takes a lot of time and it takes the senior level staff to lead this work.

Again, this work takes time and real thoughtfulness. Depending upon preparation, training or just plain lived experience, many of our staff may think that signs and symptoms of mental illness for oppositional behavior or willful acting out. Workforce education is critical here

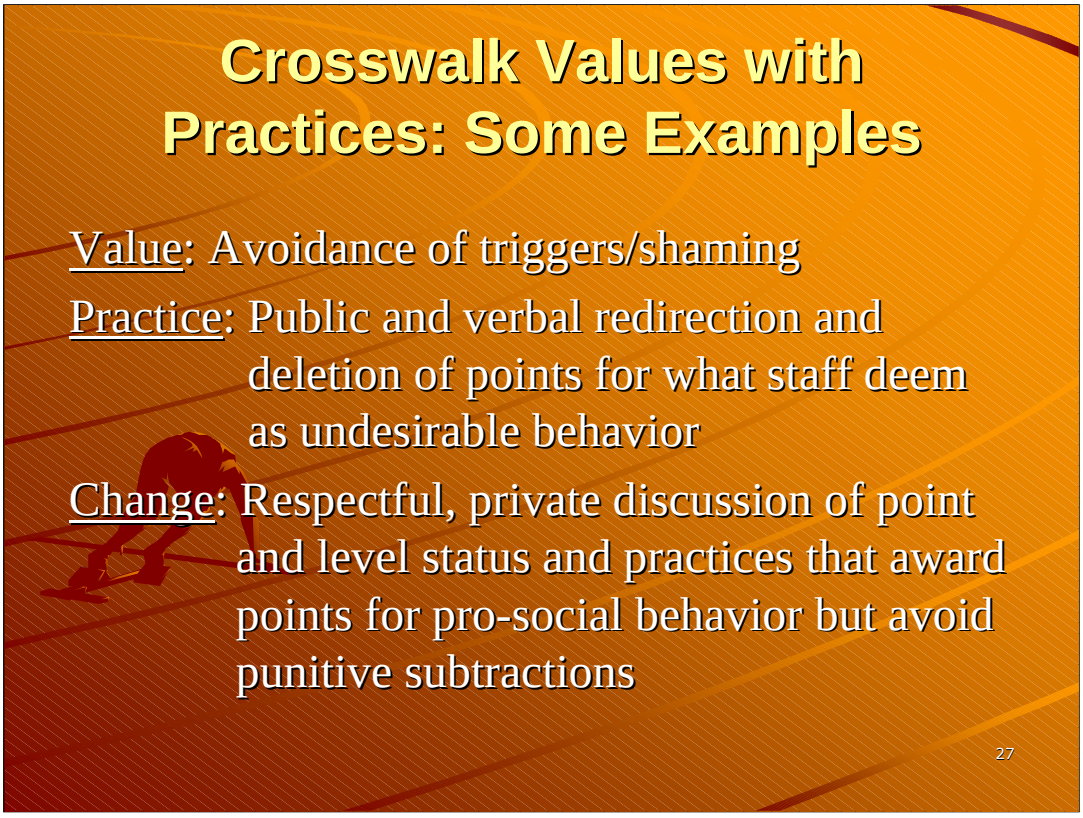
For example…:



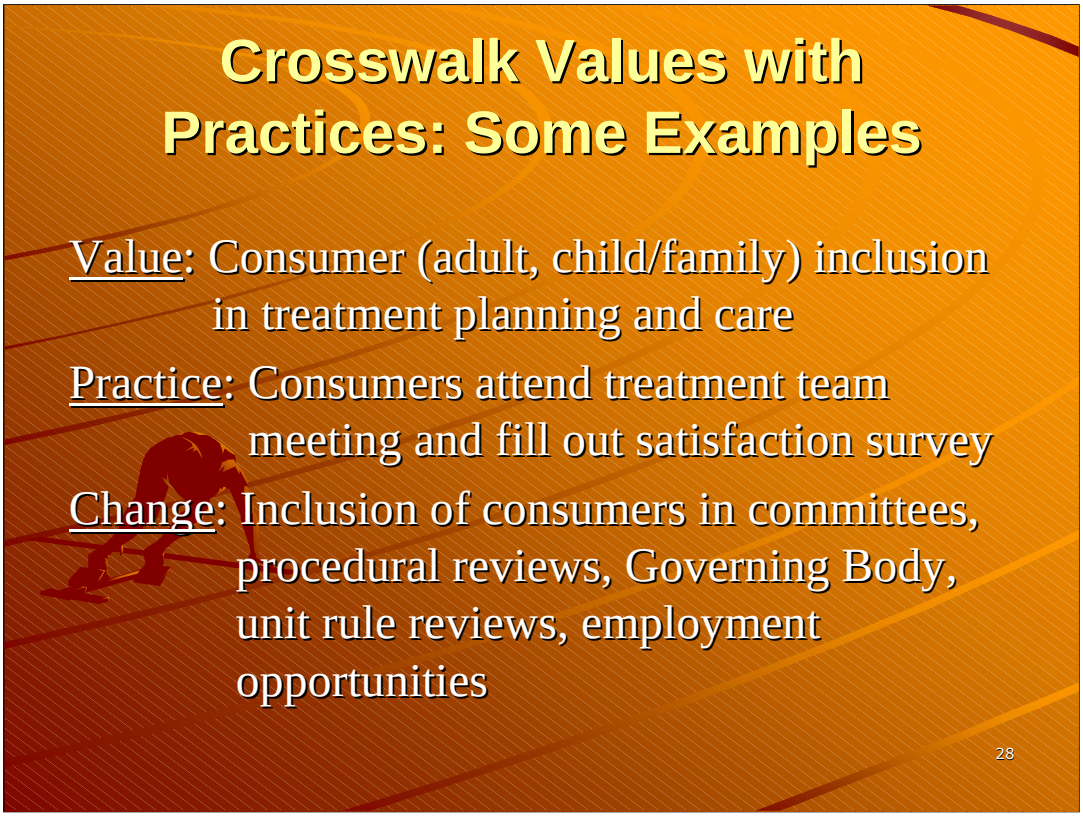
A facility might espouse person-centered care. The practice however is that everybody goes to bed at 10:30 pm and the lights are out or conversely everybody gets up at 6:30am, not because they're doing anything until 9:00 or 10:00 but because the night shift is coming on and they want everybody up. The change in practice that would be more congruent with person-centered care would be a range of bedtimes that identify and adapt to individual's difficulty with nighttime bed rules and different bio-rhythms and the same with waking time. It's more difficult to manage; yes, but its much more person-centered.



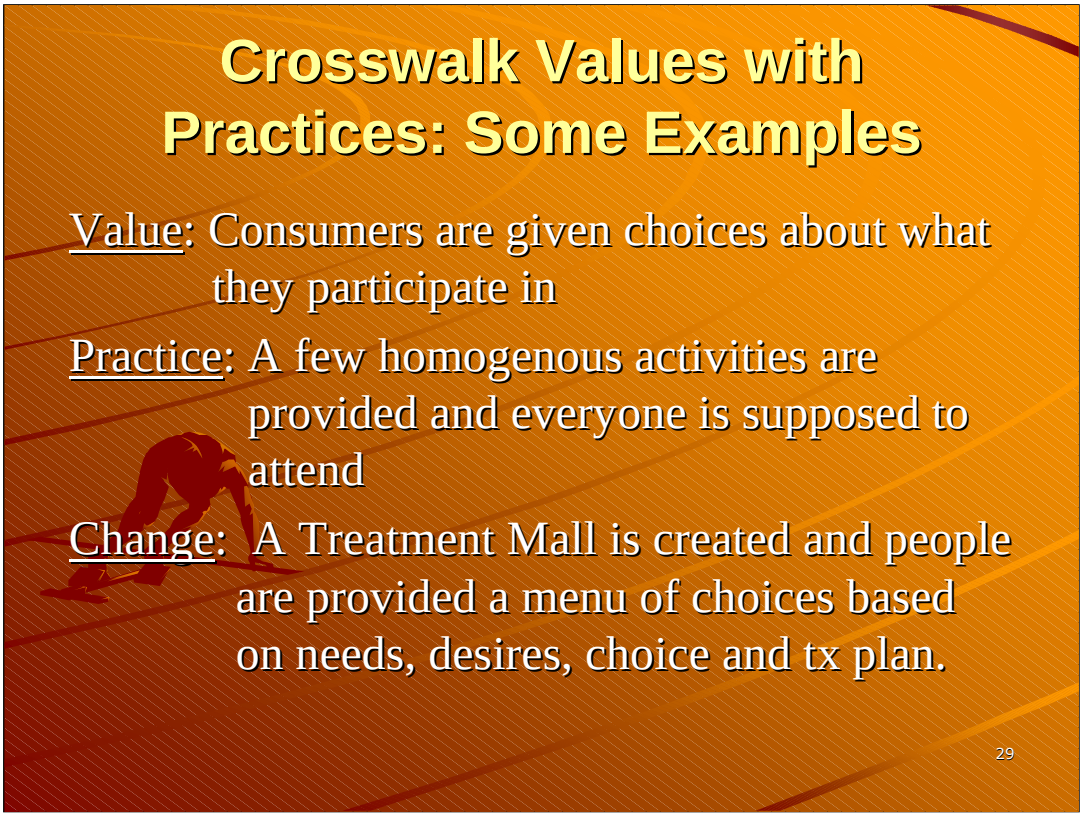
The next commonly seen value is that S/R is only used in the face of "imminent danger" The practice, however, is that S/R is used for any kind of property destruction, one time only acts of violence, or non-destructive but problematic behaviors such as lying in the middle of the floor or refusing medications. The change required here are clear definitions for staff on what constitutes imminent danger and what to try in dealing with behavior below that threshold.



Another value sometimes unwritten but present is that staff will avoid triggering clients and any kind of shaming. But redirection practices are public and include verbal redirection and deletion of points for what staff deem as undesirable behavior; sometimes loudly and sometimes in a very demeaning way. The required change here is to respectful, private discussions of behavior, including point level systems (if used). If these practices are used it is strongly recommended that these practices only award points for pro-social behaviors but avoid taking away points for what you might call behavioral failures.

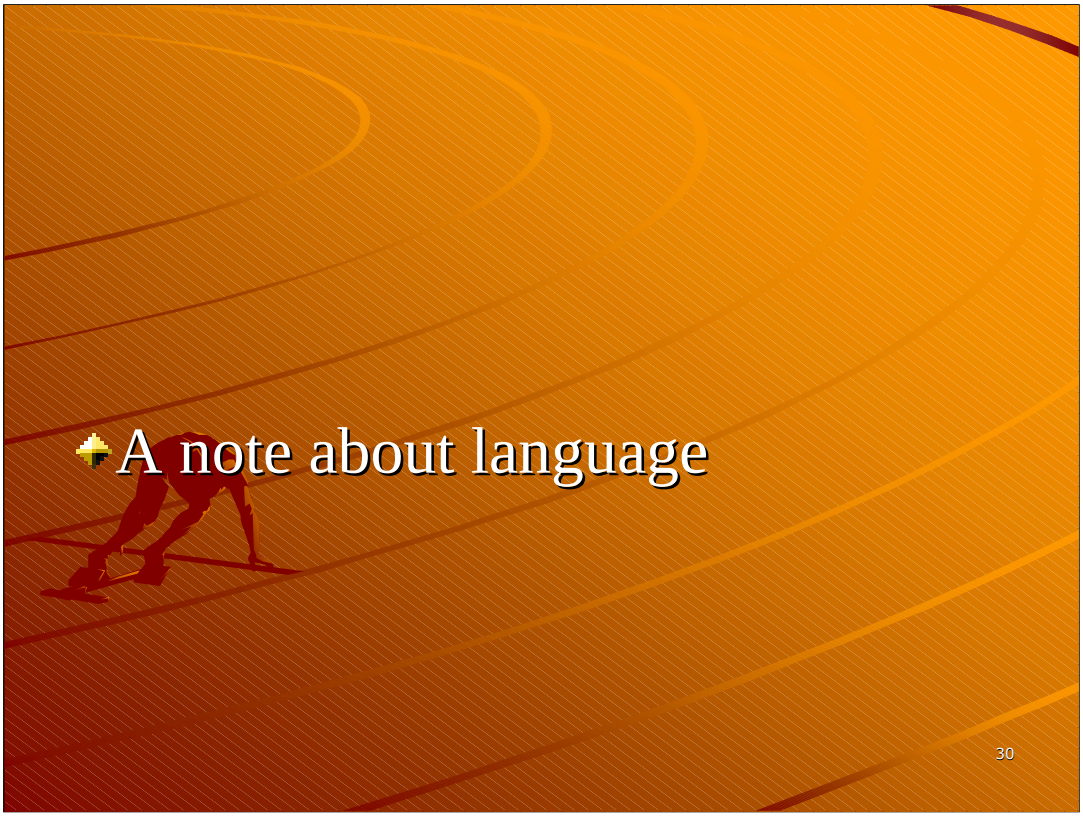


Stated Organizational Value: Consumers (kids, youth, adults), of all populations, are included fully included in treatment planning and care. This is a very common value, but it's also very much the practice that what we think that means is that if people are invited to their treatment planning session that they sit there and they sign it. And the organization may have a consumer or family satisfaction survey that people may or may not know about or may or may not take advantage of. The change; to really talk about inclusion and partnership where person's served actually are appointed to facility committees, they participate, they're full members. People receiving services are educated in their role in treatment planning and the team respects this role. That consumers look at our policies and procedures and they help us review them. They sit on the governing body; they inform our policies and practice that have to do with daily operations and we provide employment opportunities and volunteer opportunities for people both internally and externally to the agency and of course that's somewhat age-based when we're treating very young children. In those settings we will be talking to families and advocates and not the very young children.



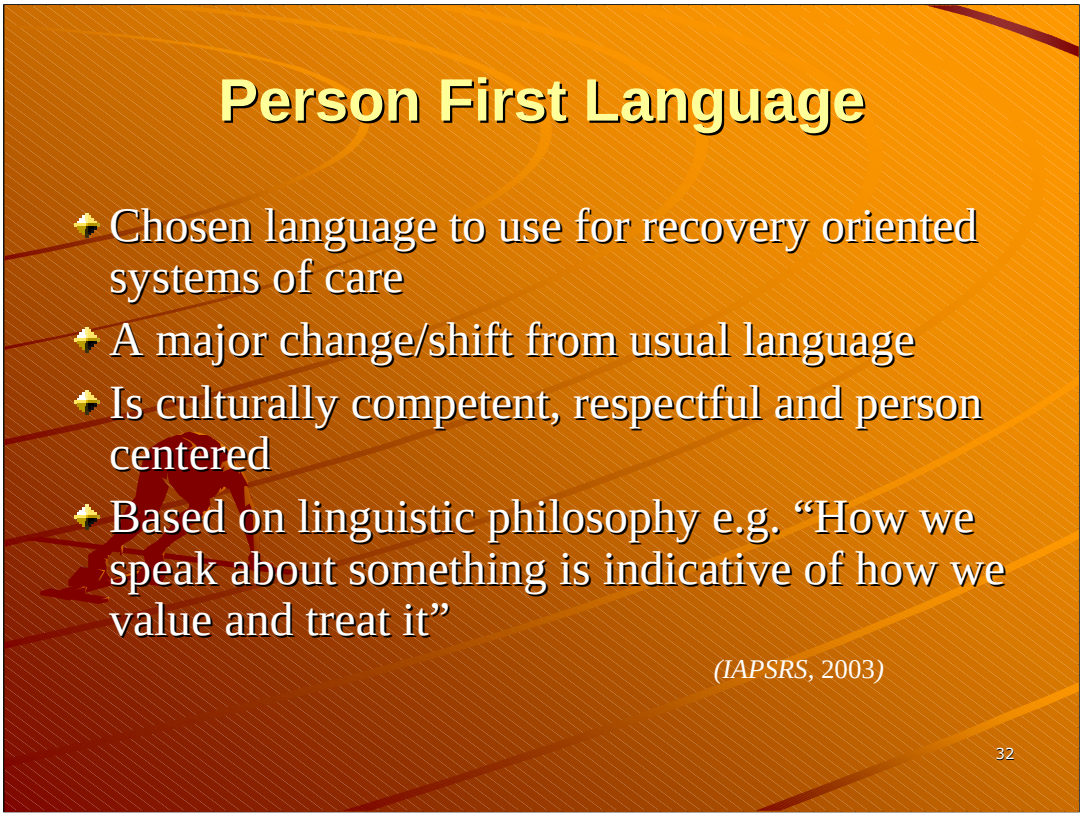
Lastly, consumers are given choices about what they participate in. Most of you have heard about treatment malls. But more often treatment activities include only whatever you provide for daily programming and very often these are a few homogenous activities that all clients are supposed to attend. Sometimes treatment is "stepwise"; clients are expected to meet the goals of sessions 1, 2, 3, whether they really need these services, before they can move to 4, 5 and 6. Everybody goes through the same activities, in general, regardless of whether they need these services and what the treatment plan says.

What we're talking about here when we start looking at that value is a treatment mall that looks more like a small community college and this can be done on a very small level because we've done it and I know many other hospitals that have done it also, where you create a menu of activities that are designed to meet the needs of the people you're serving and they sign up with their treatment team and it becomes part of their treatment plan so that we know some people need to work on perhaps hygiene skills and other people are already getting ready to learn how to interview for jobs and all that goes in-between that.

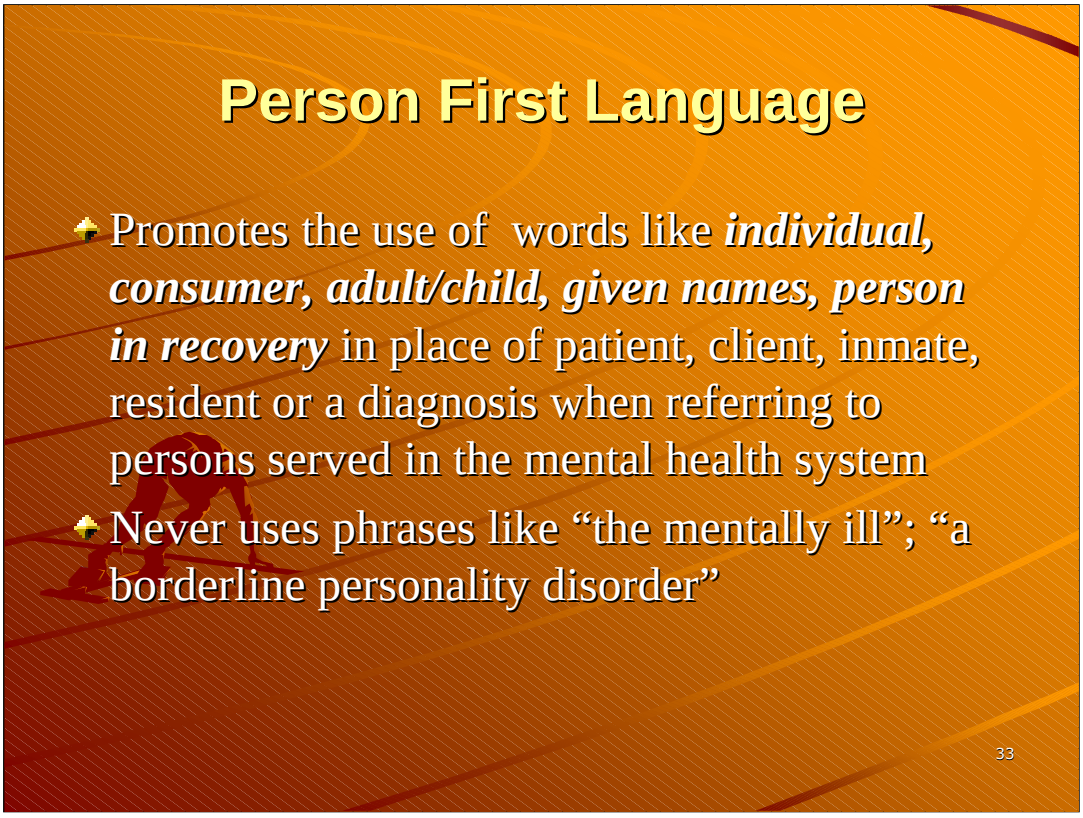


Just a quick note about language.

NTAC believes that the way we think is often the way we behave and often governs our attitudes. We need to look at our speech in mental health settings and in some cases health care completely. We use dehumanizing language sometimes and the language of conflict targets populations, line staff, “in the trenches”, “take downs”, aggression control, units, wards, lock downs, in the field, surveillance, strip searches, curfews. We call people schizophrenic, the mentally ill, borderlines, non-compliant, manipulative, attention seeking, patients and cases. Case management; does that mean as the case manager I’m managing cases or am I’m trying to help partner with a person?

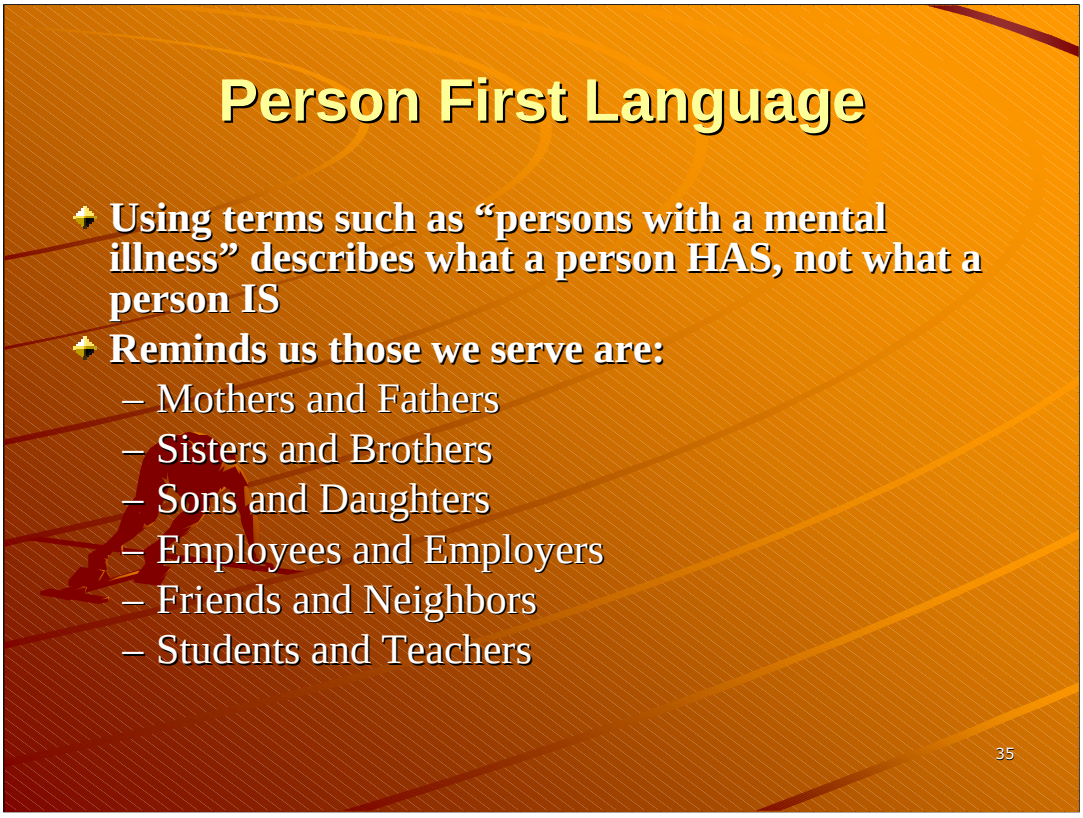


Person-first language is the chosen language of most of the consumer movement. We use it to basically start to change the way we look at our system of care and become more congruent with recovery. It's a major shift and change in our language. It takes a lot of work. When you implement this in a facility, everybody goes on a system of just kind of prompting when someone slips and it's got to be pretty open and it can be pretty gentle, but it's a way to have people stop using certain kinds of language and start to change the way they talk. It's also a place where you go through your policies and procedures. It's quite doable and it really does change at least in my experience and several of my faculty the way people eventually start to behave.



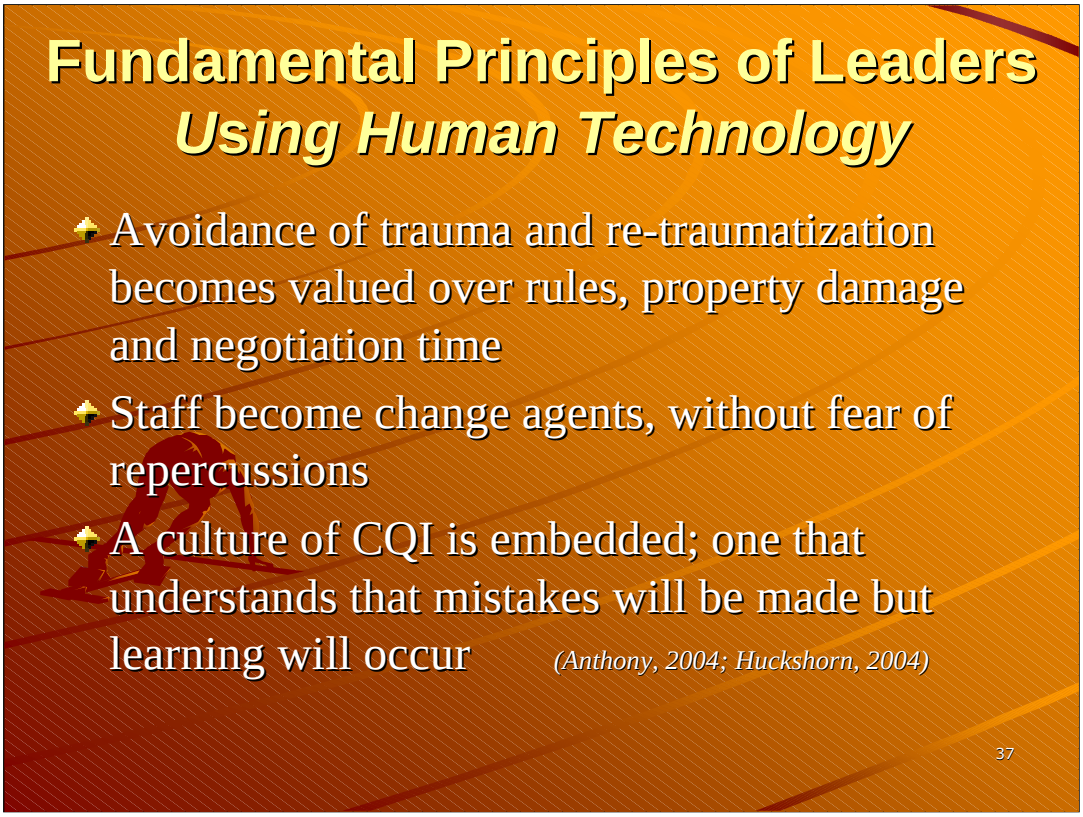
Person-first language promotes words like individual, consumer, adult/child, using given names in the medical record instead of client or patient. These systems use individualized names: Mr. Jones; James Smith, Sally. Kid's programs tend to do this more than our adult settings and our forensic settings, although that's not a rule, but they do tend to use children's names a lot more. We never use phrases like "the mentally ill" because that connotes that while that person is, they've lost all their other adult roles and now they are a mental illness instead of a person first. That's what person-first language is about.

People are people first and that they use a one word to consistently categorize a whole group of very, very different people dehumanizing and disrespectful.



Person First language reminds us that the people we serve have or have had other roles and are human first albeit with a serious illness, but not an illness first, attached to an object that can be categorized or ignored.

The third leadership principle is the best use of human technology. Leaders create processes so they can best use their workforce and their workforce can best help them get their organizational needs met. Workforce development is imperative and it's another core strategy and you'll have some more modules on that.



What happens there is that staff becomes empowered to negotiate and empower the people they're serving to provide choices and to make win/win situations. Staff are allowed to become change agents and they understand what that means and they're supported through administration, even when mistakes are made. Staff understand the need to avoid traumatizing people they serve and are given the skills to do that.

Leaders, in terms of executive staff, find leaders and create teams of these leaders to then role model to other staff. And again, adults/children and families are sought out to provide feedback on all practices

Another especially important piece here in the use of human technology which I'll be talking about a little later this afternoon is the oversight, the elevation of seclusion and restraint events so that they're consistently witnessed, reported on; facts are good and clean and they then make us be able to do a more integrity-based analysis of the event.

Another issue here that executive staff also, especially at the beginning of this process, creates consistent and routine practices and opportunities to go talk to staff about how this is for them in a safe place and what we recommend that you do is you go out to your staff, you have a series of rap sessions and you say I'm here just to take notes; tell me how I could help you do your job better, especially with regard to not using seclusion and restraint. As your staff get comfortable with that, they have an awful lot of knowledge. They can tell you what going on in the units and what seems to them to be a barrier in reducing seclusion and restraint.

Fundamental Principles of Leaders
Using Data to Inform Practice
(Six Core Strategies ©*)*

4) ***Leaders use information to drive change***

- Gather historical data by event/hours (6 mo to 1 yr) to use as baseline
- Set realistic goals or 100% reduction
- Gather and track multiple variables
- Post reports on units monthly

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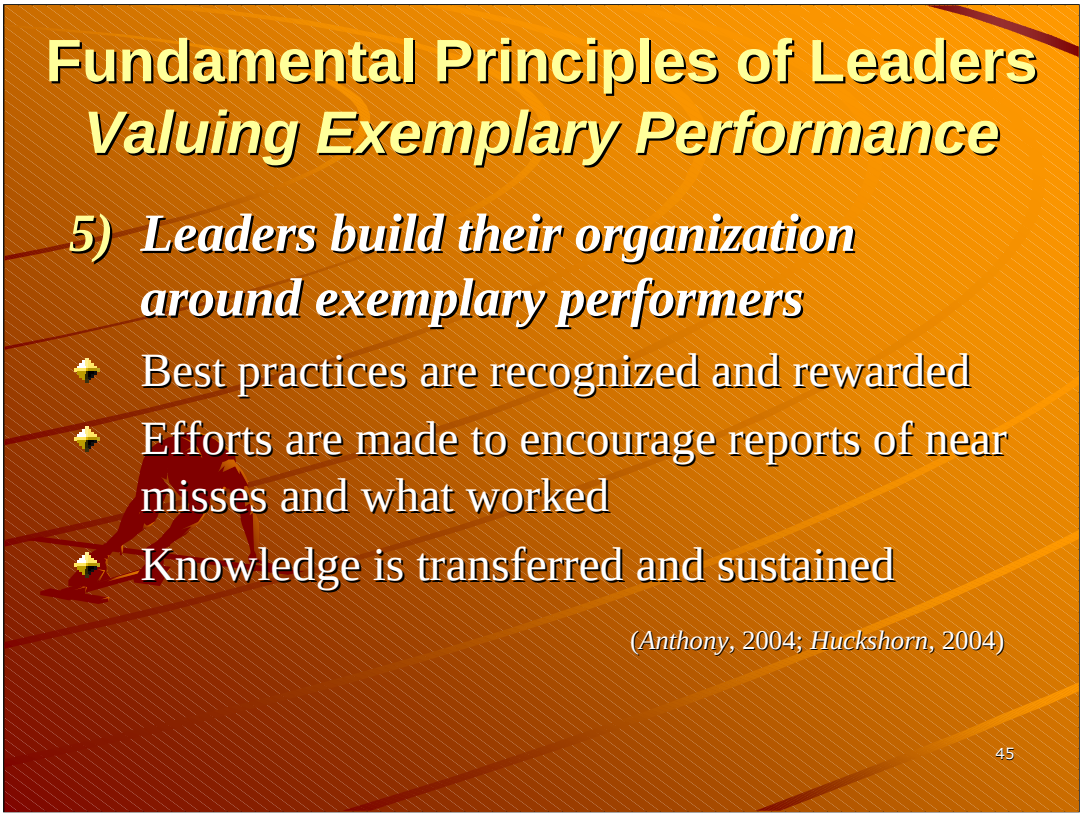
Using data to inform practice: this is another leadership core competency. This is the only place we're going to talk about data. Most of you have clean and quality data systems, so my point here is use them in this initiative. What we first suggest is that you to get a baseline and to track yourselves against the baseline. There is no nationally regarded baseline goal where we could hold up and say everybody needs to be at this particular magic number. We like to look at the reduction of seclusion and restraint and eventual elimination with a goal zero use, just like we'd want to look at the suicide prevention program. There are some means, some national means that are available to you but the problem with using those means as a goal is that mean is an average of hundreds of facilities, hundreds to thousands of patient days and facilities that are very, very different across their different cultures. Some of those facilities use an awful lot of seclusion and restraint. Some are using none. So averaging them does not give you as a state or a facility a goal, if you will. It's not really relevant to that and shouldn't be used in our opinion that way.

"Miss Peterson, may I go home? I can't assimilate any more data today."

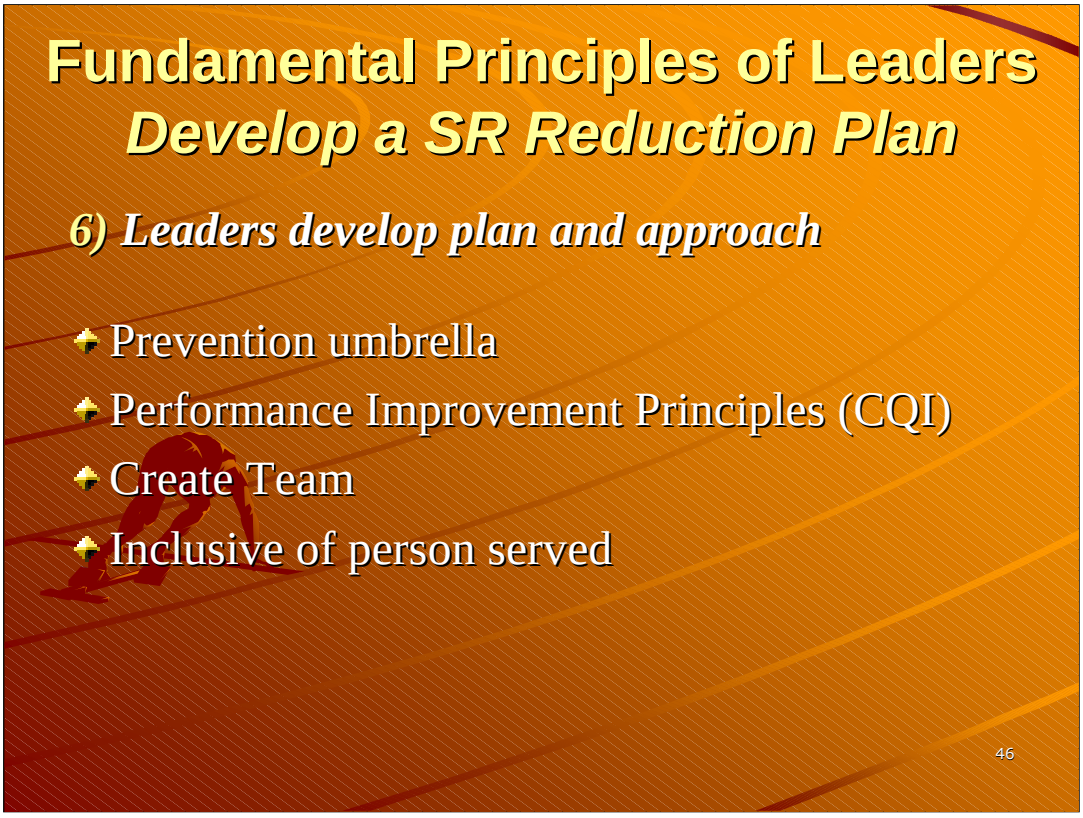
Also gather and track multiple variables and we can talk about these variables. All of you should be tracking hours and events of seclusion and restraint separately. We also, if you can do this with your data system, start looking at when these events happen; unit day; shift and time of day; age; gender; race; date of admission; diagnosis; attending physician; and the patterns of the staff involved in the events. The latter is not supposed to be used and needs not to be used as a punitive technique at all, but this will give you really interesting information on what shifts this is happening, seclusion and restraint happening and what shifts is it not. It's going to tell you what staff possibly need to be trained. It's going to also tell you what staff you have with excellent negotiation skill sets that you can use as champions to help train their peers.

The use of data will give you an awful lot of information. We use it to monitor progress, to basically target, like I said, certain people for training; to create a very healthy competition and again, when you start doing that sometimes staff get very suspicious and the only thing that will belie that suspicion is that over time they see that this information is not being used to punish people and it can't be. Part of CQI is that we use data transparently and we use it in a way that moves us forward; it doesn't try and play gotcha.

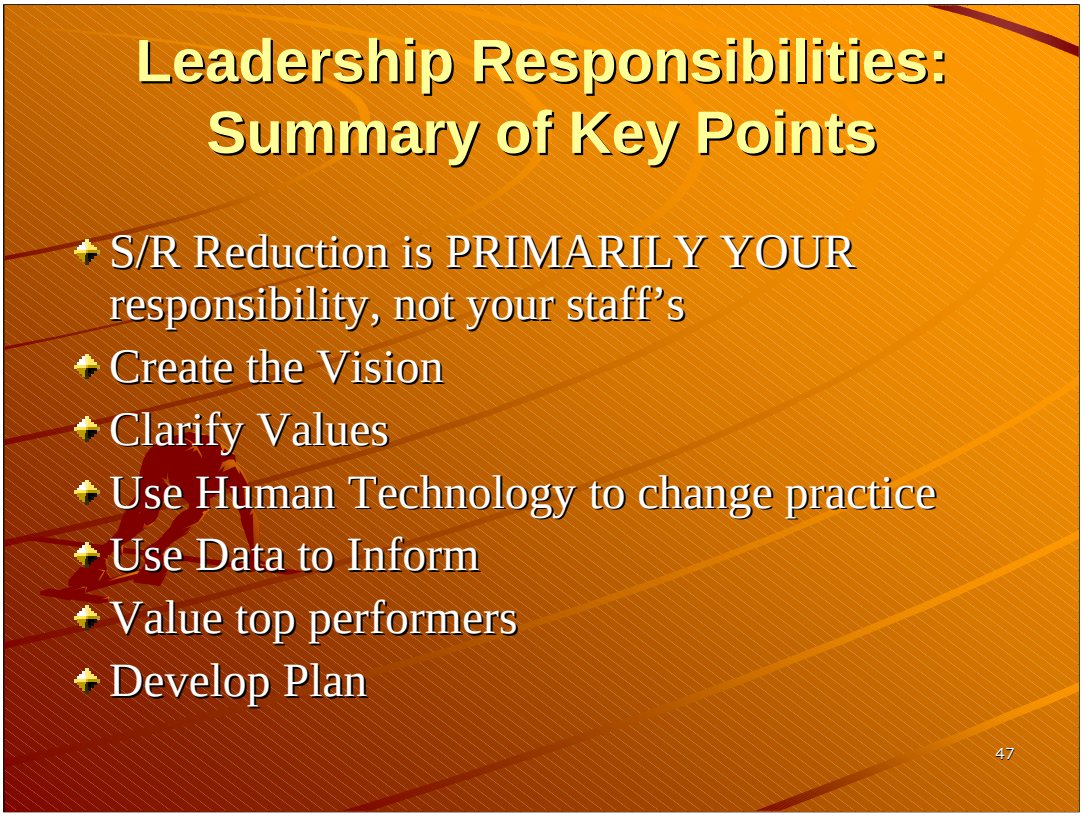


Leaders also build their organizations around exemplary performers. We often forget to reward. We're always so busy, and for very good reason, running around trying to run our fairly large organizations and keep up with all the regulations and deal with the budget cuts in the governor's office and whoever else, sometimes the state office, that we often don't take the time to reward best practice. So this is an opportunity to put in your plan how are you going to reward best practice and there's a myriad of ways to do that.

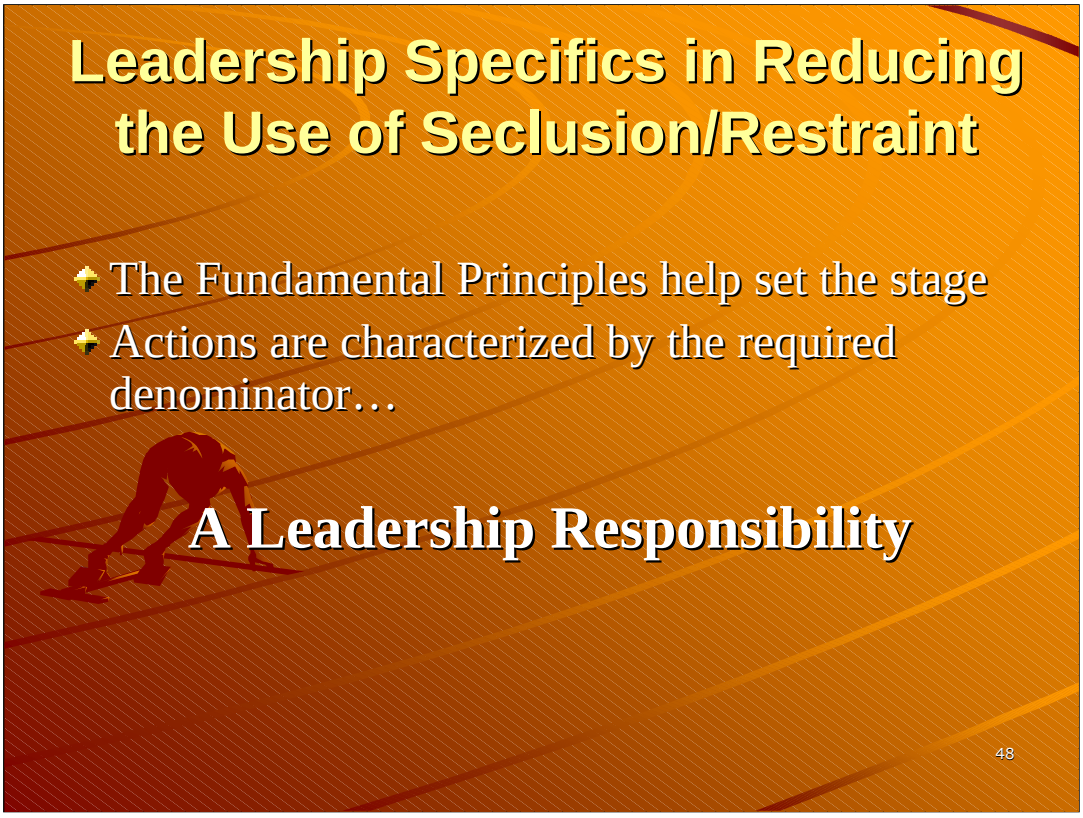
Also rewarding near misses. NTAC has heard some wonderful stories where as facilities have moved toward S/R reduction, and worked with their security staff and their unit staff so that "all of a sudden events" will be de-escalated so the conflict does not reach the threshold of eminent danger. What happened was the staff and whoever it was that was on the response team spent 45 minutes talking down the individual and everybody waited for them to do that; a very different scenario from what usually used to happen when we'd rush in; do a takedown in three minutes and someone would be restrained in five minutes and everybody went back to work. So there's a whole culture change that goes into that; a whole understanding that that's what you want to have happen. That was a near miss and really looking and analyzing at that event and rewarding the person that was able to do that, instead of defaulting to the old way which is much quicker.



Leaders develop the plan and approach using a prevention umbrella; performance improvement processes, create their team and include person served.



Summary of key points: Seclusion and restraint reduction is primarily a leadership responsibility; not your staff's primary responsibility, at least in the beginning. Leaders need to create the organizational vision, clarify the values; use human technology to help change your practices in your facility; use data to inform you of where you've been, where you're going and where you want to be; value top performance and then develop the plan.



Fundamental principles help set the stage, the one's I just reviewed. All these leadership actions are characterized by the required denominator again which is leadership and which in most cases involves the people who they serve.

Thank you very much.