



Final Report

The Cultures of Engagement In Residential Care (CERC) Project Hawaii's Initiative to Increase Alternatives to Restraint and Seclusion in the Child and Adolescent Mental Health System

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Final Report
The Hawaii Alternatives to Restraint and Seclusion SIG Project
Creating Cultures of Engagement in Residential Care (CERC)
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The Hawaii Alternatives to Restraint and Seclusion (ARS) State Infrastructure Grant project has been an exciting and successful component of efforts to improve the quality of Mental Health services for Hawaii's youth. The State Dept. of Health's Child and Adolescent Mental Health Division (CAMHD) has a long-standing commitment to providing services without utilizing unnecessary seclusion and restraint (S/R). However, until undertaking this project with funding from the federal Substance Abuse and Mental Health Services Administration (SAMHSA), we had not been able to achieve sustained major reductions in the incidence of seclusion and restraint (S/R) in our hospitals and residential programs. Since beginning this initiative, we have seen large reductions in the use of these methods in our system as a whole, and especially in the several programs where the project conducted intensive interventions. This report will provide an over-view of the project's progress toward its original goals and objectives. Some of the major "lessons learned" in the course of this work will be discussed, along with recommendations for future S/R reduction efforts of this kind.

One of the first dilemmas for the grant team was to choose a name for the ARS initiative. We decided to call it the "Cultures of Engagement in Residential Care" (CERC) Project to reflect a desire to make deeper changes in the organizational and treatment cultures of our residential programs as well as to see reductions in S/R events. The CERC initiative is continuing to have a life past the grant-funding period as part of CAMHD's central office programs as part of our Practice Development Team's ongoing efforts to improve clinical care.

Our Mission: Reduce the Use of Restraint and Seclusion in Hawaii

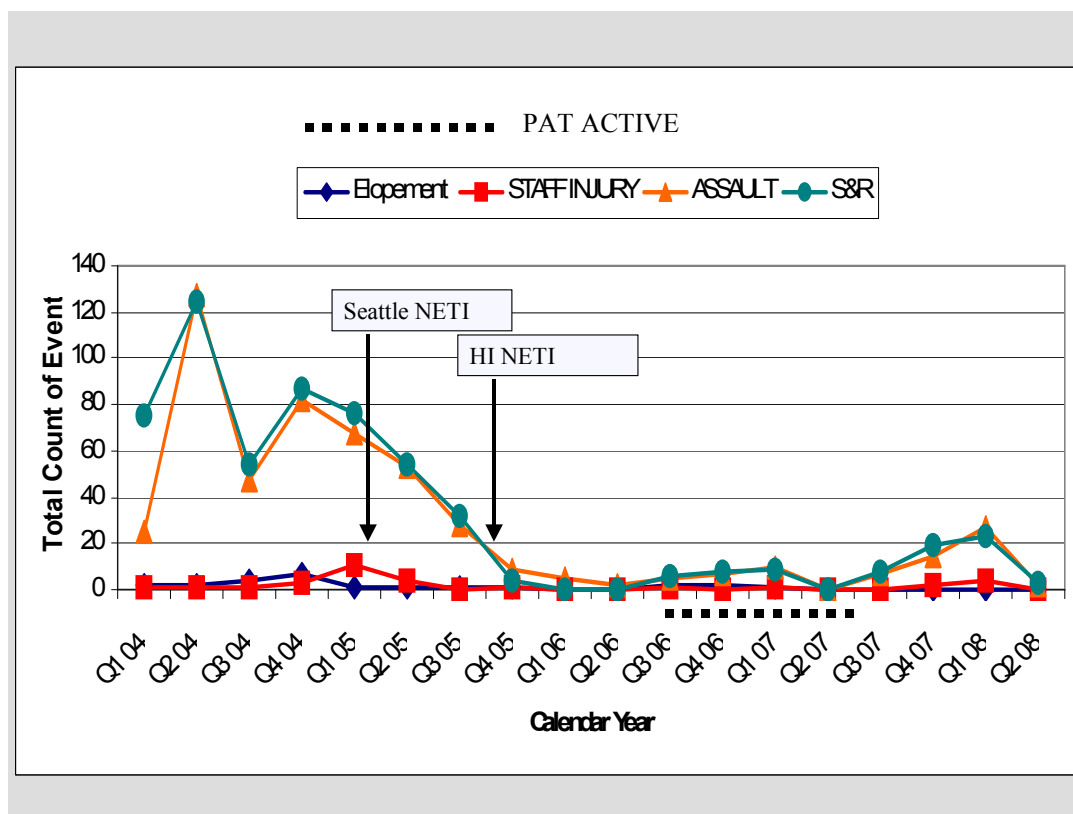
The overall mission of the project was to reduce the use of restraint and seclusion within Hawaii's system of care for children and adolescents to the lowest possible level, through a comprehensive set of awareness, training and technical assistance activities supporting service providing agencies and personnel throughout Hawaii.

The following three figures show sentinel event data from three programs that were our highest users of S/R interventions in the past. Each of these programs received intensive technical support interventions from a CERC "Positive Alternatives Team" or PAT. Each has shown a steady decline in S/R events, and this has been accompanied by declines in other events of interest including physical assaults and elopements. These declines have been achieved without any increases in the rate of staff injury.

The data displayed in these charts are taken from CAMHD's Sentinel Event database, which includes information on a range of events, reported directly to CAMHD by contractors at all levels of care as a contract requirement. Raw counts of events are reported rather than a rate per 1000 clients, which is a more standard way to display these data. This is because we have found that in our very small programs (generally

less than 20 youth served at a time), small variations in the census can have a large impact on the rate data. Raw counts give a clearer picture of what is happening in the program milieu that is comparable within that program to the same data over time. For example, 120 S/R events in a quarter would mean more than one event happening every day on the unit, while 10 events in a quarter means less than one event is happening every week – clearly a very different therapeutic milieu.

Figure 1. Sentinel Events at Queen's Medical Center January 2004 – June 2008

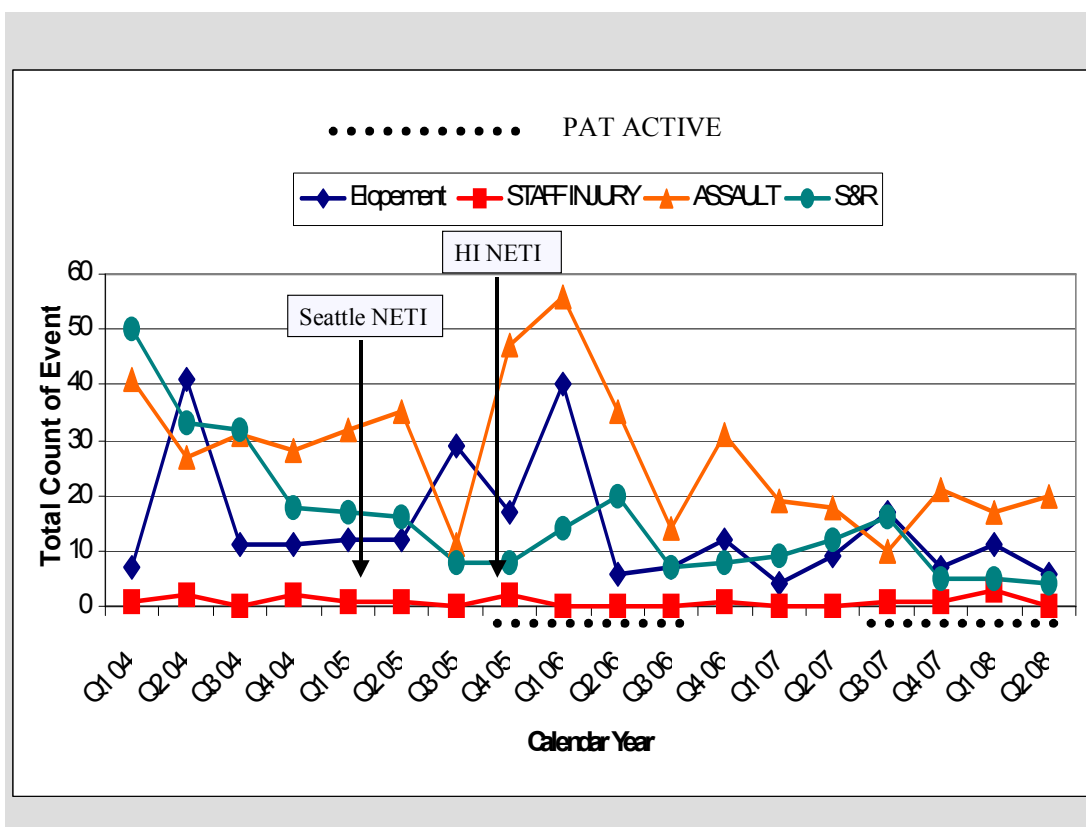


CAMHD contracts with The Family Treatment Center at Queen's Medical Center to provide Hospital-based services to youth. They have a 28-bed unit that includes separate programming for acute and residential patients and separate areas for latency-aged youth and adolescents. CAMHD contracts for up to twelve residential beds. Leaders from Queen's were engaged early on in the CERC project. Three managers from the program, including the VP for Behavioral Health attended a conference on S/R reduction in Seattle in January of 2005, along with grant personnel and other provider agency staff. Sponsored by the National Technical Assistance Center (NTAC), our grant TA group, the "National Executive Training Institute" or NETI program provided a great deal of information about successful strategies for reducing S/R. As shown in Figure 1., S/R events began to decline sharply after the Seattle NETI experience. In September of 2005, the CERC project held our "kick-off" conference for the project in Honolulu. We utilized the NETI curriculum, and the conference faculty was provided by

NTAC. Queen’s took advantage of this opportunity and sent 20 or so staff to the two-day event. Soon after the September NETI in Hawaii, Queen’s experienced its first month of no S/R events.

Queen’s leadership chose not to be part of the project’s first round of PAT technical assistance interventions because of a number of concerns, including the fact that they were introducing a new electronic medical record with a planned multi-month “roll out” and intensive staff training scheduled. As a result, the PAT intervention started in the fall of 2006, after the program had achieved significant reductions in S/R incidents. Nonetheless, the PAT intervention was able to help the program consolidate some of its gains and work in the direction of more pervasive cultural changes.

Figure 2. Sentinel Events at the Pu’ukamalu Program January 2004 – June 2008



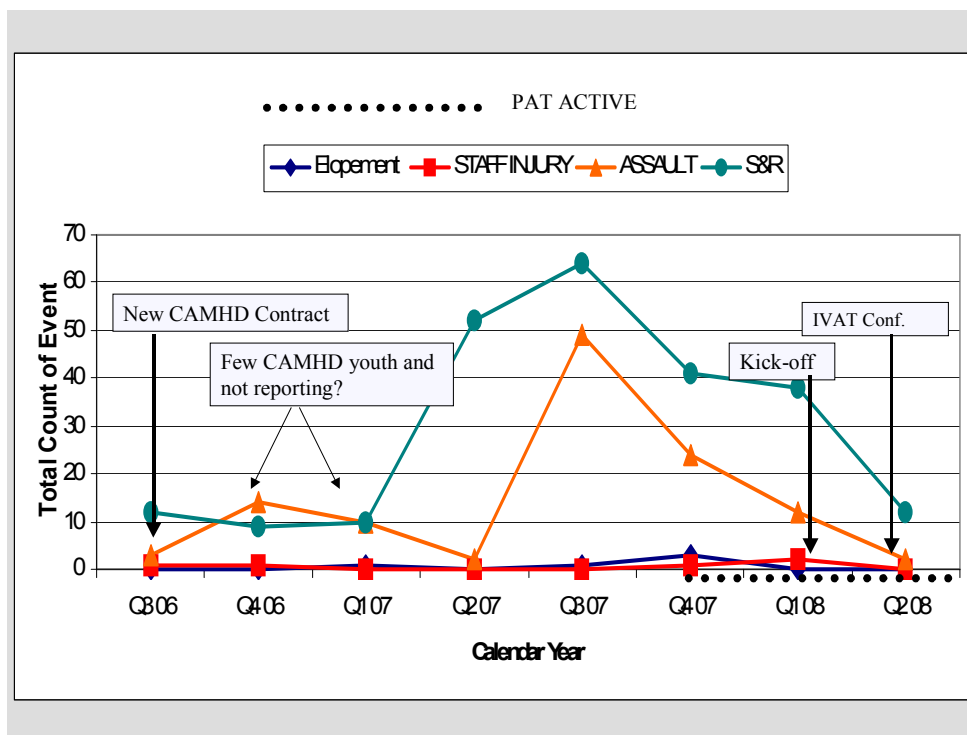
CAMHD currently contracts with Acadia Healthcare to provide Community-Based residential services for up to 24 youth ages 11-18 through the Pu’ukamalu program in Hilo on Hawaii Island. This program is located in a rural area with few workforce resources, and it has a challenging physical plant. Lack of stable administrative and clinical leadership has been a major problem there through most of the grant period.

In 2004 when the ARS grant was awarded, the Pu’ukamalu program was our second highest user of S/R interventions. At that time, another company - Kid’s Behavioral Health (KBH) - owned the program. Leaders from KBH were engaged early on in the

CERC project, and two managers from the program attended the NETI with us in Seattle in January of 2005. Information from the NETI was helpful in continuing a trend in the program toward fewer S/R events. By September of 2005 when the CERC project held our “kick-off” NETI conference for the project in Honolulu, one of these leaders had left. KBH sent four or so staff to the two-day NETI event on Oahu, with their travel supported by the ARS grant.

Pu’ukamalu agreed to be part of the first “round” of PAT interventions. Unfortunately, soon after this intervention started, the second leader whom we had taken with us to Seattle resigned from the agency. This heralded a period of increased chaos and difficulty for the program, which can be seen in the data for assaults and elopements as well as for S/R in the chart above (Q4 05-Q3 06). Soon the PAT team was absorbed in trying to support an inexperienced CEO and help the program survive. Shortly after the end of the PAT intervention the program was sold by KBH to Acadia Healthcare, the current owner. Although S/R incidents continued to show a gradual downward trend following the PAT intervention, Pu’ukamalu remained one of the top users of S/R in our state. The second CEO brought in by Acadia (the program’s fifth CEO during the grant period) expressed interest in working with the project. We went in for a second round of the PAT intervention in late fall, 2007. During this period, the program made a transition from co-ed programming to all boys programming. As the data above suggest, there has been a slow trend toward fewer sentinel events in general as well as toward significantly decreased S/R use. We recently learned that in November 2008, Pu’ukamalu experienced its second straight month of zero S/R events!

Figure 3. Sentinel Events at the Kahi Mohala Program July 2006 – June 2008



CAMHD has contracted with Kahi Mohala to provide Hospital-based services to up to 8 youth since July of 2006 when a new contract cycle began. Kahi had been a contractor in the past, but they were not awarded a contract for a six-year period (July 2000-June 2006). When they won a new contract in 2006 there were concerns around their history of frequent use of S/R. As a result, it was a high priority for the grant project to engage Kahi staff and leadership to be part of the CERC project.

July 2006 data are the first available for examination because only CAMHD contractors report sentinel events for inclusion in this database. Early in their first contracting year, reported sentinel events were relatively low, probably reflecting a low number of CAMHD youth in the program, and possibly reflecting a poor understanding of CAMHD reporting requirements. The data in figure 3 make it clear that by the spring of 2007, Kahi Mohala was reporting a high frequency of S/R incidents. CAMHD performance monitoring staff members were especially concerned about the apparent frequent use of PRN medications (which is not allowed under CAMHD Performance Standards) and the rate of chemical restraint in general. Many sentinel event reports showed the use of what we referred to as the “one-two punch” – seclusion followed by a shot (chemical restraint) followed by mechanical restraint.

In response to some very strong concerns being expressed by CAMHD managers, in the summer of 2007, Kahi leadership tried to “mandate” an end to the use of S/R by declaring that it would no longer be utilized. This had disastrous consequences, as staff members felt their only tool had been taken away from them – and S/R use increased. Kahi Mohala agreed to participate in a PAT intervention, and this started in the fall of 2007. As some real champions for S/R reduction emerged in our work with the unit, and newer hospital management started to show strong support for the initiative and greater understanding of staff concerns, S/R incidents started to decline sharply. In April 2008, staff members from Kahi presented some of their successes at a conference on trauma in Honolulu. These included significant decreases in S/R incidents and a new belief among direct care staff that it is possible to have a calm safe program in which coercive methods are not used.

Progress on Goals and Objectives

Goal 1: Organizational Culture. *Service providing agencies are committed to creating and sustaining an organizational culture based on a philosophy of using positive alternatives to restraint and seclusion*

Objective 1.1 - Raise awareness and foster buy-in and commitment at the leadership level of service providing agencies.

Objective 1.2 - Establish a Best Practices in Residential Care Network comprised of key agency personnel.

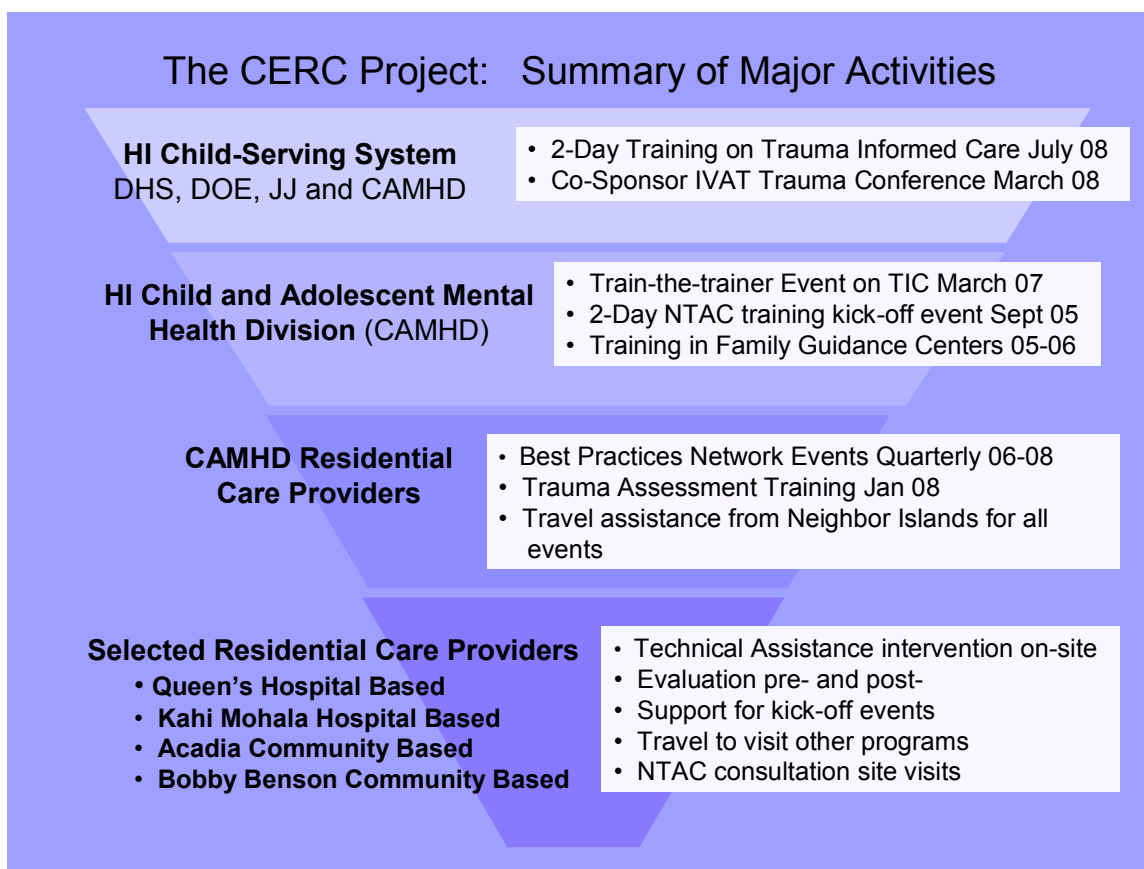
Objective 1.3 - Involve youth from residential programs and families in planning and policy making activities.

The CERC Project has worked on a number of levels to address this goal. As shown in Figure 4., the Project was designed to intervene with the broad child-serving system

(including partner agencies such as DOE), with the whole children’s mental health system (CAMHD), with the group of providers within CAMHD who provide residential care, and in a more intensive way with several individual residential programs. Data from opinion questionnaires distributed at the major kick-off and wrap-up conferences suggest that many CAMHD and contracted agency staff have become committed to a philosophy of utilizing trauma-informed care approaches and to minimizing S/R.

CAMHD has put a major policy statement in place stating “The State of Hawaii is committed to fostering violence-free and coercion-free treatment environments for children and adolescents. As part of this commitment, CAMHD advocates that Contractors seek to minimize the use of restraint and seclusion, and work to increase the effective use of positive behavioral support strategies.” (Interagency Performance Standards and Practice Guidelines, 2006, downloadable at: <http://hawaii.gov/health/mental-health/camhd/library/pdf/ipspg/purplebook.pdf>)

Figure 4. Summary of Major Activities



The Project succeeded at engaging two groups of stakeholders that met on a regular basis and developed loyal participation by members of the children’s mental health community. One was the advisory group for the project, which included two young adult former consumers who acted as co-chairs and two parent members. The other was the “Best Practices in Residential Care Network” (BPN), which was comprised of personnel

from most of our residential programs. Members of the advisory group were invited to participate in the Network meetings. Both groups met on a quarterly basis, with some of the larger Best Practice Network (BPN) meeting being held either by video or audio conference.

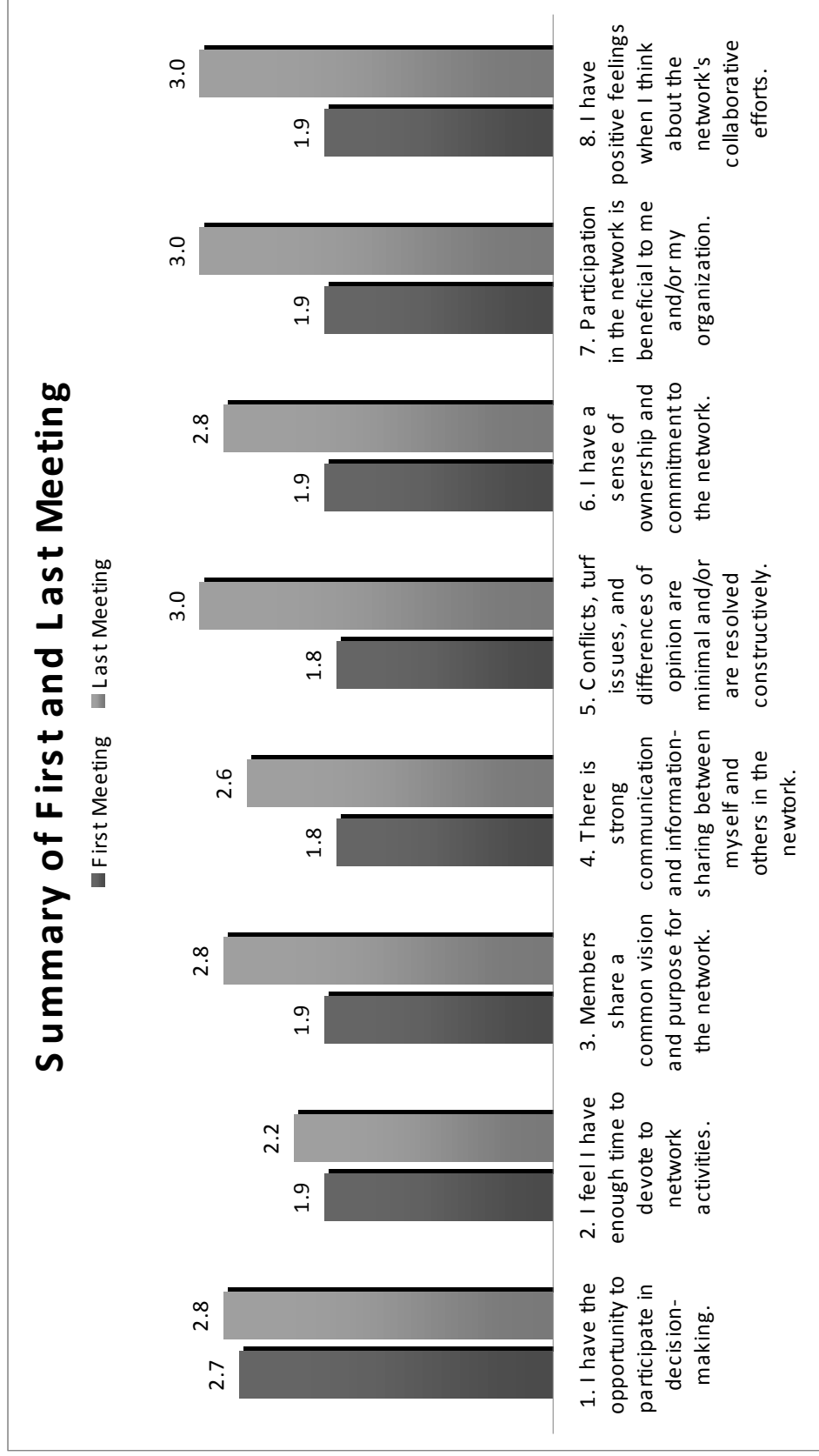
Highlights of the Best Practice Network- Data were collected at each meeting of the BPN regarding participants' feelings and opinions about participation in the group. Figure 5, below shows the average response on each of the items for participants in the first compared with the last network meeting.

There were 14 meetings of the BPN group between 11/1/05 and 9/10/08, including 7 daylong in-person meetings that generally included a training component, two videoconferences, one dinner meeting, and two telephone conferences. The membership who participated in these meetings was more variable and less reliable than we had hoped when we designed it. For this reason, it wasn't possible to measure changes in attitudes toward the network over time using a repeated measures design. Most of the individuals who completed the initial questionnaire were not present at the last meeting. This illustrates the fluid nature of the Hawaii mental health workforce – a number of positions turned over several times throughout the grant period, and also the voluntary nature of the BPN meant that those people interested in the idea attended regularly, and those who were not did not stay active in the group. The variable attendance also illustrates how difficult it is for our programs to give up the time of key leaders and clinicians. Often, they are staffed very “close to the bone” – and can't spare even one person for a day out of the building.

The private provider agencies represented in the BPN compete for state contracts and for client referrals. Because of this, many observers were skeptical that developing the network would be a successful intervention. What we observed anecdotally was that providers exchanged a lot of useful “on the ground” information in these meetings. The Network grappled with a lot of common practical issues including: smoking policies, point and level system dilemmas, ways of incorporating family members into programs, ways of providing youth leadership opportunities, developing sensory rooms, intake procedures, trauma assessment, training for direct care staff, workforce issues, etc.

Also, we observed providers choosing to visit each other's facilities to see changes that had been made and to discuss common problems. When one of our agencies won a contract to open a new residential program for latency age youth, they used their BPN relationships to set up meetings with both hospital units, which would be important “feeders” for their program, and asked for training from CAMHD on trauma informed care and alternatives to S/R for direct care staff. The data presented in Figure 5 suggest that provider agency staff that attended the first network meeting in 2006 were a bit unsure of whether this would be a useful and constructive endeavor. Those who attended the last meeting were unanimous in seeing the network as collaborative, constructive and beneficial. Feedback from providers also suggested that they came to see CAMHD staff as more helpful and human than they had in the past as a result of working with us through the network.

Figure 5. Responses to Questions about the Best Practices Network: November 2005 vs. August 2008



Disagree = 0, Disagree Somewhat = 1, Agree Somewhat = 2, Agree = 3
 First meeting n = 19; Last meeting n = 24

Goal 2: Attitudes skill and knowledge. *Personnel at the managerial, supervisory, and line levels have the attitudes, skills, and knowledge to employ positive alternatives to restraint and seclusion effectively.*

Objective 2.1 - Support the Best Practices in Residential Care Network to provide peer-to-peer training and technical assistance.

Objective 2.2 - Provide training and technical assistance to agencies operating residential programs through a Positive Alternatives Team

Objective 2.3 - Facilitate communication among project partners and stakeholders and disseminate information about project accomplishments, findings, and events.

Staff of many of the CAMHD provider agencies involved with residential care gained a good deal of knowledge about how to employ positive alternatives to S/R in the course of the CERC project. Specific information about the NTAC “Six Core Strategies to reduce Seclusion and Restraint” (Huckshorn, 2004¹) was provided to program leaders and clinicians at two major 2-day training events: the project kick-off conference in September 2005 and the wrap-up conference in July 2008.

By the time we held the wrap-up conference this summer, it was clear that many local people had become experts in this area. Provider agency personnel gave presentations as part of several panels. This included: a panel of administrators, a panel of clinicians, and a panel of direct care staff. Each person talked about his/her own experience utilizing the six core strategies and Trauma Informed alternatives to S/R. For the wrap-up conference, we focused on attracting staff from our partner agencies, including Department of Education and the Juvenile Justice system. As a result, this was also an excellent forum for us to share about our providers’ accomplishments and lessons learned through the CERC project with a broader group of stakeholders. Staff of the Queen’s program also presented at a breakout session during the conference and provided a more detailed description of how they were able to make large reductions in both S/R events and physical assaults on their unit (see Figure 1).

A “train-the-trainer” daylong event on Trauma Informed Care (TIC) was held in March of 2007, and attended by many agencies training staff (total attendance was 37 provider staff). Attendees brought the information back and in turn trained direct care (“line level”) staff in their programs.

The CERC Project provided a good deal of direct training and technical assistance throughout the project. This included presentations about the “Six Core Strategies” and TIC that were made in all of CAMHD’s Family Guidance Centers (FGC) across the state. These presentations focused on how Care Coordinators can utilize TIC ideas in working with residential care providers to assure high quality care for youth. Information on safety planning with youth was also incorporated into CAMHD’s quarterly Foundation Program for new FGC staff.

¹ Huckshorn, K.A. (2004). Reducing seclusion and restraint use in mental health settings: Core strategies for prevention. *Journal of Psychosocial and Mental Health Services*. 42(9), pp 22-33.

Highlights of the PAT interventions. A more intense dosage of training and technical assistance was provided to agencies that received the project's Positive Alternatives Team (PAT) intervention. We provided this to a total of four agencies. PAT interventions were provided as follows:

PAT Round	Time Period	Agency 1	Agency 2
1	11/05 - 6/06	Pu'ukamalu Program Community Based	Bobby Benson Center Community Based
2	11/06 – 5/07	Queen's Family Treatment Center - Hospital Based	<i>(Maui Youth and Family Services Community Based)</i>
3	10/07 – 9/08	Kahi Mohala Hospital Based	Pu'ukamalu Program Community Based

The first “round” of PAT interventions included work with one of CAMHD's stronger residential programs, the Bobby Benson Center (BBC), a co-ed Community Based Residential program that includes a focus on substance abuse problems. Like many of our residential programs, BBC has not been a high user of S/R. However, they have had a high incidence of other Sentinel events of concern, such as assaults and elopements. Moreover, leaders at BBC were excited about the idea of making a major cultural change away from coercion and control and toward engagement and trauma informed care.

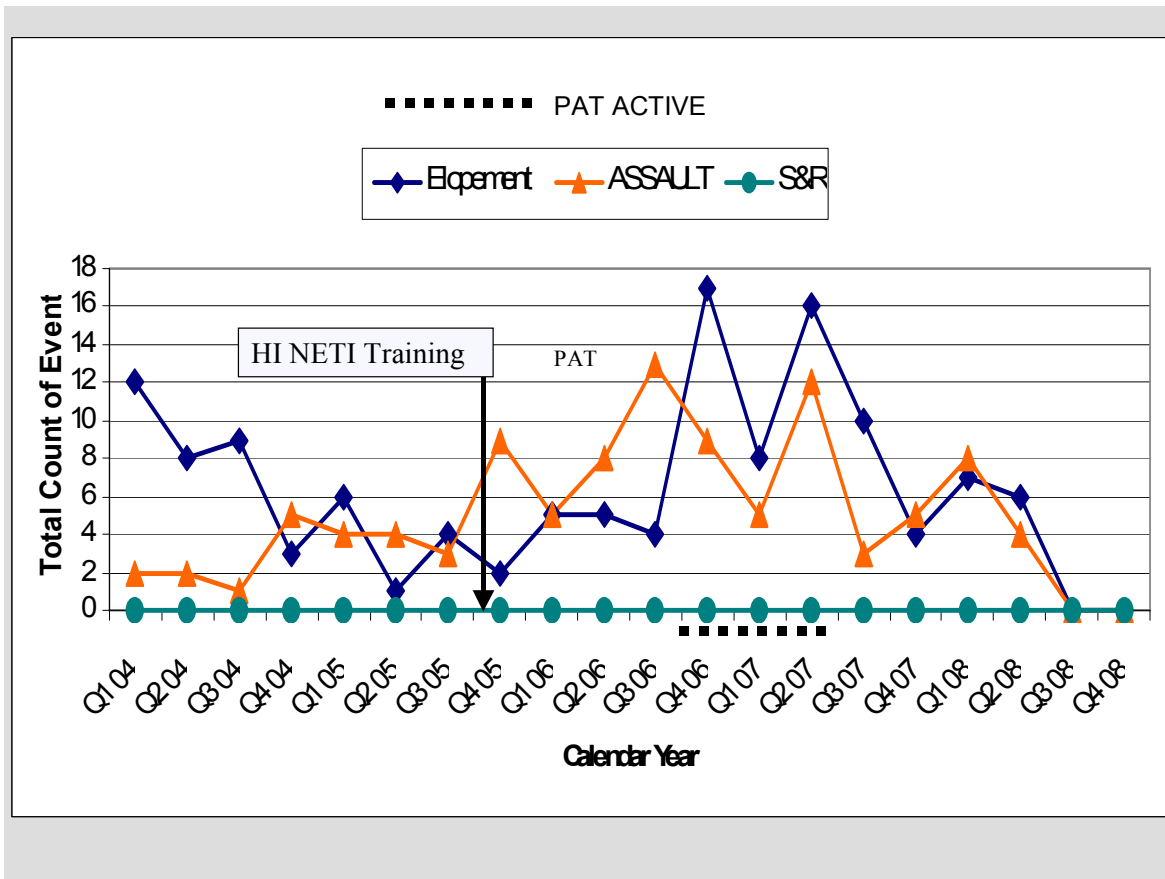
Through the technical assistance provided by the CERC project team, BBC made a number of major changes in their program design, shifting from a punishment-oriented behavior management system to one that emphasizes use of positive behavioral supports. Dr. Perreira, the CERC psychologist involved in the PAT, worked intensively with BBC leaders to reshape their program and to retrain their staff.

Sentinel Event Data from BBC (displayed in Figure 6. on the next page) suggest that the period of upheaval and change while the PAT intervention was taking place was a time of more frequent assaults and elopements. However, in the months following the changes, these events appear to drop off again, and show the promise of reaching very low levels. In April 2008, the BBC clinical director presented her experience working to develop a trauma-informed program as part of a grant-sponsored colloquium at a large annual trauma conference in Honolulu. Her enthusiasm led several of our provider agencies to arrange visits to see the changes in action at BBC.

The original design of the PAT intervention was to include a team member from each of the two agencies involved in that round along with the lead clinician (Dr. Perreira) from the CERC project and assistance from other CAMHD/grant staff as needed. We hoped to have the members from the two agencies travel to each other's programs, train each other's staff, etc. One of our main “lessons learned” is that this was not a practical design. Our residential provider agencies do not have deep enough staffing to permit any of their leaders to spend this much time away from the program – even with funding

to cover the team member's time. We were able to involve agency team members in a few visits and evaluation activities at the other program, but that was all. In later rounds of the PAT intervention, we were able to involve a youth consumer in some of the PAT activities, and this proved to be very positive. At BBC, we were able to include the program CEO as a PAT member, and although his work on the team was less intensive than initially envisioned, his role was extremely positive. This obvious commitment of the highest level of leadership to this initiative helped assure its success.

Figure 6. Bobby Benson Center Sentinel Events, January 2004-September 2008



The experience of working with the other first round PAT agency, Pu'ukamalu, presented quite a contrast to the BBC experience. In the midst of major leadership changes, and with a brand new inexperienced CEO, the agency was only able to provide an on-call nurse to act as the PAT member. This person was an excellent champion for the project's goals, but she was not an integral part of the Pu'ukamalu staff and couldn't help the team gain staffs' trust. With all the changes happening, sentinel events increased (see Figure 2, p. 3). The PAT team, along with the NTAC Grant Site visitors discovered many worrisome, coercive practices in the agency. For example, we learned that youth were being required to request toilet paper from staff when they used the bathroom! Concerns about the program's instability led CAMHD to close admissions while the agency re-grouped. This put financial pressure on the agency because of the potential for decreased revenue due to empty beds.

This first intervention attempt at Pu'ukamalu included some work on policies, some staff training in the area of TIC, and work with the program on developing more of a role for families and more intervention with families. However, the deep problems with basic organization and staffing infrastructure led Dr. Perreira to focus primarily on helping the interim CEO with stabilizing the program.

The second round of PAT interventions brought the team to Queen's, where the CERC project had maintained a good deal of less intensive collaboration during for first two years of the grant, and where major reductions in restraint and seclusion had already been achieved. The PAT member assigned by Queen's was a long-time staff member and leader among the nursing staff, and she was an excellent champion for improving the milieu and using TIC. The PAT intervention at Queen's was able to focus on refining the approach, including work on issues such as making safely planning a more integral part of the program, doing more rigorous and useful debriefing, integrating the unit psychiatrists and psychiatric fellows into the program, and developing the unit leadership team.

The plan during round two was to work with a community based residential program on Maui, run by Maui Youth and Family Services (MYFS). Just as we started to form the team for this intervention, there was a major upheaval in MYFS leadership, with the board of directors firing the CEO. With support from CAMHD, MYFS decided to bring in one of our NTAC consultants as an interim CEO and to close the CBR program temporarily. The CERC project worked with MYFS on planning for a new and improved CBR program, but we did not implement a PAT intervention there.

The third round of PAT interventions took the project back to the Big Island and the Pu'ukamalu program and to our newly contracting hospital unit at Kahi Mohala. Instead of identifying one staff member from each program to be on the PAT, Dr. Perreira focused on developing a committee of staff to lead the initiative in each of the facilities. Through the Best Practice Network meetings and other joint events, we were able to put committee members in touch with each other and foster cooperation and collaboration between the two programs. Dr. Perreira provided training in both settings to direct care staff and youth conjointly on the topics of Trauma and Trauma Informed care. Youth specialists who had worked with us on the grant advisory group joined Dr. Perreira for many of these interventions. Eventually, Kahi Mohala hired one of the youth into a staff position as a youth specialist.

Goal 3: Sustainable System Enhancements. *Infrastructure enhancements achieved by the project are comprehensive, effective and sustainable.*

Objective 3.1 - Conduct process evaluation activities to ensure project is achieving its goals and objectives in a timely and efficient manner.

Objective 3.2 - Conduct outcome evaluation activities to ensure that infrastructure enhancements activities are effective and outcomes are sustainable.

Objective 3.3 - Disseminate information about the project and its findings both locally and nationally.

The results of our on-going process evaluation activities are illustrated in the previous discussions of the evolution of major aspects of the project, including the PAT intervention and the Best Practice Network. The design of these interventions was shifted to accommodate new learning – both from our work in the field and from our Technical Assistance opportunities with NTAC.

The main outcome evaluation results of interest are the incidents of S/R events described above (see Figures 1-3 and Figure 6). These data indicate decreases in S/R events in our three main target agencies: Queen's Family treatment Center (from a high of over 120 events per quarter before the initiative to a low of 0 events per quarter), Kahi Mohala (from a high of over 60 events per quarter before the initiative to a low of just over 10 events per quarter) and at Pu'ukamalu (from a high of 50 events per quarter before the initiative to a low of just under 10 events per quarter – and a recent milestone of 0 events in October and November of 2008). Other evaluation results from the ISRRI (Inventory of Seclusion and Restraint Reduction Interventions) indicate that the four programs targeted for PAT interventions all made progress at instituting changes in policy, increasing use of S/R prevention tools, increasing use of trauma assessment tools, utilizing workforce development interventions, and other S/R reduction strategies.

Findings from the project have been presented at three national conferences and at three public conferences in Honolulu, as well as at numerous meetings for CAMHD staff and providers. Here is a list of the conference presentations:

Slavin, L.A., St. Louis, C., Wojcik-Pula, J., Mailo, T., & Murphy, T. (2008, March).

Toward a Trauma Informed System of Care for Hawaii's Youth. Symposium presented at the 5th Annual Hawai'i Conference on Preventing, Assessing, and Treating Child, Adolescent, and Adult Trauma, Honolulu, HI.

Slavin, L.A., Perreira, T.N., Wong, J., Brogan, M., St. Louis, C. & Parker, J. (2008.

February). Public-Private Collaborative Efforts toward a Coercion-Free System of Care. Poster presented at 21st Annual Research Conference A System of Care for Children's Mental Health: Expanding the Research Base, Tampa FL.

Daguio, M., Medina, C., Bowman, C. & Perreira, T.N, Voices of Youth and Families:

Advisory Group to the Cultures of Engagement in Residential Care (CERC) Project (2007, May) Symposium presented at the Annual Building on Family Strengths Conference, Portland, Oregon.

Perreira, T. N., Slavin, L.A. St. Louis, C. & Parker, J. (2007, May). Violence- and

Coercion-Free Hospital-Based Treatment for Youth in Hawaii. Poster presented at the Annual Building on Family Strengths Conference, Portland, Oregon.

Slavin, L.A., Perreira, T. N., St. Louis, C. & Parker, J. (2006, November). Violence-

and Coercion-Free Hospital-Based Treatment for Hawaii's Youth. Poster presented at the Annual Meeting of the Hawaii Psychological Association, Honolulu, HI.

Slavin, L.A., Hill, E., LeBel, J. & Murphy, T. (2006, February). Efforts by State Mental Health Agencies to Improve Residential Care and Minimize Seclusion and Restraint. Poster presented at the 19th Annual Research Conference A System of Care for Children's Mental Health: Expanding the Research Base, Tampa FL.

Slavin, L.A., Perreira, T. N., Nakamura, B., Daleiden, E., Knapp, T. & Donkervoet, C. (2005, October). Cultures of Engagement in Residential Care (CERC): The Hawaii Alternatives to Seclusion and Restraint Project Preliminary Report. Poster presented at the Annual Meeting of the Hawaii Psychological Association, Honolulu, HI.

Lessons Learned

The CERC project was a great learning experience for those of us in CAMHD who were involved in it as well as for the provider agency staff we sought to train and assist. We learned many lessons, both big and small. We have tried to present some of what we've learned in the form of recommendations for others involved in this type of change initiative. They are organized here in relationship to NTAC's "Six Core Strategies."

1) Leadership Toward Organizational Change

- Top leadership (CEO, VP, Clinical Director) can support a change initiative just by showing up at programs and events related to the initiative.

Our experience overall gives strong testimony to the importance of engaging leadership in order to be successful in making major organizational changes. When our work in an agency had support from the highest level of management, it had the greatest impact. A particular example of the importance of leadership comes from our work at Kahi Mohala. The Chief Executive Officer made a point of attending project events, if only for a brief period of time. This had a big effect in raising the priority of the project for all of the staff involved.

2) Using Data to Inform Practice

- Publish your data for everyone to see and think about – especially data on successes.

When the data on decreased S/R events started coming in for the Queen's unit early in the project, sharing it had a galvanizing effect on everyone, raising hope that positive changes can really happen throughout the system.

3) Workforce Development

- Pay particular attention to problems with staffing, including problems with not having enough people to staff the program and problems with having people on the job who are opposed to S/R reduction principles.

It is especially challenging to make changes in an organization when staffing is very “thin.” People can’t spend time on training and development if they constantly have to put out fires or cover for essential aspects of the program. The lack of back up for people in key positions also limits what is practical in the design of change interventions, as discussed earlier.

We found our hospitals with their higher level of funding and infrastructure easier to work with using the NTAC model than our Community-Based Residential Programs. Our small residential programs were more fragile than we knew. Two of them essentially collapsed at the same time we tried to intervene through the PAT process, and the greater scrutiny from CAMHD (their main source of funds) may have exacerbated their problems.

Having the wrong people working in a residential program can be toxic for everyone – especially the youth. Real change started to happen in one of our programs only after a powerful cadre of coercive staff was fired.

4) Use of Assessment and Prevention Tools

- Develop a model safety-planning tool and disseminate it as broadly as possible.

We developed our own safety-planning tool based on the many models provided by NTAC and then took it to every training event and talked about it wherever we went. This was an easy intervention with far-reaching helpful implications for youth. CAMHD is planning to require use of this type of tool in future performance standards.

- Encourage the development of comfort/sensory rooms as a visible sign of the agency’s commitment to Trauma Informed Care.

When programs were able to set aside space and purchase materials to create a sensory room, it served the purpose both of creating a new treatment resource and of communicating leadership commitment to the approach. As a result of the Best Practices Network meetings, a couple of our “non-pat” residential programs developed comfort rooms.

- Provide training on trauma assessment.

Our providers generally were not familiar with trauma assessment tools, and a basic training reviewing some of the easy to obtain instruments was very valuable in improving practice in our system.

5) Consumer and Family Roles in Care Settings

- Be prepared to spend a lot of time supporting and helping youth and young adult consumers take leadership roles in any kind of professional mental health care setting.

We learned that we initially overestimated the readiness of our bright young people to take a responsible role in situations dominated by adult professionals. Youth can make a great contribution, but they need a good deal of structure for doing so. For example, our youth representatives needed rides to get anywhere and lots of reminders and wake-up calls to get places on time.

- Look for young adults who have been in the workforce for a while to take a mentoring role with younger consumers and youth peer specialists.

Toward the end of the project, we identified a young woman former Mental Health consumer and former foster child who was working as a counselor and in graduate school to earn her MSW. This young lady was able to support some of the youth in our “Hawaii Youth Helping Youth” group, and provide mentoring to help them develop as youth advocates. If we did the project over again we would hire her to work with our younger consumers and help them be effective parts of our PAT intervention, chairs for our advisory group, etc.

- Residential programs can easily engage staff around developing increased programming for families and bringing family members into the program. This can have a positive impact on morale for everyone.

Several of our residential programs changed their rules around visitation and family contact as a result of participating in the BPN and attending our conferences. We showed slides of “Ohana luncheons” and other family events held by some of the programs, and the agencies shared stories of many benefits that came out of staff and youth working together to prepare for these events.

6) Debriefing Techniques

- Helping our agencies utilize rigorous debriefing was the most challenging of the core strategies. This may be due in part to the specific cultural concerns with being “shamed” or shaming others among our local Hawaii people with the strong Asian cultural influences here.

Developing some cultural adaptations of standard debriefing procedures could be a useful follow-up to this project. We will be incorporating this into our sustainability work.

- Staff members need help to recognize that the purpose of debriefing is not to place blame or find fault. Similarly, programs need support to utilize debriefing procedures for “near misses” as well as for actual events – partly because they tend to see it as a punitive procedure.
- Following through to connect the lessons learned from a debriefing session into changes in program procedures or into updates of a youth’s safety plan was especially challenging and an area for future growth.

Other lessons we learned included some ideas about making changes in our system of care more broadly. For example, we learned that provider agency staff really benefited from opportunities to discuss common concerns in a supportive, informal format, such as our Best Practice Network meetings. We also learned that our intervention efforts to help provider agencies can put stress on programs, and changes can lead to things getting worse before they get better.

Establishing a “Culture of Engagement” includes many levels – providers engaging youth, agency leaders engaging direct care staff, mental health workers engaging staff from DOE and Juvenile Justice, and – very importantly - the state MH agency engaging providers and consumers in efforts to improve our work at all levels.