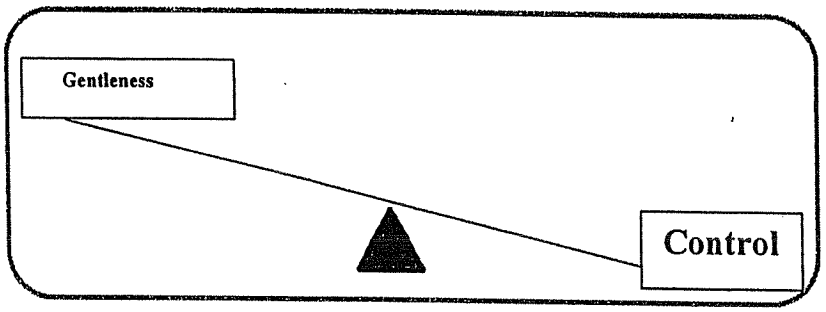
Do we inadvertently support a Culture of Control?

How we do business---Is it Gentle?

Last month I was informed by one of our Recipient Rights officers that they had just finished investigating a complaint where a AFC staff abused a resident. The Rights officer found that not only was the allegation true, but when the home manager was presented with the evidence they vigorously defended the actions of the abusive staff member. Additional evidence found this staff member had been abusing residents for 'some time'. I became puzzled why the home manager would support a staff person acting in a way that was so counter to their exposure to the Culture of Gentleness? I thought perhaps there was something about the make-up of the consumers in the home that might cause staff to act in this way, so asked Karen to send me the names of the residents on specialized services contracts. She listed 7 consumers on contracts; however her tracking system didn't identify the other 5 residents, if they were in regular foster care or even placed there by another county/CMH. This led me to wonder if there was anything in the way we 'do business' that contributed to the abusive situation? Despite NLCMH's commitment to Culture of Gentleness over the past 2 years; I continue to hear of incidents of abuse, neglect, aggression and injuries among our most vulnerable citizens and those who care for them. I see that far too often the old system, 'Culture of Control', re-emerges.



My interpretation of COC is that it emerges when there are more consumers with high needs (emotional/relationship deficits-high behavior) than care-givers can adequately meet them using the COG. Culture of Control has been replicated in the social psychologists Stanley Milgram and Philip Zimardo—who had to terminate their experiments after 'normal' subjects devolved into acts of brutality towards other subjects. In both experiments the subject felt they were required to carry out demands made by the experimenter; or that the actions of other participants required them to do things they wouldn't normally do "to regain control". I have found:

- Homes where COG is brand new and just being learned are vulnerable.
- Homes without designed COG trained Home Leaders/Mentors are vulnerable.
- Homes with a tradition of COC (physical management) are vulnerable.
- Homes with minimal support from COG trained CMH staff are vulnerable.

One of the biggest problems I see is how we as a system struggle with is to understand our consumers with 'high behaviors' real needs. COG emphasizes their traumatic 'life story'; COC emphasizes 'behaviors'. COG emphasizes recognizing the traumatic history and the necessity of building relationships. COC emphasizes gaining control over the behavior and getting the person to comply with nebulous "home "rules".

When a high needs consumer fails to improve, the home asks NLCMH for an increase in their 'per diem'.

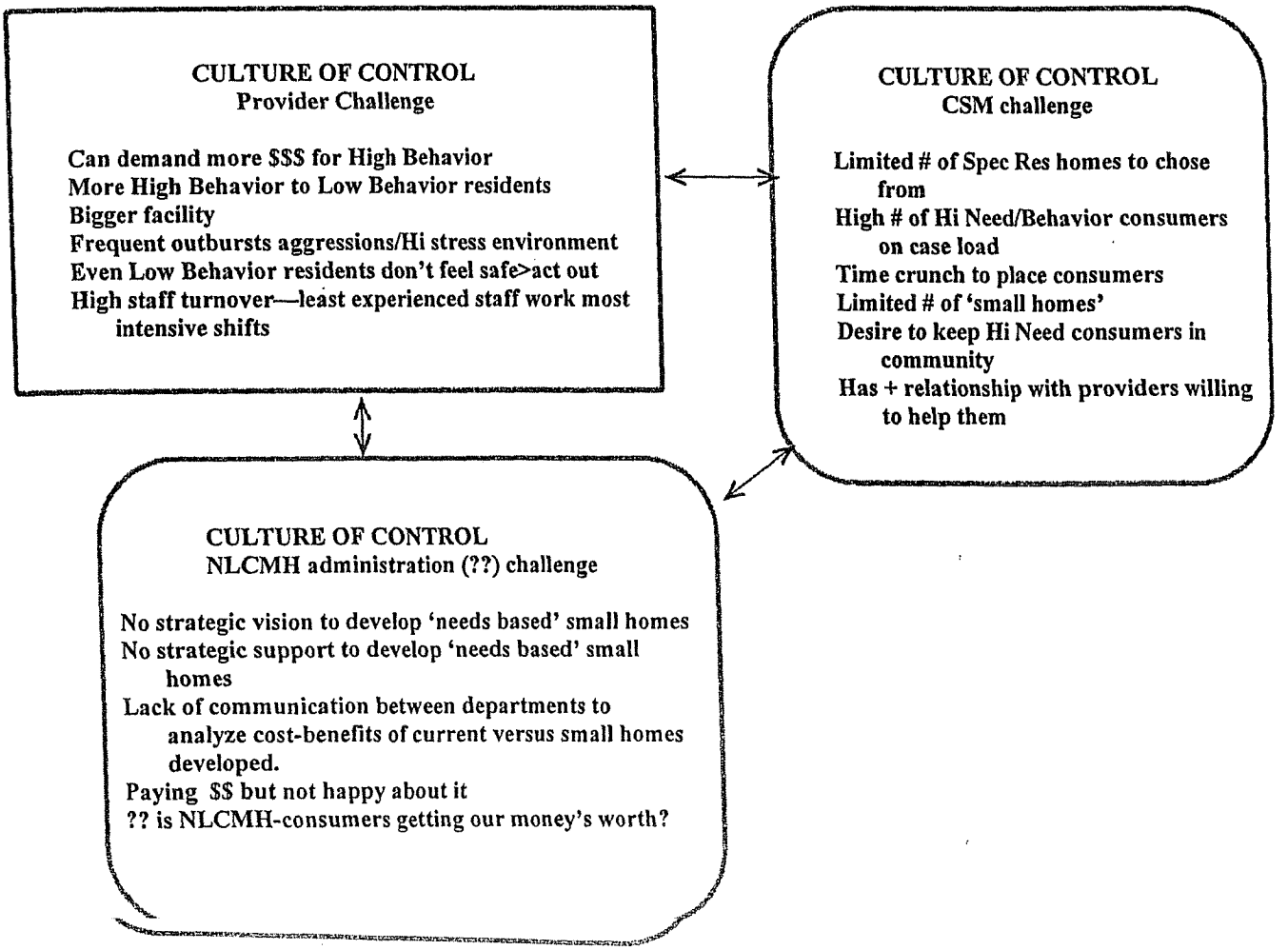
What I have found disturbing with this process is:

- Ambiguous expectations by both NLCMH and provider what we expect them to do to reduce or resolve the presenting problem.
- No specific contractual agreement (We pay you to do this—AFC agrees to do it)
- No formal system to determine if AFC has sufficient trained staff in COG to adequately building relationships with consumer (or recognize if this is necessary) to reduce or resolve the presenting problem.
- Implied expectation that home will be paid higher per diem regardless if consumer gets 'better' or 'worse'.
- Despite increased monies, home may decide to terminate placement at any time.
- No NLCMH system to evaluate HB homes; set standards for # of residents to staff ratio.
- No NLCMH tool to assess environmental, staffing, staff training, COG assessment to determine if home is capable of delivering services
- No NLCMH system to create a 'cut off'/limiting the placement of HB need consumers in home
- No NLCMH system to declare a HB provider is "at capacity" that prohibits placing any consumer into that home until the current residents needs can be successfully met and stabilized.

- No comprehensive assessment system that encompasses the entire spectrum of NLCMH administrative-clinical-provider services network to manage placement of HB consumers to homes.

Unintended consequences=A Culture of Control?

- Providers recognize financial incentive to accept 'high behavior' residents.
- Providers create larger 'facility' type environments to accommodate HB residents.
- Different CMH departments may place respective HB consumers without knowledge of how this effects the capacity of home to deliver services effectively.
- Providers with 'big hearts' take HB consumers to 'help out' CSM—not recognizing decision may 'overload' staff's ability to meet resident needs.
- Tendency to 'solve' presenting problem of HB consumer ('aggression' 'self-harm', 'elopement') by 'matching them up' with 'high behavior' home.
- HB homes tend to be noisy, chaotic—high risk of one or more consumers 'having behaviors' throughout shift/day.
- Calm in HB homes is fleeting—care-givers/consumers waiting for the 'next big blow up'.
- Chronic stress leads other 'moderate-low' consumers to escalate into 'out of the blue' behaviors.
- Line staff feel overwhelmed, unheard, helpless-hopeless=high turn over
- Increased potential for caregivers to resort to Culture of Control methods> abusive/harmful 'interventions'
- HB Consumers seen as manipulative, deliberate and malevolent =more $$
- HB consumers more likely to resort to more extreme behaviors (violence, elopement)=$$$
- Home requests 'behavior programs'; want intrusive, restrictive interventions.
- Nostalgic for the 'good old days when we could prone them/put in time out'.
- Visitors sense 'sadness' among residents/staff; home environment is 'cold'.
- No spontaneous friendly interactions between care-givers and residents; no shared, mutually enjoyable activities together.
- More Rights violations.
- High staff turnover
- High consumer turnover (hospitalization, moves)



D-Score Flow Chart
Step One

D-Score Assessment Form
(Rates Consumer Emotional-Relationship needs)

History of emotional neglect, physical or sexual abuse
Institutionalized or inpatient psych hospital history
Multiple AFC moves
Minimal family contact-involvement
1-2 friends; minimal contact with staff
Acts aloof, rarely talks, keeps to self
'Out of the blue' aggression history
History of self-injury
Strong rituals-repetitive routines
Treated for anxiety, OCD, depression

CSM conducts D-Score Assessment with consumer and 1-more persons that have relationship/know them best.

Assessment identifies intensity of Consumer E-R Needs.

D-Score is summary of Consumer current E-R needs .

1 Few or no emotional - relationship needs
2 Mild emotional -relationship needs
3 Moderate emotional -relationship needs
4 Serious emotional-relationship needs
5 Extreme emotional-relationship needs

CSM computes Consumer D-score #

Consumer D-Score # reflects their CURRENT NEED.

Use D-score to determine what home/provider will best serve consumer needs

Use D-Score to guide questions to prospective Home's ability to best serve consumer

Use D-Score as guide if added services necessary (temporary staff assist at peak stress times)

D-Score Flow Chart
Step Two

CSM examines AFC's Home D-Score # to determine if AFC-provider can meet prospective consumer's emotional, residential and other needs

Home D-Score=
1=No restrictions on placing consumer
2=Potential restriction-(if consumer D-score= 4-5)
3= Potential restriction- needs supervisor approval
4=Conditional approval-need Res-Manager approval
5=Not accepting new residents, home is 'in crisis-max capacity' until further notice

CSM examines prospective Home D-Scores for availability

Home A
D-Score Rating=1
No restriction placing consumer

Home B
D-Score Rating=2
Possible restriction-if consumer D-score is 4-5

Home C
D-Score Rating=3
Potential restriction- needs supervisor review & approval

Home D
D-Score Rating=4
Restricted access-need Res-Manager review & approval. Consumer D-Score must be 1

Home E
D-Score Rating=5

Not accepting new residents. Home is 'in crisis' or maximum capacity' until further notice

D-Score Flow Chart
Step Three

Home or Program Manager performs own "Home D-Score" assessment on all residents (monthly or sooner if D-score rises above or below 3)

# of residents improved (lower D score)
# of residents regressed (higher D score)
# of new residents since last score
# of new staff on each shift
# of trained shift leaders on each shift

Home-Program Managers computes "Home D-Score "

- Home D-Score accounts for all Residents
- D-scores are summed/averaged to determine Home D score
Rating of 1-5 (Few to Extreme) reflects AFC residents current emotional-relationship needs.
- Rating is keyed to # of staff needed to maintain maximum COG effectiveness
- *Rating is keyed to # of residents able to be served while* preserving maximum COG effectiveness

Home-Program Manager *sends* CMH Residential Manger upgraded D-Score. Score is effected by:

# of residents improved (lower D score)
# of residents regressed (higher D score)
# of new residents since last month
# of new staff on each shift
# of trained staff leaders on each shift

NLCMH Residential Manager posts Home D-Score on Intranet for CSM's to review.

How would we have Spec Res Providers assess their capacity to serve High Needs consumers?

AFC 'D' Score Assessment

(Use CPLS Environmental Assessment as framework?-WES)

Administration Measures

Level of support for COG from AFC administration
Level of support for COG by AFC home-program managers
'Presence' of admin, home-program managers onsite to monitor and mentor care-givers

Staff Measures

Number of new staff
Number of seasoned staff
Level of training in COG
Mentors/Shift leaders
Follow up training & support by COG

Home Measures: # of residents with

intrusive-restrictive behavior programs
severe autism spectrum, obsessive compulsive
severe-refratory mental illness (mood, psychosis)
and ratio of DD to MI residents
with total ADL assist needs
Multiple-complex medical/neurological needs

Staff-New Resident Measures

# of meaningful interactions between staff-residents/day
Amt. of interactions with new resident/staff/day

CMH Measures

Amount of ongoing support-training after new resident placed in home
# of meetings to assess resident 'fit'
Resident D-score evaluated on week 1, 2, 4
    Link D-scores to amount-intensity of COG support
    Link D-score to increase-reduce behavior/professional involvement