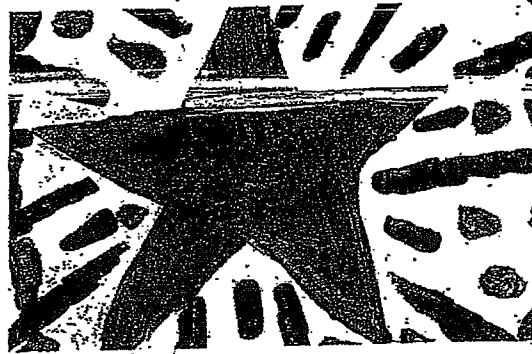


**Chapter 6:  
Leadership – Creating  
Culture Change**



# Leadership

## Creating Culture Change

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“Some are born great, some  
achieve greatness, and some  
have greatness thrust upon ‘em”

*Shakespeare, from Twelfth Night*

# Leadership

This chapter has been extracted and synthesized from the National Association of State Mental Health Program Directors' (NASMHPD) National Technical Assistance Center (NTAC)'s curriculum on eliminating treatment violence and coercion. This curriculum is part of the NTAC National Executive Training Institutes (NETI) and has been taught to more than 3,000 people from 48 states and territories in the United States as well as states within Australia and New Zealand. The Department of Mental Health thanks Kevin Ann Huckshorn, RN, MSN, CAP, ICADC; Executive Director of NTAC, for the generous use of this material.

**T**he National Executive Training Institute (NETI) has been advancing the national initiative to reduce S/R. In 2002, experts from around the country met to identify core strategies to make culture and practice change. The experts, most of whom had already successfully reduced or eliminated seclusion and restraint in their respective states or facilities, agreed that leadership was the single most important core strategy in this culture change process.

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## How can leaders create culture change to reduce S/R?

Simply put, leaders have the power, the role, and the authority to make the changes that are necessary for S/R reduction/elimination success, such as:

- Making and keeping S/R reduction a high priority
- Creating a plan for S/R reduction/elimination
- Reducing or eliminating organizational barriers.
- Providing the necessary resources
- Holding people accountable for their actions
- Identifying and valuing champions who are committed to this work

## What are the key leadership principles to creating culture change?

### 1. Commitment

Programs that want to create violence-free, strength-based, collaborative treatment environments must have leaders who are dedicated to these values and willing to make changes to existing policies, procedures, and practices to make that happen. This process can be difficult and time-consuming. It requires commitment, resources, and patience.

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Changing culture and practice generates a lot of anxiety. People may feel nervous, unsure, or skeptical. This is a natural part of the process. But leaders must hold the staff member's anxiety and be willing to model the same behavior that is expected of staff members -- utilizing a style of management that empowers and supports all staff.

## **2. Mission, vision, and values**

Many program leaders in Massachusetts, other parts of the United States, and in other countries have revised their:

- mission statements
- vision statements; and
- core values/principles

as the first step in their strategic planning process. Generally speaking, these revisions include incorporating language that reflects the desire to establish affirming, trauma-sensitive, non-violent, strength-based treatment cultures that promote collaboration rather than control. This step is generally followed by the development of an organizational position statement about the goal of the reducing and striving to eliminate S/R practices.

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Program mission statements reflect the core purpose of the program and should be inspiring and easy to communicate. Program vision statements are broad statements that describe the program's aspirations for the future. Bill Anthony, cited in the NETI Leadership module (2006), states:

**“A shared organizational vision is like a magnet, it attracts people with its special characteristics.”**

Mission and vision statements can be communicated to staff members in many ways, such as the use of metaphors, anecdotes, personalized accounts of S/R, and experiences with trauma-informed care. Mission and vision statements are important because they define who the organization is, help energize staff members, and mobilize them to work toward a common goal. They also provide a sense of purpose to staff members, children, families, and the community.

### **3. Clarifying organizational values**

Once a program vision has been established, program leaders must set clear goals for reducing and striving to eliminate S/R based on the program vision. They must also create a program culture that identifies and lives by the key values of violence-free, coercion-free care. Many programs in the Massachusetts initiative have moved from being rule-based, institutional, impersonal, and, at times, coercive, to providing person-centered care based on respect and meeting the unique needs of each individual.

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This is the point in the change process when programs conduct a comprehensive reality check and start to reexamine;

- Program policies
- Program procedures
- Treatment activities
- Rules
- Schedules
- Historic practices
- Traditions, beliefs, and unspoken rules that persist

Basically, everything must be reconsidered, reevaluated, and measured against the new program values of creating a strength-based, non-violent, respectful and caring culture that facilitates S/R reduction/elimination.

This is when you ask yourselves, "Is what we say, actually what we do?"

*Practice what you preach - examples*

<b>Value:</b>	Individualized Person Centered Care
<b>Practice:</b>	Everyone goes to bed at 9:00 PM and lights out
<b>Change:</b>	There is a range of bedtimes to accommodate differences in bio- rhythms, nighttime difficulties, and preferences.

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<b>Value:</b>	S/R only used for imminent danger
<b>Practice:</b>	Any kind of property destruction, threats, physical acting out results in S/R use
<b>Change:</b>	Children who engage in one time only hitting, break furniture, kick a staff person, throw something, or otherwise act out and then calm down are not put in seclusion or restraint but addressed in treatment team.

<b>Value:</b>	Program is trauma-informed
<b>Practice:</b>	Trauma not formally assessed or in treatment/crisis plans. Environment gives mixed message: rules posted, no welcome sign, institutional décor/color, metal detectors, searches, locked/alarmed doors, S/R rooms
<b>Change:</b>	Soften environment & reflect trauma awareness in treatment and program operations.

*Using respectful language that recognizes the person*

"Person-first" language is the preferred language for person-centered care and explicitly refrains from using labels and terms that are distancing, dehumanizing, institutional, and not recovery-oriented, such as: units, wards, line staff, in the trenches, non-compliant, manipulative, attention-seeking, an actress, etc. Person-first language is respectful and reflects the philosophy of how we speak about something is indicative of how we feel about and value it.

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Person-first language encourages individualized, respectful descriptions that do not label. For example it is better to say someone "has schizophrenia" rather calling them "schizophrenic." People are not their diagnoses. Person-first language reminds us that the people we serve are, just like us, sons, daughters, friends, neighbors, employers, employees, students, teachers, and so much more than their illness or the challenges they face.

*Examples:*

- **At Central Louisiana State Hospital in Alexandria, Louisiana:** Adolescents who are hospitalized at Central Louisiana State Hospital are referred to by their given name and called "students" by all the staff. Their policies and procedures refer to "students." The hospital leadership believes this is an important way for everyone to remember that the adolescents are there to learn, and the job of staff is to teach, support, and coach.
- **At South Florida State Hospital in Pembroke Pines, Florida:** Adults who are hospitalized at South Florida State Hospital are referred to as: "*persons served.*" This may seem different – but all the staff use this language to describe every person who is hospitalized at that facility. This is what consumers said they preferred to be called. It also reminds staff of their role, to help and serve the people in their care.

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### Leadership

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