CPI *Unrestrained* Transcription

Episode 30: Toby Estler

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Terry: Hello, and welcome to *Unrestrained*, the CPI podcast series. This is your host, Terry Vittone. And today we're going to be speaking with Toby Estler, a social service specialist at the Telecare Treatment Center in Lakewood, Washington. Hello, and welcome, Toby.

Toby: Good morning. It's nice to speak with you.

Terry: Good morning, and you as well. Let me tell you a little bit about our guest. Toby Estler is a licensed marriage and family therapist in Washington State and California. He worked at Telecare's adult inpatient evaluation and treatment center for three years as a social service specialist, and in 2014 joined the team of CPI facilitators offering monthly trainings to new and current staff.

Since starting in the field in 2000, Toby has worked in a variety of mental health delivery systems, including wraparound, acute inpatient adolescent, community mental health centers, and educational settings. He also maintains a private practice, seeing clients in person and online. When not working, he is most likely to be found running trails through the forests, hills, and mountains of Washington.

That sounds delightful.

Toby: It is. It's a good balance.

Terry: Oh, it sounds like it. Can you give our listeners, Toby—our first question—an overview of the history and mission of the Telecare Corporation, and the facility, and how the facility there in Lakewood fits into the greater overall structure of Telecare?

Toby: Yeah. Actually, Telecare has just been, last year, celebrating its 50th anniversary.

Terry: Congratulations.

Toby: Thank you. We're a company that was started in 1965 and now employs, I think, north of 3,000 people, and works in eight states, has 90 different programs. It's a very robust organization, serving 35,000 unique individuals last year.

Terry: Huge client base.

Toby: Yes, and in terms of here in Lakewood, our program is a 16-bed acute inpatient psychiatric unit, focused on crisis stabilization. And our typical length of stay for clients here is around two to three weeks. Some people stay a little bit shorter; some people stay a little bit longer. And the mission of Telecare is to provide excellent services and systems of care for people with serious mental illness.

Terry: I see. And just for some of our listeners maybe, that you guys are a locked facility, correct?

Toby: Yes, we are. Predominantly, the folks who come to us, at least initially, arrive on what's called an involuntary hold. So something has happened in the community, some kind of crisis that has led to them being assessed by a mental health professional in the community. They've declined voluntary help, and so an involuntary hold procedure has been initiated, and then they're brought here.

Terry: And is it typically initiated by a family member or a friend?

Toby: It's very varied. Sometimes family members are making calls regarding loved ones who are struggling at home. Sometimes folks come to us through the jail system, where their crisis has led to an arrest. An assessment has indicated that they're not thinking clearly enough to participate in the court process, and so they're sent to us for a mental health evaluation.

Terry: So you have some challenging clients, to say it mildly, I would imagine.

Toby: Yes. I mean if you mix in the mental health piece in addition to the fact that most people when they arrive don't want to be here (and the fact that they're locked in and come to recognize that quickly), that can be a difficult cluster of experiences to put together and still remain calm.

Terry: I would expect so, yeah. Now, I wanted to ask, and I know you guys embrace CPI training and techniques. And sometimes it's great to start our podcast interviews with a real-life, on-the-ground story about how these techniques have helped to work with a patient who's been especially challenging. And we talked about a story like that in our pre-interview. I wondered if you could tell our listeners about it.

Toby: Sure. So one of the examples that springs to mind—sometimes we have people who are actually residents of a different county to where we're situated. And when they're

initially detained, there are no acute care beds available in their county, and so they come to us. But the goal is to return them to their own county as soon as possible—that's typically where friends and family and resources that they are used to using are available.

Terry: It makes sense.

Toby: And this particular gentleman had been told that we were able to transport him back to a similar setting, an inpatient locked unit, but in his home county. And he didn't want to go.

Terry: How long had he been with you guys?

Toby: He had been with us for about a week and a half.

Terry: So he was comfortable there?

Toby: He knew us.

Terry: Might be "comfortable" is too strong a word.

Toby: (laughs) He knew the way the program worked. He knew what was expected of him. And he actually had decided that he wanted to stay in this county, but due to his residency, that wasn't going to be possible. And a bed opened up in a sister unit. Telecare has a unit in Thurston County, and so we arranged for him to be moved there.

That's typically done by ambulance. We went out to let him know this, and we asked him, "Would you have a few minutes to talk?" And he jumped into this very ferocious-looking posture, where his legs were one laid out in front of him, and one behind. His arm was cocked back; his fist was clenched, almost if you can imagine somebody about to throw a javelin. He was very kind of stretched out. And he was a fit, lean individual. And he said, "Yeah, sure. I'm willing to talk. What do you want to talk about?"

Terry: After just striking this violent latent posture. "Okay, let's talk."

Toby: Yeah. It was almost amusing if it didn't have the intensity of the situation. So I was talking with him with the nurse that was running the unit that morning. And we kept our distance, and we said, "Well, that's great. You know, thanks for being willing to talk. But we're noticing that breakfast is just coming around. So how about you have some breakfast, and then we talk a little bit later?"

And we were able to disengage from him, and he had some food. And we thought maybe with some calories in him he might feel a little bit better.

Terry: So you took a *Supportive Stance*℠ and redirected?

Toby: Yes, exactly, exactly. And then after breakfast we circled back around and said, "Hey, you feel up to talking a little bit?" And he jumped straight into the same position. (laughter) And it was clear that this was not only a dangerous situation, but because of his physique and physical fitness . . .

Terry: And now he's had breakfast.

Toby: (laughs) And now he's had breakfast, so he's energized. That this was possibly going to become a really dangerous situation, where somebody was going to get hurt.

Terry: I'm just seeing this—imagining it in my mind's eye, and how that might increase—I mean, to see that behavior repeated would certainly, as a clinician, make me understand the sincerity of his intentions.

Toby: Yes. And when we let him know that it had been arranged to move him to his home county, he said, "I don't want to go, and you know you're not going to be able to make me go."

Terry: Were there any more particular reasons for his resistance?

Toby: Not that I'm aware of. I mean certainly part of being in a locked facility is that there's a lot of loss of power. You don't get to make a lot of choices.

Terry: I see.

Toby: And so when folks feel in that position, they tend to really latch onto choices that are important to them, and defend them pretty strongly.

Terry: That makes sense.

Toby: Yeah. So again, we were looking for anything that he was doing that we could reinforce, that was positive. You know, "Thank you for being willing again to talk with us. We are going to have to move ahead with this move, but let's see if we can talk about how to make it as comfortable as possible." He didn't want to budge on that, and so again, we peeled away.

We then had the rest of the staff help to move the other clients in the room out of the room into a different part of the unit, so that if anything was going to erupt, that they weren't going to get caught up in it.

And each time we took a break away from him, we as a team would talk about "Well, if this does erupt into something more physical, how are we going to approach it?" And we took some time to plan that out.

We recognized that the ambulance was on its way, so we thought, "Well, hey, if we can string this out for another 5 or 10 minutes, then we've got another two or three individuals coming into the unit that could possibly be of support if we need it."

Terry: At this point, is he showing any—beginning to show any de-escalation?

Toby: Not really, but he's also not showing any escalation. So while the behaviors are really intimidating and frightening, at the same time he's not throwing any punches. He's not trying to hurt himself. He's not overturning any furniture. He's very intimidating, but I think one of the pieces that the CPI training has given us is being able to recognize and tolerate that level of behavior and still be able to say, "Right now, nobody's being hurt, and if we try and grab a hold of this guy, then maybe somebody will get hurt. So what we can do at least at the moment is just stay where we're at and see if we can stop it getting any more intense." And that, in and of itself, is a win.

Terry: Right, it's the least restrictive approach.

Toby: Yeah. The ambulance arrived. The team rolled onto the unit with a gurney, which would be his method of transport. And there was something perhaps about them arriving and their professional conduct, as well, in their formal uniforms, that something in him softened. And the next time that the medication nurse came to him and said, "Hey, look. This is a long trip. Would you like to take some medicine just to kind of calm your apprehension for the journey?" He said, "Yes." And about 15 minutes later he was sitting on the gurney, chatting with the ambulance folks, and they wheeled him off the unit and took him down to Thurston County.

Terry: Excellent. So setting limits and giving some options, and then the patience and the understanding of the *Supportive Stance*℠, and you're trained but also intuitive sense of feeling him out really led to the success of his transfer.

Toby: Yes. And I think to some extent the rapport that we'd built with him through all the other little bits of conversation over the week or so that he'd been here was just enough for him to hold back just enough, and—

Terry: Oh, I see. In other words—you know, first of all, it really speaks a lot, I think, that he didn't say, "Good, get me out of here." You know, I mean at least it'll be someplace different. I mean, like you said, you're in a locked situation with limited choices. If you're clinging to the choice to stay someplace where you are locked in, it must mean that you have found some respect and understanding in your environment at present.

Toby: Yes. I think that's a very astute observation, and we were a known quantity for him. And I can understand that going to somewhere new, and in some respect starting all over again, was a big frustration for him, and being able to note that to him and talk it through a little bit, I think, helped as well.

Terry: Thank you, Toby. That's a great example. So what other kinds of crises do you commonly experience among your clients there? And how does the strength of the team and the different disciplines there help with that broad mix of clients that you have?

Toby: You know, in terms of the type of crises that we have—

Terry: Well, that's a lot of questions in one. I'm sorry. (laughter)

Toby: It's okay. All right, you know, given the mental health setting we have a lot. So there's all the things that trigger people that are going on outside of them in terms of how other clients are behaving, the frustrations of being in a locked setting. We're also a nonsmoking facility. So that creates a big difficulty for a lot of folks.

And then you know, with the mental health aspect, there's also all the internal triggers that people experience, whether those are feelings of sadness, depression, hopelessness. A significant number of our folks are experiencing hearing voices, or having some kind of visual distortion. Their thinking processes are not well balanced, so they have a predilection for thinking that we might be wanting to harm them, or somebody is looking to harm them. So they've got a lot going on.

Terry: So is there a place—do they have to go cold turkey off of nicotine, or is there a time and place during the day they're allowed to have a cigarette or whatever?

Toby: Yes. There's no cigarettes here.

Terry: Okay.

Toby: We do offer them a nicotine replacement gum.

Terry: I see.

Toby: Which handles the physiological withdrawal a little bit. But you know, as a former smoker myself, I recognize that the act of smoking and holding the cigarette, and all the pieces that go with it are not replaced by gum. So people struggle with that.

Terry: The whole sort of smoking ritual—the delivery system is sometimes as important as the drug.

Toby: That's right. And then in terms of different disciplines, we have a lot. So we've got . . . as you said at the beginning, I'm a marriage and family therapist, so I do some individual and family therapy sessions. We have a music therapist. We have an art therapist. We have licensed psychologists. We have a great crew of doctoral interns.

Terry: And you're an M.A. yourself, aren't you, Toby?

Toby: Yes. We have peer counselors. Those are folks having their own experience of mental health and managing wellness. Many of them have had their own hospital stays. One of our peer counselors also provides pet therapy, and brings her dog to work a couple of times a week.

Terry: I imagine that's popular.

Toby: So we have a lot of different ways to reach out to people. And between us we can usually find a way to reach each individual.

Terry: I see. And according to information gathered by TechValidate, the facility there in Lakewood has experienced some very significant reductions in restraint and seclusion. Could you talk about those reductions and how CPI's behavior management techniques have had such an impact on restraint/seclusion at Telecare?

Toby: Yes. So we've been gathering those figures since we opened here in 2012. And CPI has been a part of our training, I think, almost from the day that we opened. And so I think as a culture we've developed greater and greater skill at using CPI. And so over that time, when we look at the figures, we've seen almost a 70% drop in the use of seclusion over the five plus years that we've been open. And we've also seen an 80% drop in the use of physical restraint.

Terry: How would you get such dramatic reductions? How are those possible?

Toby: It's a great question. It almost seems part mystery, but I think, again, over time, using the skills and seeing them work helps people develop trust. I think right at the beginning, I know when I'm training new people for the first time hearing the material, it sounds like a nice idea, but the reality of somebody having big, loud, explosive behavior—there's almost an innate response in us as human beings to think that physical containment is the best way to address that.

Terry: A lot of times the organizations that we go into, the uninitiated, believe that we are strictly a take-down course when we're really not that. Did you encounter this?

Toby: Yeah, definitely, definitely. When I asked people who were doing the training for the first time, "What are you anticipating today's going to be about?" most of them are understandably oriented to the thought that this is going to be about, you know, how I

physically restrain people. How do I defend myself when somebody is trying to attack me? So they see [*Nonviolent Crisis Intervention*® training as] some kind of blend of restraint and self-defense. And they're quite surprised when I ask them at the end of the training—they have a much different perspective where they understand that predominantly the CPI training has been about verbal interventions, about learning to identify and read behaviors, and being able to interact with folks in a way that the physical intervention is avoided.

Terry: That must bring about a sense of empowerment and relief for people once they realize that there is, you know, least restrictive and nonphysical intervention that can be even more effective than the take-down idea.

Toby: Yes. I mean certainly it matches our corporate culture as well. People like the idea that we're only going to use the more restrictive interventions as a very last resort. And the reality is, honestly, no matter how adept we are at using the physical interventions, anytime that we use that level of intervention, there's an increased chance that somebody is going to get hurt. It's just the nature of when you interact with someone at the physical level. Something can happen. We try to avoid that, and almost always it doesn't happen, but the chance is always there. So if we can avoid that for our staff and the clients, that's definitely the preference.

Terry: So these dramatic reductions have come as staff has developed more expertise in *Nonviolent Crisis Intervention*® techniques, and as the culture has shifted its understanding, perhaps, of the effectiveness of the training?

Toby: Yes. And I think, you know, having a core consistent staff that not only has the initial trainings, but then goes through refresher courses—I think we've probably gotten better at teaching it over time. People get to experience it working over time.

Terry: Now, Toby, how long have you been training?

Toby: I've been training folks for a couple of years now.

Terry: And how often do you refresh?

Toby: We have a class every month.

Terry: You do.

Toby: Yes.

Terry: Is it mandatory for everyone there?

Toby: It's mandatory for everybody to do that once a year, to do the full eight-hour program. So there are people who are going through a refresher. There's somebody going through the refresher every month, and then we have a handful of new hires that are also seeing the material for the first time. If they choose to, if somebody is feeling a little rusty, they can also choose to attend a class in between their mandated classes.

Terry: So you guys are dedicated to the consistency of providing training.

Toby: Yes.

Terry: All right. So now people won't know this, but it is in the morning here that we're talking. And after our interview, you're going about your day. What is a typical day like for a social service specialist? I mean, what's a day like for you there? Can you paint that for us?

Toby: Today's fairly typical. It would be the same for any of my colleagues in social services. We've got a couple of court hearings this morning with folks who are not yet oriented to the idea of staying voluntarily, so they have a mental health court hearing. They will be asking the court to release them. I will be offering reasons why I think they need to remain in the hospital for a little while longer.

So that also involves transporting people to and from the court. For some folks, that's an anxiety-provoking experience, and for some, there's the temptation to want to run away. So we have to manage that transportation successfully. And then after court, much of the day is spent working with the clients that are here on a discharge plan, helping them identify ways to sustain their wellness after they discharge—what's going to keep them in the community, what's going to keep them feeling well, hopeful, forward focused.

And then at any points during the day, in terms of a CPI focus, we don't have an identified CPI team. The entire staff is trained in the skills. So if something does erupt during the day, then I may be called to help out with that, too.

Terry: So you might have everything from admission to release to everything in between in a day.

Toby: Yes. Yeah. It's pretty fast paced.

Terry: It sounds like it, especially with such a concentrated group there. It sounds like you guys are able to respond quickly though, and powerfully as a team.

According to your website, Telecare follows a Recovery-Centered Clinical System, RCCS, a recovery framework. We talked about this in our pre-interview, and you spoke to the importance of a collaborative approach. Could you maybe tell us a little about the

essential components of a framework like the Recovery-Centered Clinical System, and then how collaboration is so critical to it?

Toby: Sure. So the RCCS definitely has its own language. And it's a very robust system. But if I was to synthesize that a little bit, I would say that [there are] two important pieces: one, that the culture here is focused on the idea of recovery, and [two], making that the focus of our work.

So with each individual, we're asking them to invite us into their world, and try and identify what works for them, what their strengths are, and co-create a plan with them that really speaks to their uniqueness.

Terry: And is recovery-centered thinking in contrast to an outmoded, warehousing type of idea? Is that where this clinical system is innovative?

Toby: Yes. And you know, as a broad brushstroke, maybe we'd even call it a movement that's been evolving over the last 20 years or so. It really begins to focus the recovery conversation on the individual rather than presenting them with a predestined treatment program that they either get into or don't. So you know, we're looking to help people get excited about their own wellness rather than telling them what wellness looks like.

Terry: I imagine that means you need to get to know them a lot better.

Toby: Yes, yes. And you know, unfortunately a lot of folks haven't had that experience as part of their experience in mental health. They've had a lot of experiences being told where to go, and when to go there, and what to do, and so they're cautious about being open around conversations of what they really want out of life.

Terry: And I would imagine if you were dictated to that strictly, that your paranoia might increase somewhat.

Toby: Yeah. I think that's a great observation. Yeah.

Terry: You know, in a promotional video on your site, Alex Briscoe of the Alameda County Health Services Agency says, "First and foremost, what Telecare has brought is a collaborative competence, courage, and a willingness to support the most difficult population. So when others run, Telecare stands up." That's a really, really brave and encouraging statement. Could you speak to that a little bit?

Toby: Yeah. I think, as a team, our kind of base position is that everybody deserves access to help. So it appears to me, you know, of the three years that I've been here, it appears to me that the program here, the staff here, has a willingness to accept folks that have very difficult behaviors.

Where they may not be seen as a fit for other programs in the county, we're willing to say, "Hey, we'll do the very best that we can." We certainly had some very difficult behavior here, and I continue to be really amazed by how well we connect with folks as a way to help them, you know, get back on their feet.

Terry: So thank you, Toby. As a way to close today, I just wanted to ask you personally, now, as you were going into your secondary, or rather your education as an undergrad, when did you start thinking, was it early on when you thought, "You know, I think therapy and helping people would be something professionally that would suit my talents and my interests"?

Toby: You know, I think, interestingly, it was when I started my own process of therapy, and started to have the experience of what that was like, that it really captured my interest.

So I was at a place in my life where therapy was really the thing that kept me together when everything else was falling apart. And as a result of that process I started to look at masters programs that were offering that route to licensure. I found a great program at the University of Santa Monica that actually had a focus in spiritual psychology, which was an interesting blend for me. And once I started there, I never looked back.

Terry: So in coping and getting therapy for some issues that were challenging you in your personal life, you found an inspiration to make it your profession.

Toby: Absolutely.

Terry: That's a lovely thing, Toby. Well, thank you very much. Do you have any last words for our listeners today?

Toby: I guess I would end by saying that my—so I have a colleague that I train people with. Her name is Jeanette, Jeanette Anderson, and we're both going up to Seattle later this month to train for the new enhanced version of CPI.

Terry: Oh, excellent.

Toby: So we're excited to get those new skills, and bring them back, and continue to build what we're doing here.

Terry: Excellent. Well, we will be sure and check back in with you after that, and see how the enhancements are working for you. Toby, thank you very much.

Toby: It's been a pleasure. Thank you.

Terry: And for me, too. And thank you for listening.