CPI *Unrestrained* Transcription

Episode 55: Randy Frost

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Terry Vittone: Hello and welcome to *Unrestrained*, a CPI podcast series. This is your host, Terry Vittone, and today, I'm joined by Mr. Randy Frost. Hello and welcome, Randy.

Randy Frost: Good morning.

Terry: Good morning. Let me tell you a little bit about our guest. For the past 38 years, Randy Frost has been a social worker, behavioral specialist, mental health counselor, and crisis intervention trainer in hospitals, schools, treatment centers, and juvenile justice facilities. He has expertise in crisis prevention and intervention training, team building, leadership training, therapeutic camps, adventure-based counseling programs in schools and community-based settings, parenting workshops, life skills training, and boot camps.

Randy has degrees in social work and nursing with certifications in experimental therapy and youth development. Today, Randy is the program director at the Paul Anderson Youth Home, a juvenile justice facility in Vidalia, Georgia, for young men aged 16 to 21. Many of the residents who are there through court order and behavioral issues are a day-to-day concern.

Our interview today will focus on Randy's broad expertise utilizing crisis prevention, training, and techniques for effective behavior management. Okay, Randy, let's begin today by talking about your career history in psychiatric settings. Give us an overview of that and then talk about at what point in your career that you became aware of de-escalation techniques such as those found in CPI's *Nonviolent Crisis Intervention*® training.

Randy: Okay, that was quite an opening. I appreciate that.

Terry: All right, you're welcome.

Randy: Well, back in 1980, actually, is where my career began and that was at the Topeka State Hospital in Topeka, Kansas, and I'm pretty much—I was an individual who really walked off the streets with no background, no training, no education into the mental health field. It was really interesting because at a young age, I've worked at many, many jobs and really hadn't found what I was looking for, and in day one, I walk into a pre-adolescent center and I'm exposed to, you know, these younger children and they're having all kinds of issues, and that was again back in 1980, and I feel exactly today like I did back then.

The overall feeling I had is like I found where I was supposed to be and I still feel that particular way, but as you said, I've been exposed to a lot of different areas, and certainly through those areas, there's been a great deal of acting-out behaviors, as we all know, verbal and certainly physically. In the beginning, with the lack of training, really, it was kind of survival skills on what you did and learning as you go, kind of learning on the job. Some days that was tough and some days that was rough, but we managed to get through it.

Fortunately, towards the late 80s and 90s is when, you know, a lot of organizations began to kind of look at alternatives. What can we do besides hands-on restraint? What can we do besides medicating these people and making them walk around like zombies so they'll be cool, calm, and collected? With that being said, I remember part of that was with me: I'm a pretty good-sized guy, 6'4", about 230, 235, and when there is physical acting-out, I always got to be one of those people they got to be in the midst of.

Terry: I expect so.

Randy: As exciting and seriously, as exciting and adrenaline-flowing as that was, certainly over a period of time, you know, your safety become a concern and other people's safety as well as the patient and the clients, and it was like, "Okay, we've got to learn to do something a little bit different," and that's when we began at a different place and we began to look at possible defusing, and really, I think back then, it was a lot of how to appropriately put hands on somebody rather than some of the techniques we certainly use right now.

It was definitely a learning experience. I continue to learn today, and hope to tomorrow, in this field, because I'm a person now—not just because of age and certainly sports injuries—but I'm certainly getting much more satisfaction now being able to defuse and talk somebody down rather than have to put my hands on them and end up on the floor with them.

Terry: You've found, then, through your career trajectory that things like physical and chemical restraints were more prevalent when you began, and then you started to see verbal de-escalation come in as your career progressed?

Randy: When you think about a state hospital institution, and I'm not bad-mouthing anybody, but even back then when I was licensed to give medication and it was pretty much just heavy doses of thorazine, and the patients, what they had to look forward to was cigarette breaks and food. I mean, there was not necessarily a great deal of therapeutic value, but it was really the medicine to keep them in control, and you certainly can't do that with anybody and everybody. I'm kind of an anti-medicine person. I know that sometimes you need it, you've got to have it, but I certainly, even in my counseling roles over the years, medication doesn't necessarily deal with what's going on in the head and the heart, and that's where you have to try alternative choices.

Terry: What was the first de-escalation training that you experienced?

Randy: Oh, wow. Pretty much they were kind of non-formal. I think in a lot of places, they—the senior staff—they would go over things that would work and do this and kind of don't do that and really, it was in the 90s before I actually began to go to any formal training. At that particular time, the hospital I worked at in Topeka, Kansas, it was one of the 90 charter hospitals, and we use MAB, which would manage an aggressive behavior.

Then a couple years later, they kind of added to that and then we kind of went into PMAB, which was prevention and management of the aggressive behavior which is now kind of—they're kind of out of business. That's what I was introduced to and that's where some of my knowledge and experience, I give them great deal of credit because that's when the things really, over a period of time, began to change.

Terry: I see. When do you remember when you were first certified in CPI's *Nonviolent Crisis Intervention*® training?

Randy: Oh, CPI [training] probably was, I'm guessing, six, seven years ago.

Terry: Okay. All right, because I think I have you—I looked at our—I can edit this out a little bit but I looked at our record and I think I have you first back on 6/15/2007 was your first certification so it's been . . .

Randy: Well, actually, you're right, because looking back on that now, I did [get CPI trained] and then I let that lapse because for 20 years, I kind of worked for myself and I did a lot of this other work in a lot of other places, but I normally worked for myself, at that particular time schedule-wise and I don't think I actually—I knew I had what I needed to so I let that lapse before I came back so no, that'd be pretty close, pretty good, yes.

Terry: I see. All right. Now I'm going to ask you, Randy, about your work as the program director and where you are now at the Paul Anderson Youth Home. Could you first give us a basic overview of the facility and the program?

Randy: Absolutely. I've been coming here probably for three, four, or five years and doing a lot of the staff trainings, which certainly included PMAB, and then we did go to CPI because I kind of liked this concept, what we were doing there. Then about 16 months ago, they were able to convince me to come in. During my 16 months, I've had several different titles, and titles to me are not that important, from program director to program advisor. But what I was coming up [for] was doing trainings, and once a month, I would work, actually work as a consultant.

Right now my actual title, if it needs to be, is the staff trainer as well as CPI trainer and then transition coordinator, but without all of those things, it pretty much—everybody here wears a lot of hats. We are a 53-acre campus in Vidalia, Georgia. We are a nonprofit ministry. Our young men, I like to say, they walk in as a troubled boy. We take 16 years old to 21. Now we've kind of changed that. We've actually taken a couple of 15-year-olds that we thought were mature enough.

To begin, you're talking about these are troubled boys and whether they have a mental health diagnosis which most of those don't. When you look at today's society, when talking about trouble, that can be between alcohol and drugs, certainly substance abuse. They can be many forms of addiction. [There] can be verbal acting-out, [there] can be certainly physically acting out. I'd say about seven or eight of our young men right now are involved in the juvenile system and they are court-ordered to be here, but the rest are here because parents have seen our website or heard things about us and are kind of their last resort but we are—I said they walk in as a troubled boy and I like to think they walk out of here as a young man of character. And so we are a nonprofit, we do not accept insurance. We currently have 16 boys. Our capacity is 20.

Terry: I see, and I understand from our pre-interview, Randy, that at Paul Anderson, you haven't had to go hands-on with a physical restraint with boys exhibiting acting-out behavior and that you attribute your success to CPI's approach to managing [challenging behavior].

Randy: Well, you know what? That is really, really interesting. I'm really proud to say that, and the cool part is, like I said, it's not that these boys do not act out because you think of a young boy, a young man, 16 to 21 years old, especially one that fits under the category of what we call troubled, they're not necessarily choirboys. There's a reason that each of those [boys] are here.

What I really attribute part of me coming here as a consultant [to] was convincing the staff and the people here that we can't necessarily deal with and treat a young man of that age as I did 10, 15, 20 years ago. We had to make considerable changes and we have made considerable changes, continue to, which I think is incredible. One of those things, too, was changing the concept. Here you're not going to have those young boys that walk in, sit down at the classroom, read his book, and "yes sir, " "no sir" all day. You can demand that, you expect that, but in reality, it's not going to happen.

We are very consistent, we're very structured, we have positive consequences, we have negative consequences, and to me, how the day goes determines who's here. And the biggest thing I like about what we do here is we go through an incredible screening process not only for the boys to be admitted but certainly for the staff. You have to be compassionate, you have to care, you have to have the Lord in your life and be willing to learn that if somebody gets in your face and takes a pop at you, you can't swing back at them. That doesn't mean you need to stand there.

A lot of the concept has certainly changed how we do things. I think not only CPI, the concept that we've been teaching and training here has added to that, that along with the screening and along with hiring the right people, believing in that and believing to try to talk to somebody defused and establish that relationship. I like to think I have an incredible relationship with every one of the boys here. They're very respectful to me. If I ask them, or tell them to do something, they're going to do it whether they want to or not. Again, I think a lot of that is respect, a lot of that is the concept that especially to be able to recognize behaviors, being able to defuse it, being able to communicate with somebody, to that kind of thing.

Now, ironically, I knew this was going to happen because when we spoke the other day, on Thursday afternoon, I had two of the fellows get into a little heated discussion and I actually had to physically grab one and pull him away. I kind of broke my record but here again, I want to use this. Now the young man that I pulled away is probably about 6'4", about 260, and he's used to being a bully. He's used to physically acting out, punching holes in the wall, and even though I was verbally de-escalating him, I could see in his body language that he had, he definitely had intended to use an aggressive behavior towards a smaller, younger person. At that point, I basically went in to him and kind of put my arms, wrapped them [around him] in a great big therapeutic hold and I was able to walk him down the stairs. My hold probably lasted three or four minutes then I had another staff member take him.

We were laughing about it later. I told him he broke my record but it was still recognizing the situation was passed, being able to verbally de-escalate. It was time for me to do what I need to do, and once I had him where I wanted him to go, my hands were off and there was no further problem with that. It was a 6, 5- to 6-second physical hold but again in 16 months, I'll take that one time over that. Again, I think that's a perfect example. I really do.

Terry: The classic utilization of CPI's *Crisis Development Model*℠ in determining the appropriate response to the behavior.

Randy: Exactly.

Terry: Was CPI in place when you arrived at Paul Anderson or did you bring it in?

Randy: No, actually, as I said, we began, when they started doing crisis training for the first two years, I actually implemented—the first couple of years, we utilized PMAB, and again, the reason I went away from that was because they kind of went away. PMAB was really kind of notorious about not changing, not staying modern, not staying updated, which is another factor I love about CPI, because they continue every day to work, to improve, and to modernize, and to just keep moving in the right direction. There's not a lot of—I'm a trainer in a couple of other crisis intervention trainings and I've kind of let them lapse because they kind of stay stagnant. Some of the stuff, I get it, some of the stuff, you never really change, but that has been a positive for me about CPI because we are always moving forward.

Terry: I see. You've had experience working then with several different crisis prevention programs and you've indicated you find CPI training very effective in producing the outcomes that you like. I guess you have just kind of compared and contrasted the programs you've worked with, would you like to add anything to that about differentiating CPI from other de-escalation training that you've experienced?

Randy: Well, and part of that, like in a couple weeks, I'm actually going to Tampa and Fort Myers as a contractor. What they're wanting me to do there it's interesting. I can't wait to get there because I'm going to be training four days, probably around 200, 250 people. Now what they tell me is, "We're good. We have all these verbal de-escalations. We've got that. We got

it." But then as they continued to contract with me, they said, "But we're having a great deal more [episodes of] physical acting-out." So I mentioned to them, "I'm curious, because if you have all these great verbals," and they're not a facility that has or is known to have a history of having physical aggressive behavior on a consistent basis. So my question then is, all right, somewhere there's something missing because if we had the verbal de-escalation skills, we shouldn't be having an increase in physical acting-out especially, if that's not part of our history.

What I will do there, I will see what they've got, and really, what they're wanting me to do is not CPI. They're basically simply wanting me to come down and teach them how to legally, appropriately, put hands on individuals when you have to do nonviolent physical intervention. It's going to be really interesting because as I get there, I don't know where they have the verbal de-escalation, what they have, but I'm going to really look into that because if you know that's something to think about, if we are that good at that, then we shouldn't have increased physical acting-out.

My first purpose is go down, teach, and train on how to keep yourself safe, how to keep your patient safe, but on that part, too, is really to look and see where they're at and what I can recommend them for the future.

Terry: So there may be a bridge to CPI training for this group then once they become more . . .

Randy: That's certainly something I will look into after my four days there when I actually sit down with administration and kind of do an overview, but it's just really, like I said, to modernize on. I just recently went back to Jacksonville, Florida, for another four-day training and even though a lot of—to me, a lot of the stuff continues. I know what works for me in a situation and that's just, I mean, that's confidence. That's not trying to be cocky.

I know, for the most part, what needs to—what my role is and what I need to do and whenever—and a lot of that—I mean, I've taken things from trainings with secure, with Handle With Care. I still carry things from PMAB but I think the biggest thing with CPI that has really impacted me and a lot of the people I work with is just really the—if I'm doing a training and I go into something, I'll get on the blackboard or erase board or whatever and I will put down, "If you have people, identify acting-out behaviors," people will give you, "There's all kinds of ways we act out." Then if you act out, and this is something that I didn't learn though CPI through the book but I really did, okay, identify the acting-out behavior.

Now the second thing is I promise you there's negative feelings attached to that. So if someone is hitting the wall, screaming, and throwing things, whatever, crying, there's emotional negative feelings attached to that. So all of a sudden now, once you find out what's wrong with Johnny over here in the corner, what he's feeling, what he's thinking, we know there's something that trigger those feelings that trigger the behavior. It's a great theory and that's the same theory I use a lot with CPI.

There's a problem, identify what the problem is, what's causing it, what's triggering it, and such. In a large percentage of time when you use that and know how to use that, you're not putting hands on people as much as you have to or people think you have to.

Terry: I see. Well, that's a good lesson to take from our training, for sure, and I like in an answer that you had written to me or we talked about, you said, "As a former PMAB secure and Handle With Care crisis trainer, I do speak a lot about CPI as the best and everything else as the rest," and it sounds like you've really incorporated your own experience and understanding into the basic lessons that CPI training gives you.

Randy: Oh, absolutely. In mid-July, I have to retrain everybody here and I'm excited about that because of not only the new additions that have been added to CPI. but that whole concept about being in control and working with these boys, there's a reason that we eliminate. They're going to huff and puff and they're going to blow your house down, or [they're] going to threaten to. That's okay. Big deal. If that's the worst thing they do, it's okay, but our whole concept is built around the relationships and how to deal with them, and how to set limits with them, and how to stay a step ahead no matter what they're doing. And my trainings—I have an interview with a new staff member today and really, it's just the foundation. I really believe that CPI is a foundation of how to treat people and how to take care of them no matter what comes up.

Terry: Excellent. You've had success. We talked in our pre-interview about a time when you went into a psychiatric hospital in the south, a facility in a fair degree of peril because of the outcomes they were seeing and you had a lot of success lowering restraints at the psychiatric hospital. Could you tell that story for us?

Randy: Wow. Yes, I'm proud to tell that story. As a matter of fact, I am due to talk to them again tomorrow but for—you don't have the exact dates but, I mean, for about a year and a half, I was contracted to go into this facility in Louisiana. It was a short-term acute psychiatric facility. The CEO there is somebody that I used to work with, and wherever she goes, she always incorporates and bring me in to do a lot of staff trainings. There's so much faith she has in me. But it was probably one of the most verbal, physical acting-out and I keep wanting to say violent. It was not uncommon.

They were averaging sometimes large amounts of restraint, sometimes daily, sometimes 15, 16 a month. Now I'm talking about full-blown physical restraints, hands-on, to the floor, medication type things, so very, very unsafe, very chaotic, very lack of programming. It was pretty much that same thing: "Patients, sit down, shut up, do what you're supposed to do, and that'll get you out of here."

For anywhere from 8 to 15 days a month, I was going down there for a year and a half, and I was working all shifts, because I wanted to see what was going on. Really, what we used was CPI concept, but along with that concept, we decided there were approximately 23, 25 staff that we decided to let go, because of their just negative influence. And a lot of times, they were

the ones that were causing a lot of the acting-out behavior. They didn't believe in any type of crisis interventions. It was not uncommon for me to see a patient hit a staff and a staff member hit a patient back, if that tells you anything.

Terry: Well, it's a wrong kind of—it's an integrated experience that we wouldn't recommend.

Randy: No. So over that, not only terminating people that have no business being in a psych hospital, but hiring people, and part of the hiring was giving them additional trainings, rather than [new staff] coming in, getting hired, go to the floor and you're expected to do your job. Several things they've really done is increase the staff trainings and really increase the concept of CPI. Yes, they have to get through the CPI training, but they're doing monthly ongoing trainings in regard to all the different components, from defusing to studying setting limits to all of the things that we do on our training, but often there's much more [training] than just a once-a-year basis.

And with those changes, and with programming now, and taking a TV away, and making it as a true treatment center, it's amazing the changes that have taken place there. Where before, it was a place that if I had to send a friend or family member, there's no way I would have referred that place. At this point, I would actually refer that facility for someone in need of some type of psychiatric treatment.

Terry: Well, that's a very dramatic turnaround when you would recommend somebody you know to go there after you saw such challenging conditions. We've talked about this in our pre-interview, and I'm anxious to get to it because I like the story aspect of it, but you have one behavioral episode that we talked about in particular that stands out as an example of how CPI training helped to prevent a violent outcome. Could you share that with us, Randy?

Randy: I will, because when you asked me that, that's the first one that came to my mind. As a matter of fact, I could tell that's where you were headed. This was before [I had] a lot of training and a lot of experience in a hospital. I was radioed over, along with two other staff members, to come into the unit, and the charge nurse was pointing us over in the corner, where a very large man was standing with a broken table leg. He had busted a wooden table leg off a table.

Now for those who are knowledgeable and have any idea, the example I use is from the movie *One Flew Over the Cuckoo's Nest*. If you remember the tall, gentle, giant Indian, this was a duplicate; this was a twin of that actor in that movie.

Terry: Chief.

Randy: He's a giant of a man. He's standing in the corner with a table leg. The charge nurse looks at me and two other guys, says, "I want you to go and take that table leg from him and we're going to give him some medication." I looked at her and she walked away, went to the nurses' station, turned, shut the door, and locked us out. [laughter]

I'm looking at the other two guys, we're looking at each other saying, "Oh my God, what do we do?" We didn't have security; it was us three. So besides praying, really, to make a long story short, we began to slowly move towards this guy, and I was the one who was trying to make eye contact and really watch my body language. I was introducing myself while walking to him but certainly in a nonthreatening way.

At one point, before I even got really close, I just sat down. I sat down in a chair and continued to try to talk to him. You could see in a short time the threatening stance he had, and the biggest thing [I noticed is that] he thought we were a threat to him. He thought we were going to come hurt him and harm him and who knows what. I can see his demeanor; his body language changed and he slowly began to interact with me, and I started to ask him for permission to even get closer, so little by little, I got closer to him, and he could kind of see me.

The thing was, as he said, he was just scared to death. He had had something bad happen to him before in a facility, and it wasn't very long before I'm close enough to him. Of course, those other two gentlemen are back behind me and they're praying that we didn't approach him like we want to come in and tackle him. And before long, I ask him and he puts the table leg down and we're talking and he just shook. He was scared to death. His anxiety level was high. He thought we were just going to come hurt him. And in many times, I mean, that was such a teaching moment—learning moment—for me because so many times before, if we had the numbers, we just went in and got him. We got him and we take him down and take that from him and give him a couple injections in the rear end and, wow, we won the battle. I will never forget that moment.

Terry: So you basically modeled kinesics and paraverbals, and your tone and your posture totally kind of broke through his . . .

Randy: That's what it was all about.

Terry: Yes, that's excellent. From your extensive experience with CPI training in psychiatric settings like the one you just described, and in Louisiana, do you feel that CPI training has the power to change organizational culture and improves staff sense of confidence and safety?

Randy: I do, and I think it's a huge component. I think it's part of that foundation, and again, you've got to have, in any facility, we all know you've got to have the right people at the right place and the ones who are willing to continue to learn. Like I said, I've done this for 38 years, and one of my goals every day is to get better. There's nobody that knows it all because you've got to have certain things in that foundation, and I believe the CPI component is the culture, how you do what we do. I wouldn't want to be—no matter where I am—it's funny, too, because I look back on this now, even when I began to learn crisis intervention, I used that. I used to bartend part-time and I used to—part of my bartending was sometimes being that bouncer, and it's funny. CPI is just not something I incorporate when I walk into a facility; it's something I use a lot in my everyday life and that says a lot right there.

Terry: Yes. And, Randy, thank you. I'd like to close today with, I know this is a favorite quote of yours from the writer E.E. Cummings who said, "We do not believe in ourselves until someone reveals that deep inside us something is valuable, worthy of listening to, worthy of our trust, sacred to our trust. Once we believe in ourselves, we can risk curiosity, wonder, and spontaneous delight, or any experience that reveals the human spirit." Could you talk about why that quote speaks to you?

Randy: I found that I can't even tell you how many years ago and I've had that; I carry that with me, and I've always used that even in my company brochures or whatever. I look back, I mean, at one time in my life, like, man, I was probably the most insecure, shy individual, and I look back on the things that continue to build that self-confidence and that courage and I think that's with everybody. We all have some areas that we can improve our self-esteem, that confidence, but part of that is people believing in you.

God has me on this earth. Believe me, there's some things about me and my history [that] make me wonder why I'm still here after everything I've done, and chose to do. But so much that had people believing in me and hearing me and listening to me and give me the opportunities to continue to grow. I just love that. I mean, to me, that is understanding somebody and finding what their needs are and believing and then believing in you and continuing to go forth, but you've got to have the chance to do that. And that's one of the things I like to think I've done over the years is give people the opportunity, to give people the chance to believe in other people and start to believe in their selves.

Terry: Excellent. Well, thank you so much for sharing that with us today. Today on *Unrestrained*, my guest has been Randy Frost. He's the program director at the Paul Anderson Youth Home. That's a juvenile justice facility in Vidalia, Georgia. Thank you so much, Randy.

Randy: You're very welcome.

Terry: And thank you all for listening.