CPI *Unrestrained* Transcription

Episode 63: D.C. Foster

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Note: The interview subject, D.C. Foster, revised this transcript for clarification. His changes are in red text.

Terry: Hello and welcome to *Unrestrained*, the CPI podcast series. This is your host, Terry Vittone, and today I'm joined by D.C. Foster. He is a behavioral health intervention specialist at the Arizona State Hospital and a CPI Master Level Certified Instructor. Hello and welcome, D.C.

D.C.: Hi, how are you doing, Terry?

Terry: I'm doing well. How are you today?

D.C.: Well, I'll tell you more as I'm getting ready to go home. But I'm doing okay right now.

Terry: All right. Well, let me tell you a little more about my guest and our interview today. For more than 30 years, D.C. Foster has provided long-term in-patient care and treatment to patients with mental disorders, personality disorders, or emotional conditions. Treatment at the Arizona State Hospital is considered the highest and most restrictive level of care in the state. Patients are admitted as a result of an inability to be treated in a community facility or due to their legal status.

Our interview today will focus on the results of the hospital's transition in 2013 to a new model featuring a cohesive team approach where direct care staff is fully engaged in all aspects of care.

According to the hospital's website, "This culture of care creates a better therapeutic environment for patients and residents to live and improve safety for everyone. And a central feature of implementation is CPI's *Nonviolent Crisis Intervention*® training for more than 700 members of the hospital staff."

All right, D.C., could we begin today then by having you talk about the population you serve, your role as a behavioral health intervention specialist, and then please give us an

idea of some of the challenging behaviors that you typically encounter and the nature of your interventions.

D.C.: Okay. Our hospital is a multi-treatment facility. We have a civil hospital where we treat patients with mental illnesses: PAD, GD, and DTO, and DTS behaviors. The PAD stands for persistently and acutely disabled, the GD is greatly disabled, DTO is danger to others, and [DTS is] danger to self.

We also have a forensic hospital. Our forensic hospital houses criminals who've been adjudicated also having a mental illness, and they have a community reintegration program called CRU, where when they reach a certain level, a higher level, ~~where~~ they're able to go out, but they're monitored when they go out.

We also have Arizona Community Protection and Treatment Center, an SVP Program, which is for sexually-violent persons, and they've been committed to us for treatment from the courts.

My role essentially as a behavioral health intervention specialist is to work with the teams on the unit. If there's a problem that could be a danger to others with an individual who becomes dysregulated and violent, I'm usually asked to go and see and support the team in a number of ways.

And you asked me for something else, Terry.

Terry: Well, some of the challenging behaviors that you might encounter when you get a call to go and assist.

D.C.: Well, we have individuals with varied backgrounds, but they have a mental disorder. So we may have individuals with weapons, makeshift weapons, knives, they sneak things in through the safeguards and checkpoints—to the facility, I should say, even through the mail and other areas like that. Razor blades used for grooming were once a problem, and they make weapons basically out of anything. Our population is very creative. They'll tie ropes together or braid a rope. They'll do things to try and intimidate the staff here. It's a wide variety of stuff, things and behaviors that challenge staff. We have a contraband board that shows things that we've caught over the years, knives and shanks and toy guns or cap guns and stuff; they look very real.

Terry: So, you see improvised weapons that could very well be lethal then?

D.C.: Yes, and to staff. And part of the de-escalation and deceleration approach that we use as CPI's teachings to bring this—to either slow down the behavior or bring it to a complete halt, individuals usually want something in return, so at times it's like a negotiation process that I'm involved in along with the team.

Terry: I see. Well, so, when were you first, D.C., certified in CPI *Nonviolent Crisis Intervention*® training, and how important do you feel that CPI training is in helping to sustain a culture of care and safety at the hospital?

D.C.: Well, again, it's at the core of everything we do. 2012, I believe, is when we did it. We had CPI at the State Hospital years ago. They switched to several different ones during that course, and we returned back to CPI.

In terms of its application and how to use it effectively, we work with the individuals. We try to develop the rapport that CPI talks about with many of the individuals, the heavy hitters on the various units, and try to build an alliance relationship as opposed to an adversarial one. We try to diffuse things before they get started. So we have, like, a prevention focus, in terms of rounds, with the individual every day. At least I do. I'll go to the different units and just talk, communicate with ~~them~~, patients and if they have any issues, let me know and I'll see what I could do for them. So we try to get ahead of the problems before they start.

Terry: So your prevention starts with rounds every morning?

D.C.: Yes.

Terry: That's impressive. So which staff departments at the hospital are trained in *Nonviolent Crisis Intervention*®? I see you trained 700. I imagine you trained more since then. And do you feel that fidelity of training is important to providing a consistent or a common language and violence prevention values to your staff?

D.C.: Well, again, we train everyone who comes into the hospital who is basically not a contract person. If you have direct patient contact, you're trained. And we put emphasis not only in the training, but we encourage the people to go out and talk, you know what I mean? Go and interact with the patient population, ~~so~~ on the various units.

Again, your other question was—the tail end of that question was what now?

Terry: Well, you, personally, as a Master Level Instructor, do you feel that this fidelity of training, that is that you train everybody, is that really important to providing a consistent language among different staff departments, different departments or different staff?

D.C.: Well, absolutely. The language is important for a number of reasons. One of the things we try to eliminate from our vocabulary is "no," to tell an individual "No." For instance, there was an incident that occurred where the resident or the staff miscommunicated—the staff was involved in an activity, and one of the patients had asked—made a request, who wasn't involved in an activity. The staff had said, "No," and at that point, the resident became—or the patient became upset and started tossing things around and destroying the room, breaking property, and there was a lot of damage to the area.

So, we try to eliminate "no" from our vocabulary, and that kind of language when possible. We try to talk to the patient in terms of, "What is it that you need? How can I help you right now?" instead of blaming or saying "No." It takes a lot of skill not to say "No" during the course of the day.

Terry: I can only imagine. I mean, with some of the extremity of behavior and of the diagnosis of the patients that you see, I imagine that there's some really difficult behavior to not respond to with a negative right away. And you were trained, I believe, in 2012 or 2013?

D.C.: '12.

Terry: 2012. And how often do you train? How many people do you think you've trained in your experience as a trainer, D.C.? Sorry to hit you with that. I'm just wondering if you have a ballpark.

D.C.: I'm gonna say I'm in the thousands. Training never stops, both informal and formal.

Terry: Wow, how about that. So—

D.C.: I will also sit in on classes with some of the other trainers since I'm the most senior, and work with them. It doesn't reflect in my spare class, but I wanna make sure that—again, we talk about the fidelity of instructions. I wanna make sure that there's an understanding and there's participation in the training, so that there's a clear understanding about what we mean, the terms, how we use them, and how we apply them.

Terry: I see. Now, to go along with this, I think it's really fascinating that you take this as a kind of a core value not to say "No." But you told me, D.C., in our pre-interview, that the staff at Arizona State has a saying at this. "Whatever it takes, to stay hands-off." Could you tell me why that phrase is so relevant to your care philosophy and methods?

D.C.: Well, number one, any time you put your hands on an individual, the potential for violence, escalation of behavior, also having a ripple effect with the other people or the other patients on the unit, increases greatly; it becomes exponential. "Whatever it takes," essentially, is kind of like our mantra, [our] Instructors' mantra. And what we wanna do is we wanna try to resolve the issues and problems without physical contact, and that way, we can convey that things can be worked out without the threat of violence. And that seems to be pretty good.

There was a period in the culture apparently, much before ours, where they initiated what they called "takedowns."

Terry: You eliminated that?

D.C.: Yeah, we no longer have that. Even before, one of the things we saw even prior to 2012 when CPI was reintroduced to us, is that there seems to be a problem with that. There were injuries coming up, it was a goal to get the patient off their feet. And they do seem to like going to the ground, whatever ground that was, including concrete and other things like that. It made them less dangerous, but the injuries had went up. So, we made it a special focus of ours to see if we can decelerate those behaviors or de-escalate those behaviors through verbal communication.

Terry: And that would also fit right in line with CPI's value of creating the least restrictive environments possible.

D.C.: Absolutely.

Terry: So, it sounds like prevention is a very central value there at Arizona State Hospital.

D.C.: Very much so. And we're trying to teach that and get out—to get people to get in front of situations. And we talked about the language before, and we have a little language that we use. You know, escalation is one of the things that we talk about or we document a lot, but our language here as Instructors is pre-escalation, pre-intervention, pre-crisis, pre-conditions. We wanna know what's happening before that occurs. And if we can get a handle of what kind of conditions arise prior to that, we can work on those kinds of things to avoid the latter, which is the violent and aggressive behavior.

Terry: So you have a lot of due diligence steps built into the process to preempt anything that would lead to an escalation?

D.C.: Yes. And we're trying new things every day. Give you one example, we had an individual who loved music, and he was very difficult to move from the patio—to the patio, excuse me, from the day room. There was problems with that. We wound up putting a music box out on the patio to make sure that patients got fresh air. And everybody kind of gravitated to it, including him. There was no more problem, ~~but~~ he just wanted some of his environment to go with him, and that was the issue.

So, we made it kind of homey for him. We played his music and we had less trouble and stuff like that. This was a pretty big guy.

Terry: You know, that sounds simple, but I imagine it's deceptive to have actually realized what the solution was going to be to make that outside environment more comfortable and familiar to him.

D.C.: And that's pretty accurate. We try to do that with many of our individuals. You know, a lot of them to bring books without pictures, we make their outdoor patio time worthwhile. If they wanna bring things from their rooms or from their areas, or get stuff from their property, they're permitted to do that, too, to keep on the unit, as long as it doesn't

constitute a build-up of material because we like the rooms and the areas to be clean and free.

Terry: So you need a certain amount of visible control, but within that parameter, you allow some customization for the building rapport, which leads to my next question, which I'll go into here. D.C., in one of your guest blogs, you write—and we'll link these in our podcast blog, we'll have a link to your—the fine collection of blogs you've written for CPI.

You write, "I find the building of rapport and being trauma-informed synonymous and inextricably tied together, resulting in healthier and more positive outcomes through our population." I would love it if you would unpack that statement for our listeners.

D.C.: Well, rapport is a key component of ours, and we train to our new employee orientation to start building rapport the minute you walk through the door. We have an understanding here that rapport starts when you first enter the patients' population, and again, as you come through the door. And it's not only based upon you and the individual you may be dealing with, but other people and other patients will see that, too, and they will assess you with our patient population. We'll kind of assess and look at it and saying, "Is this someone I wanna talk to or deal with?" as you deal with another patient. So, know that people will be watching all the time.

Being trauma-informed is understanding some of the difficulties that many of our patients have gone through. And in doing that, we have to open and create that dialog again. In creating that dialog, we can find out what kinds of things were traumatic to that person, what they wanna speak about, how we need to approach them, things like that, and it's worked out pretty good for us.

There was a period, I wanna say probably 30 years ago, when you would wake up people by turning on the lights and things like that. We'll sometimes turn on the lights to their rooms to get [them] up in the morning. And sometimes one of the things that they would do is ~~they~~ turn off the light. So we would ask people now, as opposed to 30 years ago, when staff were banging garbage cans together, screaming, "Wake up, wake up, wake up." We go in there, we leave the lights off and we let them know it's wake-up time so they can get their ADLs and things like that together.

We also incentivize that by bringing coffee and donuts and things like that out in the day or in the morning. So when there's a community meeting, the patients can enable the process or program—they can have a little snack, I should say.

Terry: So, let me ask you, when you start an initial conversation with a patient, how do you—it must be a really artful thing to be able to—to kind of ask them about the trauma that they might have endured in their life before the hospital. I mean, how do you initiate a conversation like that?

D.C.: Well, it involves an interview, a couple of things. I also use like a patient interest and aptitude kind of questioning. What are the things they like to do? What are the things they're good at, and then could they teach them? We have people who teach chess to other people, patients.

But we just—we sit down. Again, it's as simple as just asking. "Is there anything you wanna tell me about you growing up?" Or, "What do you like? What's your dislikes?" And we don't focus so much on the dislikes; we like to build our plans around strength-based information.

So, especially those patients that give us that information, we ask them, "Is there any way that we can help you replicate those things in here if they're safe interventions?" The patient will talk to us about that and we can bring that to the treatment team and see if we can do that.

You know, we had patients who like to do graffiti. We actually put this person in an art class, rehab. So, we didn't look at graffiti as anything bad, and he made it colorful and very nice. He had some artistic talent. So when people hear graffiti, they thought about writing on the walls and things like that, so we gave him walls and papers and posters that he could practice his craft on, and that made him happy.

Terry: So, very proactive and positive solutions after going after what—in that interview, determining what the interests and talents of what the patients are. How many patients are in Arizona State right now that you manage?

D.C.: I'm gonna guess here. Our number probably is 243, somewhere around there. We used to be as high as 1,400, not the state hospital, per se, but when we were the territorial insane asylum, we had 1,400 people.

Terry: You have quite a storied history there. I think your facility was built in the 1870s at some point.

D.C.: That's correct.

Terry: And so it's been a long—you have quite a storied history.

D.C.: We have some history here, being that we're the only state hospital in the area. We used to get people from Stockton, California, that were carted our way during those particular times, in the early 1800s. We've had some celebrities here that I can't really talk about. We have a graveyard here that's been on the property for a long time. We had a buffalo soldier who was buried here, and there was a movement to get him from our grave plot in our hospital area out to Washington and they—the word escapes me how you get him out of the ground, but they did that, excavate him, they did that and they brought him to

Washington, and he's now buried in Arlington with the recognition of having served his country.

Terry: That's beautiful. You have two acronyms there at Arizona State, CARE and STEP, that we talked about in our pre-interview and I think they're really powerful. And they're used at the hospital as reminders of your foundational values. Could you talk about CARE and STEP, and what they stand for and how they inform staff behavior?

D.C.: What we do here, we have a weekly post that people and our administrators are committed to weighing in on, stuff like that. That includes our CEO, our CMO, our CNO chief nursing officer, my boss, and all the way down the line, our executive administrator staff.

CARE, C-A-R-E, is Creating A Respectful Environment, and we look for things and ways to be able to do that. We take our tips from the patients and the other staff who have a load of talent in areas like that, and we utilize the talent that we have and we put that to paper so people can read it and remind themselves about why we're here, and it's for the patients and the residents.

The STEP is Safety Takes Every Person. That's what the STEP is about. And we look for ways to make safety catches. If we see something that may be amiss or going amiss like that, we wanna report those. And we recognize those people who look for those safety opportunities, and so much as doing the little things. I myself I pick rocks up off the patient grounds that was done when we had opened it—our hospital was in its infancy, and so was our landscaping, and every time it would rain, bigger rocks would come uncovered. But we got a contingent of staff to go out and pick these rocks up so that they couldn't be weaponized. I mean, things that simple.

If we see a piece of paper on the floor or something on the concrete grounds outside, we take the responsibility to pick that up ourselves; we're not waiting for grounds people. We're looking to have the best environment possible for our patients and our staff.

Terry: Excellent. Now, D.C., in the past, you've shared stories of CPI about behavioral crisis that occur at the hospital. Could you share one of those with our listeners?

D.C.: Well, this one doesn't make me look too good.

Terry: You're a brave man.

D.C.: I'm gonna go back to the beginning when I was hired. One of the things was that our patients had bands on their hands, and the bands would signify their ability to have access to the grounds. We had a gold band which was like unlimited grounds, per se, and that meant being able to leave the unit and coming back or checking in at certain times, medication times and changing shift times, and, you know, time for lunch and dinner.

Our blue bands, which were—excuse me, our green bands were next in line, which gave them certain hours to be out then they needed to be on the unit.

Our blue bands, which the ratio was one to five, our staff could take five of them out. They had to go with the staff and they had to return with the staff. And the white band, which meant they were confined to the unit at those particular times.

Well, it just so happens that the bands, so that people understand it, if a person with a gold band or a green band committed an infraction, if the treatment team warrant it was severe enough that they needed to go down in color, we would then take the green or the gold band and would strap a white band on it for a period of time. Well, that got to be a headache, because some people were not allowing us to do that. And as I was very tired, I looked at everybody's band and they had some green bands and gold bands, and I was the one—as the new kid on the block, I was the person who was letting them out the door and letting them on the grounds.

Well, my staff kind of okey-doked me and told me that I let a person out that shouldn't be out, and it came to my attention that I not only have to look at the band of the person—that patient was wearing, but I needed to look at the board that spoke to the privileges that was inside the office.

Not knowing this and thinking about how wonderful my teammates were, I went out after him and the patient told me when I asked him, I said, "You have to go back to the unit," and he said, "What for?" And I told him and explained to him, which he knew that already. He says, "I'm not going back." And I then looked at him and said, "Look, I'm kind of a new guy here. I let you out by accident." And I said, "Come on, help a brother out. Let's go back to the unit." He looked at me and he said, "All right, you're kind of new here, I'm not gonna take advantage of you that way, so I'm gonna go back to the unit. But if you don't start checking that board," he says, essentially, "I'm out. Next time you let me out, I'm gone."

And I said, "Shh." And I'm thinking this is a load off of me, and I start to go back, I look back and he didn't move, and I asked him, I said, "Come on, let's go." He said, "Before we go," he asked me, "who's your daddy?" And I said, "What?" He said, "Who's your daddy?" And it was something most of the patients were saying at the time. I said, give him an answer, get him inside, and then tell him, "You're ~~I'm~~ not my ~~your~~ daddy."

So, what happened was I said, "I am. You are my daddy." So, "It's okay, now I'm going with you,". And that patient actually came in, we wound up having a real great rapport. He's kind of a jokester. He's no longer here, but again, that was 30 years ago.

Terry: So you adopted a "Don't say no" and kind of a very—almost a peer-to-peer approach, saying, "Hey, give me a break, I'm new," rather than an authoritarian voice. You used more

of a brotherly voice yourself, to use the phrase, I mean. And was that do you think just part of your nature or more kind of an intuitive sense of what would bring the situation to a peaceful resolution?

D.C.: Well, I was looking for a peaceful resolution all the time. It would be shocking to have somebody new here and then having to do a hands-on and calling on the radio. You know, and these are the kinds of things that probably happened before but, you know, I got to know the patients in a different way even for the moment—and I think that was in my first week, you know, at the hospital when I did that, first few days. But that was kind of me looking at the patient, and he had been—you know, I had been around the unit for a couple of days and a couple of hours, and he wasn't one of the ones who became dysregulated and violent, he just wanted to get out. He just put one over on staff.

Terry: Did patients try—I mean, you had it on the board, but did patients try to doctor their bands, so if they were white, that they would color them in green or gold, or did you have any—I mean, I'm sure you've seen everything so far as subterfuge goes there.

D.C.: Yeah, white bands. They would keep bands from other people.

Terry: Oh, I see.

D.C.: If your band came off, you'd kept it and you were able to sell it to somebody else. If you had a band, you know, say I'm giving you a blue band, here's this green band for a dollar, you know, they try to put in on and put tape around it, you know, clear scotch tape so you can't see where it breaks. That's why you've got to read the board. So, I was a boardreader after that.

Terry: I bet. I bet. You know, you talked about that you used to wake people up by turning on the lights abruptly or banging garbage cans together, and, you know, you wrote me something, and for our last question today, D.C., I want you to maybe comment or read a comment that you sent me while preparing for this interview. You titled the comment "An Epiphany," and it says this.

"As an idealist, I've often imagined that people today who work in our hospitals and treatment facilities look back over the past 25 to 30 years and say to themselves how archaic and barbaric our practices were. So the question again can be asked, how will people 25 to 30 years from now see us? What will they think and say about us and our present practices?" Well, what about that, D.C.?

D.C.: Well, I'm gonna explain this in a couple of ways, and I'm gonna use some other—a bit of a literature here.

There used to be a program called PART, which is Patient Assault Response Training. We were involved in that for a period of time but then we moved to Pro-ACT. And one of the

reasons was, is when you say Patient Assault Response Training, that means the incident already took place, because now it's response training. How do you respond to something like this?

And looking at prevention and preemption, pre-crisis kinds of situations, and, you know, pre-intervention kind of things, we were looking to get ahead of those things. We were looking to—at the time, and I have a few people, a few staff that are involved in this practice, too. When we used the debriefing model, the postvention model that CPI provides, one of the questions we ask is, did this have to happen? We wanna look back and—I mean, if we put a person in seclusion, if we put a person in restraints, you know, heaven forbid, if we have to take an action that is not consistent with the care, welfare, and safety of the patient and the staff, we question ourselves. And in questioning ourselves, we found better ways to do things.

Dialog and rapport-building is probably two of the key elements, the key components. CPI spelled it out pretty good because they talk about: I'm gonna have three opportunities to be a team leader. If there's a problem or a crisis occurring, the first person on the scene, the person with the most experience and is comfortable, or the person who has the best rapport.

And we use these models like this, but we don't use them when there's crisis. We try to touch base with people prior to crisis. If there's a person expecting a package and has been disruptive Monday, Tuesday, I'm gonna visit this person before they even have an opportunity to come out on the ground, and let him know that I'll look into the post office for his package.

If there's a person that can't make it to group and are expecting a visitor, if it's appropriate and is telephone hours, and they call, he'll get visitors then. We do a lot of things preemptively and proactively. We don't wait for the crisis. And that's basically the changes that I think we're gonna make. There'll be a lot more preventative measures, I believe, in the next few years instead of having to learn a particular intervention that deals with a particular outburst or crisis or event. We're not gonna wait for that.

One of the models I use, too, is I ask the question, would you rather be a fireman or—excuse me—a firefighter or a fire preventionist? And people have asked, what's the difference? Well, one is you're out there fighting the fire, which is a good thing. But if you can prevent the fire with smoke alarms and things like that, make sure you don't have open flames in your areas, with candles, that goes a long way. And most people—and that's the idea I want, people to look at how to prevent these things from occurring. I would like them to spend more time in these particular areas instead of waiting for the event, the crisis event to occur, and then try to deal with it that way.

Terry: So making prevention a foundational element is really the heart of progress in treatment?

D.C.: Well, I would think so. There's a lot of people who agree with me. Now, some things are gonna happen. If I can give you one more analogy.

Terry: Please. Please do.

D.C.: In the training, some of the things I do is simply understand prevention and preemption a little bit better. I talk about if your house is burglarized, what are some of the things you have to do? You know, it's funny though because a lot of people leave out notifying their spouse. You wanna go, what was taken? They go in the house and there's a couple of things that's wrong, you know, that are not right. To enter the house that's already been broken in, you still might find the perpetrators still there. But I make sure that they understand that.

But then most of them say, "I'd call the police." And I wanna ask, does that guarantee getting your stuff back, what was taken? And they understand, no. And then I say, okay, are there measures you can take? You know, good signage job, get a dog, get a screen fence, make sure there's a peephole, put bars around your window, put a gate, an outer gate that you need access to, an access code to go through. You know, have a fire alarm and be trained in it as well like that. Get lighting in the area, a lot of lighting. Trim your hedges, things like that, so you can see very clearly. You have a lot more visibility, those kinds of things.

And I asked the same question and people contributed to those solutions and I said, "Does that guarantee that your house is not gonna be robbed?" And, again, they say, "No." But it's a better way. If an individual sees a home like this, or a home that's not protected, he's gonna go for the easier one. So you're doing some things to prevent the occurrence or preempt the occurrence of somebody robbing or breaking into your home.

So, I wanna make sure that they have that kind of understanding and I use other examples as well. So we try to do those things that would preempt a crisis or an outburst, or a crisis or dysregulation kind of event from our patients and our residents.

Terry: I see. Well, that's an excellent example of—again, you can't make yourself—you can't indemnify yourself against any scenario that might require more than verbal intervention, but you can take every reasonable measure to see that prevention is in place beforehand.

D.C.: Yes. And again, you may get alarms, but these little lessons, I think, are important. Our new classes, our new employee orientation, our trainer is given the opportunity to speak to that particular issue. And we have several of them. And can I give you one more?

Terry: Please.

D.C.: We have what's called objective and directive. One of the things that occurred once was the doctor had a call; there was a code and the doctor had wanted this individual in his

room so he can calm down. The individual was in a day room area and he says, "I'm calm right now. I'll stay here." And he asked for some PRN medication, and the doctor said, "Well, I want him in his room."

At that particular time, I was speaking with the doctor and the team, and I said, "You know, I don't want a power struggle here between him and you. You say take him to his room, you know, that's what's gonna have to happen, and I understand that. Is there any way that he can possibly remain out where he is now and if he's appropriate? Because the objective here is to have him calm down, but the record is to go to his room." And in this way, you know, the doctor and I kind thought it out and came to the same conclusion that the objective was what we wanna accomplish as opposed to his directive.

So they gave him his PRN medication, he stayed in the day room until he was a lot better and more grounded, and the rest of the day he was cake.

Terry: That's a very keen distinction between directive and objective. All right. Well, D.C., I wanna thank you for being our guest today.

My guest on *Unrestrained* today has been D.C. Foster. He's a Behavioral Health Intervention Specialist at Arizona State Hospital, and a CPI Master-Level Certified Instructor as you certainly heard in our interview today. Thank you so much, D.C.

D.C.: You're welcome.

Terry: And thank you all for listening.