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Albert E. Wall, Director
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Division of Behavioral Health
P.O. Box 110204
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Dear Director Wall:

As agreed, I visited the Alaska Psychiatric Institute (API) on December 1, 2014, in order to begin the process of consulting with the Institute and your Division. I was asked to take a comprehensive look at the facility, with a special focus on the safety of staff and patients. After that trip, I presented you with a draft of my preliminary findings and recommendations.

However, as we discussed, one day is far too brief a time to learn about a psychiatric hospital or to formulate a comprehensive set of recommendations. As agreed, I therefore returned to API for a two day visit February 2-3, 2015, to continue working with its staff and management to identify additional ways in which the facility might improve its treatment, as well as the safety of patients and staff members alike.

As part of this work, I interviewed numerous patients, nursing staff, clinicians, senior managers, and labor union officials, and reviewed a number of documents, including the following:

- API Consultation Report and Project Management Plan by Western Interstate Commission for Higher Education (WICHE) (September 2011 and May 2012)
- Patient records and treatment/recovery plans
- Numerous documents and communications detailing or summarizing complaints and allegations about unsafe conditions at API
- Remedial plan created by Dr. Melissa Ring, CEO

At the end of each visit, I conducted an informal exit conference with Dr. Ring, during which I communicated the preliminary findings and recommendations that are contained in this report.

I want to thank Dr. Ring, the senior staff, and all of the many patients and direct care workers who made me feel so welcome during my visits. They responded to my questions with candor and integrity, and made my visits as enjoyable as they were informative. I am especially grateful to Quality Manager Jacqueline Adelman, who served as my guide during my first visit, and Dr. Tamara Russell, who guided me through the second.

Introduction

API is an 80-bed psychiatric hospital consisting of 5 treatment units of various sizes, as follows:

- Chilkat – 10 beds for adolescents
- Taku – 10 forensic beds predominantly used for competency restoration
- Denali – 10 beds for older patients
- Katmai - 24 bed acute care unit for adults
- Susitna - 26 bed acute care unit for adults

The facility, which is very attractive and generally well designed, was built in 2006 and reportedly remains in very good repair.

The need for this consultation was primarily based upon two related problems. First, many members of the staff, especially Psychiatric Nursing Assistants (PNA's), report feeling vulnerable to patient violence. Second, for several reasons, during the last quarter of 2014, there had been a very frequent use of involuntary overtime, with predictable negative effects upon staff morale, fatigue, irritability, and anger. In addition, it quickly became evidence to me that API does not provide enough hours of active treatment in the day of an average patient at API, resulting in boredom, more disruptive behavior, and less effective treatment.

CEO Melissa Ring, Ph.D. explained to me her desire to enhance the hospital's commitment to the Recovery Model and Trauma-Informed Care, which have become the pillars of modern inpatient psychiatric treatment in the United States. Unfortunately, however, both of these terms have been very frequently misused and misunderstood, resulting in predictable "push-back" from some direct care staff members, who are the most important people in implementing them.

A Brief Overview of the Recovery Model and Trauma Informed Care

In order to avoid a similar misunderstanding of this report, I want to share my understanding of what the Recovery Model is, and equally importantly, what it is not.

According to the Substance Abuse Mental Health Services Administration (SAMHSA), the Recovery Model is "a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential." Key components of the recovery model include: self-direction; individualized and person-centered care; empowerment; treatment that is holistic and strengths-based; peer support; respect; and responsibility. Most importantly, the foundation of the Recovery Model is hope, and the sincere belief that people can and do recover from even the most serious mental and emotional problems. However, hope can be difficult to maintain in an acute psychiatric hospital, where treatment staff tend to see people in their worst moments of confusion, despair, and hopelessness; hospital staff seldom have the opportunity to see that same person in a non-patient role as a safe and productive member of a community.

There is nothing about the Recovery Model that endangers staff, nor does the Recovery Model promise people with mental illnesses a world without natural consequences. Indeed, teaching people how to responsibly and safely regain their autonomy is one of the most important gifts that can be given to the people we serve. The Recovery Model should inspire psychiatric hospitals to be places of learning, growth, and healing. While some degree of control is necessary to maintain a safe environment, control is a means to these ends, and should never be seen as an end in itself.

Equally important is a definition of Trauma-Informed Care. The experience of trauma (e.g., physical or emotional abuse, sexual abuse, domestic violence, war, and natural disasters) is often a precursor to or associated with alcohol and drug use, mental health problems, and related issues. Indeed, traumatic life experiences are the near-universal experience of people with serious mental illnesses. Services and supports should be trauma-informed to foster physical and emotional safety and trust, as well as to safely promote choice, empowerment, responsibility, and collaboration.

Trauma-informed care, however, is not a formulaic set of treatment approaches. Rather, it requires hospitals and other treatment settings to actively promote an environment that patients experience as safe, as well as safely maximizing patient choice, empowerment, responsibility, and collaboration. A trauma-informed staff is aware that involuntary treatments (e.g., seclusion, restraint, and involuntary medications) can inadvertently re-traumatize patients in a way that is counter-productive; they should be used only when less intrusive measures are not possible, practical, or reasonable.

Simply put, mental health professionals have historically sought to identify what is wrong with people, and for too long have failed to ask, "What has happened to you?"

Again, there is nothing about trauma informed services that should endanger staff. In fact, the opposite is true. Understanding a patient's traumatic experiences can help the staff to avoid the triggers (e.g., overstimulation) that sometimes lead to patient aggression. It can also prevent the hospital from exacerbating the disabilities that led to the hospitalization in the first place. For example, many women with serious mental illnesses who have been homeless have also been victims of rape. The experience can make restraint particularly terrifying, and restraint should be avoided or carried out in a manner that does not re-traumatize the patient and exacerbate her distress.

WICHE Consultation Reports

As noted above, I reviewed the WICHE Reports, each of which contained a number of excellent suggestions. Among other things, the reports noted the need for:

- Clearly articulated roles, responsibilities and accountability for leadership staff;
- Direct care staffing patterns based on typical treatment and programming needs;
- Inter-professional team approach for staffing, programming and interventions;
- A commitment to active treatment within its therapeutic trauma-informed recovery culture;
- Workforce development and training in behavioral health, boundaries, trauma-informed care, etc., as well as enhanced crisis intervention training and skills development;
- Timely management reports to assist leadership with monitoring key clinical operational and financial functions and activities; and
- Improved coordination and discharge planning activities with community providers and other proof support systems.

Of significant importance in the WICHE report are observations regarding seclusion and restraint. Specifically, the report noted, "API has an increase in the use of restraint (both mechanical and physical) and seclusion, which represents failure to effectively intervene and treat patients during potential crises…. The use of seclusion and restraint may be a reflection of a lack of robust early intervention training and role modeling opportunities, lack of coordinated team intervention skills, and loss of institutional knowledge, as events are more likely occur with less developed or poor engagement skills of newer staff, or it may be an indication of the culture on the units and the lack of support for the recovery model and trauma-

informed care. It is likely that it is due to a combination of many of these issues. This also is reflected in increasing patient and staff injuries."

In its 2012 report, WICHE also noted the need for improved opportunities for unit-based shift briefings and "handoff" of specific patients from one shift to the next. I strongly agree with this recommendation as well, as it allows staff of the incoming shift to be better informed about the needs and risks they will need to address. As one key example, I observed that a very staff-intensive discharge was conducted on one treatment unit during shift briefing, precluding that unit from having any meaningful shift-to-shift communications about the rest of the patients on the unit.

Meetings with CEO Dr. Melissa Ring

During both visits, I first met with Dr. Melissa Ring, who serves as CEO of API. Dr. Ring is an experienced psychiatric hospital administrator, having led hospitals in Texas and Missouri. Dr. Ring identified a number of organizational, administrative, and clinical problems, as well as barriers to solving them.

Dr. Ring presented me with a document that outlines what she called her "plan (summarized below) that accounts for everything that needs to be done."

Among the most important barriers identified by Dr. Ring, especially during my first visit, was the hospital's relationship with its primary labor union, the Alaska State Employees Association (Union.) Dr. Ring stated, "The Department of Labor Relations (part of the Department of Administration) doesn't want me to meet with the Union, even informally." Ironically, Mike Robbins of the Alaska State Employees Association agreed that the Union's inability to negotiate any local agreements with the API administration is very problematic. As noted below, this situation has been significantly improved.

As one example of this problem, Dr. Ring cited the need for a number of policy revisions. New policies were drafted but, according to Dr. Ring, they were "stopped by the Union…. State personnel said not to run them by the Union, but the (now former) Commissioner said to put them on ice." Dr. Ring explained that the Department of Personnel (part of the Department of Administration) met with the Union, without Dr. Ring. Obviously, it is quite unlikely that this separate state agency would have the same understanding of the need for new policies, which would hamper efforts at compromise that would enable new policies to be collaboratively crafted and approved.

I am happy to report that subsequent to my first visit, Dr. Ring was given permission to meet on a regular basis with the local Union, and that a great deal of progress has

been made in a short time in identifying areas of common ground (e.g., the need for additional staffing.)

Another significant barrier cited by Dr. Ring was her belief that the hospital is understaffed, by approximately 24 items. As a result, existing staff members end up working a great deal of expensive overtime. Further, at the time of my visit, much of the overtime was involuntary, which was especially destructive to staff morale. The dramatic increase in the use of involuntary or mandated overtime began in October, and was reportedly due in large part to an order requiring that additional staff be provided whenever a patient is on 1:1 status. However, Dr. Ring and the senior staff conducted a self-critical and data-based review of the effects of this policy. Subsequent to my first visit, Dr. Ring rescinded this policy, which significantly reduced the use of involuntary overtime. By the time of my second visit, this particular issue appeared to have been largely resolved.

Dr. Ring shared with me her belief that abuse and neglect at API are not treated severely enough, citing several examples where arbitrators, in her opinion, did not adequately sanction misbehavior by nursing staff. That being said, she agreed with the observation that inadequate staffing and training increase the chances of abusive behavior. Thus, in my opinion a predominantly punitive solution is unlikely to succeed.

Dr. Ring expressed her dissatisfaction with the current status of pre-service and in-service training for PNA's. She noted that the facility uses the Mandt system of training direct care staff in self-defense and de-escalation skills. Amazingly, she reported that while the initial pre-service training is in person, all refresher training is provided on-line.

I requested data on occupational injury leave over the past several years, but the data was not available. It is useful to look at these data over time in order to determine the accuracy of staff impressions regarding increases in staff injuries. Dr. Ring has since reviewed that data, but I did not have an opportunity to review it.

I asked about the organizational chart, and Dr. Ring told me that she has made recommendations for changing it, which have not yet been approved by the Department. She agreed with my observation that the organizational chart is made up of "silos" that are in conflict with current thinking about the most effective management strategies for psychiatric hospitals.

Many of the leadership challenges cited by Dr. Ring were related to difficulties in hiring senior staff. She cited two examples that were especially concerning. The Chief of Psychiatry position was vacant for more than a year; and at the time of my first visit, the Chief of Psychiatry, Dr. Alexander, had not been able to be licensed for

several months despite excellent credentials. The second example involved the Quality Manager position, which remained vacant for almost a year, apparently due to the need for reclassification of the position. Long vacancies in key senior leadership positions should be avoided, which requires the support of other state agencies.

Dr. Ring also noted problems in hiring PNA staff, which appear to be related to the fact that API is not allowed to conduct continuous recruitment of this position. Finally, it was noted that the Hospital is allowed to hire retired PNA's on a temporary or on-call basis, which is an excellent strategy to avoid overtime; however, for unknown (and seemingly arbitrary) reasons, these hires are only allowed at the PNA 1 level, which excludes the vast majority of recent retirees, including those with the best skills for managing challenging patients.

I was also able to observe Dr. Ring's training session on trauma-informed care, which I found to be excellent. As more and more staff receive this training, it is likely that the API culture will change in regard to understanding the role of trauma in the lives of its patients. My only suggestion was to provide as many examples as possible of concrete steps that each staff person can take to put trauma-informed care into practice.

Dr. Ring's Proposals for Improved Staff Safety

Dr. Ring shared with me a typed document, called "Plan for Improving Safety and Quality of Care for API patients and staff, most recently updated on 11/26/14. The document included a list of 6 "key components to a culture of safety" and 7 strategies:

Key Components of a Culture of Safety

- Culture of respect with no tolerance for disrespect[1]
- Psychological safety with no belittling or retaliation
- Continuous learning and encouragement of providing and receiving recommendations for improvement. Understanding that people make mistakes, report errors and improve processes
- Communications founded on mutual trust (commitment to safe reporting and learning from errors.)
- Shared perceptions of the importance of safety; and
- Confidence in the efficacy of preventive measures (developing, implementing, and analyzing safe processes)

[1] I believe that the terms "no tolerance" and "zero tolerance" should be avoided, as they communicate a punitive, negative, and inflexible philosophy.

Key Strategies

1. Leadership commitment to safety
2. Sufficient PNA staffing.
3. Training of staff
4. Reduce use of restraint and seclusion (especially manual restraint)
5. Improve overall treatment services and planning
6. Develop a zero tolerance policy for aggression (i.e., assaults) by patients
7. Improvements in the Risk Management Program to improve reporting relevance, follow-up, transparency, aggregation of data, and process improvement
8. Sustaining change (monthly meetings of PNA's and nurses)

Dr. Ring believes strongly in the Recovery Model, as do I. However, I find that the recovery model is seldom well understood, and API is no exception. As noted above, it is important to understand what it is, but also what it is not. The essence of the Recovery Model is hope. It advocates for interventions that increase and maximize the safe exercise of autonomy by people with serious mental illnesses (SMI). However, it is important to understand that many people are admitted to API precisely because their decisions have been deemed to pose an imminent risk of serious harm either to the person or to others. Thus, it is the job of the API staff to help each person learn the skills that are needed in order to make safe decisions. Further, the Recovery Model does not promise people a world without limits or consequences. Indeed, such a promise would be destructively misleading; for when the person leaves the hospital, consequences of inappropriate behavior are impossible to avoid. Thus, in my opinion, the essence of the Recovery Model requires that psychiatric hospitals be safe places of learning and healing. Further, it is important to stress that one patient's need for autonomy cannot be allowed to trump another patient or staff member's right to be safe.

One important strategy for teaching people how to make better decisions employs positive behavioral plans, which systematically reinforce people for pro-social behaviors and evidence of acquired social skills; it is equally important to avoid inadvertently reinforcing people for negative, aggressive, or destructive behaviors. (See recommendation below.)

Dr. Ring believes that the hospital must first create a "culture of respect with no tolerance for disrespect." However, the terms "no tolerance" and "zero tolerance" convey a message that may be viewed by line staff as disrespectful. Zero tolerance policies, while well intended, have a number of harshly negative and counter-productive effects. Originally, they were intended only to mean that even small mistakes or misbehaviors were not to be ignored, but they have increasingly come to mean that all forms of misbehavior should receive similar, harsh consequences. The results of zero tolerance policies are therefore frequently unwanted and

counter-productive. Foremost among these is creation of a tendency to hide mistakes and to lie about them; even honest and well intentioned mistakes tend to be covered up to avoid harsh consequences, thus preventing organizations from learning from their honest mistakes. Equally important, zero tolerance policies tend to equalize all forms of misbehavior, thereby increasing the likelihood that a staff member will escalate to more severe forms of misbehavior -- i.e., "In for a dime; in for a dollar." In speaking with Dr. Ring, it is clear that she shares this philosophy; however, I would recommend careful avoidance of terms such as "no tolerance" or "zero tolerance" in communications to her staff.

I realize that some oversight agencies advocate for the term "zero tolerance" in various contexts, but the term has become extremely counter-productive. Originally, the term was simply supposed to mean, "Do not ignore," but over time it has come to have a very rigid and punitive inference; i.e., all acts of violence should be treated alike, in a harsh and punitive manner.

Mutual trust, of course, is an essential component of any effective organization. Trust is founded on several key factors, including a perception of fairness and open lines of communication, yet another reason that the API leadership should be empowered to communicate openly and directly with the Union, and to negotiate local agreements, so long as they do not violate the labor-management contracts.

Attention to psychological safety is important, and should apply to staff as well as patients. Again, this argues for non-punitive, educational responses to honest mistakes; a point emphasized by the Union.

Dr. Ring notes that revised policies on "Conduct with Patients" and Patient Grievances" were "put on hold due to Union concerns." However, these concerns were never resolved, and needed policies (in whatever form they eventually take) have not been implemented, contributing to the lack of clarity and mutual mistrust between line staff and management.

When one takes into account an appropriate relief factor, additional staff for 1:1 coverage, and adequate time to allow for high quality training, Dr. Ring believes that API is short by 23-24 PNA positions (includes 2.5 items for 1:1.) This estimate is relatively close to the recommendations put forward by the consultants from WICHE. (See recommendation below.)

Dr. Ring's proposal also makes numerous references to the need for additional training, and I emphatically agree.

There are rather odd limitations on the use of non-permanent PNA staff members, who are subject to restrictions regarding the number of hours and the specific

positions they can work. As a result, API uses a great deal more overtime, which is more costly and more destructive to morale, since much of the overtime is involuntary.

Dr. Ring's proposal also notes the need to reduce the time it takes to hire each PNA. The best way to accomplish this important goal is to allow permanent, ongoing, and continuous recruitment for this position.

My only significant dispute with the plan proposed by Dr. Ring involves item #5, which reads as follows:

> *5. Develop a zero tolerance policy for aggression by patients.*
>
> - *Revise policy on police reports about aggression to an expectation of filing reports*
> - *Very rare that a person with a mental illness does not realize that violence is wrong and illegal*
> - *Consistent with Alaska standards of rights and responsibilities of persons with mental illness to have natural consequences for actions*

I disagree with this recommendation as written, for several reasons. First, the word "aggression," which appears twice in this proposal, is an unfortunate word choice, due to its vagueness. I believe that Dr. Ring's intent was to refer to assaults. More importantly, in my experience, there are very rare occasions were patient violence is clearly and exclusively predatory or premeditated, and clearly not symptomatic of the person's mental illness. More often, the causes and motives of interpersonal violence are complicated and multifactorial. In those rare cases where the person's mental illness clearly had nothing to do with an assault, it may indeed be appropriate to seek the person's arrest and prosecution. However, the proposal as written would suggest that police reports and arrests should be the default responses to inpatient violence. I believe that Dr. Ring agrees with these observations, so my criticisms are only of the drafting of this recommendation, as opposed to Dr. Ring's intent.

In contrast, the essence of good mental health care requires individualized assessment of each person and each situation in a manner that is respectful of the person's disabilities, culture, and history of trauma. Punishment is a particularly ineffective way of changing human behavior for the better, especially in a person who has a serious mental illness.

Again, this does not preclude the possibility of arrest and prosecution in extreme cases of predatory violence; however, in my opinion, these will be the rare exception rather than the rule.

All of that being said, I applaud Dr. Ring for the message, stated a bit differently, that the safety of her staff is just as important to her as the safety of API's patients.

Meeting with Senior Staff

Individually, I was impressed with the attitude, knowledge, and competence of the members of the senior staff. As a group, however, there is room for significant improvement in leadership. The most important problem in this regard is the organizational chart, which organizes the departments into "silos."

I note, however, that most members of the senior staff are relatively new. As one said, "A lot of us are new here. We're changing things." This attitude was expressed with admirable positivity and hope, and bodes well for the future of API.

One step in the right direction was combining the Rehabilitation and Psychology Departments, under one Director.

While the Senior Staff appears to share Dr. Ring's overall philosophy of patient care, they have never agreed upon the specific indicators of successful treatment and safety. These indicators should be developed by consensus, and should be the subject of simple, clear, and accurate data gathering. Finally, the results, where appropriate, should be collapsed into an easily understandable "dashboard" that is clearly understood and shared widely through the hospital.

The Senior Staff is well aware of the problems regarding staff safety, and the perceptions of many direct care staff members that their safety is not adequately accounted for. It was a source of frustration for some of the senior staff members who wanted their direct care staff to know just how much the senior staff cares about their safety.

Several members of the Senior Staff reportedly perform "clinical/administrative rounds" on a weekly basis. These include the CEO, the Director of Nursing, the Director of Psychology/Rehabilitation, and the Chief of Psychiatry). This is an excellent practice, and one that should be continued. As these meetings continue to occur over time, they will allow senior staff members who are clinicians to learn from their clinical direct care staff, and to teach them different ways of looking at difficult or challenging patients.

Morning Report

During my second visit, I attended the morning report, which includes most of the senior staff. The report consisted almost entirely of very short updates on the current status of each and every patient in the hospital, provided by Director of

Nursing Sharon Berkstad. I was frankly astounded and impressed with her detailed knowledge of each patient, and the work that had gone into reviewing reports from all of the units from the night before.

I found myself quite conflicted about the value of this morning report, which included almost no meaningful group discussion of patients. The reports were short-term (i.e., how the patient was doing last night), and made no mention of treatment plans or goals.

On the other hand, virtually every senior staff member who attended this meeting found it very useful to stay on top of the day-to-day functioning of each of their patients. It was also very clear to me that the senior staff has a great deal of caring and empathy for each of their patients. Given the perceived value of this meeting, I will be making no recommendation to change it significantly. However, I did express to the attendees that they might want to consider subtle changes in the meeting over time, to keep its positive attributes but enhance its value. For example, in future meetings, they might want to pick one or a handful of patients to review in more detail to give them a richer picture than the brief snapshots that were offered.

I should also point out that several members of the senior staff attend "clinical rounds," during which they are able to observe treatment team discussions of individual patients who are being reviewed.

Meeting with Mike Robbins of the Alaska State Employees Association (Union)

I met with Mr. Robbins during my first visit, before the change in labor-management rules at API. Not surprisingly, Mr. Robbins reported that the Union's most pressing issue was mandatory overtime. He noted that supervisors were not required to do mandatory overtime, even though the Union offered to agree to out-of-title work in order to share the load. In his view, this disparity added to the frustration that inevitably comes from involuntary overtime, and exacerbated an "us versus them" mentality among line staff. As noted above, after my December visits, Dr. Ring made several changes in policy that appear to largely remove the mandatory overtime issue as a serious concern.

At the time of my first visit, the Union had very little direct contact with the Senior Staff of API, including Dr. Ring. Instead, the Union would deals with Labor Relations, which is housed in a separate state agency within the Office of Administration. Mr. Robbins believed that Dr. Ring should be able to negotiate directly with the Union to create local agreements, and I agreed. As noted above, this change has occurred.

When there is an investigation, Mr. Robbins alleged that management used selected portions of the video evidence, taken out of context, and refused to share the entire

video with the Union. Dr. Ring explained that this was related to one case, and offered a different explanation. Again, this is exactly the kind of conversation that best occurs at the local level.

In general, Mr. Robbins explained that the union requests "more transparency and more reasonableness." For example, he stated, "There should be non-punitive interventions when staff members make honest mistakes." Ironically, I am not sure that there is a great deal of important difference between the philosophy expressed by Mr. Robbins and that of Dr. Ring. However, it is equally clear that their inability to meet and confer on a regular, informal, and frequent basis prevented them from developing a good understanding of each other's position. I am therefore extremely optimistic that labor-management relations will improve now that local meetings are allowed.

Tours of Facility

API is housed in a beautiful building with wonderful artwork. It has a very useful and attractive gymnasium. However, the treatment mall (rehab area) is very small.

Sadly, the gym was vacant most of the day, especially during my first visit. I note that each unit has an accessible courtyard, but due to the severity of the Alaskan weather, they ought to be using the gym all day long, especially during the winter season.

The Communication Center has 56 video monitors, which they claim to watch closely. However, when I visited, no one was watching the monitors. Camera images from the treatment units can also be viewed by the Quality Manager and Safety Officer in their offices; however, this only has value for post-hoc incident review to see what happened in response to an allegation.

There is an attractive and spacious courtroom, which is reportedly frequently used by judges and attorneys who participate in various kinds of hearings. Unfortunately its windows open to the gym, which would allow patients to observe the court hearings of other patients, so they block it with modesty panels, which seemed to me to be a reasonable solution.

There is also a beautiful indoor winter garden that is used for visitation and as a lounge area for staff and patients. It also contains a café.

I was frankly very disappointed in the treatment team meetings that I observed. They were frequently disrupted by radios that were turned up to apparently maximum volume. Patients were afforded very little opportunity to speak, and many of the attendees appeared to be distracted by other tasks. (In part, this is probably

attributable to staffing shortages that required (e.g.) nurse managers to be available at a moment's notice to provide direct care to any patient that appeared to be acting out.) At one treatment team meeting, the Nurse Manager spent the entire meeting writing in the chart of a different patient than the one that was being reviewed.

Coupled with the poor treatment plans, these disappointing treatment plan review meetings probably contribute to the reactive nature of care at API. Without a positive plan for enhancing skills or providing care for each patient, the staff is far more likely to pay reactive attention mainly to those patients who are exhibiting unwanted behaviors. This approach can inadvertently reinforce disruptive behaviors.

Many patients expressed gratitude to the staff, who they generally regarded as kind and respectful. However, several patients made excellent observations and suggestions about ways the Hospital could improve:

- "They should be more proactive and less reactive."
- "Staff don't have enough time for patients. They are too busy."
- "There needs to be more groups that are targeted to specific needs and skills. Like they should have a group for people with suicidal thoughts."
- "They should give us handouts before the group starts, so that we don't have to fill them out during our group time."

Findings and Recommendations

When performing a consultation such as this, I am typically asked to make suggestions for improved safety and treatment. As a result, there is a strong bias towards negative findings, and a tendency to miss the many positive things that occur at API on a daily basis. Therefore, before I list the findings that provide room for improvement, it is important to articulate the many positive findings of my brief visit to API.

Most importantly, during both visits, I saw many, many staff members who appeared to care very deeply about the well being of the patients for whom they provide care, and the safety of their colleagues. I observed a large number of seemingly small but truly important examples of empathy, kindness, and professionalism from many staff members. Even when I found a staff member's actions to be inappropriate, I saw no reason to doubt their motives or intentions. Many of the patients with whom I met spoke highly of the majority of treatment staff. Despite complaints of boredom, most patients reported that the vast majority of staff treated them with respect and even kindness.

The building itself is quite beautiful, and generally well designed. The existence of unit-accessible courtyards is an important feature, even though they may not be used very often during the Alaskan winter. The hospital was very clean and I noticed no unpleasant odors, which is very important if one seeks to create an atmosphere of decency, dignity, and hope among the patients who live there.

Medical services were generally well regarded. Despite the fact that far too many hours of psychiatric time were provided by *locum tenens* psychiatrists, I did not notice patients who appeared to be grossly over- or under-medicated. Nor did I hear many complaints from patients or providers about prescriptive services, except for the difficulties (noted below) in receiving approval for non-emergency involuntary medication when necessary. Several clinicians spoke well of the in-house pharmacy, and no problems were reported with the formulary or the processes for non-formulary prescribing or changing the formulary.

As noted above, one problem that was brought to my attention prior to my visit was the high volume of involuntary overtime (OT). Mandatory OT went up in October when Dr. Ring ordered additional staff to do every 1:1. (The previous practice had been to absorb the 1:1 into the existing staffing complement, often leaving the rest of the unit feeling dangerously understaffed. Because of this policy change, mandatory OT skyrocketed, with predictable negative effects on morale and performance. After examining the data carefully, Dr. Ring and the Senior Staff decided that the change had been counter-productive. As a result of this admirable and self-critical analysis, the rule was rescinded in December 2014. According to Dr. Ring, since the rule was rescinded, mandatory OT has returned to baseline levels.

Finally, the Department should be commended for its previous efforts to improve. For example, I found the WICHE consultative reports to be very useful and informative. In large part I agreed with their findings and recommendations, many of which have already been implemented by API.

Staffing and Staff Training

API is seriously understaffed. This finding is more important than all of the other findings in this report combined. The shortages are especially serious in regard to direct care staff at all levels, including PNA's, nurses, psychiatrists, and other clinical staff including psychologists and social workers.

The fears of staff are in large part due to understaffing on the treatment units. While a sophisticated staffing needs analysis was not possible due to time limitations, such analyses have been done by WICHE consultants and by API senior staff. When I reviewed the staffing minimums, the relief factor, and the average number of 1:1 orders, it became clear to me that the need for additional permanent, full-time

staffing is real. There is also a need for much better communication across shifts and across disciplines.

The reasons for the inadequate staffing are several. I was told that creation of an admission unit was accomplished by taking staff positions away from the treatment units. However, in an acute hospital with very frequent and often difficult admissions, this decision made no sense to me. In addition, it appears that the relief factor used to staff API is lower than it should be. The appropriate relief factor can easily be ascertained by computing the average number of actual days worked by all employees on the payroll.

API has some special challenges in regard to staffing that are seldom seen in other states, mainly having to do with its vast distances, the low population density of the State, and the frequent need for air travel for patients who are to be released or transferred from Alaska's only state psychiatric hospital. When API staff members accompany patients who are being transferred, they are off of the Hospital floor for many hours, hours that are not built into the Hospital's relief factor or minimum staffing.

Because of the staffing challenges, it is difficult for a unit that is experiencing unusually high acuity to receive additional staffing until after an assault occurs. Again, this is not the fault of API or its leadership; there simply aren't enough staff members to meet all of the Hospital's legitimate needs.

Because the work week is only 37.5 hours, there is no time for meaningful intershift briefings for PNA's. The absence of these briefings, in my opinion, is below the standard of care, and increases danger to staff and patients alike. Shift briefings afford direct care staff with the opportunity to alert their colleagues to patients who may pose a higher risk of harm to self or others, to notify their colleagues of special needs that individual patients might have at any particular point in time, etc.

It is important to understand that simply adding more staff typically will not result in a decrease in overtime expenditures, since there will be more posts to backfill when staff members call in sick. In order to decrease overtime use, at least some additional items must be strategically targeted to serve roles (e.g., 1:1) that would otherwise require overtime assignment, or roles (e.g., additional staffing when treatment units are at especially high acuity) that prevent the 1:1 orders that currently require overtime staffing. On the other hand, there is a need for enhanced regular staffing (i.e., minimums) on all of the treatment wards, and additional posts may be needed to make the hospital safer. Thus, if the State decides to increase the staffing at API, there should be a very careful balancing of these two important considerations. Further, if more staff are made available, it presents a rather unique and exciting opportunity to change the facility culture, as exemplified in Appendix A.

Some staff members reported a troubling lack of confidence in the Mandt (crisis intervention) training they receive. This training reportedly consists of 2 days of live, pre-service training, followed by annual refresher training that is delivered on-line. The lack of confidence in the Mandt training is understandable, as it is currently woefully deficient. This is not a problem with the Mandt curriculum, which is used in many psychiatric hospitals across the country. The problems include inadequate initial training, and a rather astonishing practice of conducting all inservice training on-line. In my opinion, on-line training for crisis intervention is virtually useless.

Many of the staffing problems are frankly self-inflicted wounds. For example, psychologists and social workers are the same pay grade, as opposed to reflecting market rates. Advanced Practice Nurse Practitioners are reportedly paid significantly below market rates. Licensed and unlicensed staff members are also the same pay grade, which removes much of the incentive to become licensed or for licensed people to enter state service. It was also reported to me that there may be long delays for some clinicians (e.g., nurses and physicians) to receive Alaska licensure. For example, at the time of my first visit, the API Chief Psychiatrist could not write a prescription after several months on the job, because he was awaiting action on his application for licensure.

For reasons that were unclear to me, it reportedly takes an extremely long amount of time to hire a new PNA. Not only does this create additional shortages and increase use of overtime; it also shrinks the pool from which PNA's are selected, as the best candidates are likely to take other jobs during delays in hiring.

Finally, API is allowed to hire retired PNA's on a temporary or on-call basis, which is an excellent strategy to avoid overtime; however, for unknown (and seemingly arbitrary) reasons, these hires are only allowed at the PNA 1 level, which excludes the vast majority of recent retirees, including those with the best skill set.

Recommendation #1 – In my opinion, API is significantly, and at times dangerously understaffed. When staffing is inadequate, staff members become fearful of patients; and as a result, they may spend too much time in the nursing station and not enough time interacting with their patients. Understaffing also reduces the ability of staff to intervene early in non-confrontational ways, which would allow them to avoid many of the circumstances in which they end up having to use force. While a formal staffing needs assessment is beyond the scope of this consultation, there is already ample evidence (see, e.g., the WICHE Report) to support the immediate need for creation of 24 additional staff positions.

Recommendation #2 – API should be allowed to fill a temporary position when a staff member goes out on long-term disability or occupational injury leave (i.e., workers' compensation.)

Recommendation #3 – The need for an adequate number of psychiatrists is especially important in an acute hospital such as API, for a number of reasons. First, the rapid turnover of patients required a high number of admission and discharge assessments and notes, which are time consuming to draft. Second, in an acute setting, it is difficult for psychiatrists to cover more than one unit during someone else's sick leave or vacation, as new patients are almost constantly being admitted to both units, and according to Dr. Alexander, relief is not built into psychiatrists staffing allocations.

Recommendation #4 – As future labor-management contracts are being negotiated, the State should consider raising the presumptive work week for direct care staff to 40 hours to allow for a meaningful inter-shift briefing.

Recommendation #5 - The need for additional staff and training presents a unique opportunity to "jumpstart" culture change at API. (See Appendix A for one example of how this can be accomplished.)

Recommendation #6 - Inservice training updates for Mandt (or similar) training MUST be conducted in a live, interactive manner, and must include realistic practice as part of the training. (Note – It is my understanding that this recommendation will be enacted now, due to the recent API settlement with the Occupational Health and Safety Administration; however, it appears that API received no additional resources to account for this costly change in practice, raising the possibility that allocations for temporary staffing or overtime will be reduced, thus exacerbating the staffing shortages that already exist.).

Recommendation #7 – The Department should consider reviewing the compensation offered to various professional staff, to ensure that salaries are competitive enough to recruit strong candidates. It is especially valuable to provide salary enhancement for staff members who obtain professional licensure.

Recommendation #8 - The State of Alaska should consider the need for changes in its licensing policies and processes for medical and mental health professionals, with the goal of streamlining the process without compromising the standards of each profession. For example, some states

allow for reciprocity that qualifies a clinician licensed in another state for relatively immediate temporary licensure while their permanent licensure is under consideration. When a professional licensed in another state wants to move to Alaska, it is in Alaska's interests to streamline the process. The best candidates almost always have other options, and are unlikely to be willing to wait for months in order to practice their chosen profession in Alaska.

Recommendation #9 – The Department should take steps to reduce hiring times for all staff, especially PNA's. One important option that does not currently exist is continuous recruitment of direct care line staff. This practice is quite common in psychiatric and correctional facilities across the country, and allows facilities to maintain a list from which they can hire whenever a vacancy arises. Due to time constraints, I was unable to discuss this issue with the relevant state agency. However, the Department should immediately begin the process of investigating these types of solutions.

Recommendation #10 – API should be allowed to hire retired PNA's at any level (explicitly those who retired at the PNA III level) to work as temporary or part-time employees to enhance the safety of staff and patients, and to reduce overtime expenditures.

Treatment and Treatment/Recovery Planning

Especially during my first visit, the most common complaint among patients on all units was boredom and a lack of adequate hours of active treatment. My own observations confirmed this complaint, as group rooms were frequently unused, and many of them throughout the hospital had been converted into staff offices. Patients were frequently in their rooms, often sleeping, during daytime hours when treatment should have been taking place. While the facility has a beautiful gymnasium, it goes unused most of the day, for reasons that were unclear. No staff persons are assigned to the gym, which means that enough unit staff must be freed up to take people to the gym. Since the units already believe themselves to be understaffed, this was often viewed as impossible or unsafe. As a result, the gym appears to be severely and sadly under-utilized.

Demonstrating their understanding of this problem, the Senior Staff began the practice of providing organized therapy groups on the units approximately 3 months prior to my visit. Considering that this change was so recent, it is not surprising that the program has room for improvement. Specifically, they report that patient participation in these groups is low. However, I predict, over time, that the quality of groups and the willingness of patients to participate will improve dramatically.

I note that API recently added a competency restoration program, which is 30 hours per week. Senior Staff reported that there is nearly 100% attendance. I asked why attendance was better on this unit, and they replied, "Because they have to (attend.)" Of course, this explanation is incorrect, as the patient do not in fact "have to" participate; there is no consequence for patients who decline to participate. The patients are attending because the expectation is clear and consistent, and participation in this group has become part of the ward culture. This lesson should be learned throughout the hospital.

During my second visit, it had become clear that API had made significant efforts to improve the amount of group treatment that is offered to patients. While much remains to be done, I applaud these efforts; the Hospital is clearly headed in the right direction.

It is well known that obesity and Type II Diabetes are common side affects of atypical antipsychotic medications. There is also a plethora of evidence that regular exercise is a valuable treatment for depression, anxiety, and other distressing symptoms of mental illness. Thus, exercise is an essential component of modern psychiatric treatment.

The quality of treatment plans should be improved. I was also told that for unknown reasons, the treatment plans are not included in the Electronic Health Record (EHR). I was also told that notes from the PNA's are not included in the EHR, which makes it less likely that other clinical staff will read them. For unknown reasons, I was told that patients frequently do not attend their own treatment plan reviews with their treatment team. This practice is detrimental to the treatment team's ability to provide high quality treatment and skill acquisition to its patients.

One issue that was raised was the process for reviewing and tracking lab results. However, due to time constraints, I was not able to investigate this question further. Reportedly, labs are sent to Seattle, and the reports are not electronic. Results come through API Medical Officers, which may create a reliance on the diligence of individual psychiatrists to review labs. Considering the large number of *locum tenens* hours, this may create an opportunity for improving the process. Again, however, this is a question as opposed to a finding.

I observed almost no meaningful behavioral treatment programs. I did observe several behavioral plans that appeared to be quite well written and appropriate. Sadly, however, the plans were not included or even mentioned in the patient's treatment plan, nor were the plans being used by the treatment staff. This is especially problematic in a hospital that has a problem with patient aggression, as

behavioral programming is extremely well supported by evidence of its efficacy in reducing patient violence and aggression.

Recommendation #11 - There remains a need for an increased number of hours of active treatment that is actually received by nearly all of the API patients. Much of this treatment can be provided in the form of group therapy. However, when patients are unwilling to attend group therapies, it should not be presumed that the problem lies with the patients. Instead, professional development activities should be designed to enhance the quality of group therapy, so that patients find it fun and interesting while they are learning new skills that will help them lead a better life.

Recommendation #12 - Two staff members should be assigned to the gymnasium, and the treatment units should create the expectation that regular exercise is an expected part of each patient's day.

Recommendation #13 - Clinical staff members in all of the units should receive enhanced training in the development of treatment/recovery plans. Plans must specifically attend to the problems behaviors and skill deficits of each patient, with specific goals and interventions listed. For example, it is not adequate to list "competency restoration" as the only problem and goal in a patient's plan. The plan should explain why the person has been found incompetent, and what the treatment team proposes to do to help the person regain competency.

Recommendation #14 - On a related note, patients must be allowed to attend their own treatment plan reviews with their treatment team. More to the point, the patient should be treated as a key member of the treatment team, whose goals are as important as the goals proposed by the staff.

Recommendation #15 – The PNA's are an essential part of every treatment team. Indeed, they are the staff members who spend the most time with the patients, and are crucial to implementation of treatment programs. Their input should be regarded as an essential part of the clinical record, and at least one PNA should be present for each treatment/recovery plan review by the treatment team.

Recommendation #16 - Review the process for ordering and reviewing lab results, to make sure that lab results are systematically reviewed by the provider who ordered them.

Recommendation #17 – Behavioral treatment plans and behavioral contracts should be used on a much more frequent basis. These plans and contracts must be integrated into the patient's treatment/recovery plan, and communicated to direct care staff on all shifts and across all disciplines. Behavioral contracts identify wanted and unwanted behaviors, and assign reinforcement exclusively to desired prosocial behaviors and skills. Systematic reinforcement (e.g., in the form of verbal praise) has repeatedly been shown to be the most powerful means to change behavior for the better, and should be utilized more often at API.

Maintaining Safety on the Treatment Units

Early intervention is the key to preventing patient violence. However, if the early intervention is hands-on, it is neither early enough nor likely to be effective. The idea is to intervene early with low-level interventions that serve to distract, de-escalate, and calm patients in the early stages of agitation. Note, however, that early intervention requires adequate staffing, and staff that are not fearful of the patients. For example, when a patient begins to pace angrily, a staff member might distract the person by asking them what is wrong, or suggesting a pleasant distracting activity. In other cases, a patient may become overly stimulated by a loud unit environment, and need to take some quiet time alone in his or her room. These types of non-punitive and safe interventions ought to be explicitly detailed in a behavior improvement plan for each patient that is part of the person's recovery/treatment plan.

During my interviews with staff, it became clear to me that many staff members believe that seclusion and restraint are important ways to prevent staff injuries. They also believe that the increased use of seclusion and restraint are a result of increases in patient violence and staff injuries. However, in my experience, increases in the use of seclusion and restraint can actually cause increases in patient violence and the likelihood of staff injury. Indeed, studies have shown that laying hands on patients increases the likelihood of staff injury. As evidence for this observation, hospitals that have dramatically reduced (but not eliminated) seclusion and restraint have seen decreases in injuries to patients and staff members alike.

However, if line staff members believe that they are forbidden to use involuntary treatments at all, it will increase their fear of patients and actually increase the use of these strategies.

It was reported that the Institute must clear a number of legal and administrative hurdles before they can involuntarily medicate patients on a non-emergency basis, even when the need is obvious. I understand and respect the need for some type of

due process prior to non-emergency involuntary medication. However, when that due process is overly time-consuming and burdensome, it can increase the likelihood of injury to staff and patients alike.

I was especially impressed with the 2012 WICHE recommendations regarding the prevention of falls, and recommend that the facility revisit and implement those recommendations, which might have value in preventing at least some 1:1 orders.

On some of the units, staff office windows were clouded over, which would prevent staff from observing a staff member who was trapped in an office and prevented from crying out for assistance.

The bathroom in the Admissions Area has a number suicide hazards and some safety hazards, which should be abated immediately. Similarly, the Admission Screening Office contains a number of safety hazards, including items that could be used as weapons.

Finally, on the treatment units, some storage closets were crowded, messy, and possibly unsafe. They included winter coats, some of which seemed to require cleaning.

Recommendation #18 - Instead, in training, it is important for staff to understand and internalize the goal of decreasing the <u>need for</u> seclusion and restraint, even though these restrictive measures are likely to remain necessary, at least occasionally. This requires behavior plans that explicitly individually suggest strategies for calming agitated patients and teaching them better ways to handle anger, irritation, and hyper-stimulation (See Recommendation #11). Early interventions such as verbal de-escalation should be emphasized and reinforced at every opportunity.

Recommendation #19 - I recommend that the Division of Behavioral Health convene a retreat, including advocates (e.g., civil rights attorneys, consumer organizations), labor organizations, and Institute and Division leadership. The goal of this retreat should be to discuss how to best balance the rights of aggressive patients with the rights of their likely victims, both patient and staff. This meeting should discuss the need for occasional involuntary treatment methods, for the protection of staff and patients alike. A potential outcome of this retreat could be a proposal for statutory change to clarify the rights and responsibilities of patients and staff in order to prevent violence, and to accomplish appropriate due process in a timely manner.

Recommendation #20 – Drs. Ring and Alexander should consider meeting with judges and presentations at stateside or local judicial conferences in order to create a better mutual understanding of the need for involuntary medication on a non-emergency basis.

Recommendation #21 - If it has not already done so, I recommend that API revisit and implement the 2012 WICHE recommendations regarding the prevention of falls.

Recommendation #22 - Suicide and safety hazards should be removed from the bathroom in the Admissions Area. For example, the shower door should be replaced by a modesty panel that allows staff to observe the head and feet of a showering patient to prevent suicide, while protecting the privacy and dignity of the person being admitted.

Recommendation #23 - Instead of interviewing newly admitted patients in the Screening Office; I recommend creation of a somewhat smaller interview room that should be completely devoid of hazards of any kind.

Recommendation #24 – Staff offices that are used for patient contact should have clear viewing panels.

Recommendation #25 – Closets should be inspected on a routine basis.

Leadership, Organizational Structure and Labor Relations

As noted above, the previous inability of Dr. Ring and her Senior Staff to communicate directly with Union officials on a local, informal basis helped to create mutual distrust and has harmed morale at API. I am pleased to hear that this barrier to labor-management communication has been removed.

The organizational structure of API is organized into counter-productive "silos" that discourage collaboration between departments. I was also unable to ascertain the makeup of the facility's Governing Body.

At the unit level, the organizational structure is especially problematic. There is a need for clearer and stronger leadership of each treatment unit. In short, no one is in charge of each treatment unit. There is significant room for improvement in communication between PNA's and the clinicians, between shifts, and between disciplines. There also appears to be inadequate clinical supervision of the PNA staff.

API's Senior Staff has yet to develop a consensus regarding the specific key indicators that they will track and focus upon at a particular point in time. These key indicators will change as goals are reached and new goals are established.

Recommendation #26 - I strongly recommend that the API leadership continue to communicate openly and directly with the Union, and to negotiate local agreements, so long as they do not violate the labor-management contracts.

Recommendation #27 - The organizational structure of API should be reexamined. Most importantly, the hospital is organized into "silos" that interfere with collaboration, communication, and cooperation across disciplines. Further, there must be a clearly articulated Governing Body as required by the Joint Commission.

Recommendation #28 - I recommend creation of a unit manager position, responsible for the overall management of everyone who works on the unit, with specific administrative authority over the entire treatment team (including nurses, physicians, and PNA's.) There should also be a clear organizational structure on each unit. Ideally, the unit manager could come from any clinical discipline, with leadership skills being the most important requirement. Clinical supervision should continue to be provided by discipline chiefs in areas such as nursing, social work, psychiatry, psychology, and activities therapies.

Recommendation #29 - By consensus and in consultation with staff at all levels of the organization, the hospital administration should develop key indicators of successful treatment and safety. These indicators should the subject of simple, clear, and accurate data gathering. Finally, the results, where appropriate, should be collapsed into an easily understandable "dashboard" that is shared widely through the hospital.

<u>Treatment of Geriatric Patients</u>

Some of the patients on the Denali Unit appear to be appropriate for long term skilled nursing care. However, it was reported to me that there are no available beds for psychiatric nursing home care in the community. While it was not possible for me to fully investigate this question, the most common reason for this is inadequate reimbursement rates.

Recommendation #30 - The Department should review the Medicaid reimbursement rates offered to skilled nursing facilities for the long-

term care of nursing home patients with serious mental illness, or other challenging patients in need of locked facilities or enhanced staffing.

Control Room

The control room currently has more than 50 video monitors. Not surprisingly, no one was looking at them during ay of the several periods that I passed by. It is simply unrealistic to believe that one person can meaningfully observe more than 50 small monitors, especially when that person has other duties. While recorded images can be useful in *post hoc* reviews of incidents; for many of the cameras, there is no value in maintaining the pretense of real time monitoring. Further, many of the cameras cover areas that are vacant during much of the day. API should consider outfitting many of the images with motion detectors switches, so that there is no image to monitor unless someone is within the range of the camera.

Recommendation #31 – Consider significantly reviewing the number of Control Room monitors that are expected to be viewed in real time. Consider the use of motion detector switches that will enunciate an alarm and call up an image only when someone appears in an area that is supposed to be vacant.

Summary and Conclusions

Originally, you had asked me to return again in early March of 2015. However, for several reasons I called you to recommend that we delay my return visits. First, the State is in somewhat difficult fiscal circumstances. Second, I think that Dr. Ring has a very clear idea of what needs to be done over the next months to continue to improve the Hospital. Third, and additional visit by me will do nothing to alleviate the Hospital's biggest problem, which is its need for additional staffing

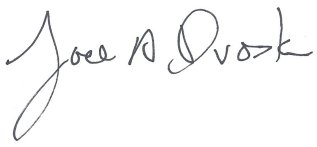
I therefore recommended to you that we delay my return visit until the new fiscal year (i.e., some time after July 1, 2015), at which time I will be happy to assist you in assessing the progress that has been made, and recommending any additional steps that are needed at that time.

The Alaska Psychiatric Institute has a number of excellent characteristics, including the building itself and the staff and managers who work there. While I found a number of ways in which treatment and safety can be improved, I found no evidence of systematic bad intentions or mean-spiritedness on the part of the people who work there, at all levels of the organization. Most importantly, I believe that the facility is in serious need of enhanced staffing and training, especially in regard to direct care workers on the treatment units.

Based upon the obviously good intentions of the vast majority of staff, I am very optimistic about the ability of API to make the needed improvements, assuming that they are provided the resources to do so.

Thank you very much for the opportunity to consult on this worthwhile project. If you have any questions or wish to correct any errors in this report, please feel free to contact me at any time.

Sincerely,



Joel A. Dvoskin, Ph.D.

Appendix A

One Possible Scenario For Implementation Of 24 New Staff Positions

The need for additional staff and training presents a unique opportunity to "jumpstart" culture change at API. I recommend as soon as possible funding of 24 additional items, which would initially be used to create an experienced and multi-disciplinary relief cadre. This cadre would cover one or two units, as noted below, for a two-week period of training. During those two weeks, the entire staff assigned to a unit, across all shifts, would participate in an 80-hour training and team building experience. This strategy would facilitate the following results:

- Communication of a coherent treatment and recovery philosophy
- Practical, hand-on training in self-defense and non-abusive de-escalation strategies and skills
- Team building across all disciplines and all shifts

The cadre would be deployed as follows:

- Cover Chilkat and Denali – 2 weeks
- Cover Katmai – 2 weeks
- Cover Susitna – 2 weeks
- Cover Taku (Forensic) – 2 weeks

(I recommend a 1-week hiatus between training experiences to allow trainers and API leadership to "recharge their batteries," as the training experiences promise to be intense.)

These training experiences can be accomplished within 3 months, at the end of which the additional positions could, for example, be absorbed into 3 areas:

- 16 Additional minimum staffing posts to reach staffing levels recommended by WICHE, using data-based statistics regarding days worked
- 6-item *per diem* overtime reduction pool, to be used primarily for 1:1 assignments that currently require (usually mandatory) overtime
- 2 items should be assigned permanently to the gymnasium, so that patients will be able to use the gym even id the acuity of the ward makes it difficult for the treatment unit to provide 2 PNA's.