My Reflections on Whiting And Inpatient Mental Health

My name is Marcus Spinner, and I'm a current employee of the Department of Mental Health and Addiction Services.

I worked at Whiting from April 2017 to November 2019.

My job title is "Lead Mental Health Assistant" and my responsibilities are to complete the daily schedule of evening unit activities and staff responsibilities. Additionally, I was trained as a Collaborative Safety Strategies (CSS) Coach, where I trained my peers on CSS techniques. This meant working with staff on different units to discuss the proper form for restraints and defensive maneuvers, but primarily non-verbal de-escalation in order to avoid any and all restraints. Additionally, I served as an 1199 SEIU Union Delegate while working at Whiting from roughly June 2017 through October 2019. My job gave me a unique vantage point to understand the strengths, weaknesses, and limitations of the direct care staff who are employed as a "Mental Health Assistant".

In my time at Whiting I participated in one restraint – a "manual hold."

I was personally assaulted once – which did not result in restraints.

I witnessed an extremely violent patient-on-patient assault – the most violent thing I have ever personally seen – which did not result in a restraint, and was managed with verbal de-escalation.

In my reflections, I'll separate my observations of operations at Whiting specifically compared to inpatient treatment at DMHAS facilities overall.

Whiting and DMHAS Management

My unit at Whiting Forensic Hospital was Dutcher North One. I did not work on any of the other units at Dutcher nor Whiting Max.

Management of the direct care staff at Whiting is split between the Nursing Supervisors and the Directors of Nursing. Nursing supervisors (who are union members and often former head nurses) manage staffing, following up with medical situations as they arise, reviewing incident reports, and overseeing day-to-day activities on the unit. At Whiting, much of the disciplinary action and performance improvement was generally managed by the Directors of Nursing (DN). The DN, who was not a union member, would randomly review camera footage, perform unit walkthroughs to oversee staff conduct, as well as implement directives from management regarding new hospital initiatives. This often meant discipline was directly handled by the DNs, while inpatient nursing care management was handled by the Nursing Supervisors. This power dynamic/relationship is not consistent across the board at other DMHAS facilities. Understanding the power dynamics exhibited by nursing supervisors and the directors of nursing is integral to understanding how the abuse was allowed to happen at Whiting.

When I arrived at Whiting, it was common discussion that the former Director of Nursing knew about the culture of physical and emotional abuse and covered it up.

It was known that if you say something, your report will be shredded and you will be retaliated against.

That was the culture.

Even recently, I witnessed a nursing supervisor at a different facility direct a head nurse NOT to document a patient restraint episode because,
"He didn't really struggle, right? You don't wanna do all that paperwork…"

The interpersonal histories between direct care staff and senior management seems to inevitably lead to office politics which interfere with making decisions which focus first and foremost on patient care. The promotional path for a direct care staff is to work their way up from staff nurse to head nurse to nursing supervisor to director of nursing. Along the way, relationships and friendships are formed which seem to make it difficult for some to make impartial decisions about corrective action and discipline. It seems to me like this was a significant factor in what lead to the abuse.

The old adage was, "if you screw up, they give you a promotion."
The idea being that, if you make a significant mistake, they'll promote you away from your current situation while using that mistake as leverage to insure compliance going forward.

It's also important to note that a patient and/or staff member's experience at any DMHAS inpatient unit will vary greatly depending on the Attending Psychiatrist and their relationships with the Director of Nursing and Nursing Supervisor at the time.

Working on North One, I felt complete confidence in our unit's psychiatrist. Our psychiatrist had an open door policy with the patients, who frequently met with her both formally one-on-one as well as informally in the hallways throughout the day shift and into the evening. Our psychiatrist also regularly spoke and listened to inpatient direct care staff to gather our observations and input on patient progress. This "open door" approach made patients feel listened to and "heard." It also made staff feel the same, and resulted in a well- rounded and less top-down, authoritarian approach to meeting patient needs. On other facilities, nursing supervisors insert themselves in making decisions about patient care and treatment in ways that at times even contradict decisions made by the psychiatrist or the treatment team.

This approach is NOT standardized across the board and patient experiences will vary GREATLY to the point where some will experience what could be referred to as
"INSTITUTIONAL NEGLECT."

What is "treatment"

Inpatient treatment seems to focus primarily on psychiatric stabilization through medication. This approach seems very "one size fits all" and, depending on the environment (Forensic vs. Acute), could be very ineffective at addressing symptoms and past traumas.

While at Dutcher, I observed patients regularly met with their treatment team, met with their psychiatrist, and had a number of therapeutic groups throughout the day. In addition, patients had off unit activities with rehab staff where they went out into the community for trips. Mental health assistants worked one-on-one with patients in a therapeutic way to teach coping skills and strategies to work through intrusive symptoms to help meet patient's needs. This was all in the context of North One; a patient on a different unit with a different attending psychiatrist and a different treatment team may have a COMPLETELY different experience. That in itself is an injustice.

Beyond this, I did not observe much in the realm of alternative approaches to health and healing beyond the traditional western models. There is a NOTABLE lack of alternative treatments - such as Reiki – because they do not align with traditional western medicine. Additionally, in some units (NOT referring to Dutcher North One) there is a notable lack of any therapy AT ALL beyond medication management.

It seems as if DMHAS inpatient treatment seeks to address mental health solely through a medical model, neglecting THOUSANDS OF YEARS OF HUMAN HISTORY TO THE CONTRARY.

The western model only the newest approach in humanities efforts to heal the mind.

What is "abuse"

While I never witnessed physical or overt verbal abuse toward patients, I did witness inconsistent enforcement of unit rules and inconsistent approaches from various staff. This often lead to understandable frustration from patients, which then could lead to a loss of privileges due to their normal, healthy verbal expression of exasperation. This could be exacerbated by staff exhaustion from excessive forced overtime.

In my time at Dutcher, restraints and seclusion at North One were nigh non-existent. Adequate treatment, attentive providers, and compassionate staff meant patients rarely became agitated to the point of lashing out physically. I did respond to several clinical emergencies on other units however 99% of these were resolved through verbal de-escalation by staff who were familiar with the patients and had a pre-existing therapeutic rapport.

The stories I've heard from patients however…

At least THREE patients told me of moments where they were ENCOURAGED by Whiting Max staff to get into physical fights with their peers.

Yes, patients stated that staff would encourage or enable them to physically strike other patients who were considered "more annoying" to direct care staff.

THREE DIFFERENT PATIENTS HAVE TOLD ME THIS AT DIFFERENT TIMES DURING MY TIME AT WHITING.

Staffing Issues

Overtime and mandates are also a significant contributing factor in the overall operations at DMHAS and the eventual patient abuse at Whiting. Due to continual cuts to DMHAS funding as well as a dearth of staff out on worker's comp, hiring new permanent employees is a lengthy process. The difficulty in hiring new staff and the lucrative overtime opportunities leads to a culture with a focus on overtime availability and overtime management and this often absorbs the focus of union vs. management negotiations. Staffing at Whiting (and Connecticut Valley Hospital) was particularly egregious, as the staffing shortage was so severe that the overtime was no longer voluntary but mandatory.

From roughly April 2019 to my departure in November 2019, I received a "Direct Order" mandate every single day.

Without an order from my medical provider, I would have been forced to work 16hour shifts back-to-back-to-back without reprieve for 7 months. An agency which seeks to improve the mental health of the people it serves shouldn't do so on the backs of the staff who do the work. It is unconscionable to force staff to work multiple 16hour shifts and doing so is another example of "institutional neglect." Under no circumstances should staffing needs become so unmanageable that mandatory overtime should ever get to that point. No excuses.

It's also worth studying the effects of forced overtime on the mental health of the staff member. Studies have shown that excessive overtime has negative impacts on the staff member's overall health. I personally witnessed one staff member pass away during a lengthy period of weeks (or months) of forced overtime. I also spoke with another staff member who had a serious cardiac incident, which her doctor said overtime was a significant contributing factor. Beyond the physical effects, what are the mental effects of overtime and sleep deprivation in the short and in the long term?

If there is to be any reforms to Connecticut's inpatient mental health system, overtime must be examined.

Race and Mental Health

It must be said, race is an issue in mental health which is almost wholly ignored.

Black and Brown staff are disproportionately written-up, disciplined, and fired. This is a documented fact, demonstrated by statistics which have been provided to both the union, to DMHAS management, and to the taskforce. If it's a fact that Black and Brown staff face disproportionate treatment at the hands of management, then what's happening to our Black and Brown patients?

As a society and as a profession, we neglect the historical impact of slavery and the centuries of systemic racism which has lead us to today's society. On North One, our patient population was roughly 50% Black and yet everyone on our treatment team above our Head Nurse was white. Beyond my direct unit, diversity within the senior administrative levels at DMHAS demonstrates a similar dynamic. Black and Brown staff are well represented at direct care levels, but when it comes time to make decisions regarding patient care and systemic policy at the hospital and agency level, Black and Brown staff lack a strong voice. This results in a "colorblind" approach to mental health where the profound impact of centuries of oppression is a mere asterisk in a patients Biopsychosocial.

It must be said, over-and-over again, that our country was built on a system of racialized capitalism.

Mental health treatment neglects the fact that the genesis of many African American's existence on this continent is slavery. Mental health treatment neglects to address that for two hundred years after slavery, the United States government ACTIVELY and INTENTIONALLY sought to oppress Black people in this country to prevent them from practicing their own culture and building collective power and wealth. Mental health treatment neglects to address how these centuries of oppression have resulted in a racialized wealth gap and hyper segregated cities where race and poverty are intrinsically linked and disproportionately represented in our mental health systems.

It follows trauma and mental illness are linked, so what are we doing to address the trauma of racism?

What is the impact of racism on mental health and what is DMHAS doing about it?

Why am I speaking before yet another all white council demanding that we do something about it?

Recommendations

1. Establish an Office of the Inspector General to investigate reports of patient abuse and administrative misconduct

2. Establish a standing statewide mental health policy oversight committee to insure issues regarding inpatient and community mental health continue to be addressed by an interdisciplinary team of advocates

3. Mandate 24/7 security camera coverage in all DMHAS operated inpatient facilities statewide

4. Hire NEW staff to insure an influx of new and enthusiastic employees with fresh ideas to prevent agency stagnation

5. Drastically reduce mandatory AND voluntary overtime across the board through increased staffing and improved FMLA surveillance/tracking

6. Increase funding to DMHAS' training programs and mandate staff participation in IN-PERSON training programs (online in-services are insufficient at training clinical skills in the human services field)

7. Invest further in peer based programs including recovery support specialists and center peer based recovery as part of the treatment process

8. Integrate anti-racist practices to address the societal factors which lead to disproportionate representation of Black and Brown people in DMHAS inpatient facilities

9. Improve the representation of Black and Brown Psychiatrists, Psychologists, Social Workers, and Senior Policy Makers with a focus on directly addressing racism

10. Conduct a detailed financial audit into the operations of Whiting Unit 5 from two years prior to its closure to present day