MENTAL HEALTH WORKERS

The Plumbers of the Fountain of Mental Health

By Bob Karnes

Cover Picture: Regents Park Fountain, London

The story goes, a Mental Health Technician was sitting at the waterless (no water in it for the patient's safety) cement fountain outside the locked unit. Some student nurses were being given a tour. They asked, "Who are you?", and he responded I am an MHT. They asked what do MHT's do? He looked behind himself and then back at them and told them "We are the plumbers of the fountain of mental health".

Mental Health Workers
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Introduction

What this book is and what it is not

This book is my general experiences from fifteen years working with many different mentally ill people in many different types of facilities. I do not intend to tell this story about working in the Mental Health System from the viewpoint of anyone except from my perspective.

This book is not just a collection of funny or terrifying experiences because without working where I worked at that time, the reader would have no context to compare or relate to. I hope some stories will help show the relationship between the clients and the workers.

This book is not professionally written by someone with a college degree. It is written from my viewpoint of a lower to a middle class, blue-collar man just trying to make a living wage and maybe to make the world a little better than when I arrived.

This book is not cheery and inspirational because of the dark nature of mental illness; it is often disturbing. If you have negative experiences in mental health care, teenage boot camp-academy, or know someone who did, this book may trigger negative memories or negative feelings.

With the national and worldwide acknowledgement that mental illness is an important and worthwhile issue to humanely treat there are hotlines to call and information about treatment is widely available, but it seems that mental health services are still underfunded.

This is not a simple or an easy story to tell. But I believe that it needs to be told. The suffering and pain of mental illness may be described as societies reoccurring problem with those who experience the world differently, they have different chemical, or genetic differences that cause behaviors that cause concern for mainstream sociality. This discussion is for somewhere else.

Nevada Mental Health Institute (NMHI) History

From http://www.asylumprojects.org/index.php/Nevada_State_Asylum

The Nevada Insane Asylum opened its doors to 1481 Nevada citizens on July 1, 1882. The "poor unfortunates" arrived by train at 4:30 AM2 from Stockton, California. Prior to their arrival at Reno, they were housed and cared for by Doctors Langdon and Clark at their Woodbridge asylum near Stockton. The patients were welcomed back to Nevada to a brand new facility, the pride of the State.

From the beginning, due to its great distance from Reno (three miles out of town and no Sparks until 1905) and in keeping with the times, the "Asylum" was a working farm and remained so through the 1960s. They grew alfalfa, fruit trees and vegetables, raised cattle, pigs, and chickens, and had a dairy. Irrigation was provided via ditches from the Truckee River and domestic water was pumped to a water tower on the grounds (see the wooden water tank on above roof in the photo above). You can still find remnants of the irrigation ditches if you walk the grounds. Later on, the river powered a generator for electricity for the site. Most of the product from the farm operation was used to feed the patients and staff, with occasional surplus being sold. Since the facility was principally self-sufficient, there were numerous support buildings as well, including barns, maintenance shops, a boiler plant, laundry, a morgue, and, of course, a cemetery.

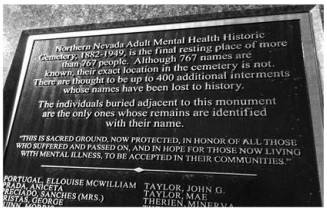
Who were the people at the Asylum in the early days? First of all, there were the patients (called inmates at the time) who came from all walks of life. The majority of the male population were farmers, laborers, and miners (makes sense) and the females were mostly housewives. Patients who were able, were given the opportunity to participate in the chores that kept the place running. The treatment practices of the day believed that restful circumstances and honest labor were instrumental in progress toward a cure for the "poor unfortunates." We have not uncovered evidence that patients were forced to work. Secondly, there were the staff members who were required to live on the premises. The Superintendent was a political appointee, in keeping with the times, and always a medical doctor. Other staff included a matron/nurse, attendants, cooks, and farmers.

Over the years, the Asylum suffered neglect by the Nevada Legislature. Beautiful as it was, the original building was poorly constructed and in constant need of repair. The Superintendents continually asked for funds from the legislature for improvements but with Nevada's boom and bust economic cycles, most of the time, nothing was done until desperate measures were needed. Adding to the repair problems was continual patient population growth. One reason for the population growth was the admission of "...old, harmless, incurable, idiotic and imbecile patients..." by the counties in which they lived in order to relieve the county of the expense of maintaining them. By 1895 the building, which had been designed to house 160 patients, contained 196. The legislature that year approved $15,000 to build and furnish an annex on the eastern end of the building to accommodate 75 additional patients.

NMHI unofficial stories as told by old-timer staff

While researching the history of incarceration of criminals and insane asylums it is important to understand the evolution to the much more regulated and more humane treatment that we have today. I have no degrees, but I have fifteen years of classes and personal experience and I have a basic understanding for the evolution of mental health treatment within my limited knowledge and experience.

I was told of the famous inmate graveyards from long ago were discovered during a Truckee river flood. The flood unearthed many bodies sent them floating down the street from forgotten unmarked graves.



Chronic or long term Adult ICU clients

In the 1980's the admission criteria is a legal process with a seventy two hour emergency if the person is a danger to themselves or others, and if the client does not sign a voluntary admission after or before the seventy two hours then a mental health court Judge holds a hearing to determine if the client needs a six month involuntary commitment. The client can and should be released when they are stabilized, and they have somewhere to go and they have available follow up care. This was not in place in the days of the lunatic asylums.

I was told that the population of several older "Chronic" clients that were on the adult unit were admitted during the previous years when the few admission regulations were misused by the powerful and the wealthier class. As an example, if a young girl were made pregnant by another family member she could be sent to the lunatic asylum to "Take care of" a family problem. If you had an annoying wife and you wanted a younger one a wife could be locked up and divorced. We had several of these sad stories with people who were probably unjustly "Legally" committed to our unit in the past when they were much younger.

Some of our clients were victims of possible well intentioned (or not) botched lobotomies or overly used chemical or electrical shock therapies. The experimentation continues in years past to current with different drug therapies to control aggressive behaviors. It is not allowed currently, and it is now called chemical restraint and it is only used as a last resort when all current less harmful psychotropic medication and behavioral treatment plans are not successful.

My Journey Begins

In 1988 I had moved back home to Reno, Nevada, USA. I came there for a fresh start far from the fast pace hedonistic lifestyle of southern California. Before arriving home, my car with all my possessions in it caught fire. Everything except the clothes that I was wearing and somehow my acoustic guitar protected by its case remained. This was my fresh start.

With my first job in Reno at a warehouse, it was very cold, but the work was not too hard. I followed my mother's advice and looked for a state or a city job, and I finally got lucky. I went to an office that provided low-income people with training or a job. The nice lady said that my mom, who worked at Sears, made too much money for me to qualify for assistance. She then slipped a piece of paper over on the desk with the name and phone number of Judy G. the charge nurse at the state mental health institute in charge of the geriatric unit.

A Day on the Geriatrics Unit

I arrived at work for day shift at 6:45 AM to get report along with team members; myself, one more MHT, a Licensed practical Nurse (LPN), and a Registered Nurse (RN). We were updated on the clients' night, their sleep pattern, or any unusual activity. The (Male) MHT's one at a time began with waking up to eight clients and assisting them to the toilet and then into the bath hydraulic lift into the bathtub. They were assisted to dry off, groomed and changed into the hospital clothes for the day. Our clients were in our care because they were too disruptive, continued intrusive, confused, or too violent for a regular nursing home. I was taught by Judy G. our charge nurse how to be patient and kind because if this client were our relative how would we want then to be treated and cared for. Our clients were sweet, funny, sad, frightened, and terrifying at times.

Some were incontinent of feces or urine and if the MHT's missed cleaning them up a nurse would do it and we felt shame and regret to have left our client in that state. Our Nurses were our bosses and our counsellors during traumatic times. They had our backs, and they would remind us when we were not attentive to our clients' needs.

We assisted the clients with breakfast and lunch. The MHT's (and sometimes the nurses) fed the confused clients and made sure to give them the proper diet and chart their intake of food and liquids.

It was important to chart their bowel movements as they could not communicate their discomfort, and this would become a medical issue. The clients would “act out” which is a bad term as if their behaviors were an annoyance to the workers. They had something to teach us workers. While clients being angry and striking out to injure themselves or others needed to be stopped, the team needed to come together and ask why did this happen? Was the client experiencing, pain, confusion, frustration, and they could not communicate it verbally? Do we need to give them a different seating partner? Do we need a medical consult? How can we do better to provide the best quality of life while they are under our care? Our goal was to help them to recover to the point where they can return to a less restrictive facility.

Alzheimer’s

It was the perfect place to learn how to manage my emotions. While getting to know each client and their visitors I heard about one client’s life before Alzheimer’s ravaged him. I remember watching his wife gently holding her husband’s hand while she was unsure if he knew who she was today, then hoping that next week the visit would be better. I still feel sad wondering like someone in a coma who wakes and remembers every word spoken around him, if my Client understood exactly how sick he was and he knew that was locked into this body not able to connect his thoughts together. We were careful to be kind as if the confused client could understand every word spoken to and around him.

Mania

We would sometimes get a younger client who was high functioning with a Bipolar (Manic Depressive) diagnosis. This is where we had to be calm but not condescending, firm and consistent. This type of client either loved or hated to be on our unit. Things could become behaviorally explosive and the helpless elderly clients could get harmed. Calm non-threatening body language, verbal skills and a soft tone of voice were used.

We would go on our institute school bus for trips to the park or to our small local lake to walk some, or if the weather was chilly, just go for a ride to get off the unit and see the sights.

Working on the "Back Ward"

I was asked to go to the adult locked unit building 5 to help with their MHT coverage. As I went up the stairs next door, I was concerned that I did not have the experience with the violent clients that this unit treated. I walked in and I noticed a large day room or communal area with a large metal industrial coffee pot with caffeinated coffee.

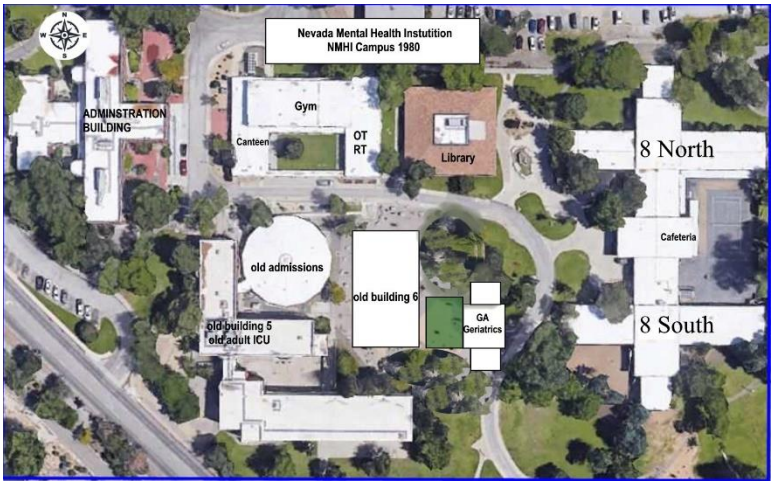
There were large ash trays and a wired cigarette lighter on the wall. There was a nursing station enclosed with plexiglass. I was told to stay in the dayroom unless they called for help. The rest of the clients were asked to stay in their rooms while the adult unit MHT's delt with the emergency.

Recreational Therapy (RT)

Back on the geriatric unit we were doing well helping the often happy and sometimes funny antics of some of our clients. We did our best to help the clients in distress with their activities. We did arts and crafts, bingo, and board games with our visiting person for on the unit groups. Our RT person was Kim. She was extra caring and dedicated and she was an accomplished folk singer. She played guitar in her groups while giving out clackers or a tambourine to play along. Music therapy was extremely helpful as short-term memory was often the first to be compromised so their long-term memory was triggered and when they heard an old folk song they would sing along. The clients and the staff went on field trips in a school bus to the park or to the lake to have a picnic lunch occasionally.

8 South Adult ICU Psychiatric Unit

After a year at the geriatric unit and working occasionally as back up at the new and improved locked adult unit at building eight I was ready to transfer there.



The Nevada Mental Health Institute Campus 1980s

Getting Report on 8 South

My first workday as a MHT Starting in 1981 on eight-south the locked adult unit. We went into our small meeting room, where we were given a “report” by a night shift MHT member. At that time, the nurses had their reports in the nurse's station. As our incoming dayshift sat joking while sitting around the large table. There were usually 4 or 5 male MHT’s and one female MHT. A night shift MHT came in and proceeded to report on how the night shift watch went. I was then introduced to the staff members as Bob, the new tech from Geriatrics (GA). First, the client headcount was given, the total number of clients, then how many were male and female, which was up to 30 clients. The night shift would report on any new emergency admissions from their shift, their admission diagnosis, the client's behaviors, and why they were admitted. The night shift MHT would report on how their night went, did the client's sleep, and if there were any outbursts or concerning behaviors that had occurred on their shift.

They notified us which clients were on special watches like, suicide watch. On suicide watch, the client would be in a bed in the day room within sight of a night shift staff member. Another special watch was the assault watch. At this time there were no watch boards carried by a scheduled staff. The same with head count we just all kept a look out on everyone unless it was a one-to-one watch then a staff member needed to be in direct eye contact with that client. Later in the late 1980's a selected staff member physically carried a watch board and the MHT would check off every half hour on where every client was.

After the Day Shift Report

I was given a set of keys, a door key, a locker key, and a thin metal restraint key. I was told to stay close to an MHT and he will orientate me to the unit and to the procedures. As the shift continued, I was handed off to another experienced MHT to continue my orientation.

The night shift had already awakened the clients so next we went to the male clients' hallway to make sure the bedrooms were cleared, and we locked them. We checked the bathrooms and did our dayshift headcount. If we did not have any problems, we had about 30 minutes before the call to breakfast in the cafeteria.

After breakfast was community meeting

We had large back metal-framed chairs in the community room, which was also called the Day Room. The chairs were too heavy and awkward to throw very far. For safety, the chairs had their backs against the walls so the view from the nurse's station was not hindered. Our front-line staff often used humor or just a relaxed demeanor to help set a relaxed mood for the unit. The MHT's took turns leading the morning meeting. Sometimes we would try to engage the clients with a question like "What is your favorite color"? Or the MHT would ask, "What are your plans for the day"?

If there were higher functioning clients, the MHT might ask, "Are there any problems on the unit? The clients would take turns in making solutions to the problem like "Mr. J is always messing up the magazines and tearing pages out" or "We want more TV time." We would turn it back over to the clients to work it out and, if possible, to work together to help keep the unit therapeutic and safe. If one client were causing continued problems, sometimes gentle peer pressure would be better than staff solving the community's problem.

Busy Day Shift

Monday through Friday held required activities before the end of the day shift. Day shift's job was to keep the clients active and engaged in their treatment activities. The activities consisted of Treatment Team meetings, Social Worker meetings, Medical Doctor Appointments, and meetings with the Psychiatrist. The MHT's would escort the clients to these meetings and sometimes remain in the room to provide security.

The MHT's would help with the on-unit Recreational Therapy groups, and the exercise groups in between the required clinical meetings when possible. In the early 1980s we would watch TV and play ping pong on the day shift during the week, but with the added meetings and more groups on weekdays, it was mostly "go here do that." It was a fast workday. Day shift would do their charting for their assigned clients. 3:00 pm, it was time to give Swing Shift report, and then Day Shift would go home at 3:15 pm.

Weekend Activities

We looked forward to the weekends as only MHTs with seniority had one day of the weekend off. The rest of us enjoyed working with minimum front office people or the professionals around the unit. We could focus on a positive, less stressful day. Our wake-up routine was more relaxed as the clients could sleep in a little longer, and we could begin the shift in a more relaxed manner. We had our outside activities in the courtyard with basketball or a great MHT and client's volleyball game. After some staff injured themselves during a game in a couple of years, there was no more volleyball allowed.

Smoke Breaks

A few of the MHTs used to smoke cigarettes. When an MHT during a quiet time in the shift wanted a smoke break, he would declare it was time for a "perimeter check" around the outside of the building. In the beginning of 1981, smoking for the clients was done inside the day room.

Cigarettes were passed out on the hour. Smoking was necessary for some clients to feel better about their stay in our facility. It was used as a reward for appropriate social behavior, and occasionally, if we had the staff coverage, we took a client outside to calm down and gave them an extra smoke break. A few years later, all smoking was done outside in the courtyard, and the smoke breaks were scheduled further apart until smoking was not allowed in the facility.

Swing Shift

We would arrive at 2:45 pm for the report and on to the unit to do the head count. The MHTs would assess the unit for locked doors to secure the unit and relieve the Day Shift Staff.

Swing shift's job was to keep the unit safe and help the clients wind down so they could sleep for Night Shift. If swing shift MHT's had the time they would do some unit cleaning while including volunteer clients to help. We had dinner at the cafeteria. Back then, they had enough food for staff that did not bring any food to work. After dinner, we had TV time. And if the unit was calm, we might open the bedrooms up a little early. Staff had more autonomy, but we had fewer people to respond to an all-call emergency.

Ping Pong Championships, Scrabble, and Spades

The day room was divided by a partition. A TV area and a group area with round tables to gather around. We had table games, cards, color crayons, and coloring books for clients to use. On a good night we would have an MHT and a Nurse working with clients on board games or card games. The Ping Pong staff championships were intense, but it became too much fun, and the powers that be shut it down to be only an occasional game with a client and a staff in a non-competitive ping pong game.

Snack Time

As in jails or prisons, food is a prime motivator, and it can calm clients down. Snacks back in the 1980s were given towards bedtime on swing shift. We used blocks of cheese, apples, crackers, white bread, and peanut butter from free government-funded food programs.

Our clients and staff looked forward to a peaceful shift with many clients preparing for bed, and they would hopefully sleep through the night.

Snacks were later used in treatment plans as in other mental health hospitals where programs like Positive Behavioral Interventions and Supports (M-PBIS) were implemented in our psychiatric inpatient unit to reduce seclusion and restraint use. Using snack therapy or later yogurt therapy and using a point system for outside or extra reactional time was needed for the violent or the disruptive client to reward positive coping skills. Some thought that the unhealthy cheap fast-food snacks were part of the problem.

Night Shift or NOC Shift

The night shift went from 10:45 pm for the report to 6:15 am the next day. Night shift could be calm with the main challenge to stay awake. Some nights it was more dangerous as there was a fewer staff than the day shift or swing shift. The mission was sometimes called fire watch as when things went well on the shift, and we did not have to do much but monitor clients sleeping.

Many emergencies and disruptive episodes can happen at night, like sexual assault or assaults on roommates. To prevent this their night-time medications were given as an essential sleep aid for their physical and mental health.

Challenges Protecting Clients and Staff

Takedowns and my martial art Training. When I was hired, I was 5’11” tall, 25 years old, and I weighed 170 pounds. While working geriatrics, I was asked to work eight-south and interaction with an aggressive male client. It was apparent that I needed help with self-defense skills. This interaction started me looking for the martial arts school that I had visited ten years earlier. As kicks, joint locks, and strikes were not allowed to be used by staff at a mental health facility by staff, the gentle tricks of a Japanese-Hawaiian martial art called Dan Zan Ryu was perfect. It is a comprehensive soft style because it blends with the attacker and redirects it, so the defender does not need to be bigger or stronger than the attacker to control the attacker to a safe position.

Dan Zan Ryu is also a character development system, so you only used force as a last option. As I progressed in the system, we formed our own unit takedown class, trying to standardize what we could do to take an assaultive client safely to the ground. It was a three-person MHT takedown. If all other de-escalation options were not successful upon the command GO with one MHT on each arm and one at the feet, the MHT's would lower the client slowly face-first to the ground.

If the client calmed down, they would be escorted with two MHTs, one on each arm, to time out. With these techniques, my martial art twice-weekly classes continued to today 40 years later. I offered these classes free to our front-line staff, and later one of my martial art school mates Gary Smith, took it to the university level, and it became a comprehensive accredited program for all northern Nevada mental health workers. It was an ever-evolving class at one time called the Assault Prevention Course.

Time out and Locked Seclusion

In the 1980s, these were the basic guidelines; If all de-escalation attempts were used and the client was unable or unwilling to control their aggressive or self-harm behaviors, we needed to isolate the client in a 10' by 12' seclusion room. It was a room with a tile floor and plain walls, sometimes with a mattress on the floor.

The first level was voluntary time out without the seclusion room door locked. Next, level two was a time out in the seclusion room with a staff member seated at the door with the door open.

Level three was with a doctor's order locked seclusion. After searching the client for contraband like hidden medication or sharp objects, the client was placed or volunteered to go into the seclusion room.

Later in the late 1980s, an MHT was seated outside the locked seclusion room.

Physical, Mechanical, and Chemical Restraints

If the client is in the act of assaulting staff or other clients, the client may need to be escorted or taken down to the ground into a physical restraint escort or hold. The nurse would then call the doctor and

ask for a PRN medication and for seclude and restrain order. Sometimes there was a need to do this in the bedroom, hallway, or the day room as a last resort as this was traumatic for the other clients to witness. If needed after the takedown, leather restraints were placed on the wrists with a belt around their waist and sometimes on the client's ankles. It was then safe for the nurse to inject the PRN medication called chemical restraints if the client refuses oral PRN medication.

The client would be taken to the seclusion room and the restraints would be removed, and the door would be locked. There would be another seclusion room with a heavy-duty hospital bed, and as a last resort, put four-point restraints on the combative or extreme self-harm client face down on the bed with the restraints secured to the bed frame.

Four-point bed restraint was common for a few long-term clients or newly admitted clients with extreme behavioral problems. It became rarer as other less restrictive methods were tried and better medications came along. Circulation was checked, water or juice was offered until the client regained their self-control and could be released.

Use of Force

There had to be documented methods of redirection. Talk therapy and offers of a snack called yogurt therapy by later staff. Other offers of exercise or time outside for a walk in the courtyard if adequate staffing was available and offering voluntary bedroom time or a smoke break, escort to another part of the unit was used to prevent the need to use takedowns and offering of PRN medication.

The client could use any force against staff or other clients, including life threatening attacks with available weapons, but the staff was limited to a few techniques of leverage control without using pain compliance or joint manipulation. In the early days, without training, staff had to use a show of numbers or to surround the client with three or more staff to help the client safely to the ground.

Some MHT Survival Strategies

Some of the ways the MHT's survived working the hostile environment of a locked unit were good and some were bad: An MHT could transfer to a safer unlocked state position and retain your benefits, and one day retire. A front liner worker could take extended sick leave or workman's compensation after a work-related injury and then return to work when recovered. Some decided to buy a new car or a house as compensation or justification for their hard work. This became a trap as there were few better jobs available.

Some MHT's would resign from employment to collect the few thousands of dollars in retirement and after a short while reapply for your old MHT position and start over building your retirement. It seemed that you could always come back and get hired back on to this state job with a good work record while there.

Some MHT's went to nursing school or took classes to become a Social Worker by working a swing or night shift. On the night shift, you could do homework while on duty.

Leaving the Mental Health Field

I was motivated by the money, cashing in my retirement, and starting a new career. After my first five years working at the mental health job, I became aware that working in a locked state psychiatric hospital was a depressing, stressful, and unnecessarily dangerous way to make a living. I used my Martial Art - Healing Arts training in Restorative Japanese Massage to attain employment at a large hotel casino health club as a City of Reno licensed Massage Therapist.

This lasted about one year before a large hotel chain bought out the family hotel-casino, and the compensation for a massage therapist became much less. I retained my Reno and State of Nevada massage licenses, and 30 years later I continue to do therapeutic massage.

My New Mental Health Prison Job

I started working as a Forensic Specialist (FS). On the grounds of NMHI in a high-security building for evaluation of the criminally disordered offender. This facility would house people who may or may not have been convicted of a crime. Our facility was equipped to securely house inmates from the max security prison. The FS was the same as the MHT, but we went to the prison system correctional officer (CO) training. Besides security, our job was to assist with the facility's mission to protect the public from the inmates' escape and assist in preparing the inmates for their evaluation to become competent to stand trial. As with the other MHT job, I also taught staff self-defense within the same rules as the NMHI unit where I first worked.

This job paid more than the MHT job, and later we were given the same retirement as the Police and the Firefighters in which we could retire in twenty years rather than the 30 years at NMHI.

It was a better and safer work environment. We had a great FS supervisor who was empowered to take extra time to help and counsel all FS workers, making it the best mental health job that I ever had. After two years, he went on to become a probation officer.

Searching Cells or Bedrooms and Property for Contraband

There was much overlap of training while working at the mental health unit or at the forensic unit. As part of my mandatory training for my Correctional Officer (CO) Certification, touring both the minimum and max security state prisons was a unique experience. Previously I had toured the large new Parr boulevard jail and the Forensic facility before they opened, but the minimum-security prison was the most frightening. Previously I had toured the large new Parr boulevard jail and the Forensic facility before they opened, but the minimum-security prison was the most frightening.

With inmates roaming around in groups yelling at our group with one or two guards visible, the only thing keeping the guards and us alive were armed guards in a couple of towers and the inmates' knowledge that they were there only a short time until their release date.

I felt safer at the Max Security Prison, where the inmates were controlled. During our max prison visit, we were given directions on how to do a cell search (a shakedown), and we were given a chance to do a routine search of an inmate's cell. I found a six-inch rebar shank in an inmate's mattress.

I received a phone call while at work on the Forensic unit from the Max Prison. I was on a conference call during an inmate's disciplinary hearing as it was his mattress that I had found the shank in. The inmate only had one question for me “Was I (the inmate) in the cell when you found it?” I stated “no.” The call was over.

A guard told me it is usually the weaker of the two inmates who were forced to conceal the weapon on their person or in their property. In many of the facilities that I worked in we were doing person, property, communal areas, and room searches. We mostly found stashed food, medication, and occasionally weapons.

Back to Work at NMHI

Working back on 8 south and 8 north from 1989 to 1992, the staff were more relaxed as the clients were split up between units with the idea that our disruptive clients deserved a chance to be on a calmer unit with higher functioning peers, so there were fewer fights and fewer need for restraints and seclusion.

There were more female MHTs, so the macho MHT of the past was balanced with a more therapeutic nurturing environment. The positive behavioral strategies of rewarding positive behaviors rather than only responding to a crisis worked much better.

After my second year back, the state had a budget crisis, and a few MHT’s were laid off. Since I had withdrawn my retirement, my grade in time had started over, so I was one of the MHTs laid off. We were offered to keep our time in grade and work at the DMV. Instead, I took a Pell grant to go to the community college, looking forward to becoming a chiropractor. I was not able to manage to work at a minimum wage job and going to school. My ability to achieve the grades and the sacrifice needed to fit in the university system was way beyond me.

I chose martial arts and taking classes in the liberal arts instead of the sure job at the DMV. My nurse girlfriend told me that I had my priorities messed up. She was right!

Mental Health Worker for SRC

I started to work with the State Developmentally Disabled (DD) from 1994 to 1998. As full-time state mental health jobs were no longer in the state budget, what was left was thirty hours a week, which sick leave, benefits including health care, and retirement were not included.

I was single, living in an attic room at the martial art school, so I could afford part-time thirty hours a week work at an acute to the higher function state center for all types of DD clients. The clients had a wide variety of needs from a lady in her thirties the size of a two-year-old and the cognitive level of a one-year-old but non-vocal to a higher functioning male in his twenties physically developed but with the cognitive level of a three-year-old. The clients were in different group home settings on the campus next to NMHI. There was a child unit up to adult group homes.

With problems ranging from nursing home type care to extremely violent or self-harm clients, it felt like working back in time in the insane asylum days. I remember how vulnerable some clients were and how strange it was to be working NOC shift, sitting in a living area by myself with the TV on low and getting up every thirty minutes to turn on the bedroom light to check, clean them and change the diapers of a few clients. They would look up at me with no expression as this was the only reality that they knew.

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I was lucky for a year working a higher functioning group home and on the NOC shift with only minor incidents. Occasionally I worked the darker more challenging units.

Working on a Sexual Offenders Unit

This was an experimental diversionary program for teenage boys who committed sexual offenses against their peers or against much younger victims. If the client did not complete the program, they could face jail time and a sexual offender criminal record stigma. The boys were not in a locked unit, but enough staff were there to protect them from each other and to protect them from the public.

The plan was to give them extensive counselling in a controlled environment so they could get a second chance to lead normal non-offending lives. I believe today that the adult sexual offender, even with treatment, has only a small chance of not re-offending while the younger males have a better chance to change and to not re-offend.

Back to NMHI

now NNAMHS I worked there this time 1999 to 2001

While working part-time at the boy's home, I was rehired back on call with NNAHMS' (Northern Nevada Adult Mental Health Services) adult psychiatric ICU Unit. I was now working two jobs without health coverage or benefits.

As I took the job we were moving into the new building. It felt like a fresh start. However, like the Forensic Unit that was designed with cobblestone communal areas with concrete seats on planters. It was clear that no front-line employees were asked about the design of the new Mental Health facility before building it.

The old institutional utilitarian design of an enclosed Plexiglass nurse's station was gone as it gave a negative impression of a jail. A fully exposed low countertop with computers and chairs for staff and nurses to work at was shocking.

More Client Friendly, Less Staff Safety

There were no longer consequences for verbal threats as we realized that punitive action was often not therapeutic or required if there was sufficient staff prepared to wait and suspend the daily activities to accommodate the agitated client or clients. We needed to evolve away from the reactive to the proactive.

Working at a Teenage Boot Camp

2002 to 2003

I was married to my first wife for several years before we moved to Montana to care for my wife's parents. Unfortunately, we divorced shortly after the move. I tried to live nearby in the small town of 1,500 people. There was only one employer for an outsider like me and most of the city, and it was a wilderness teenage residential academy. It was located one half hour away by car in a small town I will call Cold Creek.

A teenager from an often-desperate family was awakened in the middle of the night where they would see three men working for a transport agency (and one woman if the teen were a female) standing at their bed side, They would tell him or her to get dressed because they were going with them. In this case, the teen boy or girl would be taken to the airport or in a vehicle to the middle of the woods to the Cold Creek residential academy.

The parents had signed temporary custody orders over to the academy, usually for two or three years, at great expense to have their teen stay there. Unless they graduated from the academy for their drug, attitude, or behavioral issues, or their parents rescinded the custody order, they remained there. If the teenager turned 18, they could return home, or they were taken to a bus station to go wherever they wanted.

There was a total of 250 boys and 250 girls in the entire academy. The teens lived in large cabin-like dormitories with names like Willow A and Willow B. Each dorm would have two house parents who lived in the dorm 24 hours, two weeks on and two weeks off.

The two-house parents would trade off with two other house parents assigned to that dorm. They were supervising the teens in their house with up to forty teens. I worked the night shift as a staff person in charge of their safety, sitting in a chair watching them sleep while their house parent slept in a room nearby.

For a more fair and balanced representation of where I worked from an ex-student of a similar academy,

go to:

https://www.youtube.com/watch?v=lnLxd2cPJ8w

I went to a therapeutic boarding school (on YouTube).

Up to this point, I thought that all mental health facilities were government regulated the same, and they were held to high ethical therapeutic, legal standards. I found out that private or not for profit were sometimes extremely profit-driven to stay open and grow, and there were dark secrets that were revealed through ex-students and the media, as I found out later.

My Thoughts about this “Academy” changed as I realized that these teens were here against their will, and only a few were here with criminal charges using this as an alternative to juvenile sentencing in the juvenile detention system. I later had access to the internet to see the controversial news stories from around the world about these types of facilities.

One red flag was that if the parent wanted their child in the program, but the teen was non-compliant, the teen would be sent to Jamaica or Costa Rica “Academies” where the U.S. child protection laws did not apply. After these governments shut down these “therapeutic boarding schools for troubled teens”, the Cold Creek academy shut down a few years later for lack of students.

Part of the upper level 3 teen graduates job were used to have a positive influence over the lower level teens. The level 1 and level 2 could not talk to each other, but they could talk to level 3 graduates. The level 3 students went out in the woods with staff to catch fleeing teens to bring them back. Level 3 students were like junior staff. It seemed that some of the awesome house parents, staff, and counsellors were genuinely concerned for the teens, and they did help some. But other already traumatized teens became more traumatized. These reward and punishment levels and point systems helped some teens while it seemed to harm others.

During meals, the camp broadcasted positive affirmations over the PA with the focus on social skills. There were rules eliminating visual and verbal interaction with the opposite sex.

What was the alternative for caring parents and troubled, out of control teens? I made the best of being there. This is a watercolor looking out the window that I did along with reading, drawing, playing cards, and coin magic practice while watching 40 teen boys sleep as a night staff worker.

The night shift supervisor was having trouble with a few big boys assaulting staff in the small bunk house. He found out about my experience and asked me if I had been through their restraining class. I told him that I had not. He said good! Just do your best and do not get hurt as they will gang up and they have fun hurting staff. I made it through some intense nights in the hut with violent teens. I was told to go to town to be interviewed by child protective services.

Per her request, I demonstrated a takedown and hold on the lady social worker in town in her office to demonstrate how effective and gentle it was with good training and many years practice. I did this job for a while before moving to Bozeman, MT and then back to Reno, Nevada.

Developmentally Disabled Trainer

In 2003 I moved back to Reno working for a not for profit as a DDT. This was a good 30 hour a week, part-time job with no benefits that I was lucky to get. It was with a medium functioning male with whom I had already worked.

Instead of a group home with six other clients, I worked one on one with Mr. E as he was too aggressive to work in a Development Disabled workshop. The government mandate with federal funding was to give these clients as normal a life as possible with as many opportunities as a regular citizen.

I worked directly with Mr. E to keep him and other people around him safe while giving him opportunities to help him increase his social skills and help him cope with his daily frustrations. Helping to minimize his outbursts was challenging for us both, as he was nonverbal.

Now Married to my best friend, my teacher, and my best student, Alicia I could afford low paying jobs. As Alicia had a good-paying IT computer job, she was able to support both of us. There was still no hiring for full-time State Mental Health Jobs. I tried many different lower paying mental health and security jobs with no benefits.

Working with Adolescents

I started working for a for profit adolescent treatment center that I will call a branch of WC as a mental health worker. I worked 30 hours a week with no benefits. This facility was a nightmare for staff and clients alike. This facility only admitted teens whose families were wealthy or whose family had good health care insurance. Once their insurance ran out, the teen was discharged. This was a locked facility with many boys and girls with behavioral problems. Before admission, some teens were doing drugs, selling drugs, stealing, in gangs, or were in trouble and they were unmanageable at home.

Staff was regularly assaulted with no legal consequences for the teen. Some well-intentioned staff tried to help, but the admission length of time was on an emergency basis, so without long term medication and without voluntary behavioral one on one therapy, the teen was discharged back to the same environment, to the temptations that created the negative behaviors.

The defiant attitude that led to the reason for the admission remained unchanged. Some teens were often readmitted, and the cycle began again for another two-month cycle.

This is where I had to practice multiple attacker defense awareness as the bigger teens would intimidate the weaker ones to create a diversion so a gang of teens could attack staff, get their keys, escape, sometime to steal a car, and party until the police brought them back to do it all over.

Working at WC Mental Health Hospital

Working for the for-profit company of the above treatment center as a mental health worker. I will call it WC. I transferred to working for the same company at their for-profit private psychiatric and alcohol-drug treatment center thirty hours a week with no benefits. It was on call, you worked when they needed you.

This was an interesting job as it was inclusive of locked units, including pediatric, adolescent, chemical-dependent, and Adult psychiatric patients. The curse “May you live in interesting times” came true!

The experience was disappointing as there was little staff cohesion between the part-time, or on call staff, and the few full-time staff. The part-time on call Mental Health Workers (MHW) were given different units to work, changing them daily depending on the administrators' needs. If you worked better with one age group of patients or preferred to work with Chemical Dependence (CD) patients, it did not matter to the front office.

Working in Pediatrics (PDS) at WC

This group was emotionally challenging as these kids from the age of five to twelve years old were the extreme cases of assaultive or self-harm behaviors. Their case histories (with a few exceptions) were filled with terrible abuse and family dysfunction. Violent outbursts lasting for hours or days directed at themselves, their peers, or staff made this unit extremely damaging to staff and the kids.

After every less restrictive option was used and physical restraint was needed, the medication would calm the child. The adult and adolescent takedowns to the ground and physical restraint hold could not be applied as the MHW's larger body would restrict the child's breathing, and it was too psychologically damaging.

The other reason to hold anyone face down to the ground requires several staff, and the PEDS unit only had one other MHW to watch the other children and continue the unit activities.

The Child Single Stress Control Hold we used there was new to me. With a doctor's order over the phone, the child control hold was required to be used if the child was actively assaulting others or self-harming themselves. It was a standing hold with the child bent over at the waist, the MHW would hold their arm across the MHT thighs while facing the same direction as the child. As the child was held bent over at the waist out over their toes. The MHW would be safe from gouging, strikes, biting, and from being kicked.

The child would, over time, build up some soreness in their abdomen from resisting and screaming, but there was no pressure on their joints. This hold was held no longer than twenty minutes per application. The hold would tire out the child, and while in the hold, the MHW would not talk to the child until the child was calm. After the hold and if the child regained self-control, the child would be offered some bedroom time, a snack, or courtyard time to continue to calm themselves.

As a last resort was mechanical leather restraint to a hospital bed. This procedure was used on teens and adults as an absolute last resort, and only when a doctor ordered it. However, this was on a different level of horrific doing this to a child. Hearing the screams on this unit took a toll on everyone. There were good days where we went to the gym or the dining room without incident. During fair weather, we had courtyard time. When the day or night went well, the staff was so relieved, and we could help the kids have a better time until they were discharged to their family.

With good health insurance, medication, and weekly long-term a stable support system, and long-term child behavioral talk therapy, the child had a chance to learn better coping skills.

Chemical Dependency Unit (CD) at WC

This was the less stressful unit to work on. These were adult men and women, middle to upper-class adults with drug or alcohol dependency issues. They had good health insurance, and they were under voluntary admission.

The job of the MHW was more like a provider of amenities with access to snacks and other comfort accommodations like taking them outside for smoke breaks and providing coffee or sodas. The CD people were there to get medication and attend groups like Alcohol Anonymous (AA) and Narcotics Anonymous (NA).

Adult Psychiatric locked unit at WC

This unit had all levels of care for people with good health insurance. If they ran out of insurance, they were discharged or referred to the State Mental Health Hospital NNAMHS. As the staff did not know each other or continually work together, each part-time MHW was on their own to ensure their own safety. Some of the employees like myself needed to work extra or odd jobs to get closer to a living wage. My last shock working there was seeing a notice asking for donations for our employees at Christmas time to buy their kids presents. Working at that facility was not for me.

Working Low Wage Group Homes

I made other attempts to find work. I could only find mental health low wage part-time no benefits jobs. I worked at not-for-profit community group homes for the mentally ill and other group homes for the developmentally disabled. The workers at these homes were middle to lower income. Employment required a minimum high school or GED, with no experience in mental health expected.

While the residents were at the workshop or day treatment during the week, a one-day shift person was the group home supervisor. The home supervisor had a full-time position.

They had one part-time assistant; they did the shopping and transport to workshops or doctor appointments. The home leader made the schedules and filled out the required paperwork to maintain regulatory compliance.

The swing shift did most of the work serving dinner, doing the home clean up monitoring the residents' activity, or taking them on outings.

The night shift was one staff member who stayed awake and performed bedroom checks on the residents. In the morning, the night staff person would wake up the residents and get them dressed and groomed while making breakfast.

Working for another Group Home, not for Profit Company

I was in contact with a former NMHI state co-worker, and I was directed to a not-for-profit mental health group home company. It was a mobile MHW for an on-call low wage no benefit company that needed someone to call five to ten hours a week coverage for a one-on-one client job. This company had a contract with the state to provide outpatient, residential services for the mentally ill.

One client who lived in a group home, I will call her Ms. G. I had worked with her in 1985 at the NMHI state facility. They needed her, and I transported in my car to off unit activities or just go to the park for some time off from the group home. This was a pretty good job, except for the lack of hours. I could help her have a little better quality of life.

The next client came from jail, and he was vulnerable to his fellow low-end motel residents. He lived in a downtown weekly rent motel with many drug dealers and prostitutes hanging around and doing business there. I will call him Mr. M. He was a little cognitively slow, but he had some ability to communicate and manage his life when he was not incarcerated for assaults.

My job was to go to his motel and check on his food supply, the hygienic conditions of his room, and to make sure he was taking his prescribed medication. As his new "Helper" I also took him in my car to do his laundry, go shopping for utensils and groceries.

Mr. M started to mentally deteriorate and become paranoid. He stated that he wanted to beat up his social worker for getting "up into his business". He began to question my true motives for helping him. His threats of violence and paranoia were related to my supervisor. He said just keep working with him and that he probably would not hurt anyone. After reporting more threats, I was told, "Oh, that is normal for him"

The supervisor said to "just keep working with him and that he probably would not hurt anyone". After reporting more threats, I was told, "Oh, that is normal for him". I told my supervisor that Mr. M did not want me as his helper anymore, and he said that Mr. M had no choice. I had a choice, so I left that job.

Working with the Physically Disabled

I was a personal assistant at this job. This was an on-call five to twenty hours a week low wage no benefits job. I went in for a few hours in the morning to assist a high functioning person in a private or group home with a paraplegic condition. My job was two hours long to get them ready for their day.

At night for three hours, another person would need help to get him ready for bed. This felt strange as I felt that I was their servant who did as I was told without any respect. I was just another person from the agency who would give up and only last two weeks. I left that job.

Other Jobs

Driving for a cab company, odd jobs, painting fences, doing minor home maintenance, and the one or two out-call therapeutic massage clients keep me busy. Working for a security company on call for ten hours a week, mostly on weekends and at concerts or other events, was interesting at times but personally degrading and dangerous at other times.

I worked in a warehouse with the developmentally disabled in dirty and chaotic conditions for staff and clients for a short time.

Better Times and Challenging Times

Throughout my poor career choices and lack of lucky breaks for good jobs, I was lost. Although my Martial Arts training and then volunteer job as a Martial Art instructor started in 1983 and occasional work at my massage business from 1986 was a calling, not an occupation, I kept moving forward the best that I could.

My wife, my teachers, and my students kept me hopeful and positive despite my bleak employment opportunities.

Job Opportunities Happen

While waiting for NNAMHS State's full-time job to open, I worked for a commercial massage company in 2016 and continued to work both jobs for a year.

Back working full time at the State

2014 to 2016

They started me over at NMHI which was now called NNAMHS, per the policy, back as an MHT1, the same level as when I started in 1981 at the age of 25. By then, I had fifteen years in the mental health field, and I started over where I started at the age of 58 years old. The worst of my experiences working there this last time is too raw emotionally to express currently. I hope that I can recover. I thought it was something that I was good at and that, like martial arts and the healing arts, and that it was a calling to serve others.

I hope that I did more good than harm.

Dreams and Nightmares

Being in direct contact with the suffering of clients, their families, and the suffering of staff is always with me to some degree.

Ultimately, staff had the choice to work there and then get higher education to work somewhere away from the mental health treatment ICU unit's intense front line. Some staff could still accept a lower-paying job if higher education were out of their financial reach or abilities.

To the groups advocating for the mentally ill and volunteering to lead entertainment and educational impatient and outpatient groups, great job!

To the groups that propose that mental health medication and treatment is the cause of mental illness, do you give the homeless and the mentally ill in jail a safe place to live without fear, and how are you solving their real problems? You do have some interesting points that should be evaluated.

What is the duty of society to protect and provide mental and physical health care for the most vulnerable among us? All of us or a family member are one car wreck with brain trauma or a pre-existing medical condition from being a patient in a mental health ICU unit.

Looking at why I always wanted to leave the mental Health field was captured in this famous quote

“Whoever fights monsters should see to it that in the process he does not become a monster. And if you gaze long enough into an abyss, the abyss will gaze back into you”. Friedrich Nietzsche

My Current Views of the Mental Health Policies

The arch of priorities had now moved so much towards the needed improvement of client care that the need of front-line staff to endure more abuse from a more dangerous working environment was due to well-intentioned moves by the administration to maintain their compliance with their mandate to reduce the use of seclusion and restraint.

They had no choice but to put the needs of our vulnerable clients first. If front-line staff had been included in an open discussion of their concerns and safety needs before the new policy was written, they would have felt valued, and their needs were considered.

I was in one meeting where the MHTs input was asked for, and I asked, “Really, do you want to hear what I have to say?” I said my piece, which was the same complaints and concerns for our safety, that we talked amongst ourselves every night as things calmed down on the unit. I had already given notice and my wife, and I were preparing to move overseas, so I spoke freely.

In private, some of the MHTs agreed and were more upset than I with our current policy putting staff at risk but those MHTs remained silent in front of their supervisors. The justified fear about repercussions could affect them if seen as “Not being a team player.” The MHTs priority of someday retiring with what was left of their diminishing benefits was their best chance at a good life after surviving this challenging and many years of a hard-fought career.

When I proposed on unit training to reduce the increase of staff being assaulted due to the increased of jail and prison inmates being admitted, a psychologist suggested that if we could not escape the assault, it might be best to lay on the ground and our side and cover our head and our neck with our arms like a defense against a bear attack. I called this technique “Lay down and take your beating”.

Blue-collar Career MHTs move towards Temporary Collage students MHTs

Changes in staff safety and adequate staffing was replaced by hiring fewer of the blue-collar class of MHTs. By using more mandatory college classes to elevate the position of the new MHTs towards a more educated class was appealing to the administrators.

These new MHTs viewed going for a degree as a way out of the dead-end MHT career. As these mandatory classroom credits looked good on our resumes and looked good to the administration, our MHTs were short of staff coverage for weeks at a time due to MHTs at classes.

In the community college classroom, we learned impractical skills that did little to keep the clients and the front-line staff safe or to improve client care. Getting off the unit and going to the community college for a week was a good break from the locked unit, but we knew it was costing our co-workers’ and our clients' safety. Improved staff moral programs and practical on unit training was not available.

The Frontline and the Administration

The pull between custodial security of the unit through the MHT supervisor and the mental health ideals of the psychologists' new vision for the future is common. The goal was to keep the cost down by limiting the client stay and limiting admissions for both therapeutic and budget reasons. If the front-line staff worker resigned or was injured, their position for replacement was frozen.

In the 1980's it was the front-line nurse (Our heroes) and now it was the lead MHT, also known as the MHT4, to be the buffer between the administration front office and the front-line employees. The front office was responsible for the operation and maintaining the certification required to meet the legal and Medicare requirements needed to keep the facility funded and open. It seemed to conflict with the front-line employees' need to respond to emergencies on the unit with adequate staffing and adequate practical training. In the past therapeutic policies were directed by the University Psychiatrists panel and sent to our hospital director.

Later in 2000, it seemed that our psychologist and the nursing director set the policy of operation. Gratefully I was not in the loop, so I am guessing. I will acknowledge the term "front line staff" has a military feel to it and is comparable to the description of "fighting in the trenches." Which is how it felt.

These descriptions are emotionally charged, and it does separate staff from the administration. The feelings of front-line camaraderie and the sense that we were in this together like we were on the battlefield conflicted with the directions from the front office located on the other side of the locked doors in their offices. The front office had some good ideas often promoted by the lead MHT4.

Positive Administration and Volunteer Programs

A creative idea from the administration that encouraged a more positive environment and helped our confused clients to find their way to their unit or their bedroom and to change our unit appearance was the use of art. I happened into becoming their resident artist MHT. Their goal to de-institutionalize the terms Acute Unit called the "A side" from the non-Acute unit the "B side." To orient the clients to which of the two units they were on, I was encouraged to paint wall murals at the entrance of both Units with their non-institutional name.

Side A was called OCEAN, and I painted four feet by four-foot picture of an ocean scene, and side B was a three-feet by five-foot forest theme. The plan was for me to paint a forest animal above each door. Instead of referring to bedroom 1C on the forest side, it would be the wolf cub room.

At the entry door of the Forest / Wolf cub bedroom / Back entry to Forest

More Art and a Positive Evolution on our new Facility

The continued recreational therapy off the unit and the volunteers doing MHT special performances of live music were good when possible and uplifted staff and clients. More art was displayed in the arts and crafts room, including my Rock and Roll Art by Bobasan collection.

All of us on both sides of the locked doors wanted our facility to serve our clients and their families the best way possible. We had different viewpoints, and all of us could have worked better together in more productive ways. But before we can thrive, we must first survive. At times, the survival of the front-line staff was in question as the priority of perfect classroom therapeutic goals ran into the reality of real life behind the locked doors. We live in a world of imperfect, flawed humans doing the best that they can with what they were provided and with the skills they possess.

The Bird Man

A wonderful man would volunteer to bring his talking birds to the RT Room to put on a show for our grateful clients and escorting staff once a month.

On Site Recreational Therapy Activity Center

Down the hallway we had a nice RT room with many kinds of creative and relaxing projects or discoveries for our clients and the staff who escorted them. Our RT staff members were great.

Gym

An enclosed Gym with many recreational options created another space for our clients and escorting staff to get off the unit and move around some.

Beautiful outdoor courtyard

In the center of the buildings was a world away from the unit. After meals, weather permitting, or on the weekends made a relaxing way for the clients and staff to enjoy the grass, trees, and flowers in an expansive view and a good time to casually walk or jog.

Music and the WIZ

We had some professional and other musicians working as MHTs. There were small concerts and sometimes with a BBQ in the courtyard. A talented client would sometime entertain us.

Mental Health Drop-in and Day

The state opened the gym on the NNAMHS campus to an outpatient program. They provided a safe place to hang out, read, play pool, play cards, or board games. There was a place to check in with a volunteer ex-client, and they would introduce the new person to the various activities and the safety rules to be followed.

There was a state staff member to oversee the activities and to help the outpatient client's contact or have meetings with their social worker. If the staff noticed that there was a problem with the client's appearance and the client needed an evaluation, the people in the administration building would be notified. This reduced many readmissions, and it might have saved additional problems for our outpatients.

Community Mental Health Response Teams

In the USA, the prison systems, and the jails house most of our mentally ill population. A positive direction away from this is mental health professionals that are responding to emergency community mental health calls. These professionals can talk to the person and the family in crisis. If there is a functioning mental health system, they can encourage them to go with them for evaluation, get their medication renewed, or other non-criminal justice solutions.

To remain safe with the most satisfying life possible is the staff members' hope for all people in distress or unable to care for themselves.

More Stories from the Past

In 1971 I returned to Los Angeles, California to live with my Dad. After several years working at a Cadillac dealership as a car lot boy and then as an office runner. Before moving back to Reno, Nevada I moved in with my uncle. He was a grumpy guy who argued with the news on TV. He painted houses when he needed to make a few bucks for food and beer. He lived on the property behind my great grandma's house in a crudely converted old garage. I think Charles was a veteran in the US Army from WWII in Guam. He used the GI bill and was taking some college classes when he discovered the cultures of Japan and China. He spent hours practicing a single sumi-e brush stroke on stacks of old newspaper. His "house" had a large black ink painting of a traveling monk that he painted with quick, minimalist strokes. He had a bamboo Zen garden outside his sliding shoji rear wall to his back yard. His heating was a wood burning small garbage can hanging from the ceiling to a chimney. He had simple furniture and a bookshelf with one natural dark knotty branch, that looked like it had grown there, holding up the shelf on one end. He lived and ate simply. In the sparsely lit room he told me about the art and philosophy of Zen. I loved how art and philosophy was joined together.

Overview of the Job

In the early 1980's the new MHT were given a set of keys and it was left up to you whether to ask questions or yell for help. If you survived the first day and came back for your next shift you would have a job as a Mental Health Tech for the state facility. MHTs were responsible for security on and off the unit. They escorted clients to meals and different activities and drove them to offsite to doctor appointments. The MHTs were responsible for the clean-up of blood and other bodily fluids, taking vital signs, and assisting with nursing procedures. The diseases that we were subjected too were AIDS, Hepatitis A, B, C, and Tuberculous.

The MHTs sat with the clients in the day room, engaging them in conversation, and watched for changes in behavior. The MHTs would notify other staff and the psych nurse if the client needed to be evaluated for medication as needed.

My first acute client experience

I witnessed a female patient who was regularly in four-point restraints (Tied to a hospital bed) and locked in the seclusion room for up to two weeks until her medication was regulated, and she was safe to be released. I was involved in taking down to the ground violently acting out clients, holding them down for intramuscular injections of medications, restraining them, or escorting them to time out or locked seclusion. My beginner's martial art skills saved me and others many times without harming the patients.

Boredom and Terror

Work there was fun, was depressing, painful, frustrating, entertaining, rewarding and hopefully uneventful. We went from watching Jeopardy on tv one moment with the clients to running to the rescue of staff or a client. We could go from being assaulted to calling the paramedics and restraining a client who was cutting her arm or neck. Sometimes responding to one emergency and then to another unit, or to admissions to restrain a client or to break up a fight.

Chronic or long term institutionalized Adult ICU clients

Long ago If you had an annoying wife and you wanted a younger one, a wife could be locked up and divorced. We had several of these sad stories with people who were probably unjustly "Legally" committed to our unit in the past when they were much younger. We thought that we had a "gangster moll" who I will call Ms. M, a kept woman of a power full man. She told us that she knew much about his business and she needed to be kept quiet. Once a person like her had been in the asylum for several years if they were not mental ill when they were admitted they would become severely impaired years later. A couple of client's diagnoses was schizophrenia. They had severe mood swings and explosive tempers. This made for long term placement in unsupervised living group home not always successful. If they were discharged to the street without a support system or shelter, they would become victims of the higher functioning victimizers.

Some of them were treated in the 1960's with brain surgeries and electroshock or insulin convulsive therapy. Also, the overuse of medications like Haldol or Thorazine had long lasting negative effects. As they had long ago lost their support systems and the Mental Health Institute was their sanctuary. This was called institutionalization where much harm was done. The opposite happened in the 1980's called deinstitutionalization and it had its own problems of dumping the mentally ill on the streets without food or housing and mental health support.

https://en.wikipedia.org/wiki/Deinstitutionalisation

Ms. M the girlfriend of the mob

A staff favorite long term client is a lady that I will call Mrs. M. She was funny and extremely heartless with her expression of her annoyance about most everything that was beneath her perceived elevated position in life. Of course, at the same time it was sad that she had been locked up for so long. She looked like a sweet little old lady as she walked up to a nursing student who just walked into the strange locked adult unit, the little old lady smiled at her and Mrs. M blurted out “My but aren’t you FAT!” We saw that poor nursing students smile go into one of shock. We received a phone call from the Hotel Casino from across the street that an older lady and a younger male client had an unpaid bill in the show room. She knowingly, without money took a younger male client with her to the MGM to a dinner show. At the time she was presented with a check she screamed “I don’t need money, I’m J. Paul Getty’s wife”. The Casino realized that she was a resident across the street with us and they called the police to escort he back to our unit.

Colonel Sanders

We would admit younger higher functioning people on the geriatric’s unit on a temporary stay until more appropriate placement was found. Once we admitted Colonel Sanders, well not really but he was a good-looking funny guy in his 50’s that resembled and was cheerful like the real Colonel. He seemed delusional and grandiose saying that he had secret codes that can hack the government computers and while in his bed he could press a button and bring down the airlines flying above us. His usual conversation was interesting and cheery. One day the nurse got a call from the secret service wanting to know if we had the “Colonel”. They were directed to go through the administrator for authority to give them information about a client we may or may not have. The secret service told us to let them know when and where he was going to be discharged. They said that our client was once an essential computer security system programmer for the government and as he became mentally unstable. They said that he would use the phone lines to hack the government computer systems causing disruptions. The secret service needed to keep track of his current location. Some of his grandiosity was true!

Ms. M the bank robber

One day Ms. M went off grounds and with a urine specimen bottle with urine in it presented it to a banker teller downtown. She said, “I am Frank Sinatra’s wife, and this is nitroglycerine and I want a million dollars”. Ms. M was told that it would be some time before they could get the money. Ms. M said that she would be across the street at Woolworths having lunch and they could deliver the money to her there. She knew what she was doing, and she would laugh about it to a point but then become angry and more grandiose. Her mood swings were frequent, and It appeared she had a rough and a sad life.

Delusional Disorders

I will call this client Mr. P. He was pleasant to talk to with no obvious mental health concerns until you see him in crisis, or if you talk to him for a few minutes. He could become violent upon admission as he would refuse to take is prescribed medication when discharged and he would self-medicate with illegal drugs and alcohol. His main grandiose delusion was that the Beatles stole all their songs from him. He could prove it by showing you his notebook where he had many Beatles song lyrics written down that he claimed he wrote. That would be a delusion that frustrated him. He was able to function in a group home until he lost self-control with his rage. Trying to talk someone out of their fixed delusional system does not work. The delusional client can function in a safe place where they feel safe and accepted and if the client has a social support system. Treatment with typical antipsychotic drugs, Psychotherapy, or Cognitive Behavioral Therapy he may develop better coping skills to have a better life.

Another man I will call Mr. N was admitted to the forensic unit to become competent to stand trial. He had hidden in the ceiling of the city hospital for a month while sneaking down into the nurses break room for food at night. He would climb back up into the ceiling where he had a mattress and sleep during the day.

When he was admitted he was assigned to me as a teacher to help him be able to know his charges and how to help his attorney. He had stuffed toilet paper into his nostrils and into his ears. He had a stocking cap pulled down with paper stuffed into it. He thought that kitchen appliances and the TV shot thought control waves into his brain. He was likable and he had learned not to talk about his fears, but it must have been scary. I tried to describe how difficult it was talking him out of his delusions about invisible rays affecting him. I said look at this table it is solid but is made of atoms which are mostly empty space, and did you know that the human body is made of mostly water? Mr. N said to me “You are crazy”!

Playing Cards with a Murderer

I remember playing cards in the day room at the max security forensics unit with a client a man about twenty-five years old. My job that day was to spend time with him to later chart on our interactions, to report about his mood and his cognitive reasoning skills. He was completely clear in his verbal skills and his mood was level and he appeared cheerful as we played cards and socialized with me and others.

I will call him Mr. V. He told me that he was here because he had killed his wife stabbing her many times. He said that she deserved to die because he caught her having an affair with another woman. He said that in his country it was expected that he should have done this. He called it a crime of passion and any real man would do what he did. So, I charted that he appeared oriented times three, aware of person, place, and time and I charted relevant activities that he did during the shift. The only time when he appeared confused and exhibited any mental illness was when he was interviewed by a court appointed psychiatrist.

Mr. V then behaved like a small, confused child repeating "The voices, the voices" while appearing to be severely depressed. Eventually he was found not competent to stand trial as the doctors said that he did not know his charges and he could not assist his attorney and thereby he could not have an adequate defense.

Mr. J on the Adult Unit

Mr. J was a small man about 4' 11". He had schizophrenia with poor impulse control. As a child he was abandoned in a hotel closet by his family. His behaviors were attention seeking and he could be social and funny. He would be sitting next to staff socializing and suddenly punch a staff member in the face and he would then start yelling "I had a seizure, I had a seizure". He would find the biggest most dangerous client and tease him until over several hours the client would attack him or someone else. Mr. J seemed to enjoy the chaos that he created but he suffered because his behaviors and unpredictability isolated him.

Mr. J had been picking on the much larger Mr. SP for the first part of day shift. Mr. SP ignored Mr. J. Staff tried to redirect Mr. J but it did no good. Mr. J was walking away from Mr. SP and suddenly Mr. SP grabbed Mr. J under his armpits and lifted Mr. J into the air. Before staff could react Mr. SP dropped kicked Mr. J in the butt like he was kicking a football for a field goal. Mr. J was laughing and yelling "AHHHHH" as he flew through the air for several feet.

Bob and Max Aikido

A two person MHT escort turned into a ride at the end of a clients arm. A usually calm client decided to strike me with his elbow as I held one of his arms. It felt that this should go to a take down, so I stepped behind myself to redirect the strike down around to the ground. As MHT Max was holding onto the other arm he was "At the end of the whip," Max was laughing struggling to catch up with the momentum to help the client to the ground. This art works well for a one-person take down but it was not designed for two-person application.

New Max Story

Max the MHT was in the nursing office trying to get Ginger the LPN attention by politely interrupting her with a soft voice "Ginger" she was busy, and she continued on. Max softly said Ginger said a few more times then Ginger said "Max what do you want"? Max softly said, "She's not breathing" Ginger yelled "Max" and ran with him to the seclusion room to take over caring for the client from the MHTs. The client was OK but Ginger told Max "You need to show some alarm in your voice to get my attention next time not just softly say "Ginger".

The Glass Door MHT Sweep

I was watching an agitated patient at the admissions building. The soon-to-be-admitted patient tried to run out the door. He did not see or did not know that the glass doors were locked. He bounced backwards off the doors into my arms and into a rear bear hug (a rear basket hold). I did a double foot sweep (Okuri Harai) from the rear (a new variation for me) and slowly lowered him down to the ground taking the fall on my forearm.

Ashtray Takedown

Back when I worked on the adult unit, people often smoked hourly. Smokers without cigarettes would sometimes smoke discarded butts found in the big plastic ashtrays. A patient was smoking a butt when I approached him holding an ash tray and asked him to put the cigarette butt out. He flicked the lit butt into my face and before he could follow up his attack, I closed the distance between us and did a gentle heel trip to the rear. The next moment, he was lying unhurt on the ground and I was standing, still holding the ashtray upright.

Caught Overreacting

We were clearing the bedrooms on the locked adult ICU unit when an angry elderly man flung the heavy metal bedroom door open, making a loud echoing bang that startled me. At the time I was a newly-promoted green belt in DZR. I gave a yell and adopted a defensive martial arts cat stance. My boss Tom, a MHT4, started laughing, saying, “Bob!, Don’t kung fu that poor old man!”

Fire or Water Using Intent

I was working with one nurse on a for profit private substance abuse psychiatric unit. An angry and frustrated patient walked up yelling, “You better get my lunch now!” I was concerned for the nurse’s safety and motioned for her to go into the locked office. We assured him that his lunch would be brought to him as soon as possible. He became more threatening, and I consciously tried the tiger stare (Or the top dog attitude) to make him back off. It only made him angrier and more threatening. I moved away down the hall, giving him space to calm down and to give it some time for staff to arrive to help us with this patient. The patient started to charge down the hall straight at me.

I changed my strategy to an art that my teacher taught, which was to project true compassion, care, and concern. I stood still with my hands in front, palms downward. He was now very close. I was not really concerned about his physical threat to me and somehow, I knew that it would be all right. The patient suddenly stopped and started to cry and apologize for his threatening behavior. We walked together to the dining area, we sat down, and waited for lunch together. I had helped put the fire of frustration and fear out with the water of compassion and concern.

Compassion and concern wins this day.

Bob Karnes 3-16-2021

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Author Information

About the author
Bob Karnes
Bob is an artist, a dabbler on guitar
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Martial Arts and the Healing Arts
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Other interests are in Western and
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Bob is a writer of books and manuals
and waiting to see what is next.

This story begins in 1981 as a 25 year old. I started working in a locked Psychiatric Unit while I was looking for a job with benefits. I had no idea what I was getting into. As I studied a gentle martial art with the basic therapeutic behavioral classes I found out that I was good at both gentle conflict descalation and premptive therapeutic interventions. I felt that I was valued, and I was able to help the clients while working with my fellow staff to provide as safe, caring, positive, and therapeutic environment as possible.

This story in mental health work ends in 2014,
as this 64 year old man that is determined to learn from these
experiences in eight different types of facilities and
many different age groups of people in crisis.
Every two years or so I moved on to look for a safer place to land.
I hope that I learned what I needed to learn
and that I did more good than harm.