

Southwestern Virginia Mental Health Institute

Marion, Virginia

Update to the Office of the Inspector General
on Recovery Implementation for 2010

and Plan for 2011 Recovery Services Enhancement



Our Mission: We promote mental health in Southwestern Virginia by assisting people in their recovery.

*Our Values: Communication * Honesty with compassion * Trust * Teamwork * Self-initiative * Leadership * Honoring day-to-day tasks*

Our Vision: SWVMHI, in collaboration with Community Services Boards, will always be the region's center of excellence in the treatment of serious mental illness.

Table of Contents

Executive Summary.....	4
Prologue.....	5
The SWVMHI 2010 Recovery Services Self-Assessment.....	7
Results.....	7
Resident Choice.....	7
Resident Opinions of Care.....	8
Recovery Oriented System Indicators (ROSI):.....	8
Summary of Recovery Survey Findings:.....	9
Vocational Self-Assessment.....	9
Other Recovery-Oriented Programs, Activities and Events.....	10
Personal Safety Tool.....	11
Sensory Connection.....	11
Peer Services.....	11
Volunteer Services.....	12
Wellness Program.....	12
Community Integration tracks continue.....	12
Road Trip Training.....	12
Other Events supporting increased peer interactions:.....	13
Trauma Informed Care.....	14
Patient Falls Prevention.....	14
Nursing- led Patient Groups on Ward.....	15
DSA Career Pathway.....	15
Motivational Interviewing – Catalyst for Change.....	15
Patient Satisfaction Survey Data.....	16
Nursing-led HPO Workgroup.....	18
Plan for Recovery Services at SWVMHI.....	19
I. The Role of Senior Leadership.....	19
II. Workforce Development.....	19
III. Treatment Planning (now called SWVMHI Recovery Services Planning), to include enhanced recovery-oriented groups and activities.....	21
IV. The Design of the Clinical Record.....	22
V. Resident Activities and Opportunities.....	22
VI. Relationship to the Community.....	23

VII. Other Areas as Determined Relevant to Enhancing the Recovery Experience of Those Who
are Served by the Facility 24

Appendix A 25

Appendix B 27

Southwestern Virginia Mental Health Institute

Update to the Office of the Inspector General on Recovery Implementation for 2010

Executive Summary.

Southwestern Virginia Mental Health Institute made significant gains in 2010 over previous years in the implementation of a recovery-oriented environment and services for individuals needing inpatient hospitalization in southwest Virginia. This was demonstrated through an annual data collection and assessment, through staff training initiatives, and by integrating the Recovery Philosophy throughout facility operations.

The results of the Recovery Services Self-Assessment conducted in spring, 2010, as compared to the original findings of the Office of Inspector General in 2006, showed marked improvement in almost every area. For 27 of the 28 survey items, the 2010 score was greater than the 2006 score, the only exception being a 2 point decline on one ROSI item. The average improvement observed across all items was 24.7 percentage points.

The Vocational Assessment revealed that the loss of one Peer Support staff member led to the decrease in the number of Wellness Recovery Action Plans completed but not to other vocational opportunities which are coordinated by other staff. It is important to continue to develop Peer leaders through the Leadership, Empowerment, and Advocacy Program and as well as other peer leadership opportunities. Ongoing recovery -oriented programs, activities and events are supported by SWVMHI leadership and staff throughout the year, as are other activities related to wellness and recovery as noted in the body of the report.

One important effort has been the implementation, with the support of the Department of Behavioral Health and Developmental Services, of Motivational Interviewing Training. Begun in 2010 with a core of 39 staff, this training is being rolled out to all direct care staff in 2011 with the primary goal to enhance communication skills. This along with other training efforts will support direct care staff in their critically important day-to-day interactions with the individuals we serve.

It is encouraging that continued efforts have led to a pervasive understanding and support of the principles of recovery, across disciplines, through programs such as Employee recognition, and throughout all units. Recovery principles are not owned and implemented, for example, by any one department, but guide our shared vision for an even better facility. As enhancement and areas for improvement continue to be pursued, SWVMHI is recognized for fulfilling its Mission to “promote mental health in Southwestern Virginia by assisting people in their recovery.”

Prologue

(From the SWVMHI Monthly “Director’s Orientation” for new staff)

“We can envision a future when everyone with a mental illness will recover . . .
.. “ ~ The President’s New Freedom Commission on Mental Health

What do we mean by Recovery?

- “Recovery is a deeply personal, unique process of changing one’s attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life, even with limitations caused by the illness. Recovery involves the development of new meaning and purpose in one’s life as one grows beyond the catastrophic effects of mental illness.” ~William Anthony
- Mental health recovery is a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential. ~ SAMHSA’s Consensus Statement
- “Developing and further rebuilding important connections.” ~ Leroy Spaniol
- “The conspiracy of hope.” ~ Patricia Deegan
- “Remembering who you are and using your strengths to be all that you were meant to be.” ~ META Services
- The Recovery Movement often seems idealistic and unrealistic to outsiders, but it has been built by people with severe mental illnesses and the people who live and work alongside them who deeply know the practical difficulties involved. Our idealism comes not from a hopeful theoretical construct, but from the lived experience of overcoming the terrible suffering that often accompanies serious mental illnesses. When the hard work pays off and someone is able to enjoy life again and find meaning, it often feels miraculous. ~ Mark Ragins, MD, Medical Director, MHA Village Integrated Service Agency, National Mental Health Association of Greater Los Angeles

Recovery is a personal process of change experienced by each person in a unique way. It is characterized by growth beyond the effects of mental illness. People find that they are able to lead rich and rewarding lives despite the presence of symptoms. Their lives are meaningful, purposeful, and reflective of the person they are, not the diagnosis they are given. Recovery is a complex and time-consuming process. It takes time to rebuild confidence and abilities after experiencing the effects of a mental illness. Developing confidence, self-respect, and a positive purpose for one’s life doesn’t occur simply because symptoms of mental illness are lessened.

What We Know About Recovery

- An up-and-down process.
- Symptoms may remain, but people still recover!
- Symptoms are less troublesome and happen less often.
- Recovery can happen whether or not one still takes medication.
- Recovery does not mean that one did not have a mental illness in the first place.
- Recovery from the *consequences* of being ill is often harder than recovering from the illness.

Our Challenge

- Our challenge as mental health professionals is to balance safety/security and support during acute phases of illness.
- This is especially the case during psychotic illnesses where thinking processes are subverted by the illness.
- We don't want to inadvertently "stamp out hope" by making all decisions for individuals in a paternalistic, top-down, "I'm the expert, you're not" way.
- We don't want to imply, in choice of word or actions, that there is no hope because "biology is destiny."
- As the individual benefits from medication and a structured environment, the locus of control should increasingly shift from the treatment providers to the person who is recovering.
- He or she must gradually be afforded a larger role in the selection of treatments and services.
- Individuals who are recovering should be given increasing opportunities to regain control over their lives.
- If we cure the symptoms, but have not encouraged the development of hope, we have not done our jobs well!

"The future belongs to those who believe in the beauty of their dreams."

~ Eleanor Roosevelt

The SWVMHI 2010 Recovery Services Self-Assessment.

The Recovery Services Self-Assessment was conducted at SWVMHI during the week of February 26 – March 5, 2010. Surveys were administered to 23 consumers from the three adult treatment units at the facility: Acute Admissions, Geriatrics Wards E and F, and Extended Rehabilitation Services (ERS). These 23 consumers represented a sample of slightly more than 15% of the total adult consumers present over this time period. In order to provide the highest level of comfort for the consumer respondents, arrangements were made for the surveys to be administered by one peer provider from a local Community Services Board, SWVMHI's Peer Support Specialist, and two SWVMHI Direct Care Specialists. Upon completion, the anonymous surveys were sent to the Facility Director's Administrative Assistant, and were then aggregated and entered into the attached table. No data were reviewed, discarded, or altered at any point in this process.

The instruments utilized in the Self-Survey were determined by DBHDS Facility Directors in consultation with DBHBS Central Office and standardized across facilities. They included the following:

- Resident Choice: 9 items
- Resident Opinions of Care: 7 items
- Recovery Oriented System Indicators - ROSI (questions selected for appropriateness to facility setting): 12 items

In addition, a self-assessment using the Vocational Assessment Tool was also conducted during this time period.

The Resident Interviews of Choice and Opinions of Care items were combined with the ROSI items for a total of 29 questions and administered to consumers in a single interview. Consumers were selected for participation based solely upon their availability, willingness, and capacity to respond to these questions. The consumer interviews were conducted in private, allowing for a greater level of comfort, and encouraging honest appraisals of services and conditions on each adult unit.

Results.

Resident Choice.

Comparatively, scores on this set of items were the lowest of the three consumer survey instruments used in this self-survey. However, the observed scores represented the largest improvement from the original survey, administered by the Office of the Inspector General in 2006. Specifically, measures regarding choice of room and roommate were rated lowest, with fewer than 30 percent of respondents indicating that they either chose, or shared in choosing whether or with whom they shared a bedroom. However, when compared with the 2006 OIG Facility Survey, the observed score represents a 24 percent increase. Fewer than half of respondents indicated that they decided or shared in the decision as to whether they would take medications, or which ones they would take, although it is not

known how many of the respondents lacked capacity for such judgments. In 2006, respondents indicated that they had no say in this area 78 percent of the time however, so these latest data show an improvement of 26 percentage points on this item. Eighty-seven percent of respondents indicated that they at least shared in the decision-making regarding which groups and programs they participated in while in the Central Rehab area, up 40 percentage points from the 2006 survey. Fifty-seven percent of respondents viewed the timing of their discharge as either a personal or shared decision, a 45-percentage point increase in this measure since 2006. All of the respondents judged that the determination of their post-discharge living environment was either up to them entirely, or a shared decision with others, whereas only 50 percent of respondents in 2006 said likewise. Twenty-two of the 23 respondents stated that they choose their own clothing on a daily basis, while the one other consumer indicated that this was a decision that he or she shared in making. In comparison, 13 percent of respondents in 2006 indicated that they had no such choice.

On the measure Resident Choice, the average “No Choice” score was 6.25, but variation around the mean was also high, with a standard deviation of 5.7, and a range of 16.

Resident Opinions of Care.

On the whole, 93 percent of the responses on this set of items were endorsements of recovery-friendly practices on the part of SWVMHI staff members. There was very little inter-item variation in the “Yes” column across the seven questions, with a range of 4 and standard deviation of 1.46. The items with the highest levels of “No” responses concerned whether privilege level decisions were made fairly, whether the treatment team discussed with the consumer his or her specific discharge criteria, and whether each respondent had input into the treatment goals. However, the highest of these negative responses accounted for only 22 percent of the total responses for that item. The most positively endorsed items concerned consumer involvement in treatment planning, staff belief that each consumer will “get better,” and the extent to which each consumer believes that there is at least one staff person who can be counted on to help him or her.

When these scores are compared with those obtained from the 2006 survey, consumer involvement in treatment planning increased approximately 18 percentage points, consumer hopefulness increased by 27 points, staff belief in consumers’ recovery potential increased by 40 points, the belief that there is at least one person who can be counted on increased 28 points, the perception that rules governing privilege levels etc. are fair increased 23 points, and the feeling of personal safety reported by respondents increased 5 points.

Recovery Oriented System Indicators (ROSI):

This measure contains 9 positively phrased items and 3 negatively phrased ones from the perspective of recovery-orientation. If combined “Agreed/Strongly Agreed” responses (on positively phrased items), and “Disagreed/Strongly Disagreed” responses (on negatively phrased items) are taken as a measure of respondents’ endorsement of SWVMHI’s recovery orientation, their combined rating was 76 percent. The highest rated items were: “There is

a consumer or peer support person I can turn to when I need one” (96%), and “Staff at this hospital believe that I can grow, change, and recover” (91%). Items rated as lowest in terms of recovery-oriented services and conditions were: “I feel I have a say in the treatment I get here” and “My treatment goals (in my treatment plan) are stated in my own words” (both at 57%). Comparison with 2006 data showed an overall increase of almost 20 percentage points, with improvement shown on all items except one.

Variation between these scores on the ROSI was relatively low, with a standard deviation of 3.26 around a mean of 17.4.

Summary of Recovery Survey Findings:

The aggregate results for all 28 items for 2010 as compared to 2006 show marked improvement in almost every area. For 27 of the 28 items, the 2010 score was greater than the 2006 score, the only exception being a 2 point decline on the ROSI item: “Staff at this hospital interfere with my personal relationships.” The average improvement observed across all items was 24.7 percentage points.

Although scores on the “Resident Choice” survey were comparatively lower than those observed on “Opinions of Care” and the “ROSI,” the improvement shown over the 2006 survey was greater, with a mean improvement of 31 percentage points. Variation around the mean produced a standard deviation of 14.5.

The average improvement shown on the “Opinions of Care” items from 2006 to 2010 was 21.4 percentage points. The standard deviation was 12.

Average improvement shown on the “ROSI” from 2006 to 2010 was 19.5 percentage points. The standard deviation was 17.

Tables and graphs of these data are attached to the end of this document in Appendix A.

Vocational Self-Assessment.

The Vocational Self-Assessment was conducted on January 15, 2010, for the time period July, 1, 2009, through January 15, 2010. At that time, there was one full-time Peer Support staff employed at SWVMHI whose duties included WRAP Training and ongoing peer support. This was in spite of repeated efforts to recruit and hire for this position. One additional consumer served as a part-time volunteer in a support role, although not as a WRAP trainer. Four individuals paid regular visits to SWVMHI; they are consumers who were based in the community and paid by a local Community Services Board. During this time period, a total of 40 adult and 78 adolescent WRAP Plans under the guidance of a fellow mental health consumer who is a qualified WRAP trainer were completed. In addition, three individuals were volunteering regularly in the community.

The 2010 Vocational Self-Assessment was conducted in January, 2011, for the time period January, 2010, through January, 2011. SWVMHI employed a certified WRAP trainer in a full time Rehab Specialist capacity. Unfortunately, his services were lost in August of 2010 and

this negatively affected the number of WRAPs completed at the facility on all units. Completed WRAP numbers fell in 2010 to 50 (20 adult and 30 adolescent (prior to the closure of the unit), a reduction by more than half of those completed in the previous year. Effective December 10, 2010, SWVMHI employed two full-time Peer Support staff. As in the previous year, the duties include WRAP Training and ongoing peer support. We are hopeful with the hiring of the new Peer Specialist, a certified WRAP instructor, that this next year will show a marked increase of patients who will take advantage of this opportunity to develop a personal WRAP.

One additional consumer serves as a part-time volunteer in a support role, although not as a WRAP trainer. Four individuals paid regular visits to SWVMHI; they are consumers who are based in the community and paid by a local Community Services Board.

Other Recovery-Oriented Programs, Activities and Events.

1. The following is a listing of ongoing, hospital-sponsored or facilitated **peer support opportunities**:
 - a. The Consumer Empowerment & Recovery Council —The SWVMHI chapter continues to meet monthly and the four officers of the SWVMHI chapter and the two Peer Support Specialists regularly attend the Regional Consumer Empowerment and Recovery Council (R-CERC) meeting.
 - b. Southwest Clubhouse Association meetings and retreat – Three consumers and one Peer Specialist attended Club Connect, the consumer generated conference in the summer of 2010.
 - c. SWVMHI Community Roles Group -- Welcome Kits continue to be made by SWVMHI consumers and given to all new admissions.
 - d. Leadership Empowerment and Advocacy Program (LEAP) – The course was taught by consumers in the spring/summer of 2009 and again in 2010. A total of 18 individuals were in these two courses.
 - e. An individual (former SWVMHI inpatient) was trained to present “In Our Own Voice” material and was the guest speaker at Family and Friends Day 2009. In 2010, a second person trained to present “In Our Own Voice” material was hired as the second Peer Specialist for SWVMHI.
 - f. The original Peer Specialist initiated his service schedule to include 1:1 and group sessions, and assisted in conducting surveys in 2010 on the wards for the OIG report.
 - g. The newly hired Peer Specialist has completed new employee orientation and has prepared the curriculum to re-establish WRAP classes, a rehab newsletter, LEAP, and CERC involvement.
 - h. Patient groups initiated projects to be sold at the local festival in July.
 - i. The SWVMHI Activity Council continued to plan special hospital-wide events and community leisure.
 - j. Residential Community Meetings are peer run by elected spokespeople and officers for the wards. Individuals have increased say in choosing roommates, decorations, and arrangement of furniture.

- k. In 2009, a new Vocational track was developed with job availability in food service, canteen, vending, cleaning of service areas, beauty shop, and exercise equipment, recycling, and laundry. The Vocational track continues in 2010 with job availability in the same areas.
- l. SWVMHI participated in the follow-up Camp Impact project on August 19, 2009 with Mary Huggins. This is a continuation of the original ROSI project. Patient run groups are initiating projects to be sold at the local festival
- m. Two CSB peer specialists visit every Friday with individuals from their CSB, sharing hope and friendship. They also conduct trips into the community.

2. **Other information** related to wellness and recovery include:

Personal Safety Tool

- Now being used to develop recovery services plans, contingency plans, and individualized welcome kits.

Sensory Connection

- Comfort rooms – continue to be available on each unit with comfort chests and guidelines for use developed. Each still contains a comfort chest and guidelines for use.
- Comfort kits completed for all units.
- Retreat rooms complete on the A/B Admission ward and available for use by all disciplines.
- Welcome Kits continue to be stuffed by Patient Volunteers and given to all new admissions.
- Weighted blanket and weighted animals are available for individualized sensory sessions.

Peer Services

- Highlands CSBs still provide peer support to patients of their catchment area
- SWVMHI's Peer Specialist is networking with the CSBs, giving survey assistance, expanding CERC committees, and creating more peer to peer opportunities.
- An additional Peer Support Specialist has been hired. She is certified Peer Specialist, WRAP and LEAP trainer, trained to present In Our Own Voice, an R-CERC officer, and president of the SCA.
- CERC and R-CERC continue with regular attendance of SWVMHI officers.
- Activity Council continues to plan special events.

Recovery services have continued to include areas of Treatment, Enrichment, and Rehabilitation, and our Rehab services comprised of *Living, Learning, Working, Social, and Wellness areas*. All offered services are now synchronized in a single documented

schedule, including psychology, social work, and on ward services. All sessions held in the Rehab areas are considered "Open Enrollment" and can be accessed by any patient who has expressed desire and need for these offerings.

Ninety-two Vocational opportunities remain available for patient involvement. This continues to include efforts in the canteen, laundry, Beauty Shop, Food Service, and Equipment cleaning as well as vocation production that supply art/craft items for sale at the festival.

Volunteer Services

- Treasure Seekers Store, a resale/thrift store is being operated by three volunteer patients.
- Welcome Committee volunteer patients continue to stuff bags for new admissions.
- Pumpkin Patch, the garden grown with Smyth County Extension Services and maintained by four patients, produced well over 200 pumpkins.

Wellness Program

- Rehab Wellness initiatives continue in areas of physical exercise, healthy living, healthy hobbies, and use of leisure time, Diabetes issues, and Community Integration
- Newly hired LPN staff co-lead these groups.
- Occupational Therapy staff have all passed competency assessment on using blood pressure cuff to assess and monitor patients while on the exercise equipment.

Community Integration tracks continue

- Admissions patients are provided opportunities through an education group that gives experiential practice of newly acquired skill in a community setting. This group is self-supporting, raising their own funds to sponsor community trips.
- Treatment Teams on ERS are closely working with the Occupational Therapists to give patients on the discharge list opportunity to integrate, with support into the community setting.

Road Trip Training

The initial Road Trip training for existing staff was completed on November 5, 2008. In the interim, newly hired staff received classroom training on Trauma Informed Care or use of the Personal Safety Tool during the two-day TOVA class. In order to ensure that as many staff members as possible have received specific training on these topics, on October 21, 2009, a revised Road Trip was presented to twenty-seven new employees. This was the first of several sessions planned to provide orientation to topics such as

Recovery and Resiliency, Trauma Informed Care, Processing after Codes and Seclusion/Restraint Debriefing, and “New Strategies” (using sensory-based modalities for stress relief and to avoid seclusion/restraint).

Road Trip training was added to the new employee curriculum in the spring of 2010. Since that time, thirty-five new employees participated in an initial orientation to Recovery principles, Language and Environmental awareness, Trauma Based Care, and New Sensory Strategies as well as the Procedures for Debriefing patients and staff after an incident that required a code to be called. In 2010, thirty-five new staff completed the Road Trip training as part of the new employee orientation. Road Trip in Orientation is continuing on a quarterly basis and is available for all new staff as well as for a refresher course as needed.

Recovery and Resiliency sessions are presented by a CRS team liaison and a Peer Support Counselor. An occupational therapist and nursing staff member present the Trauma Informed Care session. The Personal Safety Tool is introduced during the Trauma Informed Care section. Its applicability to seclusion/restraint reduction/elimination is established, and the importance of completing this tool as soon as possible after admission is stressed. Debriefing and processing is presented by nursing staff.

The “New Strategies” are presented by an occupational therapist and Nursing Service staff member. The use of sensory modalities is introduced, with examples of application reflecting back to the Personal Safety Tool. The concepts behind the use of comfort rooms and therapy pets are also reviewed.

Training of staff (hired after November, 2008), was completed before the end of 2009. This training effort has been an excellent example of the cooperation and dedication of Nursing and Clinical Services. The outcomes have been positive and the experience has strengthened relationships between these two divisions.

Other Events supporting increased peer interactions:

- Peer Support Retreat 2010: Attended by SWVMHI’s Peer Specialist.
- SCA Retreat 2010: Attended by SWVMHI CERC officers and Peer Specialist.
- Family and Consumer Support Committee continues to work to bring training to this region, WRAP, and PEER Specialists.
- LEAP classes graduated six persons and will again be offered in the spring of 2011.
- Southwestern Virginia Mental Health Creative Ideas Committee held Mental Health Awareness events in April and May, 2010. This committee is made up of consumers diagnosed with a mental illness, family members of consumers, and professionals from the area. There are representatives from the Community Services Boards, SWVMHI, and Emory and Henry College. The committee explores ways to reduce stigma through community education and ways to encourage those persons diagnosed with a mental illness to begin or stick with their own recovery journey.

2010 Summary. *A community event* - The committee sponsored a film as a Lyceum in connection with the Arts Array film series that is offered to students and employees of Emory and Henry, Virginia Intermont, Virginia Highlands Community College, the Southwest Virginia Higher Ed Center, and King College free of charge. (General admission for others was \$7.50.) ***The Soloist*** is based on the life of Nathaniel Ayers, whose life journey takes him from study at the prestigious Julliard School of Music to living as a homeless street musician in Los Angeles. The film was offered on April 5 and 6, with two showings per day.

As part of this experience, after the showings, we offered a panel presentation to the general public about the realities of mental illness and the hope for understanding, treatment, and recovery. The panel was composed of professionals, consumers, and family members. There were over 125 attendees at the four showings.

Mental Health Awareness Seminar – On May 15, 2010, the CIC sponsored the region’s annual event that offers hope, education, and entertainment for those consumers in the area that are diagnosed with a mental illness. Consumers from many of the regions’ Clubhouses as well as patients from SWVMHI were able to participate in the event, as well as their family members and other community guests. The keynote, ***Culture Tells the Story of our Shared Strength***, was given by Mr. Steven Pocklington, the founding director and lead trainer for **Well Beyond Recovery**, an organization that promotes well-being and self-determination for all people. Lunch was offered as well as entertainment and recognition of some of those in the region that are making a difference. ***The Path***, a play, featured consumers from Cumberland Mountain CSB as actors, writers and directors. After the event, surveys were sent out to each of the Clubhouses and SWVMHI to get feedback on ideas for the 2011 event.

Trauma Informed Care

- Six nurses attended a day-long training at Wytheville Community College on June 2, 2010, regarding mental health recovery and trauma informed care.
- In September, 2010, these nurses provided two-hour training beyond the basic nursing competency for all direct care nurses including highlights from this conference regarding trauma informed care and how to incorporate patients’ history and experience into nursing care delivery.

Patient Falls Prevention

- In November, 2010, nursing staff on the Extended Rehabilitation Services Unit presented training through the Nursing Practice Committee to nursing staff leaders regarding patient falls prevention. Consideration from patients’ physical and emotional perspectives were emphasized regarding risk, prevention, interventions, and effectiveness.

Nursing- led Patient Groups on Ward:

We began to formalize the groups held on the units by the nursing staff and developed a document for every day each month to record information about the nursing-led groups on the units. The information includes the group topic and level of patient participation. Every nursing staff member receives a basic competency training in groups and are developing group notebooks describing each group, its objectives, content, and teaching methods.

DSA Career Pathway

One hundred and forty aides successfully completed Level I of the DSA Career Pathway (91 percent of total aide staff). Level I consisted of eight competency validations over a six month period. Competencies validated were: Advocacy and Empowerment, Communication, Community Living Skills and Supports, Crisis Prevention and Intervention, Documentation, Facilitation of Services, Information Gathering, and Organization Participation. One hundred percent of the staff taking the online courses received an "A" in their first course.

Motivational Interviewing – Catalyst for Change

With limited staff development resources available for calendar year 2010, SWVMHI was able to utilize VASIP-related federal funds to sponsor a training program that offers the best chance of impacting a variety of daily interactions with patients towards:

- Reducing conflict that often leads to seclusion/restraint.
- Enhancing the quality and effectiveness of our service planning process and provision of care.
- Expanding our focus on evidence-based practices.

SWVMHI leadership holds the view that the use of Motivational Interviewing, both in terms of the specific techniques involved, and perhaps more importantly, the establishment and maintenance of a general environment in which the "spirit" of Motivational Interviewing is reflected in almost everything that we do, is central to infusing our culture with a recovery-oriented mindset.

Motivational Interviewing (MI) is an evidence-based set of techniques to assist people in recognizing and clarifying what they truly value in their life, how their values and preferences often conflict, how their behaviors are affected by these values, and what they can change to move closer to a life they will find rewarding and meaningful. These techniques reflect the person-centered, collaborative values of recovery-based treatment. They have been shown to work particularly well with people who have been seen as "resistant," or "non-compliant." However, MI supports the view that every person is motivated towards certain "goals," although these goals may conflict with one another and/or be harmful to the person/others. MI approaches can be used in combination with other evidenced-based practices, such as cognitive-behavioral

therapy, or on their own. By showing efficacy with individuals who are at least ambivalent to getting treatment, MI techniques are especially applicable to environments like SWVMHI, with our high number of involuntary admissions.

Central Office assisted our facility in funding and setting up a training package that included:

- Two, two-day training sessions on Beginning-Intermediate Level Motivational Interviewing Theory and Technique, provided by a certified MI Trainer. Forty-one staff members, selected from a cross-section of clinical service providers from Nursing, Social Work, Rehab Services, and Psychology Departments participated in the training. These sessions were conducted on August 17-18, and 24-25, 2010.
- One, two-day training session on structured supervision of Motivational Interviewing, provided for ten supervisory-level clinicians who had each attended the prior MI training sessions. These sessions were held September 20-21, 2010.
- Follow-up training provided for greater numbers of facility staff, planned and provided by staff members who attended Beginning-Intermediate Level training. We have selected a multidisciplinary cross section of staff to participate in this training initiative, with the expectation that these staff members will then lead the overall facility change effort that we envision. Prior to attending their initial MI training, each participant signed an agreement to shoulder this responsibility. The "letter of agreement" contained the following paragraph:

"By agreeing to participate in the MI Training, you are accepting a role as "change agent." SWVMHI is making a commitment to MI as a basis for patient-staff interactions in a variety of settings, from the team rooms to the day rooms to the Central Rehab area. This effort will rely primarily on what you, your supervisor, and your colleagues do everyday to demonstrate the MI spirit and use the techniques."

This group is currently designing two levels of MI training; one for senior clinical staff members and another for aide level staff, both to begin in spring 2011.

Patient Satisfaction Survey Data

On the Admissions and Geriatric Units, all patients are provided satisfaction surveys following their respective Comprehensive Evaluation and Recovery Services Plan Conference and after every Recovery Services Plan Review (monthly) thereafter. The surveys consist of 5 questions:

- 1) My Treatment Team listened to me about what I want in my life.
- 2) I believe that my Treatment Team members care about me.
- 3) I understand my Recovery Plan.
- 4) I believe that this plan will help me reach my goals.
- 5) I feel safe in this hospital.

Surveys are identified only by Treatment Team. Patients completed the surveys anonymously and place them in a locked Patient Survey Box located on the Wards.

In addition, additional Patient Satisfaction data is collected on the long-term unit, ERS. Patient Satisfaction is assessed monthly with the assistance of a Human Services Care Specialist and are completed with the patients assigned to each ERS Treatment Team (I and J). Every other month all patients are provided with a seven item survey regarding their treatment and are given the opportunity to respond to the items either affirmatively or negatively as well as provide narrative support for their answers. The seven items presented are:

- 1) The Treatment Team includes me in developing my goals and plans for recovery.
- 2) I am satisfied with my progress toward discharge.
- 3) I feel safe living here each day.
- 4) I think the Treatment Team listens to me.
- 5) I think the staff helps me resolve my problems.
- 6) I think the Nursing staff help me accept myself.
- 7) I am learning about my mental illness.

In the alternate months one-half of the patients assigned to each Treatment Team in ERS are presented with open-ended, narrative discussion questions regarding their treatment to allow for more individual expression and identification of possible satisfaction/recovery issues. Once again, these questions are presented by the Human Services Care Specialist in a private setting in an effort to facilitate engagement and increase responsiveness. The questions presented during this survey process are:

- 1) How is your treatment going?
- 2) How could your meeting with the Treatment Team be more helpful to you and how can you help prepare yourself for the meeting?

The purpose of these questions to elicit clear input regarding the patient's perspective of the recovery process as well as to engage in a dialog on how to improve engagement in, and effectiveness of, the monthly Treatment Planning Conferences.

A summary of the results for 2010 revealed that the completion rate is relatively low on the Admissions and Geriatric Units. It is noted that midway through the year, a decision was made by the Geriatric Unit to submit the surveys only to individuals being served, and no longer to the authorized representatives or guardians. Due to the functional cognitive impairment/dementia of many of the individuals, this resulted in a decreased response rate. Of those returned, positive responses (that is, endorsing "All the Time" and "Most of the Time") were received from 71% to 97 % of the time on the surveys (Admissions), and from 55% to 100% on Geriatrics.

On the ERS Unit, response rate was relatively higher, both during "survey" months and in "narrative" response months. On the survey, the percentage of individuals responding positively (endorsing "Yes") to the survey questions ranged from 68 % to 87 %. Question 5 "I am satisfied with my progress toward discharge" received the least

positive responses. Responses to the narrative questions were used in subsequent discussions with the Treatment Team in order to enhance the recovery experience of individuals served. During “narrative” months, one-third to one-half of individuals on the unit chose to respond. Most individuals reported satisfaction with the team meeting process, with increased family involvement, feeling comfortable with asking questions, and preparing for the scheduled meetings in advance. There was general satisfaction with treatment, with requests for increased number of activities and a positive response to the vocational groups. Several patients, however, expressed dissatisfaction with the new activity schedule which was put into place in February, and others felt that they don’t have mental illness, did not need to continue in the hospital, and should be discharged.

The responses are gathered and presented to the Unit Programs Director for review and for presentation/ discussion at monthly unit meetings and at shift meetings. Issues identified in the survey process that require follow-up are addressed individually by the Programs Director or designated staff, with Treatment Teams, or by room or roommate changes. Data are reported quarterly to the Quality Management Committee along with actions taken in response to the results. Improvement actions pursuant to data results are generated and implemented by Unit Leadership.

See Appendix B for 2010 Patient Satisfaction data.

Nursing-led HPO Workgroup

A Nursing-led High Performance Organization (HPO) workgroup was formed in 2010 to look at further efforts at reducing seclusion or restraint episodes, especially with patients who have repeated occurrences. Several potential ideas that will be further assessed for implementation include:

- Improved communication between Treatment Team Members and direct care staff on all three shifts.
- Rapid referral to the Internal Review Committee when an individual has repeated incidents of seclusion/restraint.
- Enhanced training, especially for psychiatric aides on de-escalation techniques.
- Targeted specific training for staff on recovery concepts and alternatives to seclusion/restraint.

Plan for Recovery Services at SWVMHI

Outline for 2011

I. The Role of Senior Leadership

Senior Leadership will actively participate in and support the following recovery services initiatives:

- Director continue to present orientation for new staff emphasizing, among other issues, Facility Mission, Vision, Values and leadership Philosophy and Recovery.
- Monthly Recovery oriented Internal Case Reviews led by Director
- Emphasize Recovery-oriented and Values-based principles and behavior in the SWVMHI Employee Recognition Program, and through the quarterly recognition events
- The executive team will continue to promote communication with staff through forums, shift meetings, and written forms of communication such as the monthly newsletter, A View from the Hill. In addition, quarterly staff forums will be held to address issues pertinent to a values-based, recovery-oriented facility.
- Conduct annual Recovery Survey by March 30 of 2011.
- Review Mission, Vision, Values and Leadership Philosophy as part of strategic planning.
- Implement review of space utilization using the Principles of a High Performance Organization to guide the process. Consumer needs will be prioritized and it is likely that SWVMHI will seek a new, safe location for commitment hearings that is more easily accessible to patients.
- Develop a plan to enhance staff resilience to stress in the workplace through
 - Education about the EAP and CommonHealth programs,
 - Re-emphasis of the Peer Support program, and
 - Workplace design as considered during the review of space utilization.

II. Workforce Development

The following initiatives are regularly being held or are being planned for implementation in 2011:

- Motivational Interviewing Training for all direct care staff
 - This training complements and extends the MI training provided to 39 staff and advanced supervisory training provided to 10 staff members in 2010.

- Level I for all direct care staff who do not develop and write Recovery Services Plans.
- Level II for all direct care staff who do not develop and write Recovery Services Plans.
- Ongoing Orientation for new staff:
 - Road Trip Training (including principles of Recovery),
 - Director's Orientation (which is now open for any staff member to attend)
 - Trauma Informed Care is part of all nursing staff orientation and competency
- Conduct Risk Assessment training for direct care staff who develop and write Recovery Services Plans.
- Implement the Revised Managing Virginia Program (Supervisory curriculum) on the Knowledge Center for all supervisors
- Develop short courses (15 – 20 minutes) which can be presented in regular staff meetings which underscore and develop positive supervisory actions which reinforce the facility Mission, Vision, Values, Leadership Philosophy, and the Recovery Philosophy.
- Continue to provide quarterly Ethics training and team consultation through Dr. Michael Gillette.
- Promote the opportunity for Peer Support Services certification in Charlottesville for the peer support staff by keeping in contact with Paul Abrahms, coordinator of this training, to initiate application for one of the Peer Specialists to attend the next available class.
- **Nursing-led Patient Groups on Ward:** Assess the groups in terms of numbers of patients who participate, barriers to patients attending, and the documentation process. As the groups become more formalized, they will be presented to the Treatment Team for specific referrals followed through the Recovery Plan. Also, a second level of training in group skills for unit based nursing staff will be developed and presented in 2011.
- **DSA Career Pathway:** Of the one hundred and forty aides at SWVMHI, 28 (20%) are pursuing Level II which consists of on-line classes through a local community college and competency validation. The on-line class curriculum include Becoming a Helper, Looking Out, Looking In (communication, identifying barriers to communication and effective interventions), and Person-Centered and Positive Behavior Approaches. Two additional staff have applied for Level I. Our goal is to increase participation by at least 30% in the Career Pathway for Levels I and Levels II by increasing the emphasis of the pathway during each new employee orientation, hold at least two promotional activities in 2011 for DSA Career Pathway Level I and II, and asking Level II staff to participate in the promotional activities.

III. Treatment Planning (now called SWVMHI Recovery Services Planning), to include enhanced recovery-oriented groups and activities

The following initiatives are regularly being held or are being planned for implementation in 2011:

- Update the Recovery Service Planning process as needed based on survey/audit of Recovery Service Planning and patient satisfaction results as part of QM to recommend improvements needed and training needs?
- Continue SWVMHI Family and Friends Day, inviting CSB staff and consumers, family and friends of persons hospitalized at SWVMHI to encourage and celebrate their participate in Recovery Service Planning. Planning for the 19th annual event will begin soon.
- Continue to provide support to peer support specialists employed by SWVMHI (who now number two staff) and by local CSBs.
- Regularly measure, trend and report on Patient Satisfaction with service, with the goal to increase participation and improve scores.
- Assure regular updates of the “catalog” of all current recovery and treatment services. Involve clinical and nursing leadership in periodic reviews of the offered service delivery system. Update the offerings according to patient wants and needs using patient satisfaction data as a guide.
- With the addition of a second Peer Support Specialist, reinstate programs such as WRAP (Wellness Recovery Action Plans), LEAP (Leadership, Advocacy and Empowerment Program), and increase peer-to-peer contact. Utilize the two Peer Specialists in expanding patient involvement in the SWVMHI CERC (Consumer Empowerment recovery Council) and the Regional CERC. Seek opportunities to support involvement of patients and Peer Specialists in shaping the program and policy structure.
- Plan a Supervised Self-Medication Administration project for some individuals who are nearing discharge.
- Enhance patient food choices at meals.
- Cultural and Linguistic Health Competency informational posters will be displayed on each unit as an educational resource for consumers to be aware of the right to culturally competent care.
- Increase materials in the SWVMHI Library for individuals with limited literacy.

- The Geriatric Unit will enhance the outside environment by purchasing new outdoor furniture and making the courtyard more pleasant.

IV. **The Design of the Clinical Record**

The following initiatives are regularly being held or are being planned for implementation in 2011 (new or revised initiatives are italicized):

- Update the Recovery Service Planning documents as needed.

V. **Resident Activities and Opportunities**

The following initiatives are regularly being held or are being planned for implementation in 2011 (new or revised initiatives are italicized):

- Promote holistic wellness activities including physical exercise and physical therapy services on site. Explore the possibility for construction of a “Wellness Trail” that would provide exercise and physical involvement both inside the courtyards and at the picnic shelter area.
- Expand and enhance the SWVMHI Consumer Empowerment and Recovery Council (CERC) and Regional-CERC
- Continue to expand offsite training and networking opportunities for consumers through continued involvement with Regional-CERC, LEAP, Southwest Clubhouse Association (SCA), WRAP, and Mental Health Awareness Events
- MH Awareness Events for 2011 through the Southwestern Virginia Mental Health Creative ideas Committee (CIC). The CIC is composed of consumers diagnosed with a mental illness, family members of consumers, and professionals from the area. There are representatives from the Community Services Boards, SWVMHI, and Emory & Henry College.
 - The committee explores ways to reduce stigma through community education and ways to encourage those persons diagnosed with a mental illness to begin or stick with their own recovery journey. In 2011, the committee’s activities include partnering
 - *The Big Read* – The CIC has partnered with The Barter Theater and the Washington County Public Library in The Big Read, a program of the National Endowment for the Arts, designed to restore reading to the center of American culture. Because the book for the 2011 Big Read is The Stories and Poems of Edgar Allen Poe, the CIC has the opportunity to engage the community in a discussion about creativity and mental illness. The CIC will participate in the Kick-off event, offering education about mental health and providing attendees with literature as well. The activities sponsored by the CIC will include two presentation of In Our Own Voice, a production of ***The Path*** by CMCSB, and a

showing of the movie ***Canvas***, with a panel discussion to follow. This film tells the story of a family in crisis due to the serious symptoms of a mental illness of the mother.

- *Mental Health Awareness Event* – On May 14, 2011, from 10:00 a.m. to 2:00, the committee will be hosting the Annual Mental Health Awareness Event on the campus of Emory & Henry College. This year's theme is ***Celebrate Recovery***. In addition to a keynote being provided by a person who is in her own recovery journey, there will be 4 workshops led by the various CSB consumers. Each attendee will get to participate in each of the 4 workshops. We again will have musical entertainment during the lunch break.
- Continue to provide a wide variety of Vocational opportunities for patient involvement, including expanded efforts in the Laundry, Beauty Shop, Food Service, and Equipment cleaning. This is in addition to vending machine and patient canteen work opportunities. Explore creating jobs with environmental services. Continue to dedicate time in horticulture, woodshop, ceramic and A & C classes to design crafts for resale at local festivals.
- Explore the development of partnerships with DRS and other community agencies such as the Extension services to expand vocational and leisure options in daily service provision.
- Continue operation of the “Treasure Seekers” store to train patients in volunteerism so that increased community involvement is possible.
- Expose patients who participate in Transitional groups to existing volunteer opportunities in the community such as giving time to the local pet shelters or local thrift stores.
- Expand CERC and Patient Activity Council responsibilities to include committee work in planning and implementing financially supportive endeavors. For example: Yards Sales, Farmer’s Market booths and expansion of Treasure Seekers.

VI. Relationship to the Community

The following initiatives are regularly being held or are being planned for implementation in 2011 (new or revised initiatives are italicized):

- Continue to support and participate on the Southwest Behavioral Health Board for Regional Planning
- Continue to support and participate on the Southwest Virginia Mental Health Creative Ideas Committee (which plans the Mental Health Awareness events above)
- SWVMHI staff and consumers will continue to participate in the Crisis Intervention team (CIT) training program for New River Valley and Mt. Rogers areas

- SWVMHI staff will lead and participate in regional stakeholder meetings
- Regional Psychiatric Nursing Conference – On May 12, SWVMHI will sponsor a public conference which will have a mental health recovery theme.

VII. Other Areas as Determined Relevant to Enhancing the Recovery Experience of Those Who are Served by the Facility

Appendix A

SWVMHI RECOVERY SURVEY 2010 RESULTS				
Resident Choice		<i>I Decide</i>	<i>No choice</i>	<i>Shared Decision</i>
1	What I eat at mealtime	2	9	12
2	When I go to sleep or wake up	13	5	5
3	Whether I share a room and with whom	3	16	4
4	What I wear each day	22	0	1
5	What is my treatment plan	2	5	16
6	What classes I take at the treatment mall	11	3	9
7	Whether I take medications and which ones	3	12	8
8	When I will be ready to leave the hospital	1	9	12
9	Where I will go when I leave the hospital	12	0	11
Opinions of Care		<i>Yes</i>	<i>No</i>	<i>Unsure</i>
1. a	Do you feel that you have had input to your treatment goals?	18	4	1
1. b	Has the Treatment Team involved you in making your plan?	20	2	1
2	Have you and the Treatment Team (or other staff you work with) had a discussion about what it will take for you to be able to leave the hospital and avoid having to come back again?	18	5	0
3	Do <i>you</i> believe that your mental health condition will improve - that you will get better?	19	0	4
4	Do you think the <i>staff</i> here at this hospital believe your mental health condition will improve - that you will get better?	20	1	2
5	Is there someone - anyone - at this hospital you can count on most to help you? Someone that you really trust and relate to, and talk to? If yes, circle the one person who helps the most of the following: doctor, nurse, social worker, aide, psychologi	20	3	0
6	Do you feel the rules about your "level" - grounds privileges, etc. - are fair and fairly administered?	16	6	1
7	Do you feel safe at this hospital? If your answer is no, who do you think might harm you? (Circle) staff, other patients, both?	19	3	1
* Responses to #5: Aide (2); Patient (2); Group Leader (1); Ashley King (1); Social worker (2); nurse (1); Team 12 Step (1); "everyone" (1); doctor (4); RT (1); Psychologist (2); OT (1); Peer Support Person (1) <i>NOTE: some respondents circled more than o</i>				
** Responses to #7: staff <i>NOTE: Only one respondent who answered no indicated who</i>				

ROSI		Strongly Agree	Dis Agree	Agree	Strongly Agree	N/A Not sure
1	Most staff at this hospital listen carefully to what I have to say	0	1	13	7	2
2	Most staff at this hospital see me as an equal partner in my treatment program	0	4	14	5	0
3	Most staff at this hospital understand my experience as a person with mental health problems	1	4	11	5	2
4	I feel I have a say in the treatment I get here	2	5	7	6	3
5	Staff at this hospital have used pressure, threats, or force in my treatment	7	11	3	1	1
6	The doctor has worked with me to get me on medications that are most helpful to me	0	3	13	4	3
7	Staff at this hospital interfere with my personal relationships	6	7	5	2	2
8	Services at this hospital have caused me emotional or physical harm	8	11	1	1	2
9	There is at least one person at this hospital who believes in me	0	2	14	6	1
10	Staff at this hospital believe that I can grow, change, and recover	0	0	14	7	2
11	My treatment goals (in my treatment plan) are stated in my own words	2	5	8	5	3
12	There is a consumer or peer support person I can turn to when I need one	0	1	16	6	0

COMMENTS	
1	I have been very happy with this hospital and Ms. Sarah, Dr. Gordon, Nurse Sandy (night), Bethany, Nurse Ben, Nurse Adam, Nurse Harriet, Pam and Susan. Excellent care and team work!!!
2	Should have a smoking area
3	Parenting classes Need more of them
4	I feel the team can help me explore my horizons. Also, help achieve my goals once discharged.
5	Need legal representation that can be effective
6	I wish we could have more access to reading materials -- more library access. More resources for learning.
7	I don't feel privileges are handled fairly. I want full privileges -- be able to have after 5 privileges, then unescorted within perimeter and unescorted outside privileges.
8	Would like for family to join in on meetings -- TPC meetings. They have joined in before and this works out best for me for communication reasons.

NOTE: Not every respondent answered every question
Geriatrics = 5 surveys
Admissions = 8 surveys
ERS = 10 surveys

Appendix B

SWVMHI 2010 Patient Satisfaction Data Acute Treatment Services

	<u>#</u> <u>Returned</u>	<u>% All the</u> <u>Time</u>	<u>% Most of the</u> <u>Time</u>	<u>% No</u> <u>Opinion</u>	<u>% Not</u> <u>Often</u>	<u>% Never</u>
Jan	13	66%	20%	12%	2%	0%
Feb	8	53%	18%	23%	5%	3%
Mar	30	59%	22%	17%	1%	0%
Apr	21	66%	29%	2%	0%	4%
May	26	79%	18%	2%	0%	0%
June	42	67%	25%	5%	2%	1%
July	30	64%	29%	5%	1%	1%
Aug	22	66%	21%	11%	1%	1%
Sept	42	70%	22%	6%	2%	0%
Oct	34	51%	26%	16%	6%	2%
Nov	30	63%	31%	5%	1%	0%
Dec	40	53%	31%	14%	3%	0%

Actions Taken:

- Multiple Patient roommate changes
- Temporary ward transfers
- Discussion with Team Members regarding need to be alert to patient reading and verbal comprehension level in their interaction with patients and developing/writing treatment plans with patients.
- Key Treatment Team staff attend Motivational Interview Training with plans for them to provide such training to all staff in 2011.

SWVMHI 2010 Patient Satisfaction Data Geriatric Treatment Services

	<u># Provided</u>	<u># Returned</u>	<u>% All the Time</u>	<u>% Most of the Time</u>	<u>% No Opinion</u>	<u>% Not Often</u>	<u>% Never</u>
Jan	40	7	57%	31%	6%	6%	0%
Feb	41	10	53%	29%	10%	4%	4%
Mar	46	12	33%	32%	32%	3%	0%
Apr	48	11	67%	24%	4%	2%	4%
May	35	6	47%	33%	20%	0%	0%
June	48	7	69%	29%	0%	3%	0%
July	41	4	45%	35%	10%	5%	5%
Aug	39	5	64%	32%	0%	0%	4%
Sept	45	3	60%	33%	7%	0%	0%
Oct	39	8	53%	30%	5%	13%	0%
Nov	34	2	40%	60%	0%	0%	0%
Dec	27	1	40%	60%	0%	0%	0%

Actions Taken:

- Multiple Patient roommate changes
- Utilization of private bedrooms for aggressive patients pending improvement in mental states and behavior.
- Temporary Ward transfers.
- Actively involve A.R.'s in development and review of RSP's to enhance understanding patient care/treatment/Recovery Plan.
- Discussion with Team Members regarding need to be alert to patient reading and verbal comprehension level in their interaction with patients to help better understand the Recovery Plan.

SWMHI 2010 Patient Satisfaction Data Extended Rehab Services

	Surveys Offered	Surveys Completed	Percentage Responding Affirmatively to Survey Statements						
			#1	#2	#3	#4	#5	#6	#7
Jan	26	15	15 Patients completed the narrative discussion question interview with Jan Barrom, HSCS						
Feb	43	30	77%	87%	90%	87%	80%	87%	83%
Mar	27	23	23 Patients completed the narrative discussion question interview with Jan Barrom, HSCS						
Apr	46	35	77%	69%	80%	74%	71%	71%	71%
May	20	11	11 Patients completed the narrative discussion question interview with Jan Barrom, HSCS						
Jun	46	33	82%	70%	73%	82%	85%	85%	73%
Jul	30	29	29 Patients completed the narrative discussion question interview with Jan Barrom, HSCS						
Aug	47	34	74%	68%	71%	74%	74%	74%	74%
Sep	24	12	12 Patients completed the narrative discussion question interview with Jan Barrom, HSCS						
Oct	47	33	76%	73%	79%	76%	79%	85%	70%
Nov	31	26	26 Patients completed the narrative discussion question interview with Jan Barrom, HSCS						
Dec	44	31	77%	74%	68%	81%	87%	81%	81%

Survey Statements:

1. Does the Treatment Team include me in developing my goals and plans for recovery?
2. I am satisfied with my progress toward discharge.
3. I feel safe living here each day.
4. I think the Treatment Team listens to me.
5. I think that staff helps me resolve my problems.
6. I think that Nursing staff help me accept myself.
7. I am learning about my mental illness.

Narrative Discussion Questions:

1. How is your treatment going?
2. How could your meeting with the Team be more helpful to you and how can you help yourself prepare for the meeting?

Actions Taken:

Ward transfers

Room Changes

Updates to Recovery Service Plans

Treatment Team and Program Management reviews of behaviors and clear instruction provided to nursing staff to facilitate more positive interactions and communication strategies

Medication and other treatment changes

Group schedule adjustments

