

Southwestern Virginia Mental Health Institute

Marion, Virginia

Update to the Office of the Inspector General
on Recovery Implementation for 2012

and 2013 Plan for Recovery Services Enhancement

incorporating the 2013 - 2014 Seclusion & Restraint Plan



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.

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Executive Summary.

Southwestern Virginia Mental Health Institute made significant gains in 2012 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, 2012, as compared to the original findings of the Office of Inspector General in 2006, showed improvements in almost every area.

The Vocational Assessment revealed that the addition of one part-time Peer Support staff member led to some increase in the number of Wellness Recovery Action Plans completed. It is important to continue to develop Peer leaders through the Leadership, Empowerment, and Advocacy Program and as well as other peer leadership opportunities, such as the Patient Activity Council, the SWVMHI Consumer Empowerment Recovery Council and the Regional Consumer Empowerment Recovery Council. 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 was rolled out to all direct care staff in 2011 with the primary goal to enhance communication skills. This along with other training efforts has supported 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, 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 envision a future when everyone with a mental illness will recover, a future when mental illnesses can be prevented or cured, a future when mental illnesses are detected early, and a future when everyone with a mental illness at any stage of life has access to effective treatment and supports - essentials for living, working, learning, and participating fully in the community.”

Vision Statement

[*Achieving the Promise: Transforming Mental Health Care in America*](#) (Final report), Rockville, MD: President's New Freedom Commission on Mental Health, July 2003 (published July 22, 2003),

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!

In 2012, the following was reviewed and incorporated into training:

"With input from the behavioral health field, SAMHSA has recently developed a working definition of recovery, as follows:

Recovery from Mental Disorders and Substance Use Disorders: A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

Through the Recovery Support Strategic Initiative, SAMHSA has delineated four major dimensions that support a life in recovery:

Health: overcoming or managing one's disease(s) as well as living in a physically and emotionally healthy way;

Home: a stable and safe place to live;

Purpose: meaningful daily activities, such as a job, school, volunteerism, family caretaking, or creative endeavors, and the independence, income and resources to participate in society; and

Community: relationships and social networks that provide support, friendship, love, and hope.

SAMHSA has also identified 10 guiding principles of recovery. A brief description of each follows. A more detailed description can be found at www.samhsa.gov/recovery.

- *Recovery emerges from hope:* The belief that recovery is real provides the essential and motivating message of a better future – that people can and do overcome the internal and external challenges, barriers, and obstacles that confront them.
- *Recovery is person-driven:* Self-determination and self-direction are the foundations for recovery as individuals define their own life goals and design their unique path(s) towards those goals.
- *Recovery occurs via many pathways:* Individuals are unique with distinct needs, strengths, preferences, goals, culture, and backgrounds ☐ including trauma experiences ☐ that affect and determine their pathway(s) to recovery. Abstinence is the safest approach for those with substance use disorders.
- *Recovery is holistic:* Recovery encompasses an individual’s whole life, including mind, body, spirit, and community.
- *Recovery is supported by peers and allies:* Mutual support and mutual aid groups, including the sharing of experiential knowledge and skills, as well as social learning, play an invaluable role in recovery.
- *Recovery is supported through relationships and social networks:* An important factor in the recovery process is the presence and involvement of people who believe in the person’s ability to recover; who offer hope, support, and encouragement; and who also suggest strategies and resources for change.
- *Recovery is culturally-based and influenced:* Culture and cultural background in all of its diverse representations – including values, traditions, and beliefs – are keys in determining a person’s journey and unique pathway to recovery.
- *Recovery is supported by addressing trauma:* The experience of trauma (such as physical or sexual abuse, domestic violence, war, disaster, and others) is often a precursor to or associated with alcohol and drug use, mental health problems, and related issues
- *Recovery involves individual, family, and community strengths and responsibility:* Individuals, families, and communities have strengths and resources that serve as a foundation for recovery.
- *Recovery is based on respect:* Community, systems, and societal acceptance and appreciation for people affected by mental health and substance use problems – including protecting their rights and eliminating discrimination – are crucial in achieving recovery.

The Mission, Vision, Values, and Leadership Philosophy of SWVMHI all support an atmosphere of Recovery, respect for all individuals, and the use of the least restrictive or coercive interventions. We continue to focus on our Mission, "We promote mental health in southwest Virginia by assisting people in their recovery" by using our facility Values of Communication * Honesty with Compassion * Trust * Teamwork * Self-initiative * Leadership * and Honoring

day-to-day tasks to fulfill our Vision, “SWVMHI, in collaboration with Community Service Boards, will always be the region’s center of excellence in the treatment of serious mental illness.”

In addition, SWVMHI has recently developed and adopted a formal Seclusion and Restraint Philosophy and accompanying plan..

**SWVMHI Seclusion and Restraint Philosophy
December 1, 2011**

SWVMHI is committed to creating a trauma informed environment free of violence and coercion based on prevention strategies; assuring a safe environment for individuals receiving services as well as staff; and focusing on the elimination of seclusion and restraint as congruent with the principles of recovery and person-centeredness. This goal is consistent with a facility that treats people with dignity, respect, and mutuality, protects their rights, provides the best care possible, and supports them in the achievement of their personal vision for their lives.

“The future belongs to those who believe in the beauty of their dreams.”
~ Eleanor Roosevelt

I. The SWVMHI 2012 Recovery Services Self-Assessment.

The Recovery Services Self-Assessment was conducted at SWVMHI during March, 2012. The instrument utilized was the same as in previous years. Surveys were administered to 30 individuals on all three adult treatment units at the facility; Acute Admissions, Geriatrics, and Extended Rehabilitative Services (ERS). The 30 consumers represented approximately 20% of the total adult consumers present over this time period, as opposed to the 15% in 2010. In order to provide the highest level of comfort for the consumer respondents, surveys were administered by one peer provider from a constituent CSB, SWVMHI's Peer Support Specialist, and two SWVMHI Direct Care Specialists.

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

- Resident Choice: 9 items
- Resident Opinions of Care: 7 items (one a two-part question)
- ROSI (questions selected for appropriateness to facility setting): 12 items

The Resident Choice and Opinions of Care items were combined with the ROSI items for a total of 28 questions and administered in a single interview. Consumers were selected for participation based solely on willingness and capacity to respond to these questions. The consumer interviews were conducted in private, allowing for a greater level of comfort, encouraging an honest appraisal of services and conditions on each adult unit. Upon completion, all surveys and consumer responses were then forwarded to the Facility Director's Administrative Assistant, and were then aggregated and tabulation. No data were reviewed, discarded, or altered at any point in this process.

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

Results:

A. Resident Choice:

Comparatively, scores on this set of nine items were consistent with those obtained on the two other measures. Overall, positive responses ("I Decide", and "Shared Decision") made up 78% of the total. This is up from a total of 71% in 2010. All questions but one increased this year over past years.

The question referencing choice of roommates was rated comparatively low, at 47%, although this did represent a 17 point increase over 2010's positive score of 30%. The 2010 score, in turn was a six point increase over the original survey conducted by the Office of the Inspector General in 2006. It is difficult, when most SWVMHI beds are full on each ward every day to afford as much choice as the facility and the residents would prefer to give.

An increase was also noted in 2012 for the question which addressed making decisions or participating in making decisions related to their medications, from 48% to 67%. It is significant that fewer than half of respondents indicated that they decided or shared in the decision as to whether they would take medications in 2010, compared with 67% this year. In 2006, respondents indicated that they had no say in this area 78 percent of the time

In addition, 67% of respondents indicated that they decided or shared in deciding what they ate at mealtime, an increase of 19 percentage points over 2010.

Whereas 87% 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 in 2010, a total of 93% responded positively in 2012. This is an increase of forty-six percentage points over the original survey in 2006.

In 2011, 87% of respondents indicated that they were involved in determining their treatment plans (recovery services plans), which is slightly lower than the 93% who indicated that they determined or helped to determine their choice of groups and programming. Our interpretation is that this may indicate some confusion as to the connection between recovery service planning and the actual provision of services.

Sixty-six percent of respondents viewed the timing of their discharge as either a personal or shared decision, which is an increase of 10 percentage points from the 2010 total and 28 percentage points above the 2006 score. In addition, 67% of respondents in 2012 indicated that they had some level of choice in determining when they were ready to leave the facility.

All respondents stated that they chose their own clothing on a daily basis, consistent with 2010 responses. In comparison, 13 percent of respondents in 2006 indicated that they had no such choice.

As noted, only one item was rated more negatively that last year: 87% of all respondents judged that their post-discharge living environment was either up to them entirely, or a shared decision with others. This is down from 100% in 2010.

B. Opinions of Care:

On the whole, the majority of the responses on this set of items were endorsements of recovery-friendly practices on the part of SWVMHI staff members, with a slight overall improvement over 2010. The most positively endorsed items in 2012 concerned consumer involvement in recovery services planning (90%), hopefulness or the belief of residents that they will get better (90%), and the extent to which each consumer believes that there is at least one staff person who can be counted on to help them (97%). In 2010, these same three items were also the most positively endorsed, with the addition of the question about staff believing that the individual's mental health condition will improve.

The items with the highest levels of “No” responses concerned whether consumers felt safe in the hospital, and whether staff had discussed with the consumer “what it would take to be able to leave the hospital and avoid having to come back again.” Both of these items suffered a drop in positive responses in 2012. It was unfortunate that there were several individuals who acted out against peers in 2012 and those peers felt less safe as a result. Every attempt was made to assure that they were held accountable for their actions in order to keep others safe, in keeping with their level of understanding of their actions.

The ROSI response patterns were similar in many ways to those from 2010, although improvement in the areas of perception of privilege level fairness and input into recovery services plan goals was also noted. There are significant improvements over scores in 2006.

C. Recovery Oriented System Indicator (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 81%. There were no items below a 77% positive rating, except for the item about the availability of peer support (70%). Unfortunately, there was turnover in these positions in 2012 and one position continues to remain vacant. The 2011 overall positive rating is an 11 point improvement from 2010’s overall positive rating of 70%.

The highest rated items were: “I feel that I have a say in the treatment that I get here (83%);” “Staff at this hospital (do not) interfere with my personal relationships (83%);” “Services at this hospital have (not) caused me emotional or physical harm (90%);” and “There is at least one person in this hospital who believes in me (87%).

The most significant improvements from the 2010 survey were: “My treatment goals (in my treatment plans) are stated in my own words” (57% positive in 2010, 83% in 2012),” and “Staff at this hospital (do not) interfere with my personal relationships (57% in 2010, 83% in 2012).

Of the twelve items, six showed increases in 2011, one remained level, and five items decreased in score.

D. Summary of Findings:

The aggregate results for 2012 as compared to 2010 show improvement in most areas.

Of the 29 items, scores increased on 18 of them in 2012, in some cases dramatically. Average scores in each of the three survey sections increased in 2012 as well. Overall average across all sections increased from 74.3 in 2010 to 80.6 in 2012. The largest improvement was observed in the “Resident Choice” section, in which a seven percentage

point increase was noted. The largest increases in individual items average scores were as follows all showing an increase of 26 percentage points from 57% positive to 83% positive:

ROSI Question 4: “I feel I have a say in the treatment I get here.”

ROSI Question 7: “Staff at this hospital interfere with my personal relationships.” Note: this is one of the negatively worded items in which “strongly disagree” and “disagree” are to be interpreted as positive.

ROSI Question 11: “My treatment goals (in my treatment plan) are stated in my own words.”

The largest decrease in scores from 2010 to 2012 was noted in ROSI item 12: “There is a consumer or peer support person can turn to when I need one.” This was discussed above and, unfortunately, one peer position continues unfilled.

Overall, the positive results obtained from this year’s survey are welcome. Although specific attribution cannot be made as to their cause, SWVMHI has made consistent and continued effort to become a more recovery-oriented, less coercive facility. It is noted that given the sharp increases seen between the 2006 and 2010 surveys, we were concerned that continued increases in positive responses would be difficult to achieve. In fact, there was some concern that we would see regression to the mean in 2012, with marginally lower scores. As such, this survey brought a pleasant, if slightly surprising, result

II. Vocational Self-Assessment.

The Vocational Self-Assessment was conducted in January, 2012, for calendar year 2011 unless otherwise noted.

- A. Peer Specialists. It is the goal of SWVMHI to employ at least two Peer Specialists. Unfortunately, in 2011, the services of one full-time Peer Support Specialist were lost off and on for a significant part of the year and the position remained vacant in spite of repeated efforts to recruit and hire. While here, he worked doing WRAP, LEAP and Peer support groups and one-to-one sessions. He assisted in conducting surveys on all wards and he accompanied patients to CERC and R-CERC.

The Peer Support Specialist hired as an hourly worker in December, 2010, and then hired fulltime in September, 2011, remains employed with SWVMHI and conducts WRAP, LEAP, Support groups and 1; 1 sessions. The vacant position is being recruited; however the remaining individual is networking with the CSBs, interacting with the Consumer Empowerment & Recovery Council (CERC) and Regional CERC committees, creating more peer to peer group and one-to-one opportunities, as well as teaching WRAP, LEAP and presenting In Our Own Voice sessions. The duties of the Peer Support Specialist include:

- Peer Support Groups are held 3 times weekly with a capacity of 6 persons per group
- LEAP (Leadership, Advocacy and Empowerment Program) is being held 3 times weekly with a capacity of 6 people

- Outreach Peer Support is a one-to-one peer support session held 3 times weekly for 3 people on ERS and 3 people on Admissions
 - WRAP is held 3 times weekly with a capacity of 8 in the group
- B. LEAP. The Leadership, Advocacy and Empowerment Program (LEAP) was taught by consumers and the Peer Specialist through the spring and summer, 2011. Graduation ceremonies for the region including eight individuals from SWVMHI were held on October 28, 2011, with Moe Armstrong, nationally recognized consumer advocate, as the commencement speaker. The region has graduated more than 500 individuals from this program.
- C. Wellness Recovery Action Plans (WRAP). The Wellness Recovery Action Plan is being used across the nation as a way to help people with psychiatric disabilities work toward and reach their goals. The WRAP is a tool that uses self-help strategies that compliment other treatment methods. WRAP, developed and networked by the Copeland Center for Wellness and Recovery, is the tool chosen by peer specialist in the Commonwealth of Virginia to assist the individuals we serve to meet their recovery goals.

Specifically regarding WRAP at SWVMHI: The following individuals had an opportunity to participate in WRAP training and work toward completing their own WRAP *under the guidance of a peer mental health consumer who is a qualified WRAP trainer* (either a community-based or facility-based trainer):

WRAP Data 3/2011 to 2/20/2012

- Referred—57
 - Attended-- 43
 - Refused or discharged before finished—14
 - Finished—23 (4 ERS +19 ADM)
 - Due to individuals, at times, being discharged prior to completion of their WRAP, efforts are made by the Peer Support Specialist to provide them with information upon discharge about the WRAP and to work to complete the more critical parts of the plan. A total of 16 individuals left with the wellness toolbox section and information to complete on their own.
 - Started then refused -1
 - Still attending—3
 - A total of 31 individuals left with information on various sections of the WRAP plan such as: preventing relapse, WRAP for work and how to become a peer specialist.
- D. Ninety-two Vocational opportunities (slots) are available for patient involvement. This includes the library, the laundry, the Canteen, vending, the outside work crew, the cleaning of the Beauty Shop, exercise equipment and the Patient cafeteria, as well as vocation production that supply art/craft items for sale at Hospital sponsored events as well as Hungry Mother Park Festival.
- E. Volunteers. As of Jan 15, 2012, five individuals served by SWVMHI had a regular (at least twice a week) volunteer experience in the community.

Treasure Seekers, the SWVMHI thrift shop went through a renovation and reopened August 25 with an open house supported by staff and the volunteer patients who traditionally run the store.

- F. The patient-run Christmas Craft Sale generated over \$850.00 to support Operation Santa Claus. Patient groups initiated projects to be sold at the local July Hungry Mother Park Festival, operated the booth, and sold the items, making approximately \$600.00 for future events.
- G. One additional consumer continues to serve as a part-time volunteer in a support role, not as a WRAP trainer. Two individuals who are employed by a local Community Services Board visit weekly individuals from their community who are hospitalized at SWVMHI. They share hope and friendship, and escort individuals on trips into the community.
- H. Several consumers, as well as a family member, are members of the Southwest Board for Regional Planning and several consumers (and family members) serve on the Local Human Rights Committee.

III. Patient Satisfaction Data.

A. Results: Acute Treatment Services.

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 survey consists 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.

Individuals rate each item either "All the time," "Most of the time," "No opinion," "Not often," or "Never." Surveys are identified only by Treatment Team and individuals complete the surveys anonymously and place them in a locked Patient Survey Box located on the Wards.

Surveys were provided to all patients following their Comprehensive Recovery Services Planning Conference and following every Recovery Services Plan Review Conference thereafter. Survey results are calculated for each Treatment Team and the Unit on a monthly basis. Overall results are consistent with the 2010 data with all but one Team evidencing an improvement in percentage of desired responses.

Team	<i># Responses Received</i>			<i>% Responses All Time/Most Time</i>	
	<i>2010</i>	<i>2011</i>		<i>2010</i>	<i>2011</i>
A	144	107		91.7	86.7
B	42	87		81.0	86.4
C	75	104		84.5	89.0
D	87	84		86.4	89.3
Unit	348	382		87.5	87.8

- Actions which were taken throughout the year as a result of these data:
- Team members' increased their sensitivity to patient reading and verbal comprehension levels in order to enhance understanding and participation.
 - All staff sensitive to safety concerns resulted in:
 - Multiple roommate changes
 - Multiple ward transfers within Unit
 - Increased observation levels with disruptive patients pending clinical/behavioral stabilization
 - Direct care staff continues to receive the Multi-level Motivational Interviewing Training to enhance communication/support dynamics.

This measure will be continued in 2012.

B. Results: Geriatric/Infirmarary Services.

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 survey consists 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.

Individuals rate each item either "All the time," "Most of the time," "No opinion," "Not often," or "Never." Surveys are identified only by Treatment Team and individuals complete the surveys anonymously and place them in a locked Patient Survey Box located on the Wards.

Surveys are provided following the Comprehensive Recovery Services Planning Conference and following every Recovery Services Plan Review Conference thereafter. Surveys are anonymous, calculated by Team and Unit, and results made available to Staff, Patients, and Visitors. The overall response rate represents a reduction from the 2010 rate, but the response pattern is more positive in comparison to the 2010 data.

Team	<i>% Responses Received</i>			<i>% Responses All Time/Most Time</i>	
	<i>2010</i>	<i>2011</i>		<i>2010</i>	<i>2011</i>
E	48.6	28.5		86.3	86.0
F	18.3	17.8		80.6	90.0
Unit	33.5	23.2		84.4	88.0

Actions which were taken throughout the year as a result of these data:

- Continued to actively involve surrogate decision makers in development/review of Recovery Services Plan to enhance understanding of patient care/treatment/Recovery Plan.
- Continued 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 Recovery Plan.
 - Immediately addressed patient safety concerns:
 - Multiple Patient roommate changes
 - Increase patient observation status – C.O./1:1
 - Utilization of private bedroom for aggressive patients pending improvement in mental status and behavior.
- Social Work Staff continued to solicit regular feedback from family members and surrogate decision makers with immediate response to identified issues.
- Unit Nursing Leadership initiated a plan near the end of the year for C.N.A. “Focused Friends”, one of whom is assigned to each patient to assist patients with completion of the Satisfaction Surveys after their respective Recovery Service Plan Review Conference.
- Survey results are discussed in staff/shift meetings and disseminated to each Team along with graphs for staff, patient, and visitor access.

This measure will be continued in 2012.

C. Results: Extended Rehabilitative Services (ERS).

On ERS, Patient Satisfaction is assessed monthly with the assistance of a Human Services Care Specialist and is completed with the patients assigned to each ERS Treatment Team (H and J).

In the months of February, April, June, August, October, and December, all of the patients on ERS 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 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?

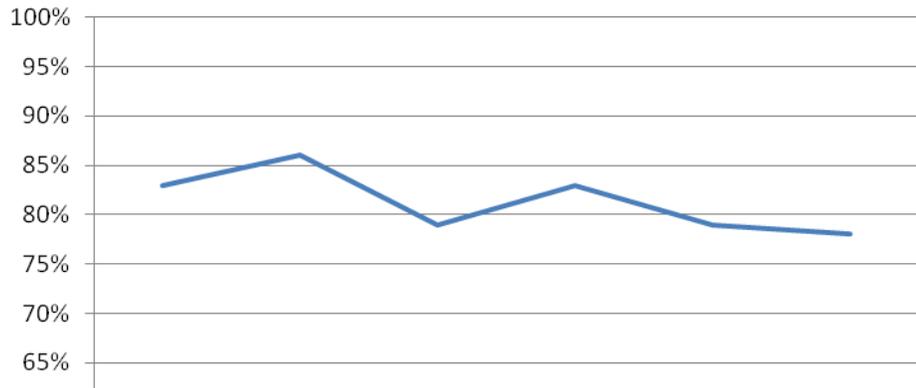
The purpose of these questions to elicit clear input regarding the patient’s perspective of the recovery process as well as to engage in a dialog on how to improve engagement in, and effectiveness of, the monthly Treatment Planning Conferences.

The responses are gathered and collated by the Human Services Care Specialist and presented to the Unit Programs Director for review and presentation/discussion at monthly Program Management Meetings. Issues identified in the survey process that require follow-up are addressed individually by the Programs Director or designated staff.

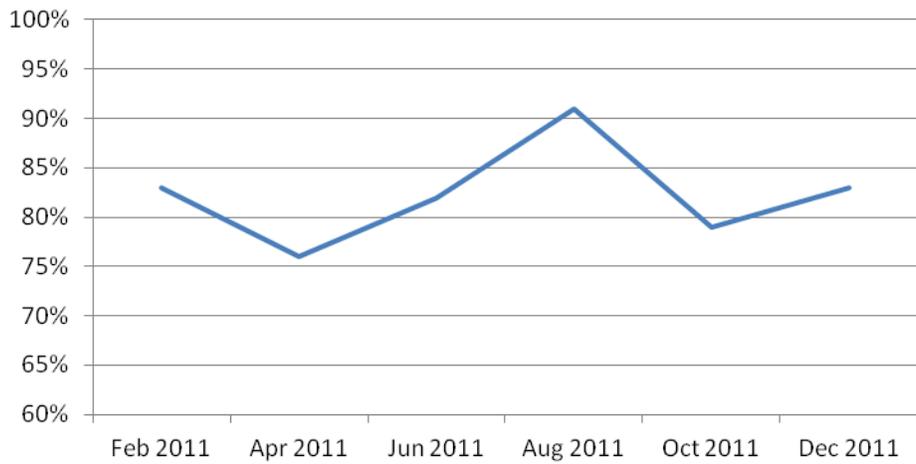
Attached are the results of the 2011 calendar year Patient Satisfaction review.

	Feb 2011	Apr 2011	Jun 2011	Aug 2011	Oct 2011	Dec 2011
Tx Team Includes Me	83%	86%	79%	83%	79%	78%
	Feb 2011	Apr 2011	Jun 2011	Aug 2011	Oct 2011	Dec 2011
Satisfied with DC Progress	83%	76%	82%	91%	79%	83%
	Feb 2011	Apr 2011	Jun 2011	Aug 2011	Oct 2011	Dec 2011
I Feel Safe Living Here	67%	73%	74%	83%	67%	78%
	Feb 2011	Apr 2011	Jun 2011	Aug 2011	Oct 2011	Dec 2011
Tx Team Listens to Me	83%	84%	89%	89%	79%	86%
	Feb 2011	Apr 2011	Jun 2011	Aug 2011	Oct 2011	Dec 2011
Staff Helps Me Resolve Problems	83%	78%	76%	86%	74%	87%
	Feb 2011	Apr 2011	Jun 2011	Aug 2011	Oct 2011	Dec 2011
Nsg Staff Help Me Accept Myself	87%	84%	82%	80%	79%	78%
	Feb 2011	Apr 2011	Jun 2011	Aug 2011	Oct 2011	Dec 2011
I Am Learning About My Illness	87%	78%	84%	80%	77%	86%

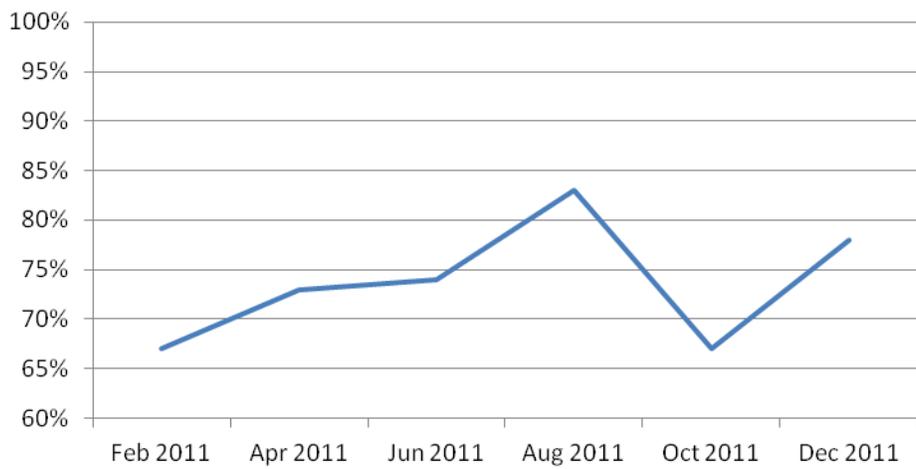
Tx Team Inclues Me



Satisfied with DC Progress



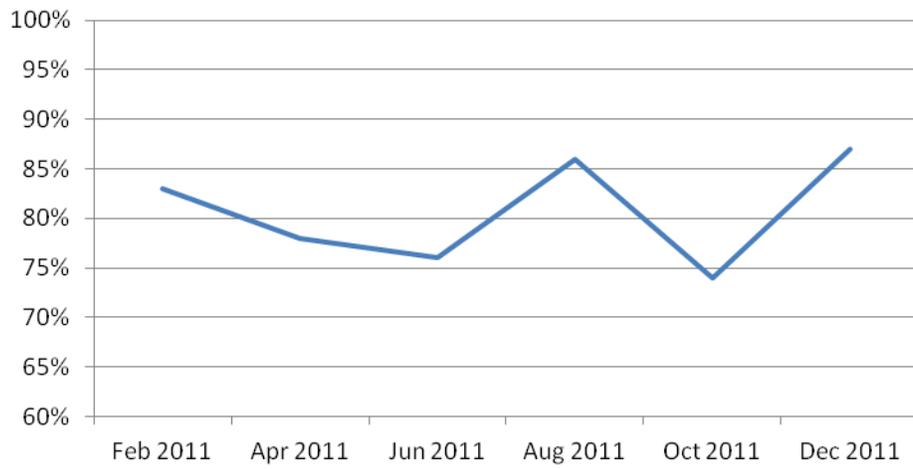
I Feel Safe Living Here



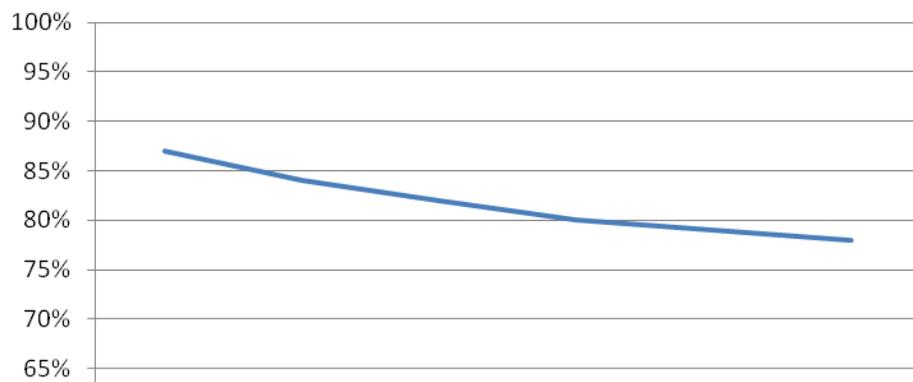
Tx Team Listens to Me



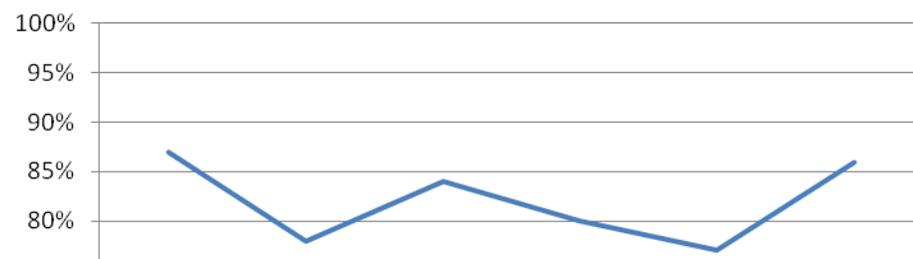
Staff Helps Me Resolve Problems



Nsg Staff Help Me Accept Myself



I Am Learning About My Illness



ERS Patient Satisfaction Summary 2011 - Review of Narrative Discussion Question Trends

January 2011: 8 Patients completed the narrative discussion questions survey with these trends:

How is your treatment going?

- Patients were divided about groups with the majority reporting groups and activities were going well, but several patients reported they did not attend groups and no desire to attend groups.
- Related understanding of medications, some expressed positive feelings about new medications that appeared to be beneficial. No prominent complaints about medications.
- Majority reported feeling actively involved in meetings with the team.
- Overall positive response.

How could your meetings with the team be more helpful to you and how can you help yourself prepare for the meeting?

- Most patients reported general satisfaction with the team meeting process, there was mention of increased family involvement and having more time in team meetings.
- Many expressed wanting more focus in discharge in team meetings.

March 2011: 24 Patients completed the narrative discussion questions survey with these trends:

How is your treatment going?

- Positive response regarding groups. Most reported enjoying groups and activities as offered.
- Overall, the vast majority of patients felt that their treatment was “good” but there was a small sub-group of patients who expressed concern about discharge issues, both related to wanting to be discharged and some fearfulness related to possible discharge.
- One year after the massive restructuring of Centralized Rehab Services groups the patients appear to have adjusted to the “new” scheduling and group procedures.

How could your meetings with the team be more helpful to you and how can you help yourself prepare for the meeting?

- Again, general satisfaction with the team meetings, some continued to express desire for more treatment team time and more focus on discharge.
- Vast majority of patients indicated that they were comfortable in talking with the team and felt prepared for scheduled meetings.

May 2011: 9 Patients completed the narrative discussion questions survey with these trends:

How is your treatment going?

- All but one patient reported positive feelings about groups. One patient indicated that the group offerings were boring and that she desired “real” groups. She chose not to elaborate on her feelings regarding what her preference for group activities would be.
- Most patients expressed satisfaction with current medication regimens with no specific complaints regarding medications.
- No prominent complaints about interaction with the treatment team, but some patients indicate that Recovery Reviews were “repetitious” and “boring”, but patients did report that they felt the team listened to them.

How could your meetings with the team be more helpful to you and how can you help yourself prepare for the meeting?

- Several patients expressed clearly the need to be open and honest with the team.
- Multiple patients expressed positive feelings for clinical staff and their interaction in team settings.
- No expressed concern about interactions with the team or being able to communicate with the team. Although there are still statements indicating that more team contact would be beneficial.
- Continues to be some dissatisfaction with the pace toward discharge and feelings that the team is somehow impeding discharge for a minority of patients.

July 2011: 22 Patients completed the narrative discussion questions survey with these trends:

How is your treatment going?

- Overall very positive responses to group activities with comments like “Groups are really good.” “I have groups five days a week, I’m very busy.” “They are alright, I like working with other people.” However, there were three patients who have negative feelings about groups stating, “I just don’t like groups.” “The groups are just too slow.” “I don’t go to groups, I don’t need them.”
- Continued expressions of positive involvement with team meetings and interactions with unit staff.
- Most patients report satisfaction with medication regimen but some state medications are “wrong” and that the doctor is a “dope pusher”. There were some statements related to feelings of having to take too much medication.

How could your meetings with the team be more helpful to you and how can you help yourself prepare for the team meeting?

- Lower volume of responses to this question during this period, many patients indicated “I don’t know.” Several chose not to answer the question. Most that did respond were focused on more rapid movement toward discharge and more time with the treatment team.
- There were limited negative responses about team interaction but overall there was little comment made to this question during this survey period.

September 2011: 8 Patients completed the narrative discussion questions survey with these trends:

How is your treatment going?

- Less than 50% of those approached to complete the survey chose to respond.
- Six of the eight patients interviewed indicated that they felt treatment was going well and that the team and all staff were being responsive to their needs. One patient indicated that her treatment was not going well and that she was not being treated well while here, she stated people “put words in my mouth” and “I backed into a corner here by the court.”
- The majority of patients surveyed reported feeling that they were progressing well and reported no prominent issues with their treatment or interaction with staff.

How could your meetings with the team be more helpful to you and how can you help yourself prepare for the team meeting?

- The majority of patients reported positive strategies for planning for their team meetings such as writing down ideas or having questions/concerns prepared in advance.
- With one exception patients reported feeling that the team listened to their concerns and made them an active part of their treatment. The one exception indicated that the team didn’t talk with her and only sat and stared at her during her meetings with the team. She stated, “I’m not the problem, the team is the problem, they were rude, I just want discharged.”

November 2011: 22 patients completed the narrative discussion questions survey with these trends:

How is your treatment going?

- Once again, mostly positive statements regarding treatment and activities offered. Common themes were: “Groups are good.” “They help me learn about myself.” “They keep me busy and out of trouble.” “I like getting off the ward to do things.”
- Most reported positive feelings regarding their medications and related treatment with statements such as, “the medicine keeps me calm.” “They keep me from fighting.” “My medicine is helping me get better.”
- A very small group of patients indicated that they felt as though they were over-medicated or that the medications were not beneficial. They stated that they had attempted to address this during team meetings.

- A small number of patients indicated that groups were not going well. One stated “I’m not going to groups any more, they don’t help.” Another related, “They are kind of boring, we do the same stuff all the time.”

How could your meetings with the team be more helpful to you and how can you help yourself prepare for the team meetings?

- Some expressed that they “just went” to team meetings but saw little benefit because they did not know when they would be discharged.
- Majority of patients continued to reflect positive interactions with the team and indicated no significant issues in interacting with the team.
- Several patients were able to relate a desire to have more information regarding expectations for discharge.

Actions taken:

- Individual meetings with patients with expressed concerns.
- Medication education by nursing and medical staff.
- Ongoing efforts to involve family and significant others in the recovery planning process. Including making increased efforts to offer conference calls to facilitate family involvement.
- Ongoing review with Central Rehab Services of group schedules to better meet patients’ wishes/needs.
- Ongoing medication monitoring and adjustments.
- Ongoing monthly meetings and reviews to assess patient satisfaction and address identified issues. This is completed at monthly Program Management meetings.
- Team and Program Management reviews of identified concerns.
- Medication changes/adjustments as needed and reviews upon requests.
- Discussion regarding patient perception of needing more time with the team. Patients will be encouraged to seek out team members for support when needed.
- Efforts to increase Clinical Services group programming through the addition of Social Work staff on the unit and return to full complement of Psychologists.

IV. Other Recovery-Oriented Programs, Activities, and Events.

The following is a listing of ongoing, hospital-sponsored or facilitated **peer support opportunities**:

- A. The Consumer Empowerment & Recovery Council (CERC). The SWVMHI chapter continues to meet monthly and the 3 officers of SWVMHI chapter and the Peer Support Specialists regularly attended the Regional Consumer Empowerment and Recovery Council (R-CERC) meeting. CERC is dedicated to helping make facility changes, is responsible for letting the facility know what is going on in the local CSBs and communities, as well as presenting updates in the committee work for state and national endeavors as it pertains to mental health. Consumers take part in committees such as education, budget & finance, legislation and make decisions about special trainings, telephone and letter writing campaigns.

- B. SWVMHI Community Roles Group. Newly admitted individuals are given “Welcome Kits” that have been prepared by the ERS Community Roles group. This group stresses the importance of volunteering and gives participants the opportunity to work together, learn new skills, and explore possibilities for volunteering once they return to their communities. “Welcome Kits” include basic hygiene items (toothbrush, tooth paste, comb, and deodorant). They also have a stress ball, puzzle pages, and Stress Relief Tips and Strategies. There is a paper insert with a message from the Community Roles participants: “This bag contains a few items we hope will make you feel welcome and let you know we’re here for you. We have experienced some of the same feelings you may be having now.”
- C. The Patient Activity Council meets monthly to plan special hospital-wide events and/or leisure events.
- D. Three “In Our Own Voice” presentations were conducted in 2012.
- E. Residential Unit Community Meetings are peer run by elected spokesmen and officers for the wards. With this group, individuals have increased say in choosing roommates, decorations, and arrangement of furniture
- F. Three members of the local CERC attended the Regional Budget hearings held at Abingdon Higher Education Center. Although they did not speak, they were able to hear requests from the community and support for SWVMHI.
- G. In May, 2012, CERC officers, patients, and staff participated in the Mental Health Awareness event by establishing one of four workshops for consumer involvement. The “Relaxation Station” drew crowds of staff and consumers to experience the sensory and relaxation equipment. Approximately 50 SWVMHI patients attended this event. SWVMHI Director, Cynthia McClaskey, Ph.D., received the GEM (Going the Extra Mile Aware for her commitment to recovery in southwest Virginia. DDBHDS Deputy Commissioner Olivia Garland, Ph.D., presented the award.
- H. In September, 2011, various recovery groups united to construct a Recovery Quilt. Each square of the quilt is recovery oriented with themes such as “what recovery means to me” or “what things help me in my recovery.” The purpose was to allow individuals to visually represent a personal recovery experience. The quilt and the Photo Voice display were taken to the VAPRA Conference November 30 through December 2, 2011 where it was hung in the main event hall for the duration of the conference. Cards were made of each square and were marketed to raise funds in support of Christmas activities and gifts for all patients.
- I. SWVMHI consumers made Apple Butter and entered it into the Chilhowie Apple Festival in September, where it won third place.
- J. The 20th Annual SWVMHI Family and Friends Day was held in Sept ember, 2012.
- K. National Wellness Week, as designated by SAMHSA, was celebrated from Sept 19 through 23 by staff and patient participation in specially designed events that

represented the 8 Dimensions of Wellness. This was the first year that individuals with mental illness were included in the nationally recognized and celebrated event.

- L. Mental Health Creative Ideas Committee
 - 2012 – 10th Annual Event held in May, 2012 with over 500 individuals attending.
 - Future Event are planned with goal to support increased peer interaction. The Creative Ideas Committee continues to plan Mental Health Awareness events for the spring of 2013.

V. Other Information Related to Wellness and Recovery.

- A. Personal Safety Tool— Continues to be developed and information used by the Teams to develop contingency and behavior plans, also used to develop individual comfort kits
- B. Sensory Connection
 - Comfort rooms – Continue to be available on each unit, each still contains a comfort chest & a guidelines for use
 - Retreat rooms have been in use on the A/B Admission ward for over one year and continue to be available for use by all disciplines
 - Welcome Kits including calming, stress relieving sensory items continue to be assembled by Patient Volunteers and given to all new admissions
 - Weighted blanket and weighted animals are available for individualized sensory sessions
- C. Recovery services have been continued to include areas of Treatment, Enrichment, and Rehabilitation. Central Rehab Services are organized into *Living, Learning, Working, Social and Wellness* areas. All offered services continue to be synchronized in a single documented schedule that includes psychology, social work and on ward services.
- D. Expansion of Wellness Program
 - Hired a full time chaplain in August of 2011. He is currently assisting with MICA groups, conducting Spiritual Wellness sessions, supporting individuals' spiritual needs through chapel services, coordinating the volunteer chaplains, and providing for individual needs and personal events.
 - Wellness Week was celebrated in conjunction with the SAMSHA in September.
 - Relaxation group has been initiated
- E. Community Integration tracks continue
 - Admission 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 Therapy staff to give patients on the Ready for Discharge list an opportunity to integrate, with support into the community setting.

VI. Making the Experience Safer, Better/Physical Plant.

- A. New seclusion rooms. In response to the May 1, 2011, revisions to Departmental Instruction 604, Physical Requirements for State Hospital Seclusion Rooms, SWVMHI made the decision to update the seclusion rooms even though they would have been grandfathered in. It was believed that modifications to the rooms would not only meet the DI but more importantly, increase the safety and comfort of the individuals we serve as well as staff.

In each room the seamed padding was removed and the room was thoroughly cleaned. The removal of the padding not only provided a better environment from an infection control perspective, but it also allowed for natural light in the room. In place of the padding, Gold Medal Safety Padding was installed. Plexi-glass was installed over the window with part of the plexi-glass painted for privacy. The room was painted a pastel color. A clock is on the wall outside of the room and is visible from the room. A mattress is on the floor. All areas of the seclusion room are observable from outside the room. There is a bathroom in the seclusion suite.

Goal for 2012: It is noted that the overall blue color of the rooms could benefit from being “broken up” with the addition of another color. The feasibility of this will be explored and if it is determined that the Gold Medal Safety Padding can be painted, this will be done.

- B. Continued use of Comfort Rooms. The use of Comfort Rooms was implemented during spring, 2009. The primary uses of these rooms are to provide individuals with a private area with a variety of sensory aids to encourage successful self-management of difficult emotions. Comfort Rooms give individuals a place to go when feeling distressed, but still in control of their behaviors, and allow them to be in an attractive, yet separate area. Upon leaving the room, individuals are asked to complete a brief evaluation/log to provide feedback to measure his or her response to the experience.

There are two on the Acute Admissions Unit (one on Wards AB and one on Wards CD), one on the Geriatric Unit (Wards EF), and three on the Extended Rehabilitation Services Unit (Wards H, I, and J).

Information about and encouragement to use the comfort rooms is provided upon admission to the ward. New nursing staff members are oriented to the concept of comfort rooms within their first month of employment in the classroom. Once on the unit, staff are reminded about promoting use of the rooms through weekly program management meetings and in monthly shift meetings. During these meetings staff members or individuals we serve may provide any recommendations about the comfort rooms and share anecdotes about the use.

The Geriatric Unit Comfort Room is referred to as “The Elderberry Comfort Room and Activity Room.” Since the individuals on this unit are less independent and less

apt to initiate use of the room in the same manner as the Admissions or ERS unit individuals, it has been set up to use for both individual and group needs. When an individual would like to participate in activities that are calming or provide diversion, some of the sensory options are: non-violent Wii games congruent to Geriatric cognitive levels, DVD player with movie and music options, television, water fall that can be turned on for audible and visual soothing, sound machine with options to listen to soothing music, waves or other, vibrating pillows for physical sensation, two glider chairs for movement, comfort, and/or physical activity; reading material of various selections, and contemplating the attractive wall murals

A log is kept of responses after using the room. All comments have been positive, and responses include “love the comfortable glider chairs,” “enjoyed the quietness of the room,” and “the scenery of the wall mural as well as looking out the window was nice on a cold rainy day.”

Extended Rehabilitation (ERS) Unit. Since the reconfiguration of ERS, one comfort room was left behind on Ward G. Ward H does not have an “official” comfort room yet, although there are quiet areas available for the individuals we serve. In 2011, there were about 300 episodes of comfort room use this year on ERS. All comments about the rooms have been positive. Most individuals say they enjoy using the rocking chair and listening to music. Items used most often include: music options, reading materials, stress balls, mood cubes with sounds and lights, comfortable furniture, and rocking chairs.

General Comfort Room Goals for 2013/ Comfort Room Continuing Improvement Plans for 2012:

- Many of the individuals we serve enjoy music for relaxation, so expanding on our music collection would also be part of our future improvement efforts.
- Replacement of sensory items, such as stress balls, coloring sheets, modeling clay, etc. will continue to be ordered and replaced due to extensive use, and damage to some items. Funds are allocated each fiscal year to budget for the purchase of these items to be replaced.
- A literature rack with informational brochures is also routinely re-stocked in the comfort room. Additional education information related to new or prevalent mental health issues in 2012 will be obtained.
- Continued education and communication to staff and the individuals we serve are an integral part of the success for the comfort rooms on the units.
- To increase participation in completing guest surveys, for the comfort room, additional surveys will be placed in the dayroom literature racks and at the nurses’ station. Nursing staff will review with the individuals we serve during community meeting groups about the importance of providing feedback on the comfort room surveys and the value of their suggestions.

- Re-create the third Comfort Room on ERS and continue to publicize its usefulness during unit meetings.

Comfort Room Conclusion. The facility is striving to seek new and innovative ways to continue encourage individuals to learn new coping skills, to further efforts toward recovery, as well as to reduce the use of seclusion and restraints. The implementation of our comfort rooms are part of that effort. Our mission is to assist the individuals we serve on their road to recovery. To that end, we will continue to work towards a seclusion and restraint free environment.

Additional milieu enhancements in 2012:

- The Geriatric Unit has improved the milieu to be more 'home-like' and utilizing Recovery Principles with activities in the following ways.
 - Hand-painted quilt squares on the wall of the Wards and Dayroom;
 - Bright-colored home-made Quilt hung in the Dayroom;
 - New courtyard furniture (table, chairs, and bench) for comfort and safety;
 - Active Patient Council for planning activities, and special events;
 - Weekly piano music;
 - Weekly Pet Therapy;
 - Grooming group twice weekly for men and women for self-esteem;
 - Special snacks/seasonal foods (i.e. bean breaking, fall cupcakes, and Christmas candy making)
 - Accommodations made for family picnics;
 - Country music band and church groups for evening activities; and
 - Special events, including Dandy Don (music and props); Ice Cream Making; St. Patrick Day Celebration; Fall Festival; Bingo (everyone wins a prize); Veteran's Day Celebration; and Birthday celebrations
- Moves of the individuals we serve to bigger wards on ERS in 2011
 - The Extended Rehabilitative Services Unit (ERS) made significant environmental changes through utilization of vacant space on Ward H. Beginning on July 13, 2011, each of the three ERS wards was transitioned to different space within the facility. The initial move involved individuals

residing on Ward J moving to Ward H. The second transition of individuals residing on Ward I to Ward J was completed on July 27, 2011, and the third move of individuals residing on Ward G moving to Ward I was finalized on August 10, 2011. Each of these moves resulted in an increase in available space, rooming options and overall comfort for the individuals we serve.

- The increases in available living space and bedroom options are anticipated to have a positive impact in regard to ongoing reduction in the use of seclusion or restraint by allowing more personal space for individuals in our care as well as increasing options to alter roommate assignments to facilitate more positive interpersonal relationships on the wards. These moves also increased the on-ward activity space to allow for improved programming options within the milieu of the unit. Increases in personal living space are anticipated to reduce interpersonal conflicts and create a calmer, more consumer-friendly environment to facilitate recovery.
- Ward C/D Milieu Enhancements 2011 including the purchase of the following items to make improvements to the patient-care areas:
 - New furniture, including loveseats for each hallway, new stackable chairs for the dayroom area, and tables for the activity rooms.
 - Communication boards to facilitate communication skills with the individuals we serve who may have communication issues, such as speech / hearing impairments or other disabilities.
 - New linen hampers for each hallway and the tub room.
 - A new shower chair for the ward.
 - Vinyl bed wedges for elevation of the head of beds as ordered by medical professionals.
 - For improvements to the comfort room, a bookcase was added. Sensory kits and sensory items were purchased to stock the comfort chest. These items included: stress balls, cross-word puzzles, sensory balls, and game sets, etc.
 - Bed and wheelchair alarms for fall prevention.
 - Outside games along with storage containers for these.
 - Storage cabinet for Activity Room C-105 for craft / art / group supplies
 - New Equipment Purchases for Medication Rooms and for Medication Safety, including :
 - 2011 Nursing Drug Handbooks for all Wards

- Nine New Medication Carts: Two for Ward AB; two for Ward CD; two for Ward EF, and three for Wards I, J, and H
- Electric Pill Crusher for Ward EF
- Digital Thermometers for the Medication Room Refrigerators (All)
- New Refrigerators for the Medication Rooms (All)
- Anti-fatigue Mats for all Medication Rooms (Admissions and ERS)
- Insulin Bins with High Alert Stickers for all Medication Rooms (All)
- New Glove Racks for all Medication Rooms
- Double Lock Narcotic boxes for refrigerators in all medication rooms

C. Plan to re-do the Admissions Suite area

Much preliminary work has been completed by a workgroup led by Jim Lundy. Goals for 2012 include the implementation of changes to enable the admissions process to be carried out in a more welcoming manner.

VII. Staff Development & Training.

A. Enhancements to TOVA Training. SWVMHI staff attended training primarily to meet the biannual recertification requirement for instructors. Listed below are three items that are enhancements or possible program strengths that are somewhat specific to our facility:

1. The SWVMHI TOVA program incorporates data collected from the *SWVMHI After Code Processing Forms* to continuously monitor and improve the effectiveness of interactions between staff and the individuals we serve during behavioral crises. Class discussions focus on therapeutic practices and interventions that have resulted in positive outcomes as well as developing trends or issues where improvement is indicated.
2. Specialized TOVA training was implemented for medical and pharmacy staff. Part one of the training is an online course that emphasizes the core concepts of the TOVA program and the facility's commitment to reducing the use of seclusion and restraint. Part two is an instructor-led session that includes a demonstration of the physical skills/hands-on restraints, a written test on the core concepts of the program and an opportunity for discussion.
3. The SWVMHI TOVA instructional team consists of eleven active instructors: eight direct care staff on all three shifts and three staff development coordinators. This team actively promotes the use of therapeutic, non-physical interventions to manage behavioral crises. This therapeutic approach includes at a minimum, using the least restrictive intervention possible and reserving the use of seclusion and restraint exclusively for emergency situations where less restrictive options are non-viable for keeping everyone safe and unharmed.

Goal for 2012: Continue to implement an excellent TOVA program, emphasizing Seclusion and Restraint reduction and Trauma-Informed Care.

- B. Road Trip Training (revitalized in 2011). SWVMHI's Road Trip Training was based on SAMHSA's 2003 plan entitled "Road Map to Seclusion and Restraint-Free Mental Health Services," written to assist facilities to reduce and ultimately eliminate the use of seclusion and restraint in behavioral health care settings. Select information from the SAMSHA plan has been used as the foundation for SWVMHI Road Trip and additional information was added specific to the challenges of providing services in southwest Virginia and according to the Mission and Values of SWVMHI.

This training was initiated in 2007, with revision/update in 2008. Leadership personnel in each of the four residential units of SWVMHI were initially trained in the content and presentation methods this curriculum. In 2007 and 2008, all three shifts on each unit participated in a one day training session, resulting in a total of 261 staff trained. In the spring of 2010 and summer of 2011, the curriculum was revisited and the curriculum was added as a component to the new employee orientation so that every employee hired is exposed to these concepts. Since that time, an additional 370 staff have attended the new employee orientation version of the Road Trip.

The presentation aims to increasing the knowledge and skills of service providers, administrators and consumers on alternatives to the use of seclusion and restraint. It is a tool to assist everyone to understand and perform competently in our system transformation so we may create and implement systems and services that support and facilitate recovery, promote resilience while eliminating seclusion and restraint. Through the following content, this information is intended to build bridges between the individuals we serve and providers. The curriculum is written to include the perspective of the individuals we serve to assist providers to work from a consumer- based philosophy and to recognize recovery and wellness are essential in providing alternatives to the use of seclusion and restraint. Trauma informed care principles is incorporated in this training.

Curriculum Content:

- Working by the Mission and Values
- Recovery and Resilience
- Incorporating Personal Experiences: Seclusion and Restraint Issues and Assumptions
- Recognizing Our Strengths
- Our Culture and Our Staff
- TOVA
- Communication Skills
- College of Direct Support
- Supervision and Coaching
- Recognizing the Impact of Trauma
- New Sensory Strategies

- Key Elements of Debriefing

- C. Motivational Interviewing Training. Motivational Interviewing is a mental health best practice aimed at helping persons to find their own motivation for making behavioral changes to enhance their likelihood of success. The approach has the associated advantage of increasing an individual's recognition that they are the most important partner in the healing alliance and consequently reducing the perception of individuals that they are being coerced. Staff persons trained in this approach are better able to avoid or resolve conflicts with the individuals we serve through verbal interaction, and consequently we believed it would help us to reduce the use of seclusion and restraint if all of our staff could apply this approach in interactions with patients.

SWVMHI began a process one and a half years ago of training our staff in this approach beginning with obtaining funding to have an outside trainer train a core group of about 40 clinicians and supervisors in clinical and supervisory Motivational Interviewing skills. Subsequently that group has worked on developing training programs adapted to this setting and the types of interventions various professionals have with the individuals we serve. Approximately 150 Clinical professionals (registered nurses, psychologists, social workers, psychiatrists, and rehabilitation staff) completed training in the use of these skills in clinical interventions and recovery services planning. The remaining staff persons who have routine interactions with the individuals we serve (Licensed Professional nurses, psychiatric aides, and admission clerks) are halfway through a six- hour course of training. All of this training has involved practical application of the skills under observation in addition to instruction.

In 2012, we continued to train staff in Level I and Level II Motivations Interviewing, assuring that implementation of MI is noted in Employee Work Profiles. Before the end of the year, meet together with the Instructors to assess the need for further modifications/changes to the program and to set additional goals.

- D. Use of Personal Safety Tool

The Personal Safety Tool was designed to be used as soon after admission as possible to give the staff an opportunity to sit one-to-one with a newly admitted individual and begin to develop a joint plan to use when and if a crisis occurs.

The components of the tool (triggers, warning signs, and crisis prevention strategies) provide a personal plan that can be implemented early on to prevent or at least lessen the severity of a crisis. The process of reviewing these areas is an early way of letting the individual know the staff is supportive and keenly interested in assisting them to avoid negative experiences. The individual identifies situations that may initiate digressing behavior and then they share the warning signs that will alert staff to begin offering alternative strategies. The strategies are specific to the individual and identify what works for them. The person may choose from the

strategies listed and they may also write down other tactics that are unique to themselves.

The remaining two areas of the Tool are “Seclusion and Restraint” and “Trauma History.” These are left to the end of the Safety Tool because they may denote intensely negative experiences. This information sheds valuable light upon the past and gives staff insight as to the person’s feelings and coping ability relative to past trauma. Seclusion and/or restraint may simulate past distress and should be avoided to prevent retraumatization.

The Personal Safety Tool is a document completed by a member of the team within 72 hours of admission. The form prompts the individuals we serve to discuss any history of seclusion or restraints. The form also gathers information as to what might trigger an individual to be agitated and what interventions would assist in calming them down. Upon completion, the original is placed in the individual’s chart and a copy is maintained in a three ringed notebook at the Nurse’s Station for staff to access and review. It is hoped that the Patient Safety Tool will assist the individual and staff to be aware of the individualized triggers. The form also will assist staff to know what the individual’s preferences in de-escalation are, in an effort to calm them down before the crisis escalates.

- E. Recognizing Best Practices, Recovery Heroes: Positive recognition for effective staff interactions that prevent seclusion and/or restraint began in October, 2010, with the monthly SWVMHI Employee Newsletter. This regular article gives positive recognition to a featured employee who worked on a patient-care unit and who demonstrated therapeutic interventions to successfully manage a difficult situation without the use of seclusion or restraint. A description of the event as well as a summary of the effective techniques used, along with the employee’s picture, offers employees administrative acknowledgement and appreciation. It also communicates particularly effective techniques to all employees and helps reinforce their continued use.

Employees who have been recognized are excited when the employee newsletter comes out and they see they are the Hero for the month. They stop her in the hallway or call her on the phone to express thanks for the feature. Many have stated that they shared the article with their friends and families and are proud that their success was highlighted. Recovery Hero articles have given renewed passion to the employees on the units by providing acknowledgement for the compassionate, often times stressful, work that they do. It also promotes actions to decrease seclusion or restraint by being person-centered.

In 2012 we continued to run Recovery Heroes articles monthly recognizing exceptional performance of staff.

- F. The Value of the Direct Service Professional Career Pathway Curriculum. The Direct Service Professional (DSP) Career Pathway has provided a mechanism by which our Direct Service Associates (DSAs or Psychiatric Aides) have gained a rich learning

environment, skill development, and gained increased competence in assisting the individuals we serve in their recovery.

Successful completion at each level in the pathway requires the DSA to demonstrate and maintain proficiency in eight competencies (Advocacy and Individual Empowerment; Communication; Community Living Skills and Support; Crisis Intervention; Documentation; Facilitation of Services; Information Gathering; and Organization Participation). These competencies are observable and measurable behaviors and have distinct progression to each level which is validated by supervisors and managers. These competencies are directly tied to excellence on the job.

In 2012, (70 percent) of our current DSA staff have successfully completed Level I and 30 percent are currently pursuing Level II, which includes taking on-line college classes. In January, 2012, SWVMHI had 18 DSAs who successfully completed 12 hours of college credit and competency validation. They received a Career Studies Certificate in Behavioral Health.

The on-line college courses for Level II include:

- Becoming a Helper – Concentration on effective helping relationships in assisting the individuals we serve with their recovery.
- Contemporary Behavior Therapy – Learning about Cognitive Behavior Therapy: coping skills; acceptance and mindfulness based on interventions, self-control, and reinforcement.
- Looking Out/Looking In – Learning to communicate in a principled manner. Presents communication not as a collection of techniques, but as a process to engage the individuals we serve.
- Abnormal Psychology and Life – Focused on a dimensional and integrative perspective toward mental disorders with emphases on reducing stigma (using clinical cases and personal narratives).

Some interesting comments have been made by staff who completed Level II which validate a paradigm shift in the culture of assisting the individuals we serve in their recovery:

“I have a better understanding of what our clients are dealing with; we have fewer codes, more listening, and generally a calmer, more therapeutic atmosphere.”

“I have observed staff having more patience with clients, listening and trying lots of techniques we have learned to have fewer codes.”

“Clients are like us, just with more problems in the end, we all are working toward recovery. I have observed staff talking with clients more, interacting more, and offering the client more choices.”

“I look at the individuals I serve in a different light. They are inspiring to me and make myself want to be more helpful to them. We are all different in some shape or form and we all have problems, but we must get beyond our problems in order to help the individuals we serve.”

On-line classes for Level III begin February, 2012. We anticipate that all 18 who have completed DSP Level II will participate in Level III classes: When the students graduate from Level III, they will have 36 college credit hours towards an Associate’s Degree in Human Services.

In 2012, we continued to promote Levels I, II and III for staff, thus expanding the education and skills of DSA staff.

- G. Nursing-led Patient Groups on Ward. During the first quarter of 2011, each unit developed notebooks for Nursing-led Groups. The forms used for logging the title of the group, content, and level of patient participation were revised. At the Nurse Practice Committee in April, Nurse Managers, Head Nurses and Psychiatric Lead Aides were given additional training for Small Group Leadership Techniques. Further plans were made for each unit to develop a timeframe with conducting daily nursing led groups/activities and to ensure group leaders have back-ups identified. Throughout the year, Unit Nurse Coordinators monitored groups to ensure that they were not cancelled due to insufficient staffing.

Nursing Led groups was a skill standard in seven of the eight competency assessments in Levels I of the Direct Service Providers (DSP) Career Pathway. Each of the 102 Direct Service Associates (DSA = our Psychiatric Aides), which is 70% of our current Aide staff, was assessed to develop skill in:

- serving as the contact person to assist and review patient goals (goal setting),
- being supportive and providing positive feedback during group activities
- teaching patients in ADLs, building and maintaining therapeutic relationships, socialization skills, and discharge planning activities
- incorporating the strengths of the patients in group activities
- documenting group activities and reporting outcomes to the charge nurse

Psychiatric Aides who met criteria for Level II (30% of those completing Level I) continued being assessed in leading groups and teaching/observing co-DSAs in nursing led group activities. Those skills were:

- serving as co-leader of groups to help individuals develop coping skills for complex personal issues(human development, sexuality, money management, disaster management, risk taking. Each DSA completed a Group Leadership Self Learning module
- teaching individuals to recognize barriers, challenges and opportunities for developing relationships

- assisting individuals in making informed choices that consider risks and consequences
- teaching and assisting individuals to “find their voice” when interacting with the treatment team, family and community contacts

In 2012, the Psychiatric Aides, with the guidance of the Coordinator for Nursing Staff Development, are developing a master manual of nursing-led patient groups and activities to be done on the wards. The manual will identify learning objectives and course content.

- H. Health Promotion/Training in Tai Chi. Health promotion activities that benefit SWVMHI employees also benefit the individuals we serve in terms of fall reduction, pressure wound avoidance, and effective coping skills. With this in mind, an interdisciplinary workgroup from the Accident Review Committee sponsored an open house event for employees to drop in and participate in learning and applying techniques to promote a SAFETY CULTURE at work and related to patient care. This was held on September 22, 2011, and titled: “We’ve Got Your Back.”

The Open-house promoted an employee and patient safety culture by associating:

- Tai Chi education and demonstration with physical and mental health benefits,
- Stress management and nutrition application promoting injury prevention, and
- Lifting and positioning techniques through proper body mechanics and use of equipment.

Almost 100 employees participated and almost 85 percent of these participants responded that they gained new information for health/safety promotions in the workplace at an “above average” ranking. The success of this event is supportive of our recovery initiatives, culture of safety, and injury prevention.

Incorporating Tai Chi into SWVMHI Programs. The use of Tai Chi has been proven to be effective in the reduction of stress. This is a totally new approach in our facility and has captured the enthusiasm of the individuals we serve as well as staff alike. For the individual, the process of learning and practicing Tai Chi offers the opportunity for very positive and exciting interaction with instructors and other students.

Slow, rhythmic movements strengthen muscles, improve balance, and help to develop core strength and focus. Blood pressure is lowered. Improved concentration and a sense of accomplishment encourage positive interactions that we believe will be another tool to help us to reduce the use of seclusion and restraint by allowing the individual to better process and respond more positively to difficult situations.

- I. Making Medication Practices Better and Safer: Implement recommendations in approved revision of DI regarding Seclusion/ Restraint implications of administering IM medications and assess for effectiveness.
- A workgroup was formed in September 2011 that consisted of the Director of Quality/Risk Management and the Unit Nurse Coordinators to review the DI, policies, and forms related to the DI.
 - Training was developed by this workgroup and education was conducted by the Unit Nurse Coordinators with the Head Nurses and the Psychiatric Lead Aides on September 29, 2011, in a “Train the Trainer Session.”
 - All Nursing Staff were trained regarding the DI during the month of October, 2011.
 - The Seclusion or Restraint Initiation and Monitoring Form Parts I and II were revised to include the section related to medications.
 - The Physician’s Seclusion or Restraint Order Form was also revised at that time.
 - Policy #3033, Emergency Use of Seclusion or Restraint, was also revised to reflect the changes as well.
- J. Self-Administration of Medications. A three-month pilot plan for self-administration of medications was started in November 2011 and ended in January 2012. Two patients on the Extended Rehabilitation Unit were participants in the plan, which involved interdisciplinary coordination with nursing, pharmacy, medical, social work, psychology, and occupational therapy. A Nurse Extern in a master’s degree program through King College identified this as her advanced-practice project and conducted an extensive literature review for evidenced-based best practices. Patient skills assessment and education was conducted, and the process was established for supervised self-administration of medications. One patient was discharged before the project ended; he remains in the community. The other patient continues successfully on the program.
- The Safe Medications Practices Committee (SMPC) has identified a goal for 2012 to expand the project to include up to five patients. Additionally, developing a more efficient process of providing patient medication education, including cultural considerations, health literacy, and increasing adherence to medication regimens are SMPC goals for 2012.
- K. Enhancing Understanding of the Impact of Trauma/Trauma Informed Care. Although six nurses attended a day-long training at Wytheville Community College in 2010, and information has been incorporated into Road Trip Training, it is recognized that there is more that can be accomplished in this area. The Facility Director was selected to attend a SAMHSA conference on this topic in November, 2011. As a result of this, SWVMHI has been selected as a recipient of a SAMHSA grant to further understanding of this important topic.