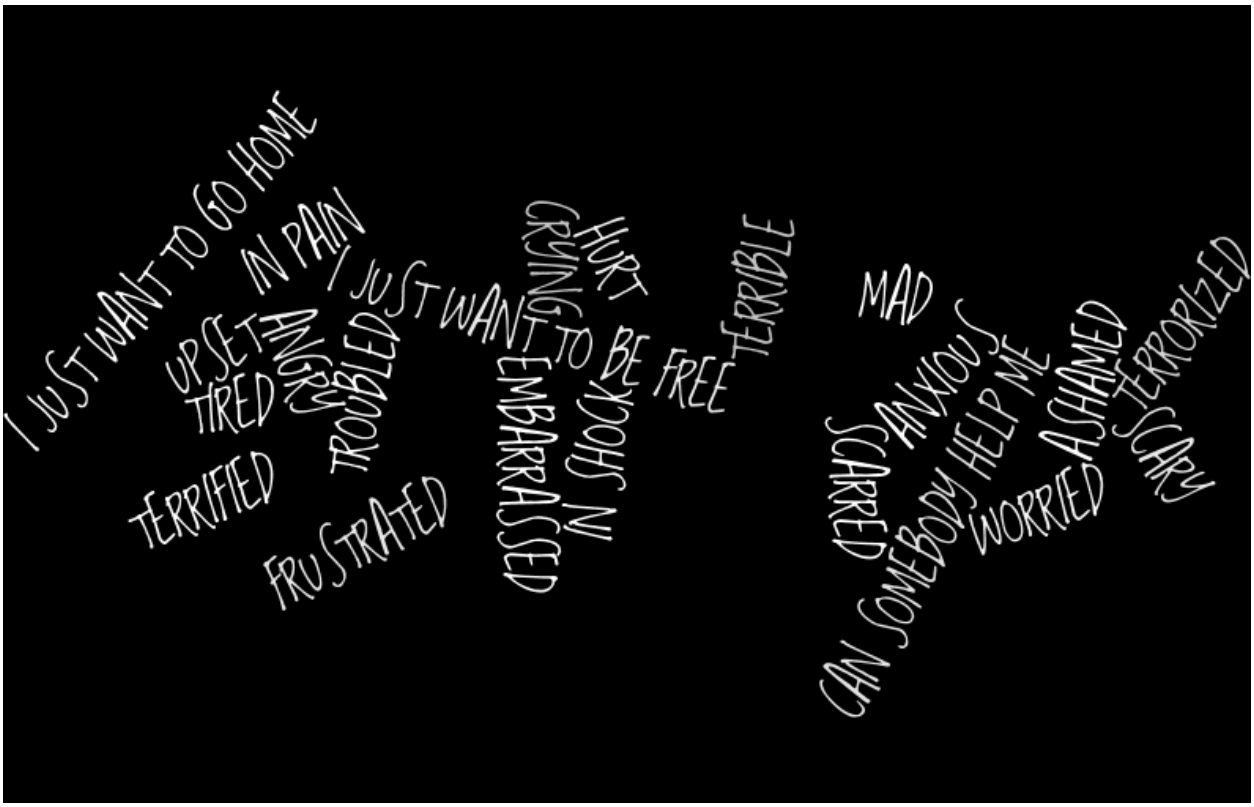
TREATMENT FAILURE:

The State of Services at Eastern State Hospital

a report from the disAbility Law Center of Virginia

August 2015

prepared by Erin Haw and Kara McCallum



Words used by consumers to describe how it felt to arrive at Eastern State Hospital in restraints.

INTRODUCTION:

The disAbility Law Center of Virginia (dLCV) is the federally mandated protection and advocacy system for Virginians with disabilities. dLCV's protection and advocacy services are legally based and authorized by a number of federal statutes, including the Protection and Advocacy for Individuals with Mental Illness Act. Advocates and attorneys knowledgeable about disability rights provide both individual representation and systemic advocacy on behalf of qualifying individuals with disabilities throughout the Commonwealth. dLCV maintains a regular presence in Virginia's publicly operated mental health hospitals, including the Commonwealth's oldest and largest – Eastern State Hospital (ESH). dLCV monitors facility conditions at these hospitals, investigates abuse and neglect, and represents individuals whose rights have been violated.

This report provides an overview of the state of services at ESH with a specific focus on the facility's adherence to seclusion and restraint best practices and the guidelines adopted by the Department of Behavioral Health and Developmental Services (DBHDS). The findings in this report are based on direct observations, meetings with key hospital representatives, consumer interviews[1] and record reviews, facility-specific seclusion and restraint data, state and facility policy reviews, and a review of nationally recognized and professionally accepted best practices.

DBHDS policy defines ***seclusion*** as the involuntary placement of an individual alone in an area secured by a door that is locked or held shut by a staff person, by physically blocking the door, or by any other physical or verbal means so that the individual cannot leave it.

DBHDS policy defines ***restraint*** as the use of a mechanical device, medication, physical intervention or hands-on-hold, to prevent or limit the ability of an individual to move his body or a medication when it [is] used as a restriction to manage the individual's behavior or restrict the individual's condition. There are three kinds of restraints: mechanical, pharmacological, and physical.

Seclusion and restraint are dangerous and coercive interventions often used in the name of safety at ESH and other psychiatric hospitals. However, both interventions are widely recognized by mental health experts and professional organizations, such as the National Association of State Mental Health Program Directors (NASMHPD) and the Substance Abuse and Mental Health Services Administration (SAMHSA), as **treatment failures**.

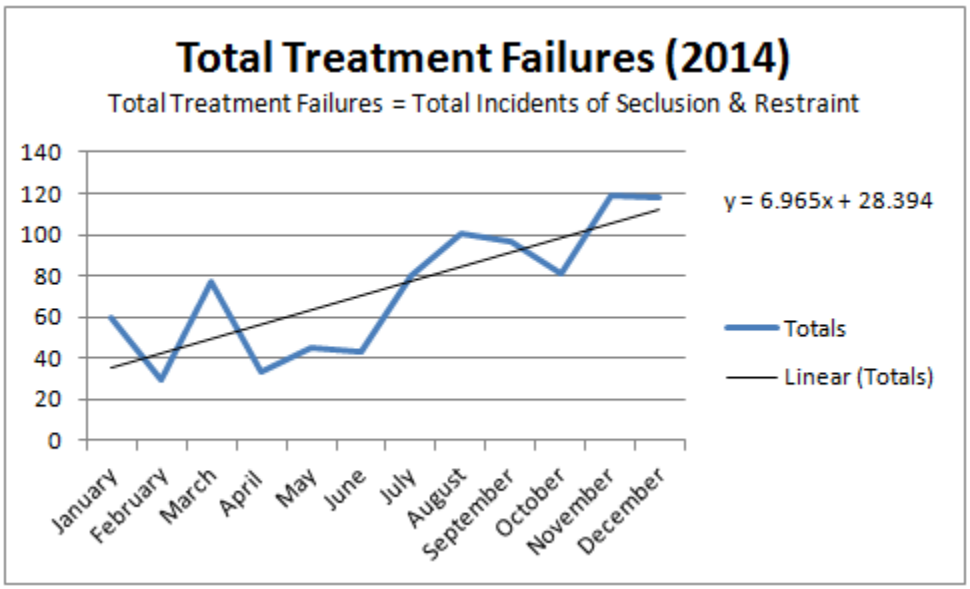
Eastern State's far too common practice of secluding and restraining individuals represents one of the most pervasive rights issues affecting individuals committed to the Commonwealth's care. Risks associated with these interventions include physical trauma (including death) and psychological trauma. ESH is charged with providing care to vulnerable individuals, the vast majority of whom are held at the facility involuntarily and have experienced trauma.[2] Other providers have successfully reduced or eliminated seclusion and restraint by offering services and fostering an environment entrenched in the tenets of trauma-informed care.

[1] Appendix A: dLCV Consumer Questionnaire

[2] Interpersonal trauma and posttraumatic stress disorder in patients with severe mental illness: demographic, clinical, and health correlates; Mueser et al, 2004.

Mental health experts advise the use of universal precautions[3] to avoid inadvertently causing distress to individuals who have experienced previous trauma. At this time, ESH has not implemented universal precautions.

Monthly seclusion and restraint data from 2014 furnished by ESH reveals an upward trend in the number of treatment failures at the facility. We applied a linear trendline to the data provided by ESH that shows seclusion and restraint episodes increasing by roughly seven incidents each month.



DBHDS provides specific guidance regarding the use of seclusion and restraint in state operated facilities in Departmental Instruction 214. This Departmental Instruction, released in 2010, includes a seclusion and restraint philosophy statement. In this document, DBHDS voices a commitment to creating a trauma-informed system of care and eliminating the use of seclusion and restraint.[4] The Departmental Instruction also requires state facilities to produce annual plans to reduce the use of seclusion and restraint. ESH has developed such a plan and has adopted the *Six Core Strategies for Reducing Seclusion and Restraint Use©*[5] to achieve this goal.

For the past year, dLCV has been monitoring ESH for indicators of the presence of trauma-informed care. Provision of trauma-informed care is closely linked to the reduction of seclusion and restraint. Because ESH has adopted the *Six Core Strategies* as their framework for eliminating seclusion and restraint, dLCV focused on the key indicators in the *Six Core Strategies* model to evaluate trauma-informed care at ESH.

The *Six Core Strategies* is a clinical model and evidence-based practice designed for use by institutions providing mental health care. This model was designed and approved by NASMHPD and endorsed by SAMHSA. The *Six Core Strategies* program works to change the way care is provided in these settings by focusing on the prevention of conflict and violence, the reduction in use of seclusion and restraint, the

[3] Universal precautions are steps taken to create an environment that makes all people feel safe and in control. It involves providing unconditional respect to people and being careful not to challenge people in a way that produces shame and humiliation. Part of universal precautions is the presumption that all people have been exposed to trauma and therefore would benefit from trauma-informed care.

[4] Appendix B: DBHDS Seclusion and Restraint Philosophy Statement

[5] Appendix C: *Six Core Strategies for Reducing Seclusion and Restraint Use* ©

implementation of trauma-informed care principles, and the fullest possible inclusion of the consumer in his or her care. Below is an overview of dLCV's assessment of the presence of the *Six Core Strategies* at ESH. dLCV's Quick Guide to ESH's Six Core Strategies Compliance is attached as Appendix D.

SIX CORE STRATEGIES FOR REDUCING SECLUSION AND RESTRAINT USE:

Core Strategy 1 - Leadership toward Organizational Change:

Leadership toward organizational change is a mandatory core intervention. Without the consistent and continuous involvement of senior facility leadership, seclusion and restraint reduction efforts are doomed. Overall, ESH has not achieved compliance with this first and mandatory core strategy.

ESH leaders have not provided a strong, directive, and consistent message that they expect reduction and, ultimately, elimination of seclusion and restraint. The ongoing fluctuations in key facility leadership positions over several years have hindered progress at ESH. Since 2010, the facility has had seven permanent or acting Facility Directors. Currently, multiple key senior leaders are new to their positions, including the Facility Director and the Clinical Director. The Director of Quality Management position remains vacant. A newly hired Patient Safety Liaison has just begun work.

ESH's failure to revise the mission and vision statements to reflect commitment to the *Six Core Strategies* are examples of missed leadership opportunities. The Executive Committee determined such changes were unnecessary.[6] Leadership has also failed to make an explicit commitment to eliminating seclusion and restraint, to creating a violence – and coercion – free facility, assuring a safe environment, and creating a trauma-informed system of care. These deficits exist even though such commitment is defined as a mandatory core intervention. The new facility director has an opportunity to change the message and has committed to monthly town hall meetings with ESH staff.

In addition, ESH lacks a "targeted facility or unit based performance improvement action plan" as described in the *Six Core Strategies.* ESH's Seclusion and Restraint Reduction Plan also lacks this component and does not mandate development of such a plan. The current Seclusion and Restraint Reduction Plan also deviates from the evidenced-based practice model of the *Six Core Strategies*. The annual update of the Seclusion and Restraint Reduction Plan was completed in October 2014; however, it has remained under revision since then. While this indicates ongoing review, a final plan has not been approved by leadership. Members of the Seclusion and Restraint Reduction Committee have reported that a revision is underway, that the new version will be clear and specific, and that it will identify and make specific parties accountable for action steps.

An essential component of the *Six Core Strategies* is the "elevation of oversight of every seclusion and restraint event by senior management that includes the daily involvement of the CEO or COO in all [seclusion and restraint] events (24/7)..."[7] All seclusion and restraint incidents are emailed to the senior leadership team in the 24 hour nursing report. However, there is no formal protocol for review of seclusion and restraint events. Although there have been examples of comprehensive review with corrective action, this is neither the norm nor the standard. Interviews reveal that ESH leadership does not consistently review all seclusion and restraint incidents. Historically, deep examination into events to

[6] Appendix E: ESH Seclusion and Restraint Reduction Plan Annual Update October 2014

[7] Appendix C: *Six Core Strategies for Reducing Seclusion and Restraint Use* ©

inform systemic change has not occurred as required by the *Six Core Strategies*. However, we were encouraged to learn that a root cause analysis was initiated after a recent seclusion event and that review was used to inform practice. We would like to see this practice become the norm, not the exception.

A trauma-informed care policy[8] has been written and approved. As a whole, the policy seems to be rooted in best practices identified and supported by SAMHSA and other leading trauma-informed care organizations; however, the policy lacks detail. There are no timelines for staff training or methods for assessing staff competencies. Furthermore, the policy offers little accountability and meaningful protections. The trauma-informed care policy includes an expectation that all facility policies will be reviewed and revised to ensure they are trauma sensitive; this is a promising yet unaccomplished step.

Another significant leadership responsibility is to monitor and improve workforce development. ESH's coercive culture requires immediate intervention from senior leadership. dLCV has observed and patients and staff have reported coercive actions, primarily with, but not limited to, nursing staff. This has been an ongoing issue and has been discussed with multiple directors, acting and permanent. Leadership has not held staff or supervisors accountable for this behavior. Therefore the culture continues. In March 2015, *all* staff were required to attend trauma-informed care trainings. The facility director reports that nearly all staff have received an initial training. However, our monitoring and staff interviews revealed varied levels of understanding of trauma-informed care among leadership. Commitment to reducing seclusion and restraint is also varied. As a result, the entirety of the senior leadership team has not consistently modeled trauma-informed care principles. DBHDS reports they intend to survey facility leadership and staff to identify staff attitudes as they relate to trauma-informed care.

ESH does have the requisite multi-disciplinary team. These are the trauma-informed care change agents who educate staff about trauma-informed care. Multiple change agents also sit on the Seclusion and Restraint Reduction Committee; however, all committee members are managers on some level. No direct care staff or peer support specialists are included in either of these groups. Staff report a desire to add a direct care staff person and a peer support specialist to the trauma informed care change agents.

Core Strategy 2 - Use of Data to Inform Practice:

> "Achievement of this goal has been hampered by several processes beyond the control of the facility or the QM Department. Multiple data bases both at ESH and DBHDS Central Office possess conflicting data and reports that have not been supportive of advanced analysis."
>
> ESH Seclusion and Restraint Reduction Plan, Annual Update (October 2014)

Individual and unit level data collection and use is also an essential component of seclusion and restraint reduction. Although ESH collects data at a unit level, the data is limited and not always accurate by ESH's own assessment. This strategy directs facilities to collect more specific information (i.e. by shift, individual, staff member involved, demographics, etc.). Staff interviews reveal that ESH is not capable of

[8] ESH Policy 090-012 - Trauma-Informed Care

capturing this data in a timely and consistent manner. Additionally, ESH does not track the use of any pharmacological restraints.

ESH has reportedly consulted with DBHDS Central Office to obtain improved, more usable reports. Even though this issue was identified in the action plan in 2013, there have been no advancements in ESH's seclusion and restraint data reporting ability. In fact, there are needed reports that are no longer available to the facility (e.g. ability to run a report specific to an individual) because this capability was removed by DBHDS' Central Office. We understand that DBHDS does not anticipate improvement in data collection until all DBHDS hospitals have converted to the new electronic health record system.

ESH has not been transparent with staff or consumers about their use of seclusion and restraint. Staff who are devoted to trauma-informed care have sought seclusion and restraint data and ESH has not provided it. Until there is an investment in quality data collection and reporting, and in using and sharing data, this indicator cannot be met.

Core Strategy 3 - Workforce Development:

According to personnel data provided by DBHDS, ESH is typically understaffed. Like many other DBHDS facilities, Eastern State experiences high rates of staff turnover, particularly among direct care staff. People are often hired with marginal qualifications and then expected to do very challenging jobs with little support or supervision.

ESH's job descriptions vary in regards to the inclusion of trauma-informed care and recovery based values. Review of recent postings reveal inconsistent messages. Nursing staff and direct care workers, in particular, will be assigned to work anywhere they are needed even though populations vary greatly from unit to unit. While manpower needs must be met, this practice creates safety concerns by placing staff with consumers with whom they are unfamiliar. It also undermines many prevention strategies which require person-specific knowledge to support individualized and appropriate care. The Chief Nurse Executive has demonstrated that consistency of staff on units is not a priority when making assignments.

The current practice of staff assignment compromises the essence of the *Six Core Strategies*. "This strategy suggests the creation of a treatment environment whose policy, procedures, and practices are based on the knowledge and principles of recovery and the characteristics of trauma-informed systems of care. The purpose of this strategy is to create a treatment environment that is less likely to be coercive or trigger conflicts and in this sense is a core primary prevention intervention."[9] ESH has policies, procedures and practices in place that speak of recovery and trauma-informed practices; however, this approach is not apparent in the actions of many staff. Leadership has not yet emphasized development of an infrastructure that supports these ideals and holds staff accountable to these concepts.

ESH's Seclusion and Restraint Reduction Plan indicates that the facility intends to train all staff in trauma-informed care principles. ESH has made great progress toward completing initial trainings. However, this strategy demands intensive and ongoing education and training which is not evident. In addition to training staff, "consistent communication, mentoring, supervision and follow-up to assure

[9] Appendix C: *Six Core Strategies for Reducing Seclusion and Restraint Use* ©

that staff are provided the required knowledge, skills and abilities, with regards to [seclusion and restraint] reduction through training about the prevalence of violence in the population of people that are served in mental health settings"[10] is required. The availability of positive mentoring and supervision varies depending on the unit. ESH's fluctuating nursing assignments negatively impact consistent supervision and accountability.


Emergency Restraint Chair

DBHDS has adopted Therapeutic Options of Virginia (TOVA) to provide staff training regarding prevention strategies and approved seclusion and restraint tactics. TOVA is a required training for all staff at time of hire and annually thereafter. Both ESH and the DBHDS Director of Quality and Risk Management have stated the primary purpose of TOVA is to prevent seclusion and restraint. However, instead of focusing on prevention tools, this year's annual TOVA training included new ways to physically restrain people. ESH has also made the use of the emergency restraint chair, a restraint device many consumers compare to an electric chair, available to nearly all units. DBHDS and ESH have demonstrated focus contrary to DBHDS's stated vision of a restraint and seclusion free service system. ESH provides staff trainings regarding trauma-informed care, recovery, and therapeutic communication. However, competency testing only exists for trainings on seclusion and restraint, including the TOVA training. There is negligible competency testing for therapeutic communication, recovery or trauma-informed responses. This practice blurs the message of prioritizing prevention before hands-on intervention.

Another aspect of this core strategy is to provide "treatment activities that offer choices...and that are designed to teach illness and emotional self-management of symptoms and individual triggers that lead to loss of control."[11] Choice is not consistently offered at ESH. Interviews indicate that people enjoy the groups that are led in the psychosocial rehabilitation program. However, not all consumers have access to these groups. Treatment is viewed not as a *right* but as a *privilege*. People are frequently restricted to their unit because of a challenging support need, an exercised right to medication refusal, or because ESH staff have failed to evaluate the individual and enter an order authorizing the person to attend groups off the unit.

Person-centered planning activities are not universal. Many consumers talk about "staying under the radar" as a survival technique and to expedite discharge. Self-determination and true partnerships with providers are often halted by coercive treatment. dLCV staff heard multiple examples of this during interviews onsite. Individuals reported that if a person disagrees with the treatment team's plan of care, the team may threaten them with negative consequences. One civilly committed person described how his psychiatrist told him that if he did not agree to take a certain psychotropic medication, he would not be allowed to move forward in the privileging process. People perceive constant threats to their freedom and rights, even from people they identify as supportive. As a result, partnerships, choice, and self-determination are limited by the control and the power asserted by professionals, reinforced by the medical model practiced by the facility. The lack of competency testing, mentoring, and supervision on

[10] Appendix C: *Six Core Strategies for Reducing Seclusion and Restraint Use* ©
[11] Appendix C: *Six Core Strategies for Reducing Seclusion and Restraint Use* ©

principles of recovery and trauma-informed care at ESH perpetuates the culture of coercion and lack of choice or involvement.

Core Strategy 4 - Use of Seclusion & Restraint Prevention Tools:

As a whole, ESH does not use individualized seclusion and restraint prevention tools. This failure to exercise universal precautions is not consistent with the *Six Core Strategies*. This strategy requires the "use of a variety of tools and assessments that are integrated into facility policy and procedures and each individual consumer's recovery plan."[12] Currently, ESH does not use a universal trauma assessment. Development is reported to be underway. The Clinical Director reports that various other assessments capture information to assess a person's seclusion and restraint history, risk for violence, and risk factors for death and injury. Some assessments may include information that could be used to create an individualized prevention or safety plan. Interviews with consumers reveal that people often do not have *any* such plan (e.g. safety plan, Wellness Recovery Action Plan (WRAP)). One consumer reported that even though he had a WRAP, it was taken from him by staff and was not accessible to him, even months later.

Without identification of psychological triggers and "warning signs," consumers and staff are left without guidance on how to proceed. Staff are not prepared to de-escalate and prevent crises or to support the individual. The increase in use of seclusion and restraint shows that staff interventions are ineffective. Our interviews reveal that direct care staff often fail to intervene in situations that then escalate into violence and use of seclusion and restraint. Observations of nursing staff on units support these reports. Multiple consumers report feeling that staff have encouraged violence between peers. In addition to failing to use prevention strategies, staff may escalate situations by requesting ESH Police to intervene, thus criminalizing behaviors resulting from ESH's failures.

Although prevention plans are not widely available, there are some tools available to assist people on units. Each unit in Building 2 has a locked quiet room. Some quiet rooms have desks and paintings, while others are stark. People cannot access these rooms without staff assistance; however, they can leave the room at will. Most individuals on the units do not know about the quiet rooms and very few people use them. ESH has sensory rooms in the group treatment area but they are typically locked and not available at all times.

Core Strategy 5 - Consumer Roles in Inpatient Settings:

Contrary to best practice, consumer and external stakeholder involvement at ESH is limited. "This strategy involves the full and formal inclusion of consumers, children, families, and external advocates in various roles and at all levels in the organization to assist in the reduction of seclusion and restraint. It includes consumers of services and advocates in event oversight, monitoring, debriefing interviews, and peer support services as well as mandates significant roles in key facility committees."[13] While one consumer has been formally identified as a trauma-informed care change agent, that individual has not been included among the Seclusion and Restraint Reduction Committee membership. None of the hospital's peer support specialists are on the committee.

[12] Appendix C: *Six Core Strategies for Reducing Seclusion and Restraint Use* ©
[13] Appendix C: *Six Core Strategies for Reducing Seclusion and Restraint Use* ©

ESH employs three peer support specialists to support the approximately 300 men and women admitted to the facility at any given time. Interviews reveal a varying degree of understanding of trauma-informed care and recovery concepts amongst the peer support specialists. The peer support specialists do have membership on senior level committees but are not directly involved as trauma informed care change agents nor on the Seclusion and Restraint Reduction Committee. There is no indication that external advocates are involved in any facility committees nor does there appear to be any plan to include them.

Core Strategy 6 - Debriefing Techniques:

The goal of implementing the core strategy related to debriefing techniques has two components. The strategy requires that a debriefing occur after each treatment failure incident. The information learned is then used to inform treatment. Based on record reviews and interviews with consumers and staff, the debriefing process is spotty and of questionable quality. Most of the time, the debriefing does not include all of the involved parties, including the consumer. The process of debriefing is not typically used as a therapeutic tool nor an "attempt to mitigate, to the extent possible, the adverse and potentially traumatizing effects of [seclusion and restraint]."[14] Without debriefings, there is no knowledge gained. Without consistent use of debriefings, practice cannot be informed and new procedures cannot be developed to prevent future treatment failures. A plan to redesign the debriefing form has been in process for some time; however, senior leadership has not prioritized the revision.

CORNERSTONE I:

Although overall progress towards trauma-informed care at ESH is dismal, the Cornerstone I unit has demonstrated good outcomes. Cornerstone I was developed with the vision of providing treatment in a community model based on the principles of trauma-informed care and peer support. This unit clearly differs from other units at ESH. Consumers use words such as calm, respectful, comfortable, compassion, peaceful, healing, and patient to describe the unit. Cornerstone I is safer and more productive than other units as indicated by lower seclusion and restraint rates, less peer to peer aggression, fewer staff injuries, and shorter average lengths of stay. Seclusion and restraint is virtually non-existent. There has been one episode of restraint since the unit's inception. There have been minimal peer to peer altercations compared to other units. Cornerstone I's average length of stay is 318 days while the overall average length of stay at ESH is 876 days. Unfortunately, only 22 men, a small portion of ESH's census, are benefiting from this treatment model. The outcomes clearly favor the Cornerstone I model[15] and demonstrate that ESH is capable of making strides to become trauma-informed.

There are key components to Cornerstone I's success that align with the *Six Core Strategies*. The unit does not have a seclusion room; instead, they have a "zen den." Inside the zen den, varied sensory tools are available for individuals to utilize at any time. People can freely access snacks and are provided with a space to keep their personal snacks. There is a daily community meeting that focuses on individual concerns. Staff do their best to respond and meet the needs of the consumers. The meeting and agenda are facilitated by consumers. Cornerstone I staff are mindful of the inherent power and control dynamics that exist in staff-patient relationships. Staff's mindfulness contributes to their ability to actively prevent conflict in the milieu. Community outings are available throughout the week and people are not

[14] Appendix C: *Six Core Strategies for Reducing Seclusion and Restraint Use* ©

[15] Appendix F: Welcome to Cornerstone

restricted from accessing the outdoors. Additionally, the program is committed to not using seclusion and restraint and frames the use of seclusion and restraint as treatment failures.

The staff structure on Cornerstone I is also different. Frontline staff at ESH have traditionally been Certified Nursing Assistants and are called Direct Service Associates (DSAs). All DSAs are required to be Certified Nursing Assistants. In contrast, Cornerstone I employs Recovery Support Specialists (RSSs) as their direct care providers. While a RSS can also be a CNA, ESH actively recruits individuals with broader backgrounds and experiences including those who have an associate's degree or bachelor's degree in human services or who are peer support specialists.

Cornerstone I's leadership has been very active in supporting, mentoring and supervising staff. The investment in staff is evident. Consistency in staff is a priority on Cornerstone I. The leadership staff serve in direct care roles as needed. Unit management tries to avoid using staff who are pulled from other units and who may not be familiar with the Cornerstone I consumers or the program philosophy. Unit management seems to recognize that inconsistent staffing may be disruptive to the milieu and possibly increase stressors.

Aside from gender, the consumers served on Cornerstone I are no different from the facility population as a whole. This is a male only unit serving individuals who are civilly committed or forensically involved. People who are served on Cornerstone I have a history of trauma. Typical referrals to Cornerstone I have not been adequately supported on other units at ESH. Cornerstone I selects individuals who would benefit from the community model and from peer support. dLCV is encouraged by the positive changes and successes achieved at Cornerstone I. We look forward to seeing the model expand to benefit all people at ESH.

"When I started to talk to the guys on [my old unit] it added to my fears and anxiety. Some had been there for five or six years. My anxiety level has decreased by going to Cornerstone. It's unfair that everyone cannot have the same treatment." - consumer

CONCLUSION:

Eastern State Hospital has reached a critical juncture. dLCV is encouraged by the steps already taken to improve the care and culture: by adopting the *Six Core Strategies*, by committing to training all staff in the basics of trauma-informed care, and by supporting Cornerstone I's efforts to create a seclusion and restraint free environment. There are multiple passionate internal champions who created and continue to create positive changes. However, substantial work remains. ESH has demonstrated that it is possible to reduce and possibly eliminate seclusion and restraint and employ trauma-informed care principles in Cornerstone I. These successful practices should be replicated facility wide. It is unacceptable to provide inadequate and potentially dangerous services to the majority of individuals served at ESH when the facility has demonstrated the ability to provide a higher level of care to a few.

The *Six Core Strategies* were developed by the National Association of State Mental Health Program Directors (NASMHPD) and create a roadmap to best practice. In the spirit of DBHDS's vision statement and these best practices, dLCV urges the Department and ESH to immediately and fully implement the *Six Core Strategies* and to aggressively promote trauma-informed care. dLCV will continue to monitor the implementation of trauma-informed care at ESH and state wide.

APPENDIX A:

Unit _____ Gender _____ Status _____

How long have you been at ESH? _____
How do you feel about your safety at ESH?

How do staff treat you? Are they respectful?

Have you been involved in any decision making activity at ESH?

Has ESH asked you about your trauma history?

Do you feel like staff know what upsets you? What helps you?

Do you have a safety plan? If yes, do you have a copy? Do staff have a copy?

Have you been restrained or secluded at ESH? If yes, what was that experience like for you? Did anyone talk to you about the restraint or seclusion afterwards?

Have you ever been or felt threatened by staff?

Can we reference your experiences (deidentified) in relation to our ongoing advocacy work in this area?

APPENDIX B:

Attachment A
Virginia Department of Behavioral Health and Developmental Services
Seclusion and Restraint Philosophy Statement
February 25, 2010

The Virginia Department of Behavioral Health and Developmental Services (DBHDS) is committed to creating an environment free of violence and coercion based on prevention strategies; assuring a safe environment for individuals receiving services and staff; focusing on the elimination of seclusion and restraint as congruent with the principles of recovery and person-centeredness; and building a trauma-informed system of care. This goal is consistent with a system 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 DBHDS is further committed to creating a collaborative work environment in which leadership, staff, and individuals receiving services work together to address the complexity of developing and maintaining a systematic approach to trauma-based services and creating an organizational environment in which traumatic experiences can be addressed. All learning activities must reflect awareness and understanding of violence, trauma and coercion and the impact of seclusion and restraint on a person's life. Strength-based clinical supervision, the careful analysis of seclusion and restraint events and data, and an open and honest exchange of ideas are necessary components for learning to occur.

DBHDS recognizes that many individuals who have been the recipients of services and their families consider the emergency use of restraint and seclusion abusive, violent, re-traumatizing, and unnecessary. DBHDS seeks to ensure that everyone is treated with dignity and respect and that environments foster voluntary and empowering alternatives to seclusion and restraint.

To accomplish this goal, the DBHDS endorses the public health model, which values input from individuals being served, their families, and staff. This is a strength-based and person-centered approach that enhances self-esteem, thereby promoting the achievement of each individual's goals for his or her life.

- Primary Prevention refers to the commitment of leadership to making the elimination of seclusion and restraint a priority for the organization. It is the development of a core set of services that are trauma informed and culturally specific; environments that support and comfort individuals who are in distress as a result of their illness or disability; and staff who collaborate with individuals receiving services to promote the achievement of each individual's goals for his or her life.
- Secondary Prevention includes early intervention strategies that are put into effect once an episode of seclusion or restraint begins, which focus on redirection and the use of creative, least restrictive alternatives, tailored to the needs of the individual, thereby reducing the need for restraint or seclusion.
- Tertiary Prevention addresses the reversal and prevention of the negative consequences when, in an emergency, restraint or seclusion cannot be avoided.

The DBHDS strongly believes that this approach is essential for establishing a culture that is proactive, responsive, and collaborative, and is free of seclusion and restraint to the greatest extent possible.

APPENDIX C:

NASMHPD

Six Core Strategies for Reducing Seclusion and Restraint Use©

Note: This document contains the following items: (1) a **Snapshot** of the Six Core Strategies©; (2) a **Planning Tool**; and (3) an **Example of Debriefing Policies and Procedures.**

A Snapshot of Six Core Strategies for the Reduction of S/R ©

(Revised 11/20/06 by Kevin Ann Huckshorn)

These strategies were developed through extensive literature reviews (available upon request from joan.gillece@nasmhpd.org) and dialogues with experts who have successfully reduced the use of S/R in a variety of mental health settings for children and adults across the United States and internationally.

1. Leadership toward Organizational Change

This first strategy is considered core to reducing the use of seclusion and restraint (S/R) through the consistent and continuous involvement of senior facility leadership (most specifically the CEO, CNO, and COO). Leadership strategies to be implemented include defining and articulating a vision, values and philosophy that expects S/R reduction; developing and implementing a targeted facility or unit based performance improvement action plan (similar to a facility "treatment plan"); and holding people accountable to that plan. This intervention includes the elevation of oversight of every S/R event by senior management that includes the daily involvement of the CEO or COO in all S/R events (24/7) in order to investigate causality (antecedents), review and revise facility policy and procedures that may instigate conflicts, monitor and improve workforce development issues and involve administration with direct care staff in this important work. The action plan developed needs to be based on a public health prevention approach and follow the principles of continuous quality improvement. The use of a multi-disciplinary performance improvement team or taskforce is recommended.

This is a mandatory core intervention.

2. Use of Data To Inform Practice

This core strategy suggests that successfully reducing the use of S/R requires the collection and use of data by facilities at the individual unit level. This strategy includes the collection of data to identify the facility/units' S/R use baseline; the continuous

gathering of data on facility usage by unit, shift, day; individual staff member's involved in events; involved consumer demographic characteristics; the concurrent use of stat involuntary medications; the tracking of injuries related to S/R events in both consumers and staff and other variables. The facility/unit is encouraged to set improvement goals and comparatively monitor use and changes over time.

3. Workforce Development

This strategy suggests the creation of a treatment environment whose policy, procedures, and practices are based on the knowledge and principles of recovery and the characteristics of trauma informed systems of care. The purpose of this strategy is to create a treatment environment that is less likely to be coercive or trigger conflicts and in this sense is a core primary prevention intervention. This strategy is implemented through intensive and ongoing staff training and education and HRD activities. It includes S/R application training and vendor choice, the adequate provision of treatment activities that offer choices to the people we serve and that are designed to teach illness and emotional self-management of symptoms and individual triggers that lead to loss of control. This strategy requires individualized person centered treatment planning activities that include persons served in all planning. This strategy also includes consistent communication, mentoring, supervision and follow-up to assure that staff are provided the required knowledge, skills and abilities, with regards to S/R reduction through training about the prevalence of violence in the population of people that are served in mental health settings; the effects of traumatic life experiences on developmental learning and subsequent emotional development; and the concept of recovery, resiliency and health in general. This work is done through staff development training, new hire applicants interview questions, job descriptions, performance evaluations, new employee orientation, and other similar activities.

4. Use of S/R Prevention Tools

This strategy reduces the use of S/R through the use of a variety of tools and assessments that are integrated into facility policy and procedures and each individual consumer's recovery plan. This strategy relies heavily on the concept of individualized treatment It includes the use of assessment tools to identify risk for violence and S/R history; the use of an universal trauma assessment; tools to identify persons with high risk factors for death and injury; the use of de-escalation surveys or safety plans; the use of person-first, non-discriminatory language in speech and written documents; environmental changes to include comfort and sensory rooms; sensory modulation interventions; and other meaningful treatment activities designed to teach people emotional self management skills.

5. Consumer Roles in Inpatient Settings

This strategy involves the full and formal inclusion of consumers, children, families and external advocates in various roles and at all levels in the organization to assist in the reduction of seclusion and restraint. It includes consumers of services and advocates in

event oversight, monitoring, debriefing interviews, and peer support services as well as mandates significant roles in key facility committees. It also involves the elevation of supervision of these staff members and volunteers to executive staff who recognize the difficulty inherent in these roles and who are poised to support, protect, mediate and advocate for the assimilation of these special staff members and volunteers. ADA issues are paramount here in terms of job descriptions, expectations, work hours, and an ability to communicate to staff the legitimacy of the purpose and function of these important roles.

6. Debriefing Techniques

This core strategy recognizes the usefulness of a thorough analysis of every S/R event. It values the fact that reducing the use of S/R occurs through knowledge gained from a rigorous analysis of S/R events and the use of this knowledge to inform policy, procedures, and practices to avoid repeats in the future. A secondary goal of this intervention is to attempt to mitigate, to the extent possible, the adverse and potentially traumatizing effects of a S/R event for involved staff and consumers and for all witnesses to the event. Recommended debriefing activities include two - an immediate post-event acute analysis and the more formal problem analysis with the treatment team. Using the steps in root cause analysis (RCA) is recommended. (Please see the attached Debriefing Policy and Procedure template.) For facilities that treat kids and who use holds frequently, the use of full debriefing procedures for each event may not be manageable. These facilities need to discriminate their use of holds and target multiple holds on same children, identify same staff member involvement in these events so as to note training needs and explore holds that last longer than usual.

APPENDIX D:

dLCV's Quick Guide to ESH's *Six Core Strategies* Compliance

Core Strategy 1 - Leadership toward Organizational Change	Evidence Present?
Consistent and continuous involvement of senior facility leadership	No
Defining and articulating a vision, values and philosophy that expects S/R reduction	No
Developing and implementing a targeted facility or unit based performance improvement	No
Action plan (based on a public health prevention approach and follow the principles of continuous quality improvement) and holding people accountable to that plan	No
Elevate oversight of every S/R event by senior management that includes the daily involvement of the CEO or COO in all S/R events (24/7) in order to investigate causality	No
Review and revise facility policy and procedures that may instigate conflicts	No
Monitor and improve workforce development issues	Partially
Involve administration with direct care staff in this important work	No
The use of a multidisciplinary performance improvement team or taskforce	Yes

Core Strategy 2 - Use of Data to Inform Practice	Evidence Present?
Collection and use of data by facilities at the individual unit level to include:	
Identify the facility/units' S/R use baseline	No
Gathering of data on facility usage by unit, shift, day	Partially
Individual staff members involved in events	No
Involved consumer demographic characteristics	No
The concurrent use of stat involuntary medications	No
Tracking of injuries related to S/R events in both consumers and staff	No
The facility/unit is encouraged to set improvement goals	No
Comparatively monitor use and changes over time	No

Core Strategy 3 - Workforce Development	Evidence Present?
Creation of a treatment environment whose policy, procedures, and practices are based on the knowledge and principles of recovery and the characteristics of trauma-informed systems of care	Partially
Intensive and ongoing staff training and education to create a treatment environment that is less likely to be coercive or trigger conflicts	No
S/R application training and vendor choice	Yes
Provision of treatment activities that offer choices to the people we serve and that are designed to teach illness and emotional self-management of symptoms and individual triggers that lead to loss of control	Partially
Requires individualized person-centered treatment planning activities that include persons served in all planning.	Partially
Consistent communication, mentoring, supervision and follow-up to assure that staff are provided the required knowledge, skills and abilities, with regards to S/R reduction through training about the prevalence of violence in the population of people that are served in mental health settings; the effects of traumatic life experiences on developmental learning and subsequent emotional development; and the concept of recovery, resiliency and health in general. ● Through staff development training ● Through new hire applicants interview questions ● Through job descriptions	Partially

● Through performance evaluations ● Through new employee orientation ● Through other similar activities	

Core Strategy 4 - Use of S/R Prevention Tools	Evidence Present?
Use of a variety of tools and assessments that are integrated into facility policy and procedures and each individual consumer's recovery plan.	Partially
Use of assessment tools to identify risk for violence and S/R history	Yes
Use of an universal trauma assessment	No
Tools to identify persons with high risk factors for death and injury	Yes
Use of de-escalation surveys or safety plans	Partially
Use of person-first, non-discriminatory language in speech and written documents	Partially
Environmental changes to include comfort and sensory rooms	Partially
Sensory modulation interventions	Partially
Meaningful treatment activities designed to teach people emotional self-management skills.	Partially

Core Strategy 5 - Consumer Roles in Inpatient Settings	Evidence Present?
Full and formal inclusion of consumers, children, families and external advocates in various roles and at all levels in the organization to assist in the reduction of seclusion and restraint.	No
Consumers of services and advocates in event oversight, monitoring, debriefing interviews, and peer support services as well as mandates significant roles in key facility committees.	Partially
Elevation of supervision of these staff members and volunteers to executive staff who recognize the difficulty inherent in these roles and who are poised to support, protect, mediate and advocate for the assimilation of these special staff members and volunteers.	Partially

Core Strategy 6 - Debriefing Techniques	Evidence Present?
Recognizes the usefulness of a thorough analysis of every S/R event	No
Values the fact that reducing the use of S/R occurs through knowledge gained from a rigorous analysis of S/R events and the use of this knowledge to inform policy, procedures, and practices to avoid repeats in the future	No
Attempt to mitigate, to the extent possible, the adverse and potentially traumatizing effects of a S/R event for involved staff and consumers and for all witnesses to the event	No
Immediate post-event acute analysis	No
Formal problem analysis with the treatment team. Using the steps in root cause analysis (RCA) is recommended	Partially

APPENDIX E:

Eastern State Hospital
Seclusion and Restraint Reduction Plan
Annual Update
October 2014

Program Goals:

It remains the goal of Eastern State Hospital (ESH) to advance a culture of Recovery and Trauma Informed Care (TIC) and to embed best practices in everything we do. In the past year ESH has made consistent strides in the development of internal systems that will be in keeping with the National Association of State Mental Health Program Directors (NASMHPD) belief that seclusion and restraint are always interventions of last resort and are only implemented when absolutely necessary and include plans for extinguishing the need for them as part of treatment planning. The Six Core Strategies to Reduce the Use of Seclusion and Restraint Planning Tool developed by National Technical Assistance Center (NTAC) and elements of Recovery and Trauma Informed Care are consistently utilized as references in advancement these goals. In a trauma informed environment it is recognized that the use of seclusion and restraint creates significant risks for staff and patients alike. ESH's Trauma Informed Care Work Group continues its efforts to support advancement of policy development, language modification, training, and ongoing systems that will support seclusion and restraint reduction and advance a culture of safety throughout the hospital in an effort to be a model program throughout the Commonwealth with a long term goal of elimination of seclusion and restraint.

Six Core Strategies:

Developed by NASMHPD, the Six Core Strategies were developed as a road map for seclusion and restraint reduction. ESH has chosen to use these strategies to guide its efforts on this front as follows.

1. **Leadership toward Organizational Change-**
    a. **Goal**: ESH will evaluate and revise as needed its Mission, Vision, and Values statements to ensure they are in congruence with the TIC initiative and efforts to reduce and eliminate seclusion and restraint.
        i. **Update**: ESH has reviewed its Mission and Vision Statements and has confirmed they are reflective of our devotion to partnering with those we serve and empowering them at every point in their recovery. No revisions have been made.
    b. **Goal**: ESH will develop a TIC policy that articulates its goals and beliefs related to TIC and seclusion and restraint reduction.
        i. **Update**: A draft policy has been developed and is being prepared for circulation.
    c. **Goal**: Seclusion and Restraint Data will be reported to the Executive Board via the Quality Management Report on a quarterly basis for review and recommendations.
        i. **Update**: Seclusion and Restraint Data has been reported quarterly to the Executive Board for review and recommendations since this plan was developed. In exploring sources of data it was revealed that there are multiple conflicting sources of data. A request has been submitted to Central Office staff for additional, meaningful and user friendly reports to be added to the Seclusion and Restraint data base shared by all DBHDS facilities as soon as possible.

d. **Goal**: This plan will be presented to the Executive Board for review, recommendations, and approval.
    i. **Update**: The Plan was presented to the Executive Board in 2013 and copies sent to all members. The 2014 Plan Update will also be presented during the October 2014 Executive Board Meeting.
e. **Goal**: ESH will review all Emergency Code system for consistency with TIC and Recovery principles and revise as necessary.
    i. **Update**: The Emergency Code System had several delays in implementation between 2012 and 2014 and was finally rolled out in the spring of 2014. After six months of use it is recommended that this Goal remain and the Emergency Codes be reviewed by the Trauma Informed Care Committee for recommendations to language and practice change.

2. Use of Data To Inform Practice-

a. **Goal**: The facility will continue to submit data related to seclusion and restraint events through the DBHDS Central Office Seclusion and Restraint Data Base.
    i. **Update**: Seclusion and Restraint data continues to be added to the Data Base. The process for collecting data and hand entering information requires several steps and many hours of QM staff time.
b. **Goal**: Seclusion and restraint data will be presented to the Quarterly Quality Committee for review, analysis, and recommendations.
    i. **Update**: Seclusion and Restraint Data has been reported quarterly to the Quality Council for review and recommendations since this plan was developed. In exploring sources of data it was revealed that there are multiple conflicting sources of data. A request has been submitted to Central Office for additional meaningful and user friendly from the Seclusion and Restraint data base shared by all DBHDS facilities as soon as possible. The Quality Council calendar will change October 2014 to support more in depth review and analysis of all reports in the hopes of facilitating a more robust QM process and directed Performance Improvement plans.
c. **Goal**: In the coming year ESH will advance its review of seclusion and restraint data and facilitate the use of statistical tools and analysis to drive improvement in the numbers and duration of events. The use of advanced tools will enable ESH to review data by type, location, time, etc. and develop meaningful strategies in support of reduction.
    i. **Update**: Achievement of this goal has been hampered by several processes beyond the control of the facility or the QM Department. Multiple data bases both at ESH and DBHDS Central Office possess conflicting data and reports that have not been supportive of advanced analysis. Individual events are processed by QM staff following hours of charts reviews across the hospital and then hand entered into the CO data base. Existing Reports would then require additional hand counts of all individual events, a process that is neither reasonable nor feasible at this time. This issue has been referred to the Director for advancement.

3. **Workforce Development-**

a. **Goal**: ESH will provide system wide training in TIC for all levels of staff and all departments.
    i. **Update**: Awareness and education are the focus of the Trauma-Informed Care committee. Committee members have signs on their doors and color-coded polo shirts that they wear on Fridays to raise awareness of themselves as resources on

trauma-informed care. Monthly messages are posted on laminated cards by Kronos time-clocks to maintain awareness of trauma-informed care philosophies. Training has been presented to Pod 3 staff, treatment team members, and executive board members. The committee plans to next provide training to nursing and direct care staff, pending scheduling arrangements. The committee is also drafting a guidance policy on trauma-informed care. Date to be determined following departure of Clinical Director.

ii. Multiple members of the leadership team were involved in this year in a revision and update of training relevant to Seclusion and Restraint usage. The first meeting was held in May 2014 with the purpose of addressing staff mind sets related to TOVA and to focus on rebuild trust and teamwork among direct care staff to include, DSA's, Nurses, Doctors, Social Work, Rehab and Psychology. A small committee was formed with accomplishing the following task: The dates indicate completion or ongoing progress.
    - Central office staff returned to ESH to retrain current TOVA Trainers in all aspects of TOVA including updated to acceptable process developed several years ago but not disseminated to ESH. (August 2014)
    - HGTC/AMHTC "Code Response Teams" identified by the Chief Nurse Executive (CNE) and Staff Development and Training (SD&T) Director. These staff members will receive advanced training from Central office staff and will function under the supervision of the CNE and Day/Evening/Night Administrator on Call (AKA Nursing Supervisor) and trained by Central Office staff.
    - SD&T staff will be assigned to individual units and RNC on those units to ensure updated TOVA Training completed by all staff. June 11, 2014.
    - Nurses in Charge of Unit will be designated as Leader in any seclusion and restraint incident. June 11, 2014.
    - Day/Night/Evening RNC to do debriefing of staff involved in all seclusion and restraint events and will forward significant findings to the treatment team and CNE/Clinical Director. Debriefing Form to be created and piloted by Nursing Department.
    - Additional trainers to be added to SD&T. The goal is to add trainers from different professional backgrounds, i.e. Rehab, SW, Psych, etc. Currently Interviewing applicants for these positions.
    - Therapeutic Communication training class was added to TOVA training curriculum. July 16, 2014
    - Training for all clinical staff on updated TOVA process (floor –chair). Training currently with completion date of December 1, 2014
    - Six TOVA training sessions on revised use of physical restraints that would allow staff to safely carry, escort and give IM medication to be facilitated by Mary Clair O'Hara. November 18th, 2014.

iii. As a result of review of TOVA training, new training has been developed on Therapeutic Communication that is now presented by members of the clinical departments to all new employees during New Employee Orientation.

b. **Goal**: Direct care staff and patients will be included in the membership of the TIC.
    i. **Update**: This goal has been successfully accomplished.

c. **Goal**: The Quality Management Department will develop and implement training in Quality Management and Performance Improvement to advance system wide understanding and skill level.
    i. **Update**: This goal has not been accomplished due to multiple competing priorities and a full time staff member being moved to support Long Term Care Programming following multiple CMS surveys in the spring. It remains a goal of the QM Department and Annual Plan.
d. **Goal**: A review of existing trainings on seclusion and restraints will be conducted and revised to reflect TIC, Recovery, and preventive interventions.
    i. **Update**: This process is ongoing and will resume following training completion November 2014.
e. **Goal:** ESH will reconvene a workforce support group in an effort to support staff members injured or traumatized in seclusion or restraint events.
    i. **Update:** Critical Incident Stress Management: 14 staff members from all disciplines have been trained to assist staff in processing critical incidents after they occur. A new policy describing the program was developed, and is now available on the intranet. Announcements have been made via email, intranet, Weekly Bulletin, and posters. This service is voluntary and completely confidential. To date one request has been received and sessions have been offered to the relevant staff.
f. **Goal**: The Behavior Management Committee (BMC) will continue to provide consultation regarding behavioral interventions, reviewing all intervention plans that utilize restrictive measures prior to implementation.
g. **Update**: BEEP continues to operate and has seen an increase in the number of referrals as noted below.
    i. 2012: 27 patients entered BEEP; 17 successfully were discharged from the program (meaning target behaviors decreased to the point they were able to return to regular programming or be discharged from the hospital)
    ii. 2013: 12 patients entered BEEP; 8 were discharged from program
    iii. 2014 to date: 20 patients have entered BEEP; 4 have been discharged from program
    iv. Currently there are 30 patients being served in BEEP. Of note, there has never been a seclusion or restraint incident during BEEP programming or on a BEEP outing.

4. **Use of S/R Prevention Tools-**
    a. **Goal:** ESH will develop tools to be utilized with patients in the development of reduction and prevention plans that are individualized and current.
        i. **Update:** This goal will remain for the coming year.
    b. **Goal:** The Behavior Enhancement and Enrichment Program (BEEP) will be utilized by patients in need of enhanced communication and socialization skills.
        i. **Update:** see above
    c. **Goal:** ESH will enhance efforts to ensure consistent staffing on individual units.
        i. **Update:** This goal will remain for the coming year.

5. **Consumer Roles in Inpatient Settings-**
    a. **Goal**: ESH TIC and Recovery Committee will include patient representatives.
        i. **Update**: This goal has been successfully accomplished.
    b. **Goal:** ESH TIC trainings will include education regarding the importance of patient and family or support person involvement in all levels of treatment and Recovery.
        i. **Update:** All TIC trainings conducted to date have included this type of education.

6. **Debriefing Techniques-**
    a. **Goal:** ESH will review its practice of Debriefing following all seclusion and restraint episodes. Debriefing practices will be made consistent throughout the hospital and involve patients and staff directly or indirectly involved. The process and expectations regarding Debriefing will be written in facility policy and training will be implemented for direct care staff regarding the policy, rationale, and expectations.
        i. **Update:** See 3.a.ii for info on debriefing

<u>Summary:</u>

During the past year Eastern State Hospital has made significant strides toward creating a recovery oriented and trauma informed culture. When reviewing seclusion and restraint data and apparent variation in report data a decision was made to begin utilizing only data from reports in the Seclusion and Restraint Data Base operated by the DBHDS Central Office utilized through Codie. The data base allows for the production of canned but limited reports requiring hand counting, making report writing difficult and time prohibitive. A request has been made to the Central Office data base administrator requesting additional and customizable reports which would better support analysis and trending of data and the development of targeted performance improvement activities.

In reviewing data for the last two quarters through the Codie data base there is evidence of a decrease in the use of mechanical restraints throughout the hospital but increases in the use of both seclusion and physical restraints since July 1st. The increase at this time is thought to be directly attributable to the system wide legislative changes which went into effect July 1st and have precipitated a significant increase in the number and acuity of the hospital's admissions. In fact, the increase in admissions began earlier in the year during the 2014 legislative session when the changes were announced and in essence were operational at that time. Admissions to the ITP/PSR programs during the October- December 2013 time period totaled at 13. During the first quarter of this fiscal year (July-Sept), IRP/PSR admissions totaled 55. During the same period, Temporary Detention Order (TDO) admissions nearly doubled.

The Seclusion and Restraint Reduction Plan for October 2014-September 2015 will need to focus on plans for addressing these changes by identifying and mitigating via treatment and milieu adaptations the increased risk associated with admissions of this volume and acuity.

APPENDIX F:

WELCOME TO CORNERSTONE

"A program that is trauma-informed realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in our clients, families, staff and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist re-traumatization." (SAMHSA, July 2014)

Cornerstone Values

- **Dignity, compassion, respect, and unconditional high regard for all**
- **Hope: We anticipate that individuals we serve will get well, stay well for long periods of time, and do the things they want to do with their lives**
- **Self-determination, personal responsibility empowerment, and self-advocacy**
- **Acceptance of diversity with relation to culture, ethnicity, language, religion, race, gender, age, disability, sexual identity, and degree of readiness to explore recovery issues**
- **Identification of individual strengths and avoidance of focusing on perceived deficits**
- **Difficult feelings and behaviors can be normal responses to traumatic circumstances, and an individual's responses to what is happening in their life should not necessarily be considered symptoms or a diagnosis**
- **Each individual we serve is always considered an expert on himself**

Cornerstone Goals

- **To foster an atmosphere of safety, respect, and acceptance**
- **To establish a milieu that presumes all individuals have experienced trauma, and seeks to provide a soothing safe experience**
- **To assist individuals in identifying their own recovery goals, and working toward realizing them**
- **To develop and maintain a strong supportive inpatient community, to build bridges to community living, and to prioritize actively assisting individuals to successfully return to the community**
- **To foster peer support opportunities both in and out of the hospital, and establish a self-governing system for the residential milieu**
- **To eliminate the use of restraint and seclusion**

Who We Serve

- 100% have experienced trauma
- 22 males between 18 and 64 years old, currently:
  - Oldest age is 61 and youngest is 22
  - Average age is 40
- Status , currently:
  - NGRI (13)
  - Civil (9)
- Length of Stay:
  - ESH: Shortest is 52 days, longest is 2865 days, average is 876 days
  - Cornerstone: Shortest is 25 days, longest is 471 days, average is 318 days
- Levels, currently:
  - Unescorted Community 48 hours (UC48) (1)
  - Unescorted Community Not Overnight (UCNO) (7)
  - Unescorted Grounds / Escorted Community (UG/EC) (4)
  - Escorted Grounds/Escorted Community (EG/EC) (8)
  - Escorted Grounds (EG) (2)
- Diagnoses include Schizophrenia, Mood Disorders, PTSD, Personality Disorders, Substance Abuse, Borderline Intellectual Functioning

Cornerstone Statistics

- 7 out of 12 UC peers attend clubhouse
- 14 out of 22 peers employed within the ESH work program
  - cafeteria, workshop, grounds crew, housekeeping
- 12 out of 12 UC peers participate weekly in at least one community based support group (NAMI, AA, NA)
- 4 out of 22 peers participate in BEEP or CAP
- Cornerstone peers and staff have maintained physical safety of self and others with a single incident of restraint
  - December 27th, 2014 lasted 1.15 hours

Culture of Safety

Sandra Bloom's *Creating Sanctuary*

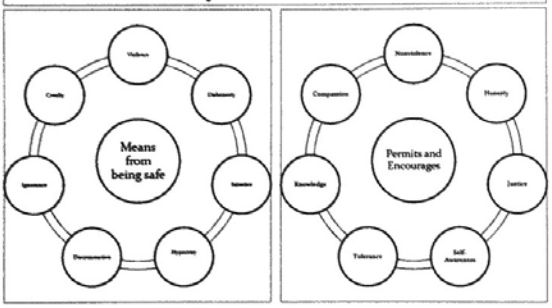
Physical Safety

Sandra Bloom's *Creating Sanctuary*

Social Safety

Sandra Bloom's *Creating Sanctuary*

Moral Safety

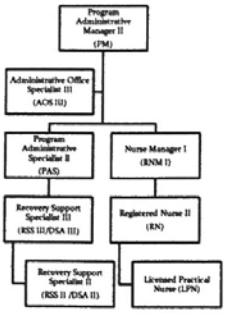


Sandra Bloom's *Creating Sanctuary*

Psychological Safety

Sandra Bloom's *Creating Sanctuary*

Organizational Structure: Program Staff



Treatment Team

- Psychiatrist
  - B. Martin, PMHNP – Tuesdays & Thursdays
  - Dr. M. Martin – Wednesdays and Fridays
- Registered Nurse (RN)
  - Kirsten Everton-Greenspon, Desiree John, Rose Mussler
  - Marzanna Krauze, Joe LaTempa, Maryann Martell
  - Henrietta Kisseadoo, Wellington Wang
- Psychologist
  - Dr. Matt Eisenhard
- Social Worker
  - Kesia Gwaltney, MSW
- Rehab. Services
  - M. Dunn, MT-BC
- Recovery Support Specialists (RSSs)
- Program Management
  - Lauren Cartwright, Program Manager
  - Joann Horvath, Program Administrative Assistant
  - Randy Hamrick, Nurse Manager
- Primary Care Physician
  - Dr. Smith
- Registered Dietician
  - Kathleen Hom
- Chaplain

Treatment Team - Core

Our Program Staff

- 8 RSS IIIs (plus 1 vacancy)
- 18 RSS IIs (plus 4 vacancies)
- 8 RN IIs (plus 1 vacancy)
- 5 LPNs
- 1 PM II, 1 PAS II, 1 RNM I
- 1 AOS III (currently provides Pod 5 AOS support)

Our Program Staff

- 3 of 8 RSS IIIs were previously RSS IIs on Cornerstone
- Prior experience working in ESH's Nursing Department
  - 4 of 8 RSS IIIs (previously DSA IIs)
  - 3 of 5 LPNs
  - 7 of 8 RNs
  - Program Administrative Specialist II (PAS)
  - Program Administrative Manager II (PM)
  - Registered Nurse Manager I (RNMI)
- The employment experiences of staff without prior ESH experience include:
  - Private psychiatric and medical hospitals,
  - Group homes and residential programs
  - Community day treatment programs

Licensed Practical Nurses

- LPNs - the glue that keeps us together
  - Geri Burguiere
  - Tanika Grayson
  - Robynn Joyner
  - G. Randolph
  - Jamie Wilson

Recovery Support Specialists

- RSS IIIs – Shift Leaders and RSS Supervisors
  - Latoya Armistead, Kim Cheeseman, Bobby Greer, Vickie Morie, Ahmed Moulki, Pam Sheffield, Jarvis Sessoms, Bill Sirman
- RSS IIs – Movers & Shakers
  - Shila Ghimire, Natacia Glover, Jasmin Jacobs, Katra Long, Tamara Morris, Latyma Smith, Tierra Wilson
  - Teresa Bartig, Florence Bivins, Patricia Goodman, Cynthia Kellow, Kiristyn Miles, Raquel Smith, Karen Spoering
  - Kelsey Daly, Mark McMahon, Shannon Raikes, Gwen Tyler

Our Daily Priorities

- Treat everyone with dignity and respect
  - At all levels and among all members of the community
  - To successfully promote the safety of:
    - Those served
    - Those serving
    - The larger community
  - For healing, recovery, wellness, and growth
- Offer choices, partner, and share power in as many ways as possible
  - Offering choices, valuing preferences, and using a strengths-based approach empowers and motivates individuals (staff and peers) to become more self-directed and independent
  - Power and control create risk and reduce safety
- Celebrate successes and embrace our short-comings and mistakes as opportunities to reflect, evaluate, improve, and grow

Community Living

- Normalized, comfortable living environment
  - Warm colors
  - Plenty of seating
  - Daily newspaper
  - Books, magazines, board games visible and accessible at any time
  - Live plants provided by "Earth Angels" aka Garden Club
    - Flower of the month presented in community meeting
  - Personalized bedroom door signs based on interests and hobbies
  - Two televisions available, 1 in dayroom & 1 in visitor's room
    - Requires peer to peer communication, respect, and problem solving
  - Piano available in the visitor's room
  - Guitar available to sign out upon request

Relaxation Spaces - Courtyard

- Unlocked from sunrise to 11:00 pm
- 11:00 pm to sunrise available upon request
- Shared community space with the peers of Community Preparation Program (CPP)
- Benches, trees, walking path, and flowers courtesy of the "Earth Angels"(aka Garden Club)
- Place to socialize, play guitar, listen to music, read a book, get some exercise, breathe in the fresh air

Relaxation Spaces – The Zen Den

- Also known as a sensory room
- Sensory items readily accessible
  - Relaxing & soothing scents
  - Calming sounds of the ocean, rainforest, waterfall, heartbeat
  - Weighted blanket
  - Stress balls
  - Natural light via window
  - Relaxed seating
  - Massage mat
- Developed by M. Dunn, MT-BC
- Peers on the volunteer cleaning committee clean and organize the space daily

Community Meeting

- Monday – Friday: 3:05pm to 3:30pm
- Peer President, Vice President, Peers, Staff, Treatment Team
- Agenda
  - Peer Presenters
    - News (One National, State, and Local story/article)
    - Weather
    - Sports
    - Trivia
  - Industrial Issues - environmental issues, needed repairs or supplies
  - Safety & Coping Strategies
  - Personal Responsibility: Pursuing Healthy Habits
  - Ideas & Suggestions
  - Success and Achievements – celebrating one another
  - Staff and Peer Announcements
  - Raffle Drawing (be there to win!)

Oscar, *Therapeutic Pet*

- Oscar the Beta Fish (Cornerstone Mascot)
- Introduced to the community in November 2014
- Vision of implementing a pet therapy program to:
  - Promote recovery and healing by easing depression and reducing stress and anxiety
  - Encourage social interaction, community awareness, unconditional love, and empathy
- Peers embrace the responsibility for Oscar's health and well-being
  - Proactively create a weekly schedule for feedings and cleanings

Self Care & Room Care

- Personal hygiene items supplied by the hospital include toothpaste, toothbrush, deodorant, lotion, soap, and shampoo.
  - May be kept in individual's room.
  - May purchase preferred brands of hygiene items.
  - Community meeting raffle includes choice of additional "specialty" hygiene supplies
- Exception: Any items with alcohol or glass are stored in secure cabinet and signed out/in each use.
- Exception: Razors, personal hair clippers, blow dryers, flat irons, etc. are labeled and stored in a secure cabinet and signed out/in each use.
- 2 washers and 2 dryers available
  - Launder clothes weekly and independently
  - RSS support available
  - Laundry Hours of Operation:
    Monday-Friday (4pm-10pm) Saturday and Sunday (8am-10pm)

Self Care & Room Care

- Clean linen provided every Wednesday and more frequently when needed or requested
- Remove own linen each Wednesday morning before PSR for facility laundering
- Except for water, food and beverages are not permitted in the bedrooms
- Keep floors clear of items to prevent falls and to allow for cleaning by housekeeping staff
- Limit clothing to the amount which can be folded and stored on the shelves in room

Cleaning Committee

- Peer volunteers sign up on a weekly & monthly basis
- Participation provides the opportunity to:
  - Serve the community
  - Practice and role-model personal responsibility
  - Receive encouragement and support, if needed, based on skill level
  - Independently perform daily living activities as a coping skill
  - Demonstrate independent living skills
- Volunteer responsibilities include:
  - Cleaning the dayroom tables and the nutrition room counters after meals
  - Communicating with peers in positive ways about the importance of maintaining a clean environment
  - Sweeping the dayroom floors after meals
  - Cleaning the relaxation aides in the Zen Den each day

Nutrition Matters

- Meals are served at the following times:
  - *Breakfast- 7:40am*
  - *Lunch- 12:00pm*
  - *Dinner- 5:30pm*
- Nutrition room is available 24/7 with crackers, juice, milk, cereal etc.
- Decaffeinated coffee available 24/7
- Personal snack lockers for non-perishable items
- Vending machines in snack room

Nutrition Matters

- "Coffee & Convo" (conversation)
  - Daily 8:00 am – 8:30 am
  - Simulated "Starbucks"
  - Peers help prepare coffee, put out creamers & sugars, and clean up when finished
  - Peers and staff interact by sharing daily goals
- Personal snack lockers for non-perishables & vending machines available at the following times:
  - 9:00 am – 9:30 am
  - 3:30 pm – 4:00 pm
  - 7:30 pm – 8:00 pm

Medications, etc.

- *Individualized* per physicians' orders
- Morning vital signs, medications, and treatments
  - Scheduled for 7:00 am may receive as early at 6:00 am or as late as 8:00 am
  - Generally begin around 6:30 am
- Mid-day medications & treatments
  - Scheduled for 12:00 pm or 2:00 pm & may be given up to one hour before or after
- Mid-evening vital signs, medications, and treatments
  - Scheduled for 5:00 pm & may be given up to one hour before or after
- Evening vital signs, medications, and treatments
  - Scheduled for 7:00 pm & may be given up to one hour before or after
- Lab work, when ordered, generally is obtained on Thursday mornings around 6:30 am

Evenings, Weekends, and Holidays

- Peers with Unescorted Grounds (UG) or Unescorted Community (UC) may take on grounds passes
- Peers with Escorted Grounds (EG) and above are encouraged to participate in "Walk & Talk" with RSS staff at 4:00 pm daily and 9:00 am on weekends and holidays as an additional opportunity for outside activity
- Peers with Escorted Community (EC) or Unescorted Community (UC) may attend NAMI with staff on Tuesdays
- Routine Community Reintegration (CR) Outings
  - Shopping for Success
  - Williamsburg Public Library
- Special Request CR Outings, Birthday Recognitions, and Special Celebrations
- Rehab activities and events in Building 2 according to the monthly calendar
- Cornerstone Programming, including, but not limited to:
  - Friday Evening JAM (Jesus and Me)
  - Chat 'n Chew
  - Earth Angels
  - Pet "therapy"
  - Aroma "therapy"

Community Reintegration Outings

- Routine CR Outings
  - Shopping for Success – every other Wednesday
  - Williamsburg Library – opposite Wednesdays from Shopping
- Peers present ideas and suggestions for outings during community meeting
- Peers and staff research, plan, and submit requests for community outings
- Staff work with peers to look at travel distance, length of outing, environment, potential expense, appropriate attire, and discuss any potential risks or triggers
- Peers submit a written request for the outing which includes the date, time, duration, location, facilitators, participants, and the participants' levels
- Requests require approval from the PAS or PM
- Upon approval, the lead RSS III meets with Tierra Wilson, Anita Kellow, or Teresa Bartig, RSS II, who coordinate the logistics for the outing (meals, tickets, transportation, etc.)
- A few examples:
  - Golden Corral (donation made by the corporate office)
  - Jamestown Settlement (free 1 day admission pass)
  - Movie Tavern (1 free drink and 1 free popcorn)
  - Passion of the Christ Musical (donation from Brenda Lee, MSW)
- Eligibility for community outings based upon:
  - Safety and privilege level
  - Active participation in treatment (PSR and community programming)
  - Community appropriate hygiene and dress

Williamsburg Library

- Every other Wednesday (opposite shopping)
- 6:00 pm – 8:00 pm
- Community reintegration, skill building, leisure, and recovery preparation
- Escorted by the RSSs
- Community established requirements for participation:
  - Clean, neat personal appearance
  - Respectful and safe behavior with peers and staff
  - Active participation in PSR and/or community programming

Shopping for Success

- Every other Wednesday (opposite library)
- 6:00 pm – 8:00 pm
- Community reintegration and skill building activity
- Escorted by RSSs
- Requirements for participation:
  - Personal money for purchases
  - Clean, neat personal appearance
  - Respectful and safe behavior with peers and staff
  - Active participation in PSR and/or community programming

Pet "Therapy" – Heritage Human Society

- Peers prepare and deliver dog treats to Heritage Human Society every month
- Peers visit the dogs at the Humane Society and feed them the homemade treats
- Peers express a sense of joy, accomplishment, pride, and making a difference as a result of their involvement
- On March 17, 2015 a thank you letter was sent to our clients on behalf of the shelter manager at the Heritage Humane Society
- Also on March 17, 2015 Cornerstone held its 1st annual award ceremony to recognize clients for their hard work, dedication, and commitment in the pet therapy group

Chat 'n Chew

- Who:
  - Patricia Goodman & Raquel Smith, RSS IIs
  - Any Cornerstone/CPP peer who is interested and commits to weekly participation for a pre-established period of time
- When & Where:
  - Mondays 6:00 pm – 8:00 pm in the Building 1 kitchen
- Purpose:
  - Meal planning, preparation, and cooking
  - Provide a community atmosphere
  - Promote independent life skills such as budgeting, decision making, time management, and etiquette
  - Provide education on healthy nutrition, including portion size and nutritional values
  - Build teamwork and communication skills

Garden Club – "Earth Angels"

- Who:
  - Cynthia Kellow, RSS II & 8 committed CSP/CPP peers
- When:
- Purpose:
  - To encourage conservation practices at Cornerstone and in our community
  - To develop a spirit of fellowship while expanding our horticultural knowledge and skills
  - To beautify our gardens
  - To expand our produce for the Chat 'n Chew Club
  - Stress relief (being in touch with nature can make you feel more removed from stressors of daily life)
  - Exercise (gardening helps with blood flow and oxygen throughout the body from the constant movement of raking and digging)
  - Social Outlet (allows the self named "Earth Angels" to interact and converse with others as well as share ideas and handy techniques)
  - Feelings of individual and collective purpose (The Earth Angels demonstrate a sense of shared purpose and individual self worth)

Friday Evening JAM – Bible Study

- Who:
  - Patricia Goodman, RSS II facilitator
  - Any Cornerstone/CPP peer who is interested, especially one who
    - Believes in one's personal ability to make a difference
    - Wishes to develop peer leadership skills
- When & Where:
  - Fridays 6:30 pm – 7:30 pm in Building 2 Sanctuary
- Purpose:
  - To provide an atmosphere where individuals are allowed to share their opinions and views without criticism about one's culture or beliefs
  - Promote peer support and reduce isolation

Aroma "therapy"

- Who:
  - Teresa Bartig, RSS II
- When & Where:
  - Monthly in the Cornerstone Dayroom
- Purpose:
  - Relieving or reducing mental conditions such as depression and insomnia
  - Encourages creativity and improves hygiene

Communications – Unit Phones

- Phone numbers:
  - 757-208-7986 (Med Room hallway)
  - 757-208-7923 (Zen Den hallway)
- Available at all times, but encouraged to be responsible:
  - Sunday – Thursday: 7:00 am to 11:30 pm
  - Friday – Saturday: 7:00 am to 1:30 pm
  - Phone usage is limited during meal times, medication times, and group times to create a more therapeutic milieu during these times
- Limit of 15 minutes per hour per person in order to support the communication needs and rights of all peers
- Peers are encouraged to respectfully bring disagreements and concerns about telephone use to community meeting

Communications – Cell Phones

- Peers with Unescorted Community (UC) may request treatment team approval to have a personal cell phone
- Requires a cell phone agreement and signature as well as a physician's order
- Personal cell phones are kept in the information center and may be signed out for use during on grounds passes and unescorted community passes
- Visitors are required to leave their cell phones in their vehicles

How to Contact Us

- Cornerstone – Building 1, 3C
  Eastern State Hospital
  4601 Ironbound Road
  Williamsburg, Virginia 23188
- Incoming mail is delivered to the unit and distributed by RSS staff daily at or before 4:00 pm
- Outgoing mail is collected daily
- Packages are opened in staff presence to ensure safety and for record keeping purposes

Visitors

- Visitation Hours:
  - Monday – Friday: 4:00 pm – 8:00 pm
  - Weekends & Holidays: 9:00 am – 9:00 pm
- Visitors under the age of 12 requires an order from the physician and must be accompanied by an adult
- Items brought by visitors are inspected by staff for safety and for record keeping purposes