RECOVERY PLAN in RESPONSE to INSPECTOR GENERAL:

Western State Hospital

August 1, 2007

Introduction:

It is the mission of WSH "to provide safe and effective treatment in a recovery focused environment." From the beginning of the Recovery initiative WSH has framed our task as one of incorporating what has been learned from those who have largely recovered, as this is what the recovery literature is primarily based, into our work with a primarily involuntary inpatient population of variably diminished capacity. What can be distilled from the relevant literature is the usefulness of hope, esteem, confidence, connection to help others, purpose, choice/control, empowerment, and, ultimately responsibility and accountability for managing one's own life. Approaching treatment holistically in terms of using treatment and support to restore or build a more engaged, satisfying life (versus simply treating an illness) is an essential point and one we have been building on for some time now. The concept of a healing environment may better describe what we are trying to accomplish than "treatment environment" so long as the vital importance of multi-modal treatment is not lost. The crucial importance of interactions between individuals, between staff and patients and families underpins much of the pragmatic implementation of recovery principles: listening, reflecting, using choice language, "coaching/teaching", etc. that generally lean in the direction of assisting hope, esteem, purpose, control, choice, etc. versus "doing for", "telling what to do", etc. . Other items such as peer support and services or the inclusion of consumers on various decision making committees or boards are other aspects of the "recovery movement".

According to the President's Freedom Commission: "***Recovery*** refers to the process in which people are able to live, work, learn, and participate fully in their communities. For some individuals, recovery is the ability to live a fulfilling and productive life despite a disability. For others, recovery implies the reduction or complete remission of symptoms. Science has shown that having hope plays an integral role in an individual's recovery". In our setting these principles can inform the spirit with which our services are delivered. In some ways it is more useful to think of them as dimensions of our services and can affect the way services are delivered, the way individuals are treated, and their experience of that service or treatment. To the extent to which services are consistently delivered in a manner that facilitates the restoration of hope and self-esteem, the development of purpose in one's day to day life, the experience of being connected to someone who is trying to help, the experience of having choices and making

them, and the sense of increasing their control over their lives (versus being tossed around by their illness, symptoms, problems, family, or system) then the likelihood is greater that the individual will take more personal control over managing their illness to achieve more satisfying life results. It is important to recognize that recovery is a process that will continue after a person no longer needs intensive hospital services. It is expected that the recovery process begun in the hospital will continue in community settings through peer support, WRAP Plans, and the inclusion of consumers on decision making panels and committees.

With respect to choice, a critical but operationally complex element in our setting, we have proceeded within the following frame. Life is a limited menu for all of us. To have choice does not mean all choices all the time nor does it mean choices independent of consequences or opportunities. However, the fact that the menu of choices is limited does not mean that there are no choices. For example, a person may not have the choice to not take medications, but may well be able to contribute to what medication they will take. Or, a person may not know what charges have been placed against them, but certainly may know what they prefer to wear or who they prefer to hang out with. This frame is readily understandable and therefore useful. Our staff is a remarkable in their ability to generate hope for people who have lost it, to connect to people who have isolated themselves, or to help people have a purpose today or this morning if not for next week or next year. This is what we need to build on.

Our task is, as it has been, to increase the consistency and effectiveness of interventions and interactions along the dimensions of hope, esteem, purpose, connection, and choice in a very real, non-ideological way.

We have previewed the Inspector General's findings related to WSH and sought to develop ideas and proposals that would have the most helpful and useful impact in helping us provide better service and meet this task. We have not attempted to address each and every item, nor been focused specifically on achieving a better "score" when the review is performed next time. It is my belief, as it has been, that this is an adjustment in our service provision, more in how we conduct certain things than what we do. I think we can move maybe 10%, maybe 15%, in terms of increasing the aggregate individual patient experience of hope, connection, choice, and purpose and in doing so increase the likelihood of a better outcome when they return to the community. We have to do this within the context of our other demands related to census, acuity, forensic work, risk management, skill building, budget, and other mandates so that what we do relative to recovery is integrated rather than disconnected from these other matters. In that way the changes will impact all services and be integral in our operation. It is through treatment that we reduce risk and facilitate improvement and recovery. Treatment is best done holistically, based on priorities, in an integrated fashion, with due attention to risks and realities, and with as much collaboration as can be attained.

Time frame: We expect this project, despite already being underway, will require a number of years. Indeed, it is conceivable that it will never be completely finished as each step forward seems likely to inform and suggest subsequent steps. For various reasons we are conceptualizing this process as a developmental one and, within the limits of a civil bureaucracy, trying to keep it as organic as possible. While we believe that after the first 12 – 18 months we will have to add more focused training, performance monitoring for some aspects of the process, adjusting practices, and further expanding and refining the roles of peer support individuals we believe those subsequent actions will be more effective if based in our assessment of progress conducted during the fall of 2008.

The Role of Senior Leadership:

Our Clinical Administrative Team (CAT) includes the Directors of Psychiatry, Psychology, Nursing, Social Work, Rehabilitative Services, and Clinical Director/PSR Chief, Hospital Director. All have been integrally involved in reviewing the OIG findings, developing plans to advance Recovery, and working with their departments on those plans. They will be involved in each component as we proceed forward from here. As for specific actions:

- Members, with the Director, will review and discuss the plan components and develop more specific information and examples to be used when meeting with Treatment Teams to review the plan and provide teaching/training. This first step will be completed by November 1, 2007. Representatives from CAT will have had their first meeting with each team by February 1, 2008 and will meet with each team semi-annually for the first 18 months of this project.
- Collaborate with each other, Peer Support Services, and with their clinical departments in developing the Recovery Handbook for WSH (see below).
- Collaborate with each other, Peer Support Services, and with their departments in developing the range of duties and necessary training materials for the Recovery Coach (see below).
- Lead collaborative efforts within each discipline and across disciplines to amend assessment instruments and the treatment plan to make it more clearly Recovery oriented. (see below)
- Help, with the new Peer Support Council (see below), define consumer roles within PSR programs and the ward milieus. This will attempt to address issues such as boundaries, confidentiality, responsibilities relative to risk statements or behaviors, etc. The first phase will be focused on group support activities and will finish by November 1, 2007. The

second phase will focus on individual peer support activities, i.e. 1:1 activities. This will be complete by January 1, 2008.

- Continue to participate in our two day Recovery Integration Workshop for direct care staff that began last year. (See below)
- Help integrate developing peer support opportunities with Treatment Teams and treatment plans.
- Director will meet with clinical departments as needed to discuss Recovery and its application in our setting, building on points made in a recent presentation at Northern Virginia "Recovery Partnerships" conference related to Recovery in Forensic Populations.

Workforce Development:

- That we institute a Recovery Coach component to our service. This would be someone designated for each individual to encourage, to connect, to reinforce hope, to be sure people know what they need to do in order to be discharged, etc. We envision this person enriching the self-assessment process and helping the individual collaborate with treatment teams. The role may vary between admission patients and long term patients as well as from individual to individual. Ultimately, we expect to have provisions for choice of who the Recovery Coach would be, within limits. We plan for the delineation of Recovery Coach duties and training needs to be completed by January 1, 2008, necessary training to be completed by July 1, 2008, and implementation to be fully in place by August 1, 2008.

- Generate a Recovery Handbook that could be used for training as well as a reference. This would articulate the WSH vision for this initiative in our operational context, provide educational information, provide examples of how to use/demonstrate recovery principles, describe how each individual staff member can contribute to the healing environment and recovery, and basically serve as a real world guide for staff and others. It would include delineation of the Peer Support programs. We have seen a nice model of such a handbook from Piedmont Geriatric Hospital although we would need to develop one that serves WSH needs. Our target date for completion of this handbook is January 1, 2008. The handbook will be distributed to staff and be present on each ward and PSR program as a reference.

- Complete the two day Recovery Integration Workshop for all direct care staff (currently approximately 50% of direct care

staff have had this training) by July 1, 2008. Key features of this training include : Active listening, milieu support, and behavioral sessions that all have a primary focus on interactions: listening, reflecting, using choice language, "coaching/teaching", etc. that generally lean in the direction of assisting hope, esteem, purpose, control, choice, etc. versus "doing for", "telling what to do", etc. Talking about difficult patient situations, using examples, and role plays or role play examples whenever possible make these two days engaging for the learners.

- We are changing the new employee training program making it longer and more integrated with on ward experience, including training with our new Mentor Program (see below) The new training should result in staff who have better skills, e.g., listening, reflecting, conveying hope, etc., than the previous training. The new orientation is scheduled to begin no later than December 1, 2007.

- Have at least one Recovery focused CME annually. This fall, Tina Champagne, OT is coming to address Sensory integration techniques.

- Recovery/PSR Annual Conference to be held again this fall and will continue annually. This year's main speaker is Gayle Bluebird, an expert in sensory therapeutic modalities and trauma-informed care. Previous years have involved Fred Friese, PhD, Suzanne Vogel-Scabilia, MD, and Amy Long, RN.

- As part of our local initiative for workplace safety related to patient aggression we will implement a Mentoring program beginning no later than December 1, 2007. This program is designed to teach new employees on a one to one basis and through role-modeling good interactional techniques that are consistent with Recovery principles. These mentors will also provide an on ward role reference for all direct care staff.

- Have all teams review Recovery principles and this plan in a team meeting with the Director and other members of our Clinical Administrative Team to help integrate it in their unique setting. Have each team take a look at cases that may have seemed hopeless to see if they can develop a fresh perspective on one or more aspects of the individual's functioning. As noted above this first meeting will be completed by January 1, 2008 and will occur semi-annually for at least the next year.

- Add knowledge of key recovery principles to required competencies for direct care staff by November 1, 2007.

- WSH staff will continue to participate in Recovery oriented training opportunities. This past year staff participated in the four regional Recovery Training Programs, VOCAL programs, and COSIG sponsored programs. We will continue to have staff and patients participate in these opportunities as they become available.

- WSH staff will continue to provide recovery oriented trainings within and outside WSH. For example, Robert Gardella, MD, and Clyde Hoy, peer support specialist are part of upcoming COSIG sponsored program on September 19.

Treatment Planning/Patient Records:

Add to the Self-Assessment:

- What do you want for your down time on the ward? Time to yourself, to be engaged, to be engaged in what, etc?
- Do you feel safe? If not, what feels unsafe, do you have ideas as to how we could make you feel safer, etc.?
- That the Self-Assessment would be the product of work between the patient and their Recovery Coach.
- The Self-Assessment will include a section for "Recovery Coach Comments" summarizing coach's involvement with patient, what plans worked and what didn't, and top 2 issues of importance for the individual.

- Ask in TPCs: Do you feel that the plan includes your input? What would help you have more input? Are you clear about what you need to be able to do to be discharged?

- More direct expressions of hope made by the Treatment Team in the TPCs. These may be limited to an issue or be broader and general depending on the situation.

Change Problem List headings to reflect recovery concepts. EX:

OLD	NEW
Psychiatric/Psychological Impairment	Psychiatric/Psychological Focus
Social Skills Deficits	Social Skills Focus
Dangerousness	Risk Management/Safety Issues

Basic Functional Deficits	Basic Functional Skills
Medical Problems	Medical Needs/Wellness
Ancillary Problems	Ancillary Recovery & Discharge Issues

- Provide different cues to stimulate recovery focused clinical assessments and summaries of Treatment Planning Conferences by using headings that focus writer on whole person. Each discipline will evaluate the clinical process note format and provide subject headings that focus the writer on recovery. Ex: in SW Clinical Process Note "Family Participation" might be changed to "Involvement with Relationships that Support Recovery" to capture wider range of supports the individual may have but do not fit under “Family Participation” heading.

- Review and consider changes to Monthly Treatment Plan Review forms and Quarterly TPC Notes/Psychiatric Evaluations to cue teams to focus on relevant recovery issues.
  --Ex: Heading that asks for "patient's recovery goals".
  --Add cue to include names of others that attended TPC or were contacted about TPC but could not attend (CSB, Family, friend, peer supporter).
  --Add a cue for "Integration of individual and team goals". We currently use headings of "team's evaluation of progress" or "discussion and plan".
- Increase the use of the patient's own words in Treatment Planning Summaries. Starting point may be integrating patient’s Self Assessment into Treatment Planning summary documents.

All treatment planning procedures and record improvements to be delineated and implemented by December 1, 2007.

Resident Activities and Opportunities/Relationship to the Community:

- Ben Smoke, MSW, has been assigned to duties as the Director, Peer Support Services with the broad goals of increasing peer support opportunities for WSH patients both within WSH and in the communities we serve. With Clyde Hoy, Lyn MacDonald, and others from within and outside WSH a number of initiatives have been or will soon be implemented:

  Form a Peer Support Council including clinicians, Members of the clinical leadership, and peer support staff to plan peer support activities, develop guidelines for and monitor the use of peers involved. This is complete. Guidelines relative to

roles, boundaries, confidentiality, risk actions, training requirements, etc. related to group involvement within PSR or other hospital activities will be complete by November 1, 2008. Similar efforts relative to individual peer support activities is described below.

Continue to encourage attendance at local Northwest Peer Connect/VOCAL and NAMI meetings. They are now well established and primarily involve consumers. Each local NAMI meeting features a presentation and the group is now looking to organize itself into different committees for advocacy purposes.

- Implemented a "buddy system" of patients to help with smoking cessation.

- Have created a room within our PSR building for peer support meetings that now occur weekly involving consumers from outside WSH coming to meet with WSH patients.

- By October 1, 2007 will implement plan to have monthly meeting of consumers from clubhouse programs in Harrisonburg, Staunton, and Region Ten with current WSH patients.

- The Peer Support Council will establish processes to integrate the "matching" of WSH patients with peer support individuals from the community to facilitate visits and Pen Pals. This should be complete by January 1, 2008. Our goal is to have ten "pairs" connected and functioning by April 1, 2008.

Train an additional employee/consumer as a WRAP Instructor with dedicated service to the Harvest Mall by January 1, 2008. This will allow us to initiate WRAP earlier in the inpatient process.

- Clarify engagement attempt requirements for staff off shifts and weekends, informed by the self-assessment information above. Implement by November 1, 2007.

- On ward second shift/weekend WRAP discussion groups led by a patient(s) for each ward that would be voluntary. Implement fully by July 1, 2008 when we will have trained Recovery Coaches to assist as needed. Where possible, in terms of patient interest and capability, such meetings can begin occurring this fall.

Make sure that all wards have Recovery materials on the wards, the patient Library, etc. This would include postings on bulletin boards as well as information that could be read individually. Implement by October 1, 2007.

Continue to pursue our new relationships with Goodwill Industries, and the Department of Labor. Goodwill has been enthusiastic about offering our consumers local training and employment, as well as job placement and job coaching services around the state after discharge. We have begun meeting with the Department of Labor and our Food Service and PPS department heads to develop plans to offer job and classroom training that would result in a certificate of competence from the DOL. Our representative from the DOL serves the HPR I, and has offered to assist in the process.

Other

Create a document that will be made available to forensic patients and their families providing education generally about the realities of forensic privileges that can also be used as a reference by all staff. Implement by October 1, 2007.

Perform our own survey twice a year covering some of the points covered by the Inspector General survey that have been the focus of improvement efforts at WSH. The items and elements will include those both from the Individual Survey and the Record Review as these are the instruments aligned with the "Recovery Experience" score. Our plan focuses are education of recovery principles, building interactional skills to support engagement and recovery, involvement in planning treatment, and increasing opportunities to receive and provide peer support. We should see improvement on elements related to hope, participation, purpose, choice, and connection. Other survey elements for staff would focus primarily on knowledge of recovery principles and the recovery mindset. Survey elements to be developed by January 1, 2008. First survey to completed by April 1, 2008. The second survey will be conducted by October 1, 2008.

Also, by March 1, 2008 we will have developed the specific monitors relative to the patient records. Some of these will be quite simple and are roughly described above. Others, however, require changes in the language used in the record, the kinds of items included in some sections of the assessments, and the full implementation of the Recovery Coach initiative. We will use or adapt items from the OIG review relevant to the changes we will be implementing, but may add some of our own as well. Determining the standards by which we will review records will require this planning time.

Our CAT will work with Treatment Teams on how best to implement and monitor initiatives relative to participation and expressions of hope as described briefly above. We will complete delineation of the requirements and monitoring process by March 1, 2008. We will delineate them by April 1, 2008 and review and discuss them with Treatment Teams during our second semi-annual meeting with them as well.

Measures of Success:

By October 1, 2008 we expect to have 90% of appropriate staff score at the 90% level on elements related to knowledge of recovery principles and attitudes.

By October 1, 2008 we expect to see a minimum of 15% improvement in all items/elements included that were not previously at the 90% level.

Chart reviews will be conducted for the first time in August-September, 2008. In chart reviews we expect to see 90% compliance with all changes in the "cues" and "headings".

We expect to see a 15% improvement in all items directly tied to an item from the OIG review not already above 90% on the reviews conducted by October 1, 2008.

We expect to see performance at the 75% level or above for observations of Treatment Planning Conferences with respect to expressions of hope, participation, safety, and the use of the revised Self-Assessment during this review.

Next Steps:

We will have a "Recovery Summit" no later than December 1, 2008 involving clinicians, patients, peer support staff and volunteers, and the clinical leadership to review the data generated from our fall, 2008 surveys, chart reviews, and observations as well as any subsequent OIG reports. We will discuss our progress, review more difficult areas or obstacles, and ultimately generate the next series of actions based on this review and discussion. We would anticipate these steps to range from minor revisions to processes going reasonably well, to taking further steps in the area of peer support provisions, e.g. peers as Recovery Coaches in some cases, to specific actions required to bring lagging Treatment Teams or programs forward more effectively. We will also be determining the training needs for some next steps and perhaps amending the survey or monitoring processes.