COUNTY OF MILWAUKEE
Behavioral Health Division
INTEROFFICE COMMUNICATION

DATE: September 6, 2011

TO: Supervisor Lee Holloway, County Board Chairman

FROM: Geri Lyday, Interim Director, Department of Health and Human Services
Prepared by: Paula Lucey, Administrator, Behavioral Health Division

SUBJECT: **From the Interim Director, Department of Health and Human Services, Providing an Informational Report Regarding the Status of the Implementation of Recommendations from the Mixed Gender Unit Report**

Issue
The Behavioral Health Division submitted an informational report in January 2011 outlining a comprehensive review of the issue of mixed gender units within a mental health facility. The report was informational and accepted by the committee. Several recommendations were generated and BHD is now returning to the Board to provide information about the status of implementation of those recommendations.

Discussion
A planning and implementation workgroup has been meeting to further develop the concepts contained in the initial report and outline action steps. Recognizing that the changes recommended in the original report are significant and that the success of these changes will depend on careful planning, the focus has been to create mission statements, admission criteria, programming, reallocate staff resources, define staff education needs and identify internal and external training resources.

<u>Women's Treatment Unit</u>

Program Description
The Women's Treatment Unit (WTU) will be a short-stay, inpatient unit for women with severe mental illness including mood or anxiety disorders, who may have experienced trauma (sexual, physical and emotional abuse) and have co-occurring addiction and/or medical needs. Individualized treatment includes: assessment, diagnostic clarification, stabilization, focused treatment interventions and facilitation of community linkages. Model of service is to

incorporate the principles of Sanctuary and Trauma Informed Care with the goal to restore optimal functioning in the community. Average length of stay is anticipated to be eight days.

Originally, the overall BHD bed capacity requirements necessitated that approximately nine of the beds on the WTU would need to be reserved for medically compromised or geriatric clients (5 to 6 males and 3 to 4 females). Additional discussion noted that the presence of any males, despite not being a current threat, might be retraumatizing for women who have a history of abuse. Therefore, the overall capacity and mission of the remaining units was again reviewed with a final decision to decrease overall bed capacity to 21, ensuring the option for women to be on a unit with only female clients.

While considering the likely patient population and the concepts of trauma-informed care, the planning group was able to develop an innovative program description and treatment approach. The goal is to provide care based on Trauma Informed Care principles and incorporate concepts from the Sanctuary Model.

Unit Treatment Milieu and Programming

Treatment Milieu will reflect training in Trauma Informed Care models and be based on Recovery principles. Staff will work together as part of a Recovery Team to identify individual client's needs and conduct treatment programming accordingly. This unit will not have a seclusion and restraint room and will utilize de-escalation strategies and other treatment interventions in its place.

Peer Specialists, who offer support by identifying themselves as persons in recovery, building rapport through active listening, and modeling hope, will play a significant role in promoting changes in individual patterns and behaviors. They will assist peers in developing a Wellness Recovery Action Plan, self-direction, and knowledge of community resources by providing advocacy and promoting a strengths-based approach as active members of the treatment team. Peer Specialists will be involved in developing their roles on the WTU.

Treatment Modalities will include **Skills Groups,** utilizing approaches including Dialectical Behavior Therapy (DBT) and Cognitive Behavioral Therapy, which will be offered to increase skills in the areas of interpersonal effectiveness, self-direction, emotional regulation, distress tolerance, mindfulness, problem solving, acceptance and change, and self-esteem. A **Sensory Room** will be provided to improve emotional modulation and clients will also have the opportunity to participate in **Music and Occupational Therapy Groups**. All groups will be developed within an overall framework informed by Trauma Informed Care models and will appropriately take into account evidence-based practices specific to the acute inpatient setting and length of stay.

Individual Recovery Plans will be based on a multidisciplinary assessment of both individual and contextual factors including current professional and social supports, housing,

employment, educational needs, transportation, income/budgeting, spiritual needs, trauma history, cultural issues, relationship status, psychological symptoms, and medical issues. Insight, readiness and capacity for change, treatment history and current engagement in treatment will be evaluated and used to inform recovery planning.

Personal Responsibility for recovery will be emphasized and the ability to access and use available resources will be assessed. The treatment model seeks to teach clients how to manage their mental illness for success in the other areas of their life.

Quality of Life after Discharge will be taken into account in discharge planning and each client will participate in planning using the DBT concept of creating a life worth living. Clients will be made aware of community resources such as housing, treatment options, financial assistance, educational and vocational opportunities, legal aid, spiritual communities, social centers, and support groups in order to maximize the potential for successful transition into the community with the goal to reduce any unnecessary use of the inpatient service. Community partners will be involved in helping to facilitate a seamless transition to the community by providing presentations and information on services they offer to clients.

Staff Education Needs

Internal and external training resources will be used to provide staff with the skills and knowledge needed to create the above milieu and provide a high quality of care. Community partners who will be available upon discharge will be asked to participate in activities while clients are inpatient in order to facilitate engagement and follow through after discharge.

Quality Assurance

Administrative staff will be involved in developing outcome measures and routinely informed regarding the success and opportunities for growth of the initiative contained herein. Successful outcomes will be monitored so that a transfer of knowledge, experience, and skills to other BHD staff and units can occur.

Next Steps

Administrative staff will be involved in with the internal unit staff, support services and external partners. The next big issue is defining the staff education plan and unit policy and procedures. To accomplish this, it is will be necessary to determine the process for staff selection and movement at all levels of staff. Additional items requiring planning and consideration, although not limited to, include: census management during implementation, personnel scheduling and assignment, and the identification of community discharge provider options. In addition, Environment of Care modifications will need to be identified and completed and fiscal implications need to be assessed. The Department is working toward an opening date of December 19, 2011 for this unit.

Intensive Treatment Unit

Program Description

The Intensive Treatment Unit (ITU) will provide rapid stabilization to patients at high risk for aggression. A variety of therapeutic modalities will be provided to assure that effective treatment occurs in a non-coercive and supportive milieu. Recognizing the special needs of this population, the principles of trauma-informed care will be applied. Presently, plans call for this to be a 16-bed unit, which will allow additional options for single-bed rooms and an increase in personal space. Staff will be specially trained at early intervention and de-escalation to minimize the use of seclusion and restraint and preserve patient safety and dignity. Additionally, staff will have education about the use of medication to create rapid de-escalation and will have the skills needs to provide physical monitoring as well.

Admission Criteria

Patients may be admitted directly from PCS to the ITU based upon past histories of significant aggressions, current mental status, or score on the Broset Violence Assessment tool. Patients may also be transferred from other inpatient or observation units based on currently assessed need. The ITU will work to rapidly stabilize patients to allow for safe return to other therapeutic environments or discharge to the community. Early discussions are also underway related to the acceptance of transfers from other facilities.

Though the ITU will be available to all patients served by BHD, specific oversight of patients with medical frailties and/or developmental disabilities must occur to assure the safety of these individuals in this environment. Similarly, the unit will not be designed to treat patients whose primary issue involves risk of suicide or self-injurious behaviors, as the staff on all acute care units is competent and comfortable with caring for patients with this profile. The ITU will also not be an appropriate option for those patients exhibiting stable behaviors but who are experiencing placement dilemmas secondary to previous displays of aggression or maladaptive coping strategies.

Unit Treatment Milieu and Programming

The ITU will maintain a non-judgmental, non-coercive, and problem-based approach to patients at current high risk for aggression and other maladaptive behaviors. The milieu will promote a sense of safety and calmness despite the acuity of individuals who will be treated there. Programming will be focused on activities that promote socially acceptable means to reduce aggressive impulses. A psychologist will develop meaningful and effective plans with the staff to address behavioral issues, perhaps including a rewards-based contingency model. All staff will work effectively as a team to help promote quick resolution of the behaviors that had precipitated the patient's ITU admission.

Pharmacologic modalities will be effectively utilized to minimize risk. Staff will be trained to recognize early warning signs of patient escalation and intervene with early and appropriate calming medications. Whenever possible, patient input into routine and emergency plans of care will be employed with the use of advance directives for de-escalating interventions,

including preferred medications. Additional strategies, including sensory modulation rooms, will be utilized on the ITU. These interventions will be part of the patient's treatment planning process so that referring units will have an understanding of effective management strategies upon the patient's return. Behavioral treatment interventions demonstrating efficacy will be similarly taught by the psychologist to those treatment teams assuming on-going care responsibilities for individuals stabilized in the ITU.

The treatment team will review ITU clients care daily. Intensive recovery planning will occur twice weekly for all individuals admitted to the ITU to assure prompt responses to changes in condition and successful use of individualized treatment strategies determined to promote wellness. The goal will be to have a length of stay that is 6-8 days.

Staffing Considerations

Effective patient stabilization will require a highly trained and consistent staff that works as a team to promote optimal patient outcomes. The specific staffing pattern has not been determined but it will have a higher nurse to patient ratio than is seen on other units. Activity therapists who have demonstrated proficiency with this at-risk population will be utilized extensively to promote self-soothing strategies, increased distress tolerance, as well as enhanced self-recognition of early warning signs for aggression. These methods will form the basis of an on-going treatment plan, which these individuals will bring forward as they transition out of the ITU. The role of para-professionals on this unit is currently under discussion. However, all staff, including professionals, para-professionals and supportive staff, must demonstrate competencies to assure special proficiency in early recognition and de-escalation of aggression.

Staff Education

All staff will have demonstrated competencies in violence prediction and de-escalation technique. Staff education will include methods of de-escalation including procedures for physical restraint in a way to protect the patient and themselves. On-going in-servicing will be a part of continuing staff development. Staff will have regular meetings to assure consistency of approach.

Quality Assurance

The program will have regular metrics assessed to assure reduction in rates of aggression and maladaptive behaviors for patients, both during their stay on the ITU and after transfer to on-going treatment units. Staff training will occur at regular intervals and competencies addressed to assure evidence-based best practice models of care. Patient satisfaction with the ITU will be regularly reviewed to assure care in an affirming and non-coercive environment.

Next Steps

Activity therapies will continue to be researched to ensure we implement best-practice individual and group strategies to reduce rates of aggression and maladaptive behaviors. Fiscal will need to review the likely impact of enhanced staffing ratios and the possibility of an enhanced reimbursement rate for this specialty level of care. The group will meet on an every-

other week basis to develop and implement concepts described in this outline with a goal to open the unit by January 1, 2012.

Recommendation
Progress is being made on the implementation of the two units identified in the Mixed Gender report. A number of innovations and changes in the philosophy of care are included in this work. BHD is developing the WTU and the ITU with the goal that, as appropriate and applicable, these innovations will be able to be implemented on the other two Acute Adult Units. The unit will be functioning as envisioned before the end of 2011.

This is an informational report and no action is necessary. A progress report will be brought to the Board in December 2011. A fiscal analysis is currently being conducted and any necessary budget changes related to this item will be brought to the Board in October.

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