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November 15, 2010

To Whom It May Concern:

Attached please find the "Colorado Mental Health Institute at Pueblo Behavioral Health Consultant Report, November 1, 2010," completed on behalf of the Colorado Department of Human Services by Joel Dvoskin, PhD, James E. Smith, L.C.S.W. and Susan A. Stone, J.D., M.D. The Department of Human Services hired these nationally recognized consultants to complete a thorough review of operations at the Colorado Mental Health Institute at Pueblo after three patient deaths over the past year.

The Colorado Mental Health Institute at Pueblo (CMHIP) is one of the state's two publicly funded mental health hospitals. It is the only facility in the state that provides psychiatric services to the jail and prison populations for inmates in acute psychiatric distress. CMHIP has 120 beds for patients not involved in a criminal proceeding (i.e. 'civil' patients). Patients charged with a crime (i.e. criminally insane patients), number over 300 and are the largest part of the population at the CMHIP. As a result, the care and treatment provided at CMHIP requires the provision of active mental health treatment in a high security physical setting.

Over the past decade, CMHIP increased overall treatment and rehabilitation services and implemented the best outcome-based treatment practices found in the literature. Over one-third of long-term court commitment patients (150 patients) were successfully returned to community living by the courts after they were provided rehabilitation services, vocational training and a comprehensive assessment of risk. Since the start of calendar year 2000, CMHIP has served over 19,000 inpatients and had over 7,000 episodes of seclusion and restraint. Prior to recent events, there had been no deaths in seclusion and restraint at CMHIP as far back as records were kept (1964) and there had not been a suicide in ten years.

With the opening of the new High-Security Forensic Institute (HSFI) facility in June 2009, CMHIP experienced significant stresses on its operations and staffing by virtue of the huge transition of moving nine patient units to the new building and adjusting to the new patient care and security systems. The economic downturn created high state deficits and the need for budget cuts and hiring freezes, as well as administrative staff furloughs. The long-standing challenges in recruiting psychologists and psychiatric technicians remained. In addition, the number of forensic court ordered referrals to CMHIP has continued to grow, pushing CMHIP for faster admissions to HSFI from county jails.

The Department asked the consultants to review overall hospital operations including personnel and management; policies, procedures, and protocols; high-risk areas; and overall patient care.

The consultants' recommendations confirm the findings of the Department's own internal reviews of these incidents. The Department is pleased that many of the activities it has already started in response to its internal

reviews and the findings of the Department of Public Health and Environment, place the Department on a solid path for implementing the recommendations included in this report.

Many of the consultants' recommendations identify structural issues within CMHIP. While many of these problems cannot be fully resolved overnight, the Department proceeded with immediate concrete actions to address these issues. Some of these actions include:

- Multiple policies and procedures were reviewed and revised involving the monitoring of patients and the environment, such as the elimination of the use of prone restraint. Comprehensive training was provided for staff at all levels including but not limited to refreshers in seclusion and restraint techniques and emergency drills. It appears not all staff were performing procedures correctly, so managers are conducting individual assessments of staff's ability to follow policy and procedure and conduct random visits to the units to perform procedures with staff to assure that correct methods are applied. Hospital management is systematically examining CMHIP policies for review and improvement.
- Multiple facility modifications and repairs have been completed, such as modifying locks and patient doors.
- CMHIP completed a comprehensive study of actual nursing coverage on the units and used similar studies completed in the Department's Regional Centers for persons with developmental disabilities and the Division of Youth Corrections to determine an estimate of CMHIP's staffing shortfall. The Nursing Department is using its comprehensive staff plan to identify minimum staffing levels and opportunities to increase cross-shift communication. CMHIP has been unable to meet basic staffing requirements in recent years, so this formal study and a funding request were completed in October 2010 for consideration of funding for more staffing.
- CMHIP formed a suicide risk mitigation committee, which had its first meeting in October 2010. A comprehensive suicide prevention plan will be developed by the end of November. Training will be increased and curriculum improved. The revised training will use examples of real patient behaviors and illnesses to increase staff awareness of specific patient risk levels.
- Clinical processes are under review for improvement, including options for increasing total treatment hours, enhancing the therapeutic environment and communication with patients, monitoring and assuring opportunities for increasing patient privileges, and reducing use of emergency procedures like seclusion or restraint.
- The Governing Body (the oversight body for CMHIP) met in October 2010 to assess leadership and made changes to the structure and bylaws. The consultant report recommends more changes that will be addressed through Governing Body work sessions to occur over the coming months.

The Department and CMHIP staff are committed to providing high-quality care to the patients in our care. After a decade free of these types of tragic events, the stresses created by these statewide environmental conditions have been brought to the forefront and the Department and CMHIP are committed to fulfilling these recommendations as completely as possible and taking steps to proactively prevent these types of events in the future.

COLORADO MENTAL HEALTH INSTITUTE AT PUEBLO
BEHAVIORAL HEALTH CONSULTANT REPORT

November 1, 2010

PREPARED BY:
Joel Dvoskin, PhD
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SUBMITTED TO:
COLORADO DEPARTMENT OF HUMAN SERVICES
COLORADO DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

FORWARD

Sentinel events can create opportunities. As a result of three such events within the past 12 months at the Colorado Mental Health Institute at Pueblo (CMHIP), the Colorado Department of Human Services (CDHS) contracted with a team of behavioral health experts to review the operation of and care provided at CMHIP. Subsequent to the assembly of this team, the Colorado Department of Public Health and Environment issued a Conditional Certificate to Operate a Psychiatric Hospital to CMHIP, effective October 1, 2010. That certificate also required for independent review "by industry experts to proactively identify deficient practice." As such, this expert report is being submitted simultaneously to the two agencies.

This report notes both positive findings and recommendations for remediation. We discuss strategies to balance clinical and security issues and alternatives to emergency interventions. We analyze clinical roles and relationships, and provide detailed recommendations about modifications to the organizational structure. A pivotal finding in our review is that the facility is significantly understaffed, contributing to many of the issues listed above. Finally, we provide guidelines for the development of a comprehensive suicide prevention plan.

This consulting team was consistently impressed with the dedication and compassion exhibited by both CMHIP staff and patients during this review. We are confident that there is sustained momentum to lead CMHIP to become a national model for state hospitals.

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BACKGROUND AND SCOPE OF WORK:

As a result of three sentinel events within the past 12 months at the Colorado Mental Health Institute at Pueblo (CMHIP), the Colorado Department of Human Services (CDHS) contracted with a team of behavioral health experts to review the operation of and care provided at CMHIP. As will be noted below, the consulting team has a wide array of expertise relevant to operation of such a facility. The CDHS asked us to review and provide opinions on the following topics:

- Staff roles and responsibilities in providing patient care and treatment;
- Delivery of behavioral health services;
- Staffing resources;
- High-Risk Review;
- Hospital management; and
- Organizational structure.

Subsequent to the assembly of this team, the Colorado Department of Public Health and Environment issued a Conditional Certificate to Operate a Psychiatric Hospital to CMHIP, effective October 1, 2010. That certificate also required for independent review "by industry experts to proactively identify deficient practice."

As such, this expert report is being submitted simultaneously to the two agencies.

We certify that we have not been influenced in any way by the nature of this evolution of events, and submit these opinions and recommendations from a position of objectivity and neutrality. We further certify that there have been no attempts on the part of either the CDHS or CDPHE to influence the opinions expressed in this report, although both agencies were cooperative and helpful in providing us with factual information that greatly enhanced the validity of our findings.

EXPERT QUALIFICATIONS:

- Joel Dvoskin, PhD

Joel A. Dvoskin, Ph.D., ABPP is a psychologist, licensed in the states of Arizona and New Mexico, who has worked extensively as a clinician, researcher, administrator,

mediator, educator, and consultant. Dr. Dvoskin has provided consultation to federal, state, and local governments in more than 30 states, most often regarding the assessing the risk of suicide and interpersonal violence, and treatment of serious mental illness and co-occurring disorders, especially to consumers with histories of violence and criminal justice involvement.

Dr. Dvoskin has extensive experience in directly managing psychiatric hospitals, and served as Acting Commissioner of Mental Health for the State of New York in 1995, after more than a decade as New York's Director of Forensic Services and Associate Commissioner. He has served as a Monitor for federal courts in Washington, Michigan, New Mexico, and Colorado, overseeing compliance with settlement agreements and court orders governing psychiatric hospitals, jails, and prisons. He has served as a mediator in class actions involving hospital and community mental health services, and is frequently asked to provide consultation, training, and program audits at state hospitals in crisis. Dr. Dvoskin has served as design consultant for more than 10 architectural construction projects for public psychiatric facilities, including the New St. Elizabeths Hospital in Washington, DC.

Dr. Dvoskin studied psychology and law at the University of Arizona, where he received his Ph.D. in clinical psychology in 1981, and currently teaches on the faculty of the Department of Psychiatry at the University of Arizona College of Medicine. He maintains a private and consulting practice in clinical and forensic psychology in Tucson, Arizona. He provides a wide array of training and consulting services to state mental health and criminal justice agencies, federal courts, corporations, and universities throughout the United States and Canada.

- James E. Smith, LCSW, DCSW

James E. (Jim) Smith, LCSW, DCSW has over thirty-five years experience in public mental health, twenty of which have been in state psychiatric hospital administration. He currently serves as Superintendent of the North Texas State Hospital, a 600 bed Joint Commission accredited hospital with two campuses approximately 60 miles apart. The Wichita Falls campus is a regional inpatient civil psychiatric facility that serves children, adolescents and adults from a large geographic area in north Texas. The Vernon campus serves the entire state, providing adult maximum security forensic and secure adolescent forensic inpatient services. Mr. Smith currently serves as President of the Board of Directors of the Southern States Psychiatric Hospital Association (SSPHA), is a member of the National Association of State Mental Health Program Directors (NASMHPD) Forensic Division Executive Committee, and a past Chairperson of the division. Smith is also a member of the NASMHPD Research Institute (NRI) Technical Workgroup, which helps oversee a national behavioral health performance measurement system for state psychiatric hospitals throughout the country.

Mr. Smith has chaired and served on numerous national and state mental health issues committees and project teams and currently chairs the Texas Department of State Health Services (DSHS) Forensic Services Committee. He has twice chaired state agency project teams to review and update the state's Manifest Dangerousness Review rule. This body of administrative law governs the determination of manifest dangerousness as regards state hospital inpatients, provides for their movement to appropriate care settings and affords them due process protections. He previously chaired a special DSHS project team aimed at helping Texas state hospitals reduce restraint and seclusion use. He has been a speaker and presenter at numerous professional conferences, addressing a wide range of forensic mental health issues. Mr. Smith is a Licensed Clinical Social Worker (LCSW), a member of the Academy of Certified Social Workers (ACSW) and a Diplomate in Clinical Social Work (DCSW).

- Susan A. Stone, J.D., M.D.

Susan A. Stone, J.D., M.D. is a licensed attorney, board-certified psychiatrist, board certified forensic psychiatrist, experienced mediator and consultant. Using her expertise in both law and medicine, Dr. Stone provides a unique perspective to consensus building and planning endeavors. She has extensive experience with organizational politics, interagency coordination, strategic planning, and managing difficult relationships. Dr. Stone provides mediation and facilitation services for a variety of private and public sector clients, and serves as a management consultant to assist organizations in tackling systcm design dilemmas.

Dr. Stone has worked extensively with the interface between mental health and the criminal justice system, serving as a consultant to the National GAINS Center, the Texas Coordinating Office for Offenders with Mental and Medical Impairments, the United States Department of Justice, and many local and state facilities. In addition to the consulting roles described above, she is also a practicing psychiatrist, practicing forensic psychiatrist and serves as the Executive Coordinator of the Mental Health Task Force in Austin, Texas.

Dr. Stone graduated from the University of Texas at Austin, with Honors, with a Bachelor's Degree in History. She graduated from the University of Texas Law School in 1985, and has been a member of the State Bar of Texas since 1986. She graduated from the University of Texas Health Sciences Center Medical School in 1990, and went on to complete her psychiatric residency at that same institution. She is the former Associate Medical Director and Director of Forensic Services at the Texas Department of Mental Health and Mental Retardation, and former Ethics Advisor for the Texas Department of Criminal Justice.

INFORMATION GATHERING PROCESSES:

CMHIP is a large and varied hospital complex, and the time frame of this review was limited. Nevertheless, this consulting team did its best to address the issues presented to us. Dr. Dvoskin and Mr. Smith spent three days on site, interviewing numerous staff members and touring facilities. Dr. Stone spent two days on site, touring facilities and meeting with professional staff. All three members of the team spent significant time talking with patients of the facility. While we did review overall operations across the facility sites, we focused most specifically on the newly opened High Security Forensic Institute (HSFI), where all three sentinel events took place. We were not asked to specifically address these sentinel events in this report, but we did review materials and medical records pertaining to those events in formulating our opinions and recommendations.

FINDINGS

- Positive Findings
  - Medical records were well organized and medication management appeared appropriate.
  - Written treatment plans were excellent--likely the result of an impressive facility-wide effort to build the recovery model into the treatment planning process.
  - Most patients at CMHIP appeared satisfied with the care and treatment they are receiving. Patients interviewed spoke highly of their treating clinicians. Even those patients who were dissatisfied with their own progress toward discharge identified staff as caring and competent.
  - All three consultants were impressed with the level of dedication and care expressed across all facilities on the part of CMHIP staff and clinicians.
  - Root cause analyses around the three sentinel events were thorough and comprehensive in scope.
  - We were particularly impressed with the adolescent unit. Youths were engaged and informed about their treatment, despite a relatively short length of stay.
  - Many of the cross shift briefings we observed consisted of meaningful and informative discussions of each patient, including their mental health and physical health needs.
  - In many parts of the Hospital, we were greatly impressed with the cleanliness of the floors and treatment environments. The performance of facility custodial staff is very important in communicating to patients that they are deserving of a clean, safe environment, and clean floors should never go unnoticed.
- Recommendations for Remediation

- Staff Morale

In order to improve patient morale, it is also necessary to tend to the morale of staff at all levels of the Hospital. Simply put, morale is currently low, in part due to the recent sentinel events and the outside scrutiny they have caused.

One important measure of staff morale involves the use of unscheduled sick leave and occupational injury leave. We were told that in 2010, unplanned sick leave by nursing staff has doubled, which supports the consistent reports we received from direct care staff at all levels that morale is low.

Recommendations:

- At the risk of sounding naïve, an important recommendation is that staff at all levels be nicer to each other, and empathetic about the difficulties experienced by other staff members. From the top down and from the bottom up, we recommend that everyone make efforts to share more positive feedback with each other. This positivity will undoubtedly improve the nature of informal communications between staff and patients, which should also be more positive.

- Staff members should be trained to systematically identify and reinforce pro-social behavior by patients, especially when those behaviors are the targets of treatment plans.

- Balancing Security and Clinical Issues

Even before the three sentinel events, it appears that the culture at CMHIP focused more on security issues than clinical care. We believe this has been exacerbated by the recent events. For example, as one member of our team put it, "the entire hospital is on suicide watch." Staff members appear anxious, significantly heightening patient stress levels.

This is particularly true at HFSI. The design of that facility was intended to create strong external security, in turn resulting in greater flexibility of movement and programming for patients. The concept behind the treatment mall (an area for therapeutic programming at the center of the facility) was that most of the patients would be there, participating in programming, most of the day. In operation, however, it appears to be rarely used. While this was attributed to staffing shortages, it also appears to be based on fear of negative outcomes, such as the sentinel events. As a result, most patients stay in their

residential pods most of the time. This kind of restriction is counter-productive to clinical progress.

In fact, the overall environment at HFSI is "stark." Patient rooms are barren of personality, with nothing even hanging on their walls to reflect any individuality. This is particularly striking given the long-term hospitalization of many of these patients. It evokes an atmosphere of despair, increasing the risk of negative clinical results, including suicide, agitation, and the need for emergency and involuntary interventions.

Hope is also difficult to maintain when patients feel that their progress and privileges are being arbitrarily denied, especially for non-clinical reasons. Multidisciplinary treatment teams should control movement of patients between privilege and security levels, as will be elaborated below.

Throughout the Hospital, there are metal, "fun-house" mirrors that are distorting to the point of disfigurement of the images of patients. There are now available mirrors made of safety glass, which, if broken, break into non-dangerous balls instead of chards of glass. Considering the importance of self-image as part of a person's recovery, these mirrors are simply unacceptable.

Recommendations:

- CMHIP must examine ways to create an atmosphere of hope and flexibility in the clinical environment. While many of our recommendations in this report are more specific, we believe this one must be nurtured at the facility level. However, as one example, patients should be encouraged to personalize their rooms with pictures and personal effects.
- Approval of increased privileges should be timely and clear. Patients should be given a meaningful opportunity to disagree and appeal Treatment Team decisions.
- The Disposition Committee should routinely review any patient who has not experienced some clinical improvement, manifested by increased privileges or decreased structure, within the past six months. Teams should routinely be asked to articulate barriers and solutions to patient progress.
- Metal mirrors that produce distorted images should be replaced by mirrors made of safety glass.

- Emergency Interventions

Similarly, CMHIP relies too heavily on emergency interventions such as restraint and seclusion. We noted several instances in our clinical review where restraint and/or seclusion were used as a primary patient management approach. There is good clinical evidence that alternatives to restraint/seclusion decrease staff and patient injuries, and improve overall outcomes. Reduction of restraint and seclusion requires a culture shift from negative to positive reinforcements. Simple interventions, such as development of comfort rooms that patients can voluntarily utilize when in distress, can decrease restraint and seclusion by as much as 50%.

For the past fourteen years, the NASMHPD Office of Technical Assistance has promoted utilization of a prevention based training curriculum called the Six Core Strategies. Through extensive national research this curriculum has been shown to be easily implemented and dramatically successful in a variety of treatment settings.

Recommendations:

- CMHIP should implement NASHMPD Six Core Strategies curriculum facility wide and embrace the culture of reduction of seclusion and restraint. While it may be impossible to completely eliminate all use of these interventions with this patient population, dramatic reductions are realistic and essential.

- Policies and procedures related to seclusion, restraint, and involuntary administration of medications should be reviewed and amended. They must be clear, concise, and easily understood by the staff members who are expected to carry them out.

- Clinical Roles and Relationships

The clinical approach at CMHIP revolves around a "treatment team," consisting of a Team Leader, Nurse, and Psychiatrist. We found this approach to be faulty--in fact there was no "team." Medical staff reported that psychiatrists have been relegated to medication management and are not actively engaged in overall treatment planning. "Team Leaders" are not really leaders of the team—neither is anyone else. This results in uncoordinated and inefficient care.

Psychiatrists at the facility are frustrated and angry about staffing levels and the clinical structure, leading to significant recent and pending attrition. Psychiatric staffing has gone well below the 1:18 ratio agreed upon in the most recent lawsuit against the facility. Requests for relief in hiring emergency staffing by

way of locum tenens have been denied, resulting in additional stress upon the remaining psychiatrists. Existing medical staff members have increasing concerns about their ability to provide quality care in this environment.

Psychiatrists have not generally been seen as leaders at CMHIP. This only recently changed when a decision was made "from the top down" that medical staff would be the final authority on movement of patients between units. There is no structure in place to support this shift in responsibility. If psychiatrists are to absorb these functions, they will need leadership training and more support.

Recent closure of the Medical Surgical Unit (Med-Surg) at the CMHIP presents another clinical challenge. This decision was made without consultation of medical staff, and has resulted in complications related to continuity of care. Prior to the closure, patient medical problems were addressed internally. This is particularly important for this long-term patient population, for whom CMHIP is a primary clinical care home.

Since there is no public medical hospital in the area, patients are now transported to private hospitals for medical care. As one staff member stated: "any cost savings…come at the expense of angry private facilities." The lack of communication between these private facilities and CMHIP was also noted as a critical quality and continuity of care issue.

A particularly disturbing recent development is a ruling by the Colorado Health Department that all documentation of clinical care by physician assistants and nurse practitioners be co-signed by psychiatrists. These physician extenders are a critical component of clinical care at CMHIP, as they have significant difficulty recruiting physicians due to low salaries. Further, it is our understanding that Colorado State Law recognizes them as independent providers. This decision to require their orders to be countersigned essentially relegates physician extenders to essentially the role of medical students, greatly diminishing their utility at this critically understaffed facility.

Recommendations:

- Psychiatric staff should be more actively engaged in the organizational structure, policies and procedures, and administrative decisions. If expected to be leaders, psychiatric staff must be provided the training and structure to support that role.

- CMHIP must revisit the clinical care structure, including the development of true "treatment teams." These clinical teams should parallel the overall organizational structure, outlined below. All decisions made should

ultimately revolve around clinical progress of CMHIP's true stakeholders: the patients.

- While we will address overall staffing later in this report, psychiatric staffing is a critical component—this is a psychiatric hospital. We recommend returning to the 1:18 ratio for this acute/chronic patient population. (Note -- If Nurse Practitioners and Physician Assistants are allowed to return to their status as independent providers, they would essentially count as physicians for purposes of this ratio.)

- Virtually all of the recommendations contained in this report, and indeed the proper functioning of any psychiatric hospital, require the presence of an adequate number of competently trained psychiatric providers. We recommend that the salary structure for new and existing psychiatrists be examined and adjusted to ensure that it is competitive with nearby competitors.

- CMHIP should investigate opportunities to coordinate care with local medical hospitals, including access agreements to their Electronic Health Records, potential liaison functions between the facilities, and integrated training opportunities to increase comfort levels and continuity of care between physical and behavioral health care providers.

- CMHIP should investigate alternative interpretations of statutory law regarding the use of physician extenders at psychiatric facilities. The CDHS opinion requiring co-signatures will significantly impact quality of care at the facility, and is contradictory to practices in other states across the country. If necessary, the Department should consider seeking legislation to clarify that nurse practitioners and physician assistants are independent providers.

- <u>Organizational Structure</u>

Similarly, the organizational structure at CMHIP is in disarray. While there are many examples of good patient care, the hospital's current organizational structure serves as a barrier. Typically a hospital's Governing Body, with its "high altitude" view of organizational functioning and performance would identify such problematic trends and direct a course correction. This has not been the case at CMHIP.

Below are some concerns we have with the current Governing By-Laws structure at CMHIP.

While slated to meet "at least quarterly and more often as determined by the Chair or designee;" …"there are no quorum or attendance requirements for the meetings." This, in addition to the informal nature of the Governing Body structure, leads to the perception of a lack of transparency. For example, when Governing Body members are absent, the Chair determines what business may appropriately be transacted and may appoint or approve a designee to act on behalf of the Governing Body member. Presumably, the Superintendent could call a special meeting of the Governing Body, name designees to act on behalf of other members and conduct business as he or she determines appropriate and not be in violation of the current bylaws. Clearly, there is nothing to suggest these kinds of abuses have occurred. The concern is that the bylaws don't anticipate the potential problems and liabilities of this approach to structure and therefore cause one to question the actual and practical importance of the Governing Body to the overall functioning of the hospital.

Minutes of Governing Body meetings don't consistently reflect the kind of follow through or "loop closing" one would expect from such a body. For example, the current bylaws state, "The Governing Body shall set goals and objectives for itself annually and shall evaluate its own performance relative to the success of meeting." A review of quarterly Governing Body meeting minutes for a one-year period (ending with the August 10, 2010 Governing Body meeting) suggests this was not done. While the February 9, 2010 Governing Body meeting minutes include a reference to "Leadership Self-Evaluation 2010" and describe a process for ranking the top three items to be accomplished in 2010, minutes of the following two quarterly meetings do not reflect any follow-up on the issues. This is in fact a fairly common occurrence. Governing Body meeting minutes do not consistently reflect follow-through on issues from one meeting to the next and even when actions are planned subsequent to discussion of issues, seldom is there any mention of time frames for task completion. Unfortunately, this communicates the message that the one body in the organization's structure that should be a model of accountability and transparency is not, or at least not consistently. Also of concern, the meeting minutes reviewed do not reflect any effort by the Hospital's Governing Body to solicit public comment, thereby denying possible stakeholders outside the hospital's organizational structure the opportunity to make comments and suggestions; and likewise denying the Governing Body members and the Executive Committee the opportunity to learn and benefit from their stakeholders and constituents.

The Hospital's Executive Committee also has structural weaknesses and a track record of performance reflecting failure to close loops. Among the team's most significant structural concerns has to do with the assignment of responsibility for critical functions. In some cases, functions that arguably should be grouped together under the same responsibility center or manager are not. For instance, the table of organization shows a position described as Chief Psychiatrist for Quality Assurance and Standards Compliance. Though these functions are appropriately considered quality support

services in nature, this position has a reporting line outside of the Quality Support Services Department. There are numerous other examples of questionable grouping of functions under the Executive Committee structure. This practice becomes problematic in that it is inherently confusing and sets the stage for potential conflicts over issues of managerial authority and responsibility. As a consequence, the organization is overly dependent on individual relationships as opposed to structural and managerial relationships that are mission driven. We also find that when tracking many of the reporting lines from the Executive Committee to the point in the organization where direct patient treatment is provided, it becomes less and less clear as to who is actually empowered to make decisions about patient care; this is especially problematic when decisions cut across disciplines.

The team also finds that committee structures are not consistently effective and are not always linked to positive clinical outcomes. This has resulted in low morale across the facility. This is not lost on the patients, who stressed that fear on the part of staff members leads to anxiety for them as well.

The team agrees that the flaws in the current organizational structure require more than simple repair. In order for the hospital to accomplish its mission and realize its vision for the future, a significant overhaul of the entire structure is necessary. We spent a great deal of time discussing various organizational options, and thought it best to start with a clear articulation of the goals of a revised organizational structure:

1. The structure should be clear to everyone who is in treatment or works at CMHIP.
2. The structure should allow for decisions to be made based upon an inclusive process that informs the decision-maker in a timely manner.
3. Although there is no way to avoid multiple lines of authority (i.e., matrix management), there must be clear, single points of accountability.
4. The sole purposes of the organizational structure are to provide and document high quality patient care, within the context of appropriate management of risks to patients, staff, and the community.
5. Senior executives should provide an environment of safety that allows their subordinates to take reasonable risks, which are necessary for patient growth and recovery. The management structure must be perceived as protective of reasonable risks, even when outcomes are undesired.
6. Every committee and every meeting should have a clear purpose, and result in clear decisions that are well-informed, timely and clearly communicated to all stakeholders.

We believe the recommendations in this report regarding the restructuring of the hospital's Executive Committee and the corresponding patient care delivery model, will meet these goals.

We acknowledge that the following recommendations represent a blueprint for sweeping organizational change at all levels. While this will result in significant role changes for many individual staff members, it also offers a meaningful role for all current staff who are willing to make an investment in the organization's success. Recommendations for change must be underpinned by a comprehensive implementation and roll-out plan developed and lead by the hospital's leadership. Change of this magnitude will take time and will require training and support for those staff assuming new roles and responsibilities.

Recommendations:

- The CMHIP Governing Body Bylaws should be amended so as to designate the Director, Mental Health Institute Divisions as Chairperson. Doing so will better distinguish the roles and responsibility of the hospital's Chief Executive Officer (i.e. Superintendent) and the Chairperson of the Governing Body.

- The Governing Body Bylaws should be amended to define circumstances when decision-making requires a quorum as well as what constitutes a quorum and specify attendance requirements for Governing Body members. Simply put, if the Governing Body is important to the life of the Hospital, its members should attend its meetings.

- The Governing Body should adopt a format for its meeting agendas and meeting minutes that clearly reflects time devoted to standing reports, unfinished business, and new business items. Meeting minutes should clearly capture pertinent discussion, actions to be taken in response to business items, persons responsible for actions and follow-up, and clear timeframes for task accomplishment. Adopted formats should be cascaded throughout the organization's committee structure. This simple but effective strategy will improve efficiency, accountability, usefulness of documentation and facilitate "loop closing."

- As per its bylaws, the Governing Body should engage in setting annual goals and objectives, and it should evaluate its own performance relative to the success of meeting them. Doing so is important to preserving its own integrity. (In other words, "If you say you will do something, do it." Only by holding otself accountable can the Governing Body maintain the credibility needed to lead the Hospital, it's staff, and it's patients.

- Time should be set aside at each Governing Body meeting for public comment, and the Hospital should make a reasonable effort to inform external stakeholders and the general public of that opportunity in advance of its meetings.

- The hospital's organizational structure as reflected in its current Table of Organization should be changed as needed to achieve better economy regarding the grouping of critical functions and corresponding staff responsibilities. This process should be mission driven and underpinned by the value that quality patient care is everyone's job and staff derive their importance in the organization by how well they do that job and not by title or position. Specifically, the Hospital's Executive Committee should be chaired by the Superintendent and consist of the following members who are direct reports to the Superintendent:

  - Clinical Director – This position has direct responsibility for and supervision of the following positions: All of the Hospital's Division Chief Psychiatrists; Director of Psychology; Director, Spiritual Care; Director of Social Work; Nurse Executive; and Director of Ancillary Patient Services.

  - Medical Director – This position has direct supervisory responsibility for the following: Chief of (Non-Psychiatric) Medicine; Chief of Dentistry and Dental Clinic Coordinator; Director of Pharmacy; Director of Medical Records; Surgeon; Director, Clinic Services; Division Manager, MSS and Director of Pathology.

  - Assistant Superintendent – This position has direct supervisory responsibility for the following: Director of Forensic Aftercare Program (FCBS); Coordinator of Court Services; Chief of the Department of Public Safety; Director of Nutrition Services; Coordinator Incident Occurrence Officer and HIPAA Privacy Liaison; Patient Representative; Director, Public Relations and Volunteer Services; Safety and Risk Manager; and serves as the hospital's principle liaison with the agency maintenance and food services departments.

  - Director of Quality Support Services – This position has direct supervisory responsibility for the following: Manager of Utilization Review; Manager of Liaison Functions; and Chief of Quality Assurance and Standards Compliance.

  - Nurse Executive – While this position does not directly report to the Superintendent, the position's scope of responsibility nevertheless warrants membership on the hospital's Executive Committee. This position directs the delivery of nursing care, treatment and services.

  - Director of Ancillary Patient Services, is a new upper level management position that reports to the Clinical Director, and may be included as a member of the Executive Committee. This new position has direct

supervisory responsibility for the following: Director of Vocational Rehabilitation Services; Director of Occupational Therapy; Director of Recreation Therapy; Director of Education Services; Director of Admissions; Director of Staff Education; and Lead Trainer VJ and Ripp Restraints.

The position of Division Manager, MSS and Director of Pathology continues to have direct supervisory responsibility for the Department Directors for EEG, Speech and Hearing Pathology, Physical Therapy, Respiratory Therapy, Radiology, and Clinic Care Services.

- The team continues to have concerns regarding the line of supervision for the Director, Quality Support Services. Previously, this position reported directly to the Hospital's Superintendent. The position now reports directly to the Director, Mental Health Institute Division and has some system-wide responsibilities. This position is very important to the life of this hospital. While the current supervisory arrangement might be workable with diligent effort, we believe it poses an untenable risk of destructive triangulation in the relationships between these three critical staff. We recommend that the Hospital have its own dedicated Director of Quality Support Services position and that this position report directly to the Superintendent. The Department very likely has system-wide quality improvement needs that would warrant a separate, Department-wide position; however, our recommendations are limited to CMHIP.

- The structural model for providing psychiatric patient care must be fundamentally consistent throughout the hospital, while flexible enough to respond to the nuances associated with serving diverse patient populations (e.g. adult civil, maximum security forensic, adolescent, etc.). While encouraging collegiality among members of the professional disciplines represented, the model must clearly speak to who has ultimate authority for decisions about patient care. We recommend the following structural model for providing psychiatric care.

    - The Hospital should be divided into four, possibly five patient programs. For example, there could be a Maximum Security Program, a Medium Security Program, a Long-term care Program serving intermediate and minimum security forensic as well as longer term civil patients, an Acute care program serving acute civil patients and adolescents, and perhaps a Specialty Care Program, serving specialized programs such as the Circle Program. These divisions are merely suggestions offered for example; we are not wedded to how the hospital defines specific programs, as long as their size is consistent and manageable.

- Each Program should be led by a Program Management Team (PMT), headed by a Chief Psychiatrist and also consisting of a Nurse Manager (probably a Nurse IV) and a Program Services Coordinator (typically at least a master's prepared clinician).

- PMTs provide supervision to each of the program's treatment teams, with the Chief Psychiatrist having direct supervisory responsibility for each ward's staff psychiatrists and the Nurse Manager having responsibility for the maintenance of the highest standards of professional nursing care for all nursing services personnel (professional and paraprofessional) assigned to the program. The Program Services Coordinator is responsible for facilitating and coordinating patients' access to services not directly located and available within the Program (e.g. Treatment Malls, Vocational Rehabilitation, Recreational Therapy, General Medical Services, patient library, etc.). PMTs are responsible for program management that results in a therapeutic milieu consistent with the specific program's patient care mission.

- Each program will have between three and five distinct treatment teams. Treatment teams are headed by a staff psychiatrist and consist of a supervisory nurse (probably a Nurse III), a psychologist and a social worker as core members. Although staff psychiatrists have direct line authority for all core treatment team members, team members also receive discipline specific consultative supervision from the appropriate discipline director in the case of psychologists and social workers, and from the program's nurse manager in the case of the nurse member of the treatment team. Although treatment team caseloads may vary depending on the nature and acuity of the patient population served, they will typically consist of an average of twenty-four patients. Other staff knowledgeable with regard to individual patients, especially direct care line staff, should be invited by the treatment team to participate in treatment planning, patient staffing conferences, etc.

- The hospital's committee structure must be reviewed with an eye toward streamlining and improving operational efficiency. However, doing so prior to implementing this report's other recommendations for structural change would likely prove premature.

➢ Processes/Communication/Transparency

Not a single staff member of the facility felt empowered in the current organizational structure. Interactions are too often motivated by fear. Several staff members reported punitive consequences for expressing disagreement with

policies, procedures, and clinical care. "Accountability measures" are seen as "dinging staff members for errors." In fact, a Hospital Survey on Patient Safety Culture performed in April of 2010 reflected that 44% of respondents did not feel free to question the decisions or actions of those with more authority and were afraid to ask questions if something did not seem right.

There appeared to be a significant disconnection between administrative decisions and clinical care. Policy development has been piecemeal and reactive. Historically, adverse events at the facility have led to "knee-jerk" modifications of policies and procedures. The process of getting policies approved is cumbersome, involving three separate committees. This has resulted in complicated, sometimes unintelligible policies that are frequently not followed. By his own admission, the Superintendent has only been engaged in the certain areas of policy that are of interest to him. In interviews with other staff we consistently heard that the process for policy and procedure development is largely a mystery. Only a few upper level administrative staff could describe the labyrinth like process now in place.

It was also noted that decisions are often made by individuals that do not have the appropriate knowledge base. While this may be a training issue, it is also a likely result of the current "silos" inherent in the organization's structure. These impede staff access to other staff who may have the requisite knowledge for better decision making. Some large and complex organizations have found that a clear articulation of corporate values serves to improve the quality of decision-making. A statement of corporate values provides a basis by which every decision contemplated at every level in the organization may be evaluated. It affords everyone in the organization the opportunity to ask, "How does this square with our values?" when making decision. The hospital has credible mission and vision statements as well as a solid hospital Code of Ethics. However, we did not find a clear articulation of corporate values which at the least represents a missed opportunity.

We found there to be no clear and universally understood set of guidelines for patient movement along the continuum of security levels (i.e. maximum, medium and minimum) within the hospital. Likewise, it is not clear as to what due process protections exist for patients who want to challenge/appeal decisions made regarding their movement along the continuum. This is not to disparage the quality of clinical decision-making regarding such decisions. It is more a matter of making sure everyone, staff and patients alike, understand the "rules of the game" around this important process.

Recommendations:

- CMHIP should engage a local consultant (preferably someone with clinical experience and skill as an editor) to review the necessity and content of current policies and procedures and make recommendations about how to streamline and prioritize them. Staff should then be assigned to develop clear, concise, and accessible policies in the areas recommended. The Superintendent must review and approve 100% of policies and procedures developed through this process.

- The Superintendent and Executive Committee should, using inclusive processes, develop and articulate a clear statement of organizational values. Once done, this values statement should be cascaded throughout the organization and be included in the orientation of new staff.

- The hospital should develop a clear set of guidelines for determining patient movement along the hospital's security level continuum. It should also provide a consistent and understandable means of appeal for patients who want to challenge decisions made regarding their movement along this continuum.

➢ Staffing

- Staffing ratios have decreased considerably over the past several years. After thorough analysis, this consulting team believes that CMHIP is understaffed by as much as 20%. In investigating this phenomenon, these shortages appear to be related to inadequate funding of relief for positions that must be back-filled when a staff member is out sick or injured. We also note that unlike many state workforces, CMHIP reportedly cannot recruit for a vacancy until the job is actually vacated, building unreasonably long delays into the hiring process.

Recommendations:

- CDHS should advocate increased funding for staffing at CMHIP as a priority with the Colorado legislature.

- Known upcoming vacancies should allow immediate recruiting, to minimize the time that jobs are left vacant.

- Environmental Risk Assessment/Suicide Prevention Plan

The heart and soul of any suicide prevention plan is ongoing assessment of suicide risk; in other words, knowing one's patients. Maintenance of a therapeutic alliance between staff and patients is essential to maximizing the likelihood that staff will find out about a patient's suicidal thoughts prior to a serious attempt.

In any hospital, it is simply impossible to remove all suicide hazards, and any patient who remains acutely suicidal and intent on ending their life will, sooner or later, very likely find a way to do so. Pretending that the environment is hazard-free will create a false sense of security, and works against the clinical diligence that allows the hospital to identify suicidal patients in advance of serious attempts. To be quite clear, when patients are not on suicide watch status, there is no way to prevent them from killing themselves. Further, allowing patients to heal, grow, and recover from mental illness requires that they be allowed some degree of freedom to make decisions and mistakes.

On the other hand, the majority of suicides are impulsive attempts to end psychological pain, and it is important that patients at chronically higher risk of suicide, including those with histories of multiple suicide attempts and gestures, and those with high levels of impulsivity and impaired judgment, be prevented from easy access to a means of ending their lives. In other words, it should not be easy to die.

Balancing these seemingly competing requirements is one of the challenges that every psychiatric hospital must address. In our opinion, the single most important way to prevent suicide is to create a real therapeutic milieu, so that staff are perceived as a potentially helpful resource when patients are experiencing intolerable psychological pain. Identifying suicidal patients and putting them on appropriate watch status is imperative in order to accomplish this important duty.

When patients are deemed to be a high and acute risk of suicide, the clinical staff should immediately take steps to ensure the person's safety until a comprehensive suicide risk assessment can be completed. Any clinical staff member should be able to initiate a suicide watch, so long as the required clinical reviews take place in a timely manner. The goal in initiating a watch is to err on the side of caution. If mistakes are to be made, they should be mistakes of caution.

Responses to suicidal patients should be beneficent and non-punitive, and clinical teams must be constantly vigilant to look for signs of suicidal intent by patients. Efforts should be made to enlist the entire community of patients on a ward to report suicidal statement by a peer, but in order for this to happen, patients must be confident that such reports will not result in punitive responses to the patient of concern. Put simply, suicide prevention is everybody's business.

We do not believe that so-called "accountability checks" are particularly useful in preventing suicides among patients who have not been identified as being at acute risk of suicide, although some sort of routine check-ups on patient welfare and safety are useful for other purposes. Too-frequent checks on patients who have earned freedoms within the Hospital can be a source of friction between patients and staff. Indeed, the name "accountability checks" sends a harsh and uncaring message about their purpose; we'd prefer a name that communicates caring, such as "welfare" or "safety" checks.

The manner in which the checks are carried out must also communicate appropriate levels of concern, caring, and trust. For example, when a patient is awake, staff members should offer a brief conversation or a kind word. When a patient is sleeping, every effort must be taken not to awaken a patient, as sleep is a crucial need for everyone, but especially people with serious mental illnesses.

Every psychiatric hospital must have a comprehensive approach to prevention of suicide. Both forensic and civil patients, of all age groups, are very likely to have been deemed to be a danger to self at various times just before and during their hospitalization. This duty is spelled out in constitutional, statutory, and common law; however, a legal analysis of a hospital's duty to make reasonable efforts to prevent suicide is beyond the scope of this report.

The best prevention against suicide is not over-control of the patients; it is the creation and maintenance of hope. Hopeful people do not kill themselves. To the extent that despair is accepted and tolerated, it will be difficult to identify those poatients whose hopelessness has reached crisis levels. For that reason, many of the other recommendations in this report, aimed at creating a hope-filled and therapeutic milieu, are the heart and soul of the Hospital's suicide prevention plan.

Recommendations

Every psychiatric hospital has an explicit legal, ethical, and moral duty to make every reasonable effort to prevent suicide. In order to carry out this duty, a hospital should have various components in place:

1. A suicide prevention plan for the institution - This plan should be spelled out in writing, and known to the Governing Body, the Executive Team, and all staff (and perhaps even patients) of the Hospital. The plan should include all of the elements we describe in this section, and must be spelled out in policies and procedures. Finally, the plan must be monitored so that the Hospital leadership knows that it is being carried out as planned.

2. Policies and Procedures regarding suicide prevention - It is imperative that the policies and procedures regarding suicide prevention be current, frequently updated, and known and understood by everyone. They should include all of the elements contained in this section, and spell out in datail the manner in which various forms of suicide watch are to be carried out and documented.

3. A suicide prevention committee - This committee should include representation from a wide array of staff from many departments of the hospital, including clinical, maintenance, police/security, medical, etc. The committee should review data

regarding suicide prevention (e.g., staff training logs, statistics regarding suicide watches and attempts, etc.) and should be tasked with identifying especially egregious and unnecessary hazards that exist in the environment. The committee must have the ability to bring concerns to the Superintendent and the Governing Body in a timely manner, and to monitor compliance and implementation of responses.

4. Documentation - When the Hospital decides to take steps to protect patients, it is imperative that implementation and compliance with required actions be documented and monitored. This includes specific steps such as maintenance of suicide watches for individual patients, as well as hospital-wide steps such as CPR and suicide prevention training, inspection of cut-down tools, conducting of planned and unplanned/unannounced response drills, etc.

5. Mandatory pre-service and in-service training for all direct care staff - All staff should be trained in at least the following areas:

a. recognizing the signs and symptoms that should occasion a referral for suicide risk assessment
b. steps to take when a patient appears to present an acute risk of suicide, including
c. how to make a timely referral, and
d. how to maintain the patient's safety pending such an evaluation;
e. How to respond to suicide attempts.
f. How to document routine and emergency actions regarding suicide prevention

6. Mandatory training of appropriate clinical staff in how to do a comprehensive suicide risk evaluation - In order to take a person OFF of suicide watch, clinicians should complete a reasonably comprehensive evaluation, one that is documented to have attended to the patient's current mental health and mental status, current suicidal ideation, what as changed since the person was deemed to be at acute risk of suicide, and a plan going forward to re-assess and support the patient. More specifically, we recommend that the Hospital consider creation of a form that allows clinicians to effectively document the following essential components:

□□□ 1. Is□□□ there a recent history of admitted suicidal intent?
□ 2. Has the person thought about how they might end their life? Did they have a plan?□
□ 3. Does the person have the means to carry out the plan? Was the plan reasonable?□
□ 4. Does the person express feelings of peace/resolution?□
□ 5. Attending to Personal Effects□
□ - Did the person write goodbye letters?□

- Did the person give away their belongings?

6. History of Suicide Attempts
    - Recent?
    - Severity?
7. Current mood
8. Current cognitions about suicide
9. Known risk factors – ideographic (individual or idiosyncratic) and nomothetic (general or group)
10. Known protective factors
11. Stated intentions about suicide
12. What has changed since attempt?
13. Evidence or absence of futuristic thinking
14. Evidence of connectedness

The treatment staff should also conduct routine environmental scans of suicide hazards in the places that the patient will inhabit especially the patient's room, even after the patient is removed from suicide watch.

7. Review and investigation of completed suicides or serious attempts, aimed at preventing recurrences - Every completed suicide and serious (esp. potentially lethal) attempts must be thoroughly investigated. This requires that selected clinicians or teams be explicitly trained in how to conduct investigations, interview staff and patient witnesses, and to report their findings with objectivity and candor to the Executive Team and the Governing Body. When such investigations lead to suggested changes in a peatient's treatment, these changes must be communicated to the treatment team, with appropriate follow-up to ensure that they are addressed.

8. Quality improvement processes to ensure compliance with suicide prevention plans, policies, and procedures - These processes are of two types:

a. Routine reporting of compliance (e.g., staff training logs)

b. QI projects to address specific concerns that emerge, e.g., from the Suicide Prevention Committee, incident reviews, etc.

9. Evidence in Governing Body meetings that suicide risk assessment is routinely addressed as a core mission of the facility, and addressing any issues that have emerged since the last meeting.

CONCLUSIONS

Sometimes sentinel events create opportunities. We sensed significant motivation for change across all levels of the facility to change the culture from one of despair to one of hope. We encouraged staff members to start that process by asking themselves: What

does hope look like? This team has great confidence that this momentum will succeed in making CMHIP a national model.