Mailing Address:
1 Baldwin Street
Drawer 33
Montpelier, Vermont 05633-5701

Tel.: (802) 828-2295
Fax: (802) 828-2483

STATE OF VERMONT
JOINT FISCAL COMMITTEE
1 Baldwin Street
Montpelier, Vermont 05633-5701

MEMORANDUM

To: James Reardon, Commissioner of Finance & Management

From: Rebecca Buck, Staff Associate RB

Date: April 18, 2008

Subject: Status of Grant and Position Request

No Joint Fiscal Committee member has requested that the following item be held for review:

JFO #2320 –$552,410 grant from the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) to the Department of Mental Health. These grant funds will be used to implement alternatives to the use of restraint and seclusion in institutional and community based settings that provide mental health services. Joint Fiscal Committee approval is being requested to establish one (1) new sponsored limited service position--VSH Alternatives to Seclusion/Restraint Coordinator--for the duration of this grant.
[*JFO received 03/19/08*]

In accordance with 32 V.S.A. §5, the requisite 30 days having elapsed since this item was submitted to the Joint Fiscal Committee, the Governor's approval may now be considered final. We ask that you inform the Secretary of Administration and your staff of this action.

cc: Linda Morse
Cynthia LaWare
Michael Hartman
Molly Paulger
Jenny Audet

From: Anne Donahue
To: Michael Obuchowski,GLeach@vdh.state.vt.us
Date: 4/5/2008 9:35 AM
Subject: Re: JFO 2320 Mental Health grant and position

CC: Matt.Riven@ahs.state.vt.us,Rebecca Buck,Steve Klein,mhartma@vdh.state.vt...

I am pleased to hear that the disclosures were not made, since it was the position of many advocates that they were unnecessary to achieve the purposes. After objections were made publically, the Department never provided the information that it had withdrawn the intended sharing of information. Its continued position that it would have been appropriate, however, remains a cause for concern. Whether it is a valid exception under the HIPAA "health care operations" exception is not necessarily responsive to the additional federal protections for substance abuse records, which the grant indicates are applicable to this project; nor to Vermont public policy under the patient bill of rights and under state law regarding VSH records, as well as to public policy in Vermont. The intention to permit another hospital to review confidential records in order to assess patient profiles for further engagement in the Futures Project, in light of the fact that the same information could have been conveyed either with patient consent, with redacted files, or in conference with VSH staff withholding names, demonstrated a preference for convenience over concern for patient privacy. Although this is an ongoing concern, I am not suggesting that it be grounds to turn down the grant, as opposed to legislative awareness and a stated expectation that higher standards are expected, whether or not there are arguments for technical compliance.

It is accurate that I gave permission for Commissioner Hartman to include my letter as an attachment. I did not anticipate that such permission would mean it would be listed under a heading of "letters of support," which would indicate to anyone not reading the attachments in full that the application had the support of a state legislator.

It is also accurate the the Department has made some increases in its efforts to include consumers in dialogue than at the time this application was prepared, and fully developed before seeking "after the fact" responses despite the federal requirement that consumers participate in that actual development of the grant. The Department continues to struggle in its interpretation of participatory involvement in planning and effective communications. It can be hoped that under the aegius of this grant, there can be more aggressive and appropriate progress in this area.

Thank you for the opportunity to respond to the Department's reply to my concerns.
Anne

>>> "Leach, Gary" <GLeach@vdh.state.vt.us> 04/01/08 3:28 PM >>>

> Rep. Obuchowski:
>
> Responding to concerns expressed by Rep. Anne Donahue regarding JFO
> #2320.
>
> 1. The application to SAMHSA was submitted by DMH with an appendix
> titled "Letters of Support" which included a copy of a letter from me
> strongly opposing approval of the grant.
>
> 1. Response: Prior to the submission of the grant application,
> Commissioner Hartman spoke with Rep. Donahue about her concerns, and
> she gave DMH permission to include her letter in its application.
> Commissioner Hartman speaks to Rep. Donahue's letter and her concerns
> in his cover letter that was submitted with the application (see
> attached).
> <<Hartman LOS.doc>>
> Despite Rep. Donahue's objections to how DMH has handled this issue
> previously, we feel her input and focus on this issue will help to

> improve implementation of the grant. There were many concerns and
> issues raised by different stakeholders who were involved in the grant
> planning process, but the vast majority of these stakeholders felt
> Vermont should apply for this grant opportunity and supported our
> grant application.
>
> 2. The "standard terms of award" (grant award p. 3) includes the
> statement, "Grant funds cannot be used to supplant current funding of
> existing activities. Definition: Supplant is to replace funding of a
> recipient's existing program with funds from a federal grant." The
> Agency of Human Services review memo (unnumbered page; Giffin to Riven
> memo) states: "Per the instructions of the Secretary of
> Administration, the Agency of Human Services separately requested the
> Department of Human Services to abolish a vacant limited service
> position (840160) in the Department of Mental Health to offset the
> additional position in this grant request." It appears that this
> "offset" may violate the terms of the grant.
>
> 2. Response: The position abolished was vacant, i.e., there was no
> funding for the position. Therefore there was no supplantation.
>
> 3. Standard condition 6 on page 3 requires compliance with federal
> standards regarding confidentiality of patient records. The Department
> of Mental Health knowingly evaded those standards in a planned
> disclosure of confidential patient records within the past month.
>
> 3. Response: We believe Rep. Donahue is referring to a discussed, but
> never executed, sharing of patient information with Rutland Regional
> Medical Center for the purposes of planning for new psychiatric
> inpatient capacity. While we believe that the sharing of necessary
> patient information for the purposes of health care operations is
> permissible under HIPAA - we concluded that the information that RRMC
> sought for planning purposes was not necessary and therefore there was
> not unauthorized disclosure of confidential patient records. Rep.
> Donahue is apparently reacting to incomplete information.
>
> Please let us know if you want further discussion of these issues or
> have additional questions. You may contact Nick Nichols by email to
> nnichols@vdh.state.vt.us or by phone at 652-2029. Thank you.
>
>
> Gary Leach
> Vermont Department of Health Business Office
> 863-7384
>
>

From: "Leach, Gary" <GLeach@vdh.state.vt.us>
To: "Michael Obuchowski" <OBIE@leg.state.vt.us>
Date: 4/1/2008 3:28 PM
Subject: JFO 2320 Mental Health grant and position
Attachments: Hartman LOS.doc

CC: "Hartman, Michael" <mhartma@vdh.state.vt.us>, "Nichols, Nick" <nnichols@...

> Rep. Obuchowski:
>
> Responding to concerns expressed by Rep. Anne Donahue regarding JFO
> #2320.
>
> 1. The application to SAMHSA was submitted by DMH with an appendix
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>
>
> Gary Leach
> Vermont Department of Health Business Office
> 863-7384
>
>

VERMONT

Department of Health
Division of Mental Health
108 Cherry Street, PO Box 70.
Burlington, VT 05402-0070
Healthvermont.gov

[phone] 802-652-2000
[fax] 802-652-2005
[tty] 800-253-0191

Agency of Human Services

May 10, 2007

Crystal Saunders, Director of Grant Review
Office of Program Services
Substance Abuse and Mental Health Services Administration
Room 3-1044
1 Choke Cherry Road,
Rockville, MD 20857

Dear Ms. Saunders

This letter is sent as notice indicating interest by the Vermont Department of Health (VDH), Division of Mental Health, in pursuing the SAMHSA grant application # SM-07-005 to reduce the use of seclusion and restraint at two locations providing inpatient psychiatric care. The decision to apply for this funding is based on the internal assessment by VDH that the next step of improvement for care at both the Vermont State Hospital, our single state operated mental health facility, and The Retreat Healthcare, a private psychiatric facility for children and adults, is to focus on this important area of care.

The Vermont State Hospital (VSH) and The Retreat Healthcare (RHC) are the primary providers of involuntary care for Vermonters, and thus are faced regularly with decisions of if or when to use seclusion and restraint as a method of control when coping with threatening or dangerous behavior. Both facilities have recognized that the occurrences of these behaviors are not unpredictable phenomena. Rather, these events have precursors, which, when recognized, offer opportunities for intervention previous to an outcome of restraint and/or seclusion. Both also recognize that such events are trauma inducing episodes that have a negative impact on patient trust of a provider, and can create new issues of loss of personal control, fear of harm, and embarrassment for both the patient being secluded or restrained as well as patients who observe such interventions.

In the past few years, VSH has struggled through periods of care compromises which resulted in increased use of emergency procedures, loss of certification on two occasions by the Center for Medicaid/Medicare Services and most challenging, the death of two patients. At this time VSH has been able to bring its rate of seclusion and restraint down to a range comparable to national averages. However, the State has yet to regain the momentum of working with consumer advocacy partners in the effort that existed as late as 2004. At that time, VSH and VDH

leadership had committed to a reduction, and were actively working with Vermont Protection and Advocacy (VP&A) and other advocates and consumers on a plan to do so. However, the events mentioned above occurred, and in the ensuing time period momentum was lost. Retreat Healthcare has not experienced the extreme challenges of VSH, but has had management changes which have slowed some important strides toward the reduction of seclusion and restraint. Similar to VSH, the RHC had also committed to change and had worked with VP&A toward a reduction of seclusion and restraint, but subsequent changes in leadership at that hospital had an impact on the momentum there as well.

Thus, as both entities have now stabilized under new leadership, the recognition of the need to continue in the direction that was set out previous to these difficulties has concretized. Vermont's commitment to recovery and self-directed care has now also gained a significant third area of concern in the area of trauma informed care, which requires a new look at the use of coercion and restraint within the system of care. Historically this commitment has been made via legislative and policy initiatives. These are reflected in two primary examples.

The first example is the commitment to addressing coercion in the system of care. As Former Commissioner Copeland stated in a 1999 policy paper (Vermont's Vision Of A Public System For Developmental And Mental Health Services Without Coercion, October 1999) regarding the position of the then Department of Developmental and Mental Health Services,

> "...we must measure the success of DDMHS's systems of care by improvements in the wellbeing of our citizens. DDMHS believes that the various forms of coercion are powerful negative forces working against us as we strive to assist citizens to enhance the quality of their lives...Put another way, we do not believe that we can achieve the highest quality of care and supports without paying close attention to the presence of coercion in its various forms in our system of care."

The paper goes on to describe a range of coercive practices, factors that may lead to coercion and ideas related to its elimination. These ideas included self-directed care, recovery education for providers, best use of informal alternatives and the use of natural supports

The second example is that of commitment by the state of Vermont to reduce involuntary procedures as an aspect of care. In 1997 the Vermont Legislature added a subsection on legislative intent in Title18 of the Judicial Proceeding Chapter 181. This states, "(c) It is the policy of the general assembly to work towards a mental health system that does not require coercion or the use of involuntary medication."

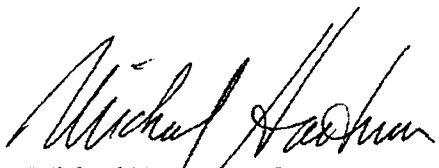
Vermont's system of care has not been able to maximize the strong support of governmental leadership and solidly establish a system without coercion as stated by the former commissioner. In fact, we have struggled to respond to demands made by VP&A and other advocates and consumers to make a strong and solid commitment to this effort. This struggle is evident in the attached letters of support by the VP&A Director, the Vermont - NAMI Director and Rep. Anne Donahue. There are clearly some differing perspectives on the work that VSH and VDH have done in this area in the past four years. It is important to acknowledge, as I believe we do in this application, that the efforts in this area have been insufficient to address the need for establishing new expectations of care and articulating appropriate interactions of staff with patients when collaboration has failed to be established. We offer these letters in our application to be clear and honest about the need for change, and to validate the views of the advocacy community.

At this time, however, the system is ready for this culture change, and will make maximum use of the SAMHSA funds to achieve this goal. The Governor, the Secretary of the Agency of Human Services and the Commissioner of Health have committed to fund and support improvements to the system of care for inpatient psychiatry. This is exhibited not only by increased funding for inpatient and community mental health services during each of the past three years, but also by the support of new residential alternatives such as the recently opened Second Spring program. This program is moving selected VSH patients out of the hospital and into an intensive level of residential care in a community setting. This residential alternative is trauma-informed, consumer centered, and works in partnership with Vermont Psychiatric Survivors to reinforce the principles of recovery based programming.

Since 1999 the Agency of Human Services and VDH have required that all ten mental health service agencies have at least 51% consumer/family representation on their corporate boards. The Agency has supported the creation of 11 consumer advisory groups for adult mental health, one at each of the ten service agencies, and one for statewide issues. In addition, since 2004 the Vermont State Hospital Futures Advisory Committee, a consumer/family/advocate/provider advisory group, has initiated planning in tandem with VDH to develop new replacement services for VSH, an institution with residential units in buildings of between 70 and 115 years old. This group has worked to create not only a preferred plan for a new hospital, but has also spawned three new community programs that now exist. In addition, the group has planned for 2 – 4 other services that will further create community-based treatment options for persons at risk of hospitalization.

It is with this level of commitment that VDH's Division of Mental Health applies for this funding opportunity. We believe that our work in restructuring VSH and our partnership with the Retreat are of the nature that will make this project highly successful because it affords an opportunity for Vermont to make a significant move ahead in the area of highest quality patient care. We firmly believe our system to be in a state of evolution that can support and make very effective use of this funding opportunity.

Sincerely,



Michael Hartman, MSW
Deputy Commissioner for Mental Health
Vermont Department of Health
Division of Mental Health

From: Rebecca Buck
To: gleach@vdh.state.vt.us
Date: 3/31/2008 9:26 AM
Subject: Re: Fwd: JFO 2320 Mental Health grant and position

CC: Klein, Steve; Obuchowski, Michael

Good morning Gary. I am forwarding concerns that Rep. Anne Donahue expressed to Rep. Michael Obuchowski regarding JFO #2320. Steve and I are asking that you respond directly to Rep. Obuchowski with a "cc" to us. Thank you. --Becky

>>> Michael Obuchowski 3/31/2008 9:07 AM >>>
FYI Please investigate these concerns. Thank you.

>>> "Anne Donahue" <counterp@tds.net> 3/31/2008 10:59 PM >>>
Hello Michael,
I apologize for not replying sooner; you asked that a copy be sent to me regarding the request of the administration to accept a grant from SAMHSA for reduction of restraint and seclusion at VSH and the Retreat.

I do have several things to note about this grant:
1. The application to SAMHSA was submitted by DMH with an appendix titled "Letters of Support" which included a copy of a letter from me strongly opposing approval of the grant.

2. The "standard terms of award" (grant award p. 3) includes the statement, "Grant funds cannot be used to supplant current funding of existing activities. Definition: Supplant is to replace funding of a recipient's existing program with funds from a federal grant."
The Agency of Human Services review memo (unnumbered page; Giffin to Riven memo) states:
"Per the instructions of the Secretary of Administration, the Agency of Human Services separately requested the Department of Human Services to abolish a vacant limited service position (840160) in the Department of Mental Health to offset the additional position in this grant request."
It appears that this "offset" may violate the terms of the grant.

3. Standard condition 6 on page 3 requires compliance with federal standards regarding confidentiality of patient records. The Department of Mental Health knowingly evaded those standards in a planned disclosure of confidential patient records within the past month.

Anne Donahue

From: "Leach, Gary" <GLeach@vdh.state.vt.us>
To: <obie@leg.state.vt.us>
Date: 3/24/2008 12:46 PM
Subject: Questions with regard to JFO #2320 (SAMHSA grant and ltd service position)

CC: <rbuck@leg.state.vt.us>, "Riven, Matt" <Matt.Riven@ahs.state.vt.us>, "Ha...

Rep. Obuchowski :
Becky Buck forwarded your questions regarding JFO #2320. Our responses follow.
1) On page 33 of the Project Abstract, in Section F - Budget Justification - Budget Year One, there is a total of $30,000 in general fund which also is reflected on page 37 (and extends into the next 2 budget years at $27,000 and $24,500 respectively) that is not reflected in the AA-1. Please explain why it's not included in the AA-1 in item 10 (budget information). Also with increasing scarcity of general funds, please explain why are we committing $81,500 in general funds over the next 3 years?
(1) - Yes, the narrative budget in our application did describe the expenditure of General Funds for equipment and renovations at the State Hospital. These funds were not included on the AA1 because expenditure of these funds is not a requirement for receipt of the Federal funds; there is no required match under this grant. This item was included in our narrative budget only to make our application for Federal funds more competitive. Conversely, these General Fund monies will need to be expended for equipment and renovations at the State Hospital whether or not the Federal grant is accepted.
2) On the AA-1 Form under item 9 (impact on existing programs if grant is not accepted) the department response was "None". If that is true why is Joint Fiscal being asked to approve this grant and limited service position?
(2) - It has been the Department's usual practice to answer "None" under item 9 on the AA-1. It is our understanding that this question intends to discover whether declining the grant would require the Department to curtail any of its current programs or activites. It would not. If the grant is not accepted, current Department activities will continue without interruption or change. We are asking that this grant be accepted in order to enhance our current programs at the State Hospital, as we've described in the narrative attached to the AA1.
We would be happy to provide additional information on this grant, or further discussion of its role in improving our programs at the State Hospital, at your request. Please let Nick Nichols know if you have more questions, by email to nnichols@vdh.state.vt.us or by phone at 652-2029.
Thank you.
Gary Leach, Vermont Department of Health Business Office, 863-7384

From: Rebecca Buck
To: Nichols, Nick
Subject: Questions from Rep. Obuchowski re: JFO #2320

Hello Nick. Representative Michael Obuchowski has the following questions with regard to JFO #2320 (SAMHSA grant and ltd service position):

1) On page 33 of the Project Abstract, in Section F - Budget Justification - Budget Year One, there is a total of $30,000 in general fund which also is reflected on page 37 (and extends into the next 2 budget years at $27,000 and $24,500 respectively) that is not reflected in the AA-1. Please explain why it's not included in the AA-1 in item 10 (budget information). Also with increasing scarcity of general funds, please explain why are we committing $81,500 in general funds over the next 3 years?

2) On the AA-1 Form under item 9 (impact on existing programs if grant is not accepted) the department response was "None". If that is true why is Joint Fiscal being asked to approve this grant and limited service position?

If you need further clarification on any of these questions, don't hesitate to let me know either by phone (828-5960) or at the above e-mail address. Please be sure and cc me on your response to Representative Obuchowski (obie@leg.state.vt.us) . Thanks. --Becky

CC: Klein, Steve; Obuchowski, Michael; Riven, Matt

JOINT FISCAL OFFICE
1 BALDWIN STREET
DRAWER 33
MONTPELIER, VT 05633-5701

PHONE: (802) 828-2295
FAX: (802) 828-2483

MEMORANDUM

To: Joint Fiscal Committee Members

From: Rebecca Buck RB

Date: March 25, 2008

Subject: JFO #2320 (Mental Health grant and position)

Senator Susan Bartlett asked that I forward to you a copy of the enclosed memo.

cc: Rep. Anne Donahue
Stephen Klein

VERMONT

Agency of Human Services

Department of Mental Health [phone] 802-652-2000
108 Cherry Street, PO Box 70. [fax] 802-652-2005
Burlington, VT 05402-0070 [tty] 800-253-0191
www.healthvermont.gov/mh/index.aspx

Memorandum

To: Susan Bartlett, Chair Joint Fiscal Committee
From: Michael Hartman, Commissioner Department of Mental Health
Date; March 20, 2008
Re: **JFO #2320**

The request from the Department of Mental Health regarding **JFO #2320,** a $552,410 grant from the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) to DMH is made to assist in our continuing efforts to address seclusion and restraint reductions in the Vermont system of mental health care. The SAMHSA opportunity is ideal in that it compliments work that began at VT State Hospital and the Brattleboro Retreat Children's Inpatient Unit in coordination with VT Protection and Advocacy about 4 years ago. Both institutions have actively been engaging in training and environmental designs to reduce the need for these interventions, and the grant would enable DMH to develop a model that could be duplicated in care settings—i.e. other inpatient units, emergency room departments—across our state.

The three year grant will provide for one limited service state position at VSH, a second position via contract with Retreat Health Care their site, and funding for consultation and environmental changes that would support better non-coercive interventions at both locations. The optimal outcome for this grant will be reduced rates of seclusion and restraint and improved environment of care that may increase collaboration between care providers and patients. There can be other benefits derived from this effort such as reduced use of involuntary medication as well.

In addition to the services at the two sites, DMH has committed to bring new knowledge and trainings to other AHS departments, the Designated Agencies, and local hospitals. The need for this kind of support for health care workers is significant as it is a profession that must be highly accessible to all persons thus the environment of care is one that is vulnerable to the rare occasion when anxiety and safety concerns create possible conflicts. From my visits with all Vermont hospitals last summer and feedback both from consumers and providers it is clear this is a priority of all participants in our system of care.

I will be glad to respond to any concerns the committee may have regarding this request.

Mailing Address:
1 Baldwin Street
Drawer 33
Montpelier, Vermont 05633-5701

Tel.: (802) 828-2295
Fax: (802) 828-2483

STATE OF VERMONT
JOINT FISCAL COMMITTEE
1 Baldwin Street
Montpelier, Vermont 05633-5701

MEMORANDUM

To: Joint Fiscal Committee Members

From: Rebecca Buck, Staff Associate RB

Date: March 20, 2008

Subject: Grant and Position Request

Enclosed please find one (1) request which the Joint Fiscal Office recently received from the Administration:

JFO #2320 –$552,410 grant from the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) to the Department of Mental Health. These grant funds will be used to implement alternatives to the use of restraint and seclusion in institutional and community based settings that provide mental health services. Joint Fiscal Committee approval is being requested to establish one (1) new sponsored limited service position--VSH Alternatives to Seclusion/Restraint Coordinator--for the duration of this grant.
[*JFO received 03/19/08*]

The Joint Fiscal Office has reviewed this submission and determined that all appropriate forms bearing the necessary approvals are in order.

In accordance with the procedures for processing such requests, we ask you to review the enclosed and notify the Joint Fiscal Office (Rebecca Buck at 802/828-5969; rbuck@leg.state.vt.us or Stephen Klein at 802/828-5769; sklein@leg.state.vt.us) if you would like this item held for legislative review. Unless we hear from you to the contrary by April 3 we will assume that you agree to consider as final the Governor's acceptance of this request.

cc: James Reardon, Commissioner
Linda Morse, Administrative Assistant
Cynthia LaWare, Secretary
Michael Hartman, Commissioner
Molly Paulger, Classification Manager
Jenny Audet, Classification Program Technician

INFORMATION NOTICE

The following item was recently received by the Joint Fiscal Committee:

JFO #2320 –$552,410 grant from the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) to the Department of Mental Health. These grant funds will be used to implement alternatives to the use of restraint and seclusion in institutional and community based settings that provide mental health services. Joint Fiscal Committee approval is being requested to establish one (1) new sponsored limited service position--VSH Alternatives to Seclusion/Restraint Coordinator--for the duration of this grant. [*JFO received 03/19/08*]

STATE OF VERMONT
GRANT ACCEPTANCE FORM

JFO # 2320

GRANT SUMMARY:	3 year grant to implement alternatives to restraint and seclusion in institutional and community based settings that provide mental health services.
Title:	State Incentive Grants to Build Capacity for Alternatives to restraint and Seclusion
DATE:	**3/17/2008**
DEPARTMENT:	Department of Mental Health
GRANTOR / DONOR:	US Substance Abuse and Mental Health Services Administration (SAMHSA)
FEDERAL CATALOG No.:	93-243
GRANT/ DONATION:	Funding for development and implementation of policies and procedures for alternatives and one (1) limited service position
AMOUNT / VALUE:	$552,410.00 FY08 ($124,600), FY09 ($213,905) & FY10 ($213,905)
POSITIONS REQUESTED:	1 new Limited Service position (VSH Alternatives to Seclusion/Restraint Coordinator).
GRANT PERIOD:	Starting Date: **9/30/07** **Ending Date: 9/29/10**

COMMENTS: see attached.

DEPARTMENT OF FINANCE AND MANAGEMENT:	(INITIAL)
SECRETARY OF ADMINISTRATION	(INITIAL)
SENT TO JOINT FISCAL OFFICE:	DATE: 3/17/08

RECEIVED
MAR 19 2008
JOINT FISCAL OFFICE

FORM AA-1 (Rev. 11-05)

STATE OF VERMONT
REQUEST FOR GRANT ACCEPTANCE

1. Agency: Human Services
2. Department: Mental Health
3. Program: Adult Mental Health

4. Legal Title of Grant: State Incentive Grants to Build Capacity for Alternatives to Restraint and Seclusion

5. Federal Catalog No.: 93.243

6. Grantor and Office Address: Substance Abuse and Mental Health Services Administration Rockville, Maryland 20857
7. Grant Period: From: 9/30/07 To: 9/29/10

8. Purpose of Grant: The purpose of the grant is to implement alternatives to the use of restraint and seclusion in institutional and community-based settings that provide mental health services. (see attached summary)

9. Impact on Existing Programs if Grant is not Accepted: None

10. Budget Information	(1st State FY) FY 2008	(2nd State FY) FY 2009	(3rd State FY) FY 2010
EXPENDITURES:			
Personal Services	$ 39,300	$ 117,955	$ 117,955
Operating Expenses	$ 5,300	$ 15,950	$ 15,950
Other (Grants)	$ 80,000	$ 80,000	$ 80,000
TOTAL	$ 124,600	$ 213,905	$ 213,905
REVENUES:			
State Funds:			
Cash	$	$	$
In-Kind	$	$	$
Federal Funds:			
(Direct Costs)	$ 117,490	$ 192,575	$ 192,575
(Statewide Indirect)	$ 1,000	$ 2,985	$ 2,985
(Dept. Indirect)	$ 6,110	$ 18,345	$ 18,345
Other funds:			
(source)	$	$	$
TOTAL	$ 124,600	$ 213,905	$ 213,905

Grant will be allocated to these appropriation expenditure accounts:

Appropriation Nos.	Amounts
3150070500	$124,600

11. Will grant monies be spent by one or more personal service contracts?
[X] YES [ ] NO

If YES, signature of appointing authority here indicates intent to follow current guidelines on bidding. X _____

12a. Please list any requested Limited Service positions:

Titles	Number of Positions
VSH Alternatives to Seclusion/Restraint Coordinator	1
TOTAL	1

12b. Equipment and space for these positions:
[✓] Is presently available.
[ ] Can be obtained with available funds.

13. Signature of Appointing Authority

I certify that no funds have been expended or committed in anticipation of Joint fiscal Committee approval of this grant.

_____ 2/21/08
Signature of Appointing Authority Date

Cynthia D. LaWare 2/22/08
Signature of Agency Secretary or Designee Date

14. Action by Governor:

[✓] Approved
[ ] Rejected

_____ 3/14/08
(Signature) (Date)

15. Secretary of Administration:

[ ] Request to JVO
[ ] Information to JFO

Ronda P Moore 3/18/08
(Signature) (Date)

16. Action by Joint Fiscal Committee: (Dates)

[ ] Request to be placed on JVC agenda _____
[ ] Approved (not placed on Agenda in 30 days) _____
[ ] Approved by JFC _____
[ ] Rejected by JFC _____
[ ] Approved by Legislature _____

_____ _____
(Signature) (Date)

STATE OF VERMONT
Joint Fiscal Committee Review
Limited Service - Grant Funded
Position Request Form

This form is to be used by agencies and departments when additional grant funded positions are being requested. Review and approval by the Department of Human Resources must be obtained prior to review by the Department of Finance and Management. The Department of Finance will forward requests to the Joint Fiscal Office for JFC review. A Request for Classification Review Form (RFR) and an updated organizational chart showing to whom the new position(s) would report **must** be attached to this form. Please attach additional pages as necessary to provide enough detail.

Agency/Department: AHS/Mental Health Date: 2/20/08

Name and Phone (of the person completing this request): Nick Nichols, 652-2029

Request is for:
- ☒ Positions funded and attached to a new grant.
- ☐ Positions funded and attached to an existing grant approved by JFO #_____

1. Name of Granting Agency, Title of Grant, Grant Funding Detail (attach grant documents):

Department of Health and Human Services-Substance Abuse and Mental Health Services Administration

State Incentive Grants to Build Capacity for Alternatives to Restraint and Seclusion
(Short Title: Alternatives to Restraint and Seclusion SIG)

2. List below titles, number of positions in each title, program area, and limited service end date (information should be based on grant award and should match information provided on the RFR) position(s) will be established only after JFC final approval:

Title* of Position(s) Requested	# of Positions	Division/Program	Grant Funding Period/Anticipated End Date
VSH Alternatives to Seclusion/ Restraint Coordinator	**1**	**Vermont State Hospital**	**10/1/07 – 9/30/2010 / April 1st, 2011**

*Final determination of title and pay grade to be made by the Department of Human Resources Classification Division upon submission and review of Request for Classification Review.

3. Justification for this request as an essential grant program need:

This grant funded position will be responsible for coordinating the implementation of alternatives to seclusion and restraint at two inpatient facilities (Vermont State Hospital and Retreat Healthcare). Coordination of this multi-site initiative requires a full time position and could not be done by an existing state position.

I certify that this information is correct and that necessary funding, space and equipment for the above position(s) are available (required by 32 VSA Sec. 5(b).

Signature of Agency or Department Head — Date: 2/22/08

Approved/Denied by Department of Human Resources (Molly Paulus) — Date: 2/22/08

Approved/Denied by Finance and Management (Susan Zeller) — Date: 3/7/08

Approved/Denied by Secretary of Administration (Linda P. Moore) — Date: 3/10/08

Comments: Position # 840160 will be abolished if the new limited service position is approved by JFC. MOP


RECEIVED
FEB 22 2008
STATE OF VERMONT
DEPT. OF PERSONNEL

Request for Grant Acceptance
Alternatives to Restraint
Summary
2/20/2008

The Department of Mental Health (DMH) has been granted approximately $213,905 a year for three years by the Substance Abuse and Mental Health Services Administration to implement alternatives to the use of seclusion and restraint (S/R) in institutional and community-based settings that provide mental health services. Specifically, DMH will implement alternatives to S/R at the Vermont State Hospital (VSH) for adults with serious mental illness and Retreat Healthcare (RHC) for children and adolescents with serious emotional disturbances. SAMHSA's Six Core Strategies to Reduce the Use of Seclusion and Restraint will guide the development of strategic plans at each hospital and will help create the culture shift necessary for the use of less coercive measures for ensuring patient and staff safety. The goals of the project are:
Goal 1: Vermont will strengthen and enhance its oversight, leadership and coordination capacity at the state level and at VSH and RHC to enhance the development of alternatives to restraint and seclusion.

Goal 2: Using the SAMSHA Six Core Strategies as a guide, Vermont will develop and implement a strategic plan to complete S/R Reduction efforts at VSH and the RHC.

Goal 3: Vermont will implement specific S/R Reduction Techniques (e.g. Sensory Modulation) at VSH and the RHC to reduce and prevent the need for S/R.

Key activities under this grant will include:

1. Establish/enhance a stakeholder steering committee at each institution to oversee S/R Reduction activities
2. Create a state-level position to coordinate S/R Reduction grant activities and assist in the implementation S/R reduction efforts at VSH
3. Create a "S/R Reduction Coordinator" at RHC to oversee the implementation of alternatives to S/R at that organization.
4. Complete Core Training on SAMHSA's Six Core Strategies to Reduce S/R at VSH and RHC.
5. Complete an Organizational Assessment re: the Six Core Strategies at VSH and the RHC
6. Create and Implement a Strategic Plan to Develop Alternatives to S/R at VSH and the RHC
7. Augment current training for VSH and RHC staff using SAMHSA's Roadmap to S/R-Free Mental Health Services
8. Implement improved debriefing techniques at VSH and RHC for staff and consumers following an incident of seclusion or restraint
9. Develop and modify of policies and procedures at VSH and RHC to support S/R reduction, including the creation of clinical practice protocols,
10. Develop improved methods for using consumers to support the prevention and reduction of S/R
11. Implement improved methods for collecting, analyzing and reporting on the use of S/R at VSH and RHC.
12. Implement Sensory Modulation techniques and approaches at both institutions
13. Establish "Sensory Spaces" (e.g. Calm Rooms, Multisensory Treatment Rooms) at VSH and the RHC to provide a choice of different sensory experiences to help ground, calm, center and/or alert individuals.

Approximately $80,000 of these funds will be sub-granted each year to the Retreat Healthcare to support implementation at that organization. $35,000 will be used each year to purchase expert consultation and training on the Six Core Strategies and the implementation of Sensory-Based Approaches. Approximately $62,000 will be used to fund a state-level position to coordinate the project and oversee implementation of alternatives to S/R at VSH. The remaining funds will be used by the Department to cover the costs of travel and meetings necessary to support the project.

The Department of Mental Health is hereby requesting acceptance of $124,600 in new Federal funds during State Fiscal Year 2008. The remainder of the Federal funding will be included in the Department's future budget requests. The Department is requesting the establishment of one limited service position to serve as VSH Alternatives to Seclusion/Restraint Coordinator. We are including a copy of our application, a copy of the Federal grant award and a copy of the position request for your information.

VSH Alternatives to Seclusion/Restraint Coordinator

The **VSH Alternatives to Seclusion/Restraint Coordinator** will oversee the implementation of alternatives to seclusion and restraint (S/R) grant activities and will serve as a liaison between the Commissioner of Mental Health, the Principle Investigator and the project staff leaders at both VSH and Retreat Healthcare. This position will also be responsible for coordinating S/R reduction activities at VSH. This individual will be a state employee, and will be recruited upon notification of the grant award.

Major Job Duties and Responsibilities

- Oversee the planning, implementation and coordination of grant activities
- Work closely with both VSH and the Retreat to guide the development of a strategic plan that incorporates the 6 core Strategies. Both plans should be reviewed and updated annually to reflect project progress and experience
- Work closely with both institutions to develop data collection methods and ensure that routine program data is collected, analyzed and reported.
- Coordinate the expert consultation of Tina Champagne, OTR, to maximize the use of her time to teach and train each institution about effective, empirically-based organizational and clinical strategies for reducing restraint and seclusion.
- Facilitate communication between VSH and the Retreat to share information about project successes, challenges and effective strategies for accomplishing the goals of the project.
- Maintain an effective presence at DMH, VSH and the Retreat to ensure project visibility and stimulate and sustain the engagement of key staff in the change process
- Manage reporting obligations to SAMHSA and communication between the Commissioner's office, the two participating hospitals and interested stakeholders
- Serve as the S/R Reduction Coordinator for VSH

Skills, Qualifications and Experience

- Demonstrated experience as change leader
- Demonstrated effectiveness in program development, implementation and management
- Knowledge of and experience with people with acute severe mental illness
- Understanding of data collection and analysis methods
- Effective verbal and written communication skills

Vermont Agency of Human Services

To: Jim Giffin

From: Matt Riven

Date: February 22, 2008

Subject: Review of AA-1 Request for Grant Acceptance

Agency: AHS/DMH/VSH

Grant title: State Incentive Grants to Build Capacity for Alternatives to Restraint and Seclusion

Grantor: U.S. Substance Abuse and Mental Health Services Administration (SAMHSA)

Grant Period: 9/30/07 to 9/29/10

Amount:
SFY08: $124,600
SFY09: $213,905
SFY10: $213,905

Explanation: The Department of Mental Health (DMH) has been granted $213,905 for each of three federal years by SAMHSA to implement alternatives to the use of seclusion and restraint in institutional and community-based settings that provide mental health services. DMH will implement alternatives to seclusion and restraint at the Vermont State Hospital for adults with serious mental illness and Retreat Healthcare for children and adolescents with serious emotional disturbances.

Position analysis: Implementation of the grant includes creation of one state position to coordinate grant activities and assist in implementation of alternatives to seclusion and restraint at the Vermont State Hospital. The required materials – position request; job specifications; and organization chart – are included in the material. Per the instructions of the Secretary of Administration, the Agency of Human Services separately requested the Department of Human Services to abolish a vacant limited service position (840160) in the Department of Mental Health to offset the additional position in this grant request.

Request for Classification Review
Position Description Form A

For Department of Personnel Use Only

Date Received (Stamp)

RECEIVED JAN 18 2008 STATE OF VERMONT DEPT OF PERSONNEL

Notice of Action # 08-840186-A

Action Taken: ______

New Job Title ______

Current Class Code 505500 New Class Code ______

Current Pay Grade 23 New Pay Grade ______

Current Mgt Level N B/U 01 OT Cat. 17 EEO Cat. 02 FLSA A

New Mgt Level ______ B/U ____ OT Cat. ____ EEO Cat. ____ FLSA ____

Classification Analyst ______ Date ______ Effective Date: 1/20/08

Comments:

Date Processed: ______

Willis Rating/Components: Knowledge & Skills: ______ Mental Demands: ______ Accountability: ______
Working Conditions: ______ Total: ______

Incumbent Information: Curr Cw: EIN 212, L+K 92, E2S 100, MC 40

Employee Name: [ ] Employee Number: [ ]

Position Number: [ ] Current Job/Class Title: [ ]

Agency/Department/Unit: [ ] Work Station: [ ] Zip Code: [ ]

Supervisor's Name, Title, and Phone Number: [ ]

How should the notification to the employee be sent: ☐ employee's work location [ ] or ☐ other address, please provide mailing address: [ ]

New Position/Vacant Position Information:

New Position Authorization: [ ] Request Job/Class Title: VSH Alternatives to Seclusion/Restraint Coordinator

Position Type: ☐ Permanent or ☒ Limited / Funding Source: ☐ Core, ☐ Partnership, or ☒ Sponsored

Vacant Position Number: [ ] → 840186 Current Job/Class Title: [ ] → VSH QA Analyst

Agency/Department/Unit: Agency of Human Services/Department of Mental Health/Vermont State Hospital Work Station: Waterbury Zip Code: 05671

Supervisor's Name, Title and Phone Number: Michael Hartman, Commissioner, 652-2000

Type of Request:

☒ **Management:** A management request to review the classification of an existing position, class, or create a new job class.

☐ **Employee:** An employee's request to review the classification of his/her current position.

1. Job Duties

This is the ***most critical*** part of the form. Describe the activities and duties required in your job, **noting changes (new duties, duties no longer required, etc.) since the last review**. Place them in order of importance, beginning with the single most important activity or responsibility required in your job. The importance of the duties and expected end results should be clear, including the tolerance that may be permitted for error. Describe each job duty or activity as follows:

- **What** it is: The nature of the activity.
- **How** you do it: The steps you go through to perform the activity. Be specific so the reader can understand the steps.
- **Why** it is done: What you are attempting to accomplish and the end result of the activity.

For example a Tax Examiner might respond as follows: **(What)** *Audits tax returns and/or taxpayer records.* (**How**) *By developing investigation strategy; reviewing materials submitted; when appropriate interviewing people, other than the taxpayer, who have information about the taxpayer's business or residency.* (**Why**) *To determine actual tax liabilities.*

This position will oversee and administer a statewide grant project focusing on the development of alternatives to seclusion and restraint (S/R) at the Vermont State Hospital and Retreat Healthcare (RHC). Major Job Duties and Responsibilities include:

• Oversee the planning, implementation and coordination of grant activities

• Work closely with VSH and Retreat Healthcare to guide the development of a strategic plan that incorporates the 6 Core Strategies to Reducing Seclusion and Restraint.

• Work closely with both institutions to develop data collection methods and ensure that routine program data is collected, analyzed and reported.

• Coordinate use of expert consultation on effective, empirically-based organizational and clinical strategies for reducing restraint and seclusion.

• Facilitate communication between VSH and Retreat Healthcare to share information about project successes, challenges and effective strategies for accomplishing the goals of the project.

• Maintain an effective presence at Department of Mental Health, VSH and Retreat Healthcare to ensure project visibility and stimulate and sustain the engagement of key staff in the change process.

• Manage reporting obligations to grant funder (SAMHSA) and communication between the Commissioner's office, the two participating hospitals and interested stakeholders.

• Work with S/R reduction consultants to implement sensory modulation techniques among VSH and RHC staff and serve as the in-house expert on these approaches at VSH.

• Facilitate VSH S/R Reduction Steering Committee.

• Identify organizational needs for and operational barriers to successfully reducing the use of involuntary procedures at VSH , and communicate these to VSH leadership and interested stakeholders.

2. Key Contacts

This question deals with the personal contacts and interactions that occur in this job. Provide brief typical examples indicating your primary contacts (**not** an exhaustive or all-inclusive list of contacts) other than those persons to whom you report or who report to you. If you work as part of a team, or if your primary contacts are with other agencies or groups outside State government describe those interactions, and what your role is. For example: you may *collaborate, monitor, guide, or facilitate change.*

Works closely with key leadership and operations staff (Executive Director, Medical Director; Operations Director) at Vermont State Hospital to coordinate implementation of alternatives to restraint and seclusion. Works with VSH leadership team to develop and modify existing policy and operations practices. Works with core treatment staff at VSH to adopt specific alternative interventions (e.g. Sensory Modulation) to reduce incidents of seclusion and restraint. Coordinates use of expert consultation/training. Collaborates with key leadership and operations staff at Retreat Healthcare to monitor and guide implementation of alternatives to seclusion and restraint at RHC. Regular contact with state-level representatives of multiple stakeholder groups (e.g. Vermont Psychiatric Survivors, Vermont Protection and Advocacy) to faciliate input and consensus-building regarding implementation of alternatives to S/R at VSH. Faciliatates stakeholder project steering committee. Collaborates with project evaluator and federal grantors to ensure proper collection and reporting of project outcomes.

3. Are there licensing, registration; or certification requirements; or special or unusual skills necessary to perform this job?

Include any special licenses, registrations, certifications, skills; (such as counseling, engineering, computer programming, graphic design, strategic planning, keyboarding) including skills with specific equipment, tools, technology, etc. (such as mainframe computers, power tools, trucks, road equipment, specific software packages). Be specific, if you must be able to drive a commercial vehicle, or must know Visual Basic, indicate so.

Education: Professional degree in Occupational Therapy, Nursing, Activities Therapy or other clinical profession (e.g. Master's Degree in Social Work, Psychology or Counseling).

Experience: Experience in operation of inpatient services to people with mental illness. Demonstated experience in successful program development, implementation and management.

Skills and Knowledge:

-Knowledge of and experience with people with acute severe mental illness

-Understanding of data collection and analysis methods

-Effective verbal and written communication skills

-Knowledge of best and evidence-based practices regarding inpatient psychiatric treatment

-Knowledge of the principles and practices of public administration

-Knowledge of supervisory principles and practices

-Knowledge and skills in strategic planning and systems change

-Knowledge and skills in project management

-Skills in leadership and multi-stakeholder consensus-building

-Ability to develop and negotiate contracts

-Ability to evaluate program effectiveness

-Ability to communicate effectively orally and in writing.

-Ability to coordinate and provide training

-Ability to establish and maintain effective working relationships.

4. Do you supervise?

In this question "supervise" means if you direct the work of others where you are held **directly** responsible for assigning work; performance ratings; training; reward and discipline or effectively recommend such action; and other personnel matters. List the names, titles, and position numbers of the classified employees reporting to you:

No.

5. In what way does your supervisor provide you with work assignments and review your work?

This question deals with how you are supervised. Explain how you receive work assignments, how priorities are determined, and how your work is reviewed. There are a wide variety of ways a job can be supervised, so there may not be just one answer to this question. For example, some aspects of your work may be reviewed on a regular basis and in others you may operate within general guidelines with much independence in determining how you accomplish tasks.

Works with supervisor and federal grantor to effectively set goals and establish priorities;understand, prepare and adhere to project goals, objectives, tasks, deadlines and time lines.

Effectively solicits, integrates and responds to regular input, consultation and directives from multiple sources, including VSH and RHC leadership teams, project steering committee, state leadership, national expert consultants, federal administrators, treatment providers, consumers, families, and community representatives.

Works with supervisor to montior and adhere to expectations and requirements of federal adminstration funding the project.

Clearly communicates grant project and departmental expectations, desired outcomes, and effectively delegates responsibilities to project staff, providing necessary supervision and resources to accomplish expectations.

Performs work activities with modest superivion; expected to complete many work projects independently without direct superivion.

6. Mental Effort

This section addresses the mental demands associated with this job. Describe the most mentally challenging part of your job or the most difficult typical problems you are expected to solve. Be sure to give a specific response and describe the situation(s) by example.

- For example, a purchasing clerk might respond: *In pricing purchase orders, I frequently must find the cost of materials not listed in the pricing guides. This involves locating vendors or other sources of pricing information for a great variety of materials.*

- Or, a systems developer might say: *Understanding the ways in which a database or program will be used, and what the users must accomplish and then developing a system to meet their needs, often with limited time and resources.*

Expected to effectively understand, evaluate, and develop strategies to overcome multiple, complex organizational barriers to alternatives to S/R.

Expected to oversee implementation of multi-year, systems change initiative involving two separate complex inpatient organizations.

7. Accountability

This section evaluates the job's expected results. In weighing the importance of results, consideration should be given to responsibility for the safety and well-being of people, protection of confidential information and protection of resources.

What is needed here is information not already presented about the job's scope of responsibility. What is the job's most significant influence upon the organization, or in what way does the job contribute to the organization's mission?

Provide annualized dollar figures if it makes sense to do so, explaining what the amount(s) represent.

For example:

- A social worker might respond: *To promote permanence for children through coordination and delivery of services*;
- A financial officer might state: *Overseeing preparation and ongoing management of division budget: $2M Operating/Personal Services, $1.5M Federal Grants.*

Overseeing implemenation and management of three-year, $ 640,00 federal grant.

Overseeing implementation of new/improved interventions for individuals who are a danger to themselves or others to ensure their safety, wellbeing and protection of legal rights.

Reducing the use of seclusion and restraints and associated staff and patient injury at Vermont's two primary inpatient facilities for adults and chilren.

8. Working Conditions

The intent of this question is to describe any adverse conditions that are routine and expected in your job. It is not to identify special situations such as overcrowded conditions or understaffing.

a) What significant mental stress are you exposed to? All jobs contain some amount of stress. If your job stands out as having a significant degree of mental or emotional pressure or tension associated with it, this should be described.

Type	How Much of the Time?

b) What hazards, special conditions or discomfort are you exposed to? (Clarification of terms: **hazards** include such things as potential accidents, illness, chronic health conditions or other harm. Typical examples might involve exposure to dangerous persons, including potentially

violent customers and clients, fumes, toxic waste, contaminated materials, vehicle accident, disease, cuts, falls, etc.; and **discomfort** includes exposure to such things as cold, dirt, dust, rain or snow, heat, etc.)

Type	How Much of the Time?
Working with potentially violent clients	5 %

c) What weights do you lift; how much do they weigh and how much time per day/week do you spend lifting?

Type	How Heavy?	How Much of the Time?

d) What working positions (sitting, standing, bending, reaching) or types of effort (hiking, walking, driving) are required?

Type	How Much of the Time?

Additional Information:

Carefully review your job description responses so far. If there is anything that you feel is important in understanding your job that you haven't clearly described, use this space for that purpose. Perhaps your job has some unique aspects or characteristics that weren't brought out by your answers to the previous questions. In this space, add any additional comments that you feel will add to a clear understanding of the requirements of your job.

This position will oversee a project that will attempt to achieve substantial change across two separate complex inpatient organizations, one of which is state-run and the other being privately-run. Because of this, this position has been placed directly under the supervision of the Commissioner of Mental Health but will also work closely with the Director of VSH.

Employee's Signature **(required)**:_____Date:_____

Supervisor's Section:

Carefully review this completed job description, but **do not** alter or eliminate any portion of the original response. Please answer the questions listed below.

1. What do you consider the most important duties of this job and why?

• Work closely with VSH and Retreat Healthcare to guide the development of a strategic plan that incorporates the 6 Core Strategies to Reducing Seclusion and Restraint.

• Coordinate use of expert consultation on effective, empirically-based organizational and clinical strategies for reducing restraint and seclusion.

• Maintain an effective presence and leadership at Department of Mental Health, VSH and Retreat Healthcare to ensure project visibility and stimulate and sustain the engagement of key staff in the change process.

• Work with S/R reduction consultants to implement sensory modulation techniques among VSH and RHC staff and serve as the in-house expert on these approaches at VSH.

• Identify organizational needs for and operational barriers to successfully reducing the use of involuntary procedures at VSH , and communicate these to VSH leadership and interested stakeholders.

This grant has the potential to bring about significant change in the way mental health inpatient services are provided to adults and childlren who are a danger to themselves and/or others. To make these changes, key stakeholders within both institutions, as well as advocates, consumers and family members will need to work together to achieve cultural and behavioral changes at both VSH and RHC. Previous attempts to reduce seclusion and restraint at VSH and RHC have resulted in mixed succsess, and this issue has become highly charged and political. To achieve the goals of this grant, a complex mix of training, consultation, technical assistance and consensu-building will need to be coordinated in a systematic and focused manner.

2. What do you consider the most important knowledge, skills, and abilities of an employee in this job (not necessarily the qualifications of the present employee) and why?

-Effective verbal and written communication skills

-Knowledge of best and evidence-based practices regarding inpatient psychiatric treatment

-Knowledge and skills in strategic planning and systems change

-Knowledge and skills in project management

-Skills in leadership and multi-stakeholder consensus-building

-Ability to evaluate program effectiveness

-Ability to establish and maintain effective working relationships.

Explanation:

This position will attempt to build consensus and achieve organizational change at two complex organizations workiing with diverse stakeholders who currently have strong and sometimes opposing viewpoints of how to achieve change.

3. Comment on the accuracy and completeness of the responses by the employee. List below any missing items and/or differences where appropriate.

N/A

4. Suggested Title and/or Pay Grade:

VSH Alternatives to Seclusion/Restraint Coordinator PG: 26

Supervisor's Signature **(required):** _____ Date: 12/21/07

Personnel Administrator's Section:

Please complete any missing information on the front page of this form before submitting it for review.

Are there other changes to this position, for example: Change of supervisor, GUC, work station?

☒ Yes ☐ No If yes, please provide detailed information.

Michael Hartman is now Supervisor

Attachments:

☒ Organizational charts are **required** and must indicate where the position reports.

☐ Draft job specification is **required** for proposed new job classes.

Will this change affect other positions within the organization? If so, describe how, (for example, have duties been shifted within the unit requiring review of other positions; or are there other issues relevant to the classification review process).

no

Suggested Title and/or Pay Grade: PG 26

VSH Alternatives to Seclusion/Restraint Coord

Personnel Administrator's Signature **(required):** _____ Date: 1/18/08

Appointing Authority's Section:

Please review this completed job description but **do not alter** or eliminate any of the entries. Add any clarifying information and/or additional comments (if necessary) in the space below.

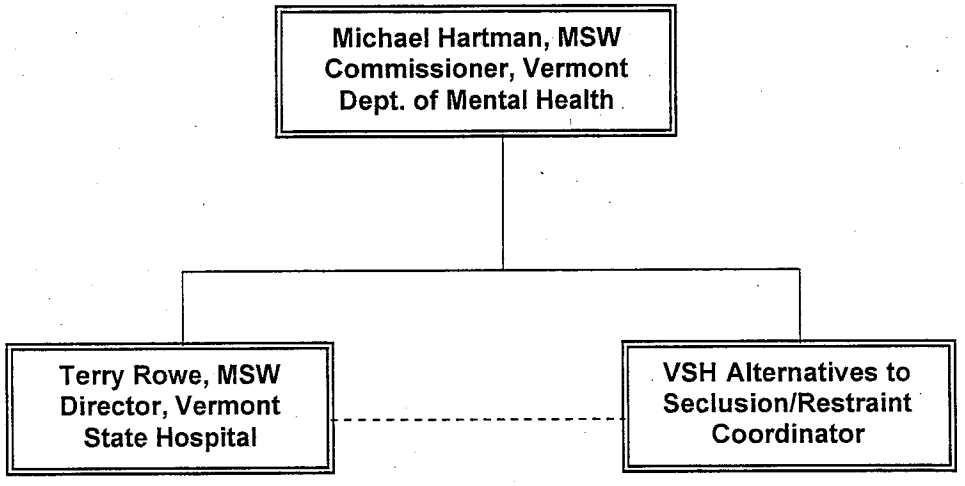
Suggested Title and/or Pay Grade:

As Above PG 26

Appointing Authority or Authorized Representative Signature **(required)**

12/21/07
Date

Organizational Chart for Vermont State Hospital (VSH) Alternatives to Seclusion/Restraint Coordinator



The VSH Alternatives to Seclusion/Restraint Coordinator will be supervised by Michael Hartman, Commissioner of the Department of Mental Health, but the position will be based at the Vermont State Hospital, and so the position will also work closely with the director of VSH.

Notice of Grant Award

Restraint and Seclusion
Department of Health and Human Services
Substance Abuse and Mental Health Services Administration
Center for Mental Health Services

Issue Date: 08/31/2007

Grant Number: 1H79SM058125-01

Program Director:
William McMains

Project Title: Implementation of alternatives to restraint and seclusion

Grantee Address	Business Address
VERMONT STATE DEPT OF HEALTH Mr. Thomas Ciaraldi Chief Financial Officer Division of Mental Health 108 Cherry St Burlington, VT 054020070	Mr. Thomas Ciaraldi Chief Financial Officer Vermont Department of Health 108 Cherry St Burlington, VT 05402-007

Budget Period: 09/30/2007 – 09/29/2008
Project Period: 09/30/2007 – 09/29/2010

Dear Grantee:

The Substance Abuse and Mental Health Services Administration hereby awards a grant in the amount of $213,905 (see "Award Calculation" in Section I and "Terms and Conditions" in Section III) to VERMONT STATE DEPT OF HEALTH in support of the above referenced project. This award is pursuant to the authority of 42 U.S.C 290aa et seq. and is subject to the requirements of this statute and regulation and of other referenced, incorporated or attached terms and conditions.

Award recipients may access the SAMHSA website at www.samhsa.gov (click on "Grants" then SAMHSA Grants Management), which provides information relating to the Division of Payment Management System, DHHS Division of Cost Allocation and Postaward Administration Requirements. Please use your grant number for reference .

Acceptance of this award including the "Terms and Conditions" is acknowledged by the grantee when funds are drawn down or otherwise obtained from the grant payment system.

If you have any questions about this award, please contact your Grants Management Specialist and your Government Project Officer listed in your terms and conditions.

Sincerely yours,

Gwendolyn Simpson
Grants Management Officer
Division of Grants Management, OPS
Substance Abuse and Mental Health Services Administration

See additional information below

SECTION I – AWARD DATA – 1H79SM058125-01

Award Calculation (U.S. Dollars)

Salaries and Wages	$47,403
Fringe Benefits	$14,221
Personnel Costs (Subtotal)	$61,624
Travel Costs	$6,650
Other	$124,300
Direct Cost	$192,574
Indirect Cost	$21,331
Approved Budget	$213,905
Federal Share	$213,905
Cumulative Prior Awards for this Budget Period	$0
AMOUNT OF THIS ACTION (FEDERAL SHARE)	$213,905

SUMMARY TOTALS FOR ALL YEARS	
YR	AMOUNT
1	$213,905
2	$213,564
3	$213,777

* Recommended future year total cost support, subject to the availability of funds and satisfactory progress of the project.

Fiscal Information:

CFDA Number:	93.243
EIN:	1036000274B8
Document Number:	H9SM58125A
Fiscal Year:	2007

IC	CAN	Amount
SM	C96C127	$213,905

SM Administrative Data:
PCC: CMHS-S&R / OC: 4145

SECTION II – PAYMENT/HOTLINE INFORMATION – 1H79SM058125-01

Payments under this award will be made available through the DHHS Payment Management System (PMS). PMS is a centralized grants payment and cash management system, operated by the HHS Program Support Center (PSC), Division of Payment Management (DPM). Inquiries regarding payment should be directed to: The Division of Payment Management System, PO Box 6021, Rockville, MD 20852, Help Desk Support – Telephone Number: 1-877-614-5533.

The HHS Inspector General maintains a toll-free hotline for receiving information concerning fraud, waste, or abuse under grants and cooperative agreements. The telephone number is: 1-800-HHS-TIPS (1-800-447-8477). The mailing address is: Office of Inspector General, Department of Health and Human Services, Attn: HOTLINE, 330 Independence Ave., SW, Washington, DC 20201.

SECTION III – TERMS AND CONDITIONS – 1H79SM058125-01

This award is based on the application submitted to, and as approved by, SAMHSA on the above-title project and is subject to the terms and conditions incorporated either directly or by reference in the following:

a. The grant program legislation and program regulation cited in this Notice of Grant Award.
b. The restrictions on the expenditure of federal funds in appropriations acts to the extent those restrictions are pertinent to the award.
c. 45 CFR Part 74 or 45 CFR Part 92 as applicable.
d. The DHHS Grants Policy Statement.
e. This award notice, INCLUDING THE TERMS AND CONDITIONS CITED BELOW.

Treatment of Program Income:
Additional Costs

SECTION IV – SM Special Terms and Condition – 1H79SM058125-01

SPECIAL CONDITIONS OF AWARD

Within 30 days of award, the grantee must provide to the SAMHSA Grants Management Specialist a revised budget for approval. The budget and justification must clearly identify a cost breakdown for the following items:

1. Contractual (Consultants) Name, annual salary, level of effort, salary being requested, fringe benefits, travel costs, other direct costs, indirect cost, etc

2. Other Direct Cost Sensory Equipment and Physical Plant Renovations i.e. building sensory/calming rooms is listed twice in the budget , please justify.

STANDARD TERMS OF AWARD:

1. This grant is subject to the terms and conditions, included directly, or incorporated by reference on the Notice of Grant Award. Refer to the order of precedence in Section 111 on the Notice of Grant Award.

2. The grantee organization is legally and financially responsible for all aspects of this grant, including funds provided to sub-recipients.

3. Grant funds cannot be used to supplant current funding of existing activities. Under the DHHS Grants Policy Directives, 1.02 General -- Definition: Supplant is to replace funding of a recipient's existing program with funds from a Federal grant.

4. The recommended future support as indicated on the Notice of Grant Awarded reflects TOTAL costs (direct plus indirect). Funding is subject to the availability of Federal funds, and that matching funds, (if applicable), is verifiable, progress of the grant is documented and acceptable.

5. By law, none of the funds awarded can be used to pay the salary of an individual at a rate in excess of the Executive Level I, which is $186,600 annually.

6. "Confidentiality of Alcohol and Drug Abuse Patient Records" regulations (42CFR 2) are applicable to any information about alcohol and other drug abuse patients obtained by a "program" (42 CFR 2.11), if the program is federally assisted in any manner (42 CFR 2.12b).

Accordingly, all project patient records are confidential and may be disclosed and used only in accordance with (42 CFR 2). The grantee is responsible for assuring compliance with these regulations and principles, including responsibility for assuring the security and confidentiality of all electronically transmitted patient material.

7. Accounting Records and Disclosure - Awardees and sub-recipients must maintain records with adequately identify the source and application of funds provided for financially assisted activities. These records must contain information pertaining to grant or subgrant awards and authorizations, obligations, unobligated balances, assets, liabilities, outlays or expenditures, and income. The awardee, and all its sub-recipients, should expect that SAMHSA, or its designee, may conduct a financial compliance audit and on-site program review on grants with significant amounts of Federal funding.

8. Per (45 CFR 92.34) and the PHS Grants Policy Statement, any copyrighted or copyrightable works developed under this cooperative agreement/grant shall be subject to a royalty free, nonexclusive and irrevocable license to the government to reproduce, publish, or otherwise use them and to authorize others to do so for Federal Government purposes. Income earned from any copyrightable work developed under this grant must be used a program income.

9. A notice in response to the President's Welfare-to-Work Initiative was published in the Federal Register on May 16, 1997. This initiative is designed to facilitate and encourage grantees and their sub-recipients to hire welfare recipients and to provide additional needed training and/or mentoring as needed. The text of the notice is available electronically on the OMB home page at www.whitehouse.gov/wh/eop/omb.

10. The DHHS Appropriations Act requires that to the greatest extent practicable, all equipment and products purchased with funds made available under this award should be American made.

11. Program Income accrued under the award must be accounted for in accordance with (45CFR 74.24) or (45 CFR 92.25) as applicable. Program income must be reported on the Financial Status Report, Standard Form 269 (long form).

Program income accrued under this award may be used in accordance with the additional costs alternative described in (45 CFR 74.24(b) (1)) or (45 CFR 92.25(g) (2)) as applicable. Program income must be used to further the grant objectives and shall only be used for allowable costs as set forth in the applicable OMB administrative requirements.

12. Actions that require prior approval must be submitted in writing to the Grants Management Officer (GMO), SAMHSA. The request must bear the signature of an authorized business official of the grantee organization as well as the project director. Approval of the request may only be granted by the GMO and will be in writing. No other written or oral approval should be accepted and will not be binding on SAMHSA.

13. Any replacement of, or substantial reduction in effort of the Program Director (PD) or other key staff of the grantee or any of the sub-recipients requires the written prior approval of the Grants Management Officer. The GMO must approve the selection of the PD or other key personnel, if the individual being nominated for the position had not been named in the approved application, or if a replacement is needed should the incumbent step down or be unable to execute the position's responsibilities. A resume for the individual(s) being nominated must be included with the request. Key staff (or key staff positions, if staff has not been selected) is listed below:

, Project Director

14. None of the Federal funds provided under this award shall be used to carry out any program for distributing sterile needles or syringes for the hypodermic injection of any illegal drug.

15. Refer to the back of the Notice of Grant Awarded for information regarding grant payment information (1) and the Health and Human Services Inspector General's Hotline for information concerning fraud, waste or abuse.

16. As the grantee organization, you acknowledge acceptance of the grant terms and conditions by drawing or otherwise obtaining funds from the Payment Management System. In doing so, your organization must ensure that you exercise prudent stewardship over Federal funds and that all costs are allowable, allocable and reasonable.

17. No DHHS funds may be paid as profit (fees) per (45 CFR Parts 74.81 and 92.22(2)).

18. RESTRICTIONS ON GRANTEE LOBBYING (Appropriations Act Section 503).

(a) No part of any appropriation contained in this Act shall be used, other than for normal and recognized executive-legislative relationships, for publicity or propaganda purposes, for the preparation, distribution, or use of any kit, pamphlet, booklet, publication, radio, television, or video presentation designed to support or defeat legislation pending before the Congress, except in presentation to the Congress itself or any State legislature.

(b) No part of any appropriation contained in this Act shall be used to pay the salary or expenses of any grant or contract recipient, or agent acting for such recipient, related to any activity designed to influence legislation or appropriations pending before the Congress or any State legislature.

19. Where a conference is funded by a grant or cooperative agreement the recipient must include the following statement on all conference materials (including promotional materials, agenda, and Internet sites):

Funding for this conference was made possible (in part) by SM-07-005 cooperative agreement from SAMHSA. The views expressed in written conference materials or publications and by speakers and moderators do not necessarily reflect the official policies of the Department of Health and Human Services; nor does mention of trade names, commercial practices, or organizations imply endorsement by the U.S. Government.

REPORTING REQUIREMENTS:

1. Financial Status Report (FSR), Standard Form 269 (long form) is due within 90 days after expiration of the budget period and 90 days after the expiration of the project period. If applicable, include the required match on this form under Transactions (#10 a-d), Recipient's share of net outlays (#10 e-i) and Program Income (q-t) in order for SAMHSA to determine whether matching is being provided and the rate of expenditure is appropriate. Adjustments to the award amount, if necessary, will be made if the grantee fails to meet the match. The FSR must be prepared on a cumulative basis and all program income must be reported. Disbursements reported on the Financial Status Report must equal/or agree with the Final Payment Management System Report (PSC-272).

2. Grantees must provide annual and final progress reports. The final progress report must summarize information from the annual reports, describe the accomplishments of the project, and describe next steps for implementing plans developed during the grant period.

3. The grantee must comply with the GPRA requirements that include the collection and periodic reporting of performance data as specified in the RFA or by the Project Officer. This information is needed in order to comply with PL 102-62, which requires that SAMHSA report evaluation data to ensure the effectiveness and efficiency of its programs.

4. Submission of audit reports in accordance with the procedures established in OMB Circular A-133 is required by the Single Audit Act Amendments of 1966 (P.L. 104-156). An audit is required for all entities which expend $500,000 or more of Federal funds in each fiscal year and is due to the Clearinghouse within 30 days of receipt from the auditor or within nine (9) months of the fiscal year, whichever occurs first, to the following address:

Federal Audit Clearinghouse
Bureau of the Census
1201 E. 10th Street
Jeffersonville, IN 47132

Failure to comply with this requirement may result in DHHS sanctions placed against your organization, i.e., classification as high risk, conversion to a reimbursement method of payment, suspension or termination of award.

HUMAN SUBJECTS:

Under governing regulations, Federal funds administered by the DHHS shall not be expended for, and individuals shall not be enrolled in research involving human subjects without prior approval by the Substance Abuse and Mental Health Administration of the project's procedures for protection of human subjects. This restriction applies to all Multiple Project Assurance grantee institutions and performance sites without human subjects certification. For institutions with a Single Project Assurance, but no certification at time of award, no funds may be expended or individuals enrolled in research without prior approval by the Office for Human Research Protection (OHRP) of an assurance to comply with the requirements of (45 CFR 46) to protect human research subjects.

INDIRECT COSTS:

1. Grantees that have not established indirect cost rates are required to submit an indirect cost proposal to the appropriate office within 90 days from the start date of the project period. If the grantee requests indirect cost reimbursement but does not have an approved rate agreement at the time of award, the grantee shall be limited to a provisional rate equaling one-half of the indirect costs requested, up to a maximum of 10 percent of salaries and wages only. If the recipient fails to provide a timely proposal, indirect costs paid in anticipation of establishment of a rate must be disallowed.

SAMHSA will not accept a research indirect cost rate. The grantee must use another-sponsored program rate or lowest rate available.

Please contact the appropriate office of the Division of Cost Allocation to begin the process for establishing an indirect cost rate. To find a list of HHS Division of Cost Allocation Regional Offices go to the SAMHSA website www.samhsa.gov then click on "grants"; then click on "Important offices".

All responses to special terms and conditions of award and post award requests must be mailed to the Division of Grants Management, OPS, SAMHSA below:

For Regular Delivery:

Division of Grants Management
OPS, SAMHSA
1 Choke Cherry Road, Room 7-1091
Rockville, MD 20857

For Overnight or Direct Delivery:

Division of Grants Management,
OPS, SAMHSA
1 Choke Cherry Road, Room 7-1091
Rockville, MD 20850

John Morrow, Program Official
Phone: (240) 276-1783 **Email**: john.morrow@samhsa.hhs.gov

Sherie Fairfax, Grants Specialist
Phone: 240-276-1415 **Email**: sherie.fairfax@samhsa.hhs.gov **Fax**: 240-276-1430

STATE INCENTIVE GRANTS TO BUILD CAPACITY FOR ALTERNATIVES TO RESTRAINT AND SECLUSION

Catalogue of Federal Domestic Assistance (CFDA) No.: **93.243**

Project Abstract

State of Vermont – Division of Mental Health

Proposal to Implement Alternatives to Restraint and Seclusion

The purpose of the project will be to improve mental health inpatient treatment by implementing alternatives to seclusion and restraint (S/R) at the Vermont State Hospital (VSH) for adults with serious mental illness and Retreat Healthcare (RHC) for children and adolescents with serious emotional disturbances. SAMHSA's Six Core Strategies to Reduce the Use of Seclusion and Restraint will guide the development of strategic plans at each hospital and will help create the culture shift necessary for the use of less coercive measures for ensuring patient and staff safety. The goals of the project are as follows:

Goal 1: Vermont will strengthen and enhance its oversight, leadership and coordination capacity at the state level and at VSH and RHC to enhance the development of alternatives to restraint and seclusion

Goal 2: Using the SAMSHA Six Core Strategies as a guide, Vermont will develop and implement a strategic plan to complete S/R Reduction efforts at VSH and the RHC.

Goal 3: Vermont will implement specific S/R Reduction Techniques (e.g. Sensory Modulation) at VSH and the RHC to reduce and prevent the need for S/R.

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Section A: Statement of Need

The State of Vermont proposes to build capacity for alternatives to seclusion and restraint (S/R) at two inpatient institutions: The **Vermont State Hospital** (VSH), which is Vermont's only state-run institution for adults with serious mental illness, and **Retreat Healthcare** (RHC) a private, not-for-profit mental health and addictions treatment center for people of all ages. RHC serves as the Vermont State Hospital for children and adolescents with serious emotional disturbances. Because of the unique and specialized services that these two institutions provide, both serve the entire state of Vermont's population of 620,000.

Both VSH and RHC have focused on the reduction of S/R for the past several years. However, each institution has had different challenges and opportunities related to their efforts at reducing S/R. Consequently, each institution joins this proposed project with a different set of needs. The activities proposed in this grant will build upon the accomplishments and past "lessons learned" from both organizations.

Grant activities described in this proposal will focus on adults with serious mental illness at VSH, and children and adolescents at Retreat Healthcare. However, it is the anticipated that the institutional learning from this grant will benefit the adult populations served by RHC as well.

Vermont State Hospital

VSH is a 54-bed state psychiatric hospital providing intensive psychiatric treatment and secure observation when no adequate less restrictive alternative exists. VSH has an average daily census of about 50 patients. Between 70-80% of VSH admissions are for emergency evaluations and the remaining admissions are patients transferred from less restrictive care settings. The VSH physical plant is over 70 years old.

VSH admits the state's most acutely ill psychiatric patients, most of whom have been deemed to be too high an acuity level for care at any of the other five Vermont hospitals offering inpatient psychiatric services. These patients generally suffer from psychotic illnesses, and have often demonstrated recent violent behaviors prior to admission to VSH. Many of the patients admitted to VSH have refused to accept treatment for their psychotic illness, such as taking antipsychotic medication or attending treatment focused activities.

VSH serves both civil and forensic male and female patients. The civil and forensic populations are housed together and there is generally little control over when and how often court-ordered admissions (generally for forensic fitness to stand trial evaluations) are admitted. VSH may receive several admissions through the courts on any given day, and needs to assimilate multiple persons with untreated psychosis and recent histories of violence and/or trauma onto already crowded units.

The average number of individuals served annually at VSH over the last 4 years was 225. It is anticipated that this will remain the average number served at VSH through the life of this grant. On average, 65% of patients served at VSH are male and 35% are female. The majority of people served are over the age of 35 (66%) and only 5% are 20 years old or younger. Ninety-two

of people served at VSH are Caucasian, with 8% of Asian, Hispanic or African American descent. The median length of stay is 2 months and the mean length of stay is 1 year, nine months.

Seclusion and Restraint VSH

In the summer of 2002, the Commissioner of Mental Health and the VSH Executive Director recognized the need for change at VSH and commissioned a study of options for reducing seclusion, restraint and other coercive measures at VSH. The study, called *A System Under Siege,* documented the "many symptoms of an institution struggling with the impact of chronic stress." The report concluded that VSH needed a facilitated cultural transformation in order to successfully change course and reduce the use of seclusion, restraint and other coercive measures. During that same time, a team of Vermont representatives, including members of VSH, the Division of Mental Health, Vermont's Protection and Advocacy organization, and Vermont's statewide consumer organizations, attended an intensive training on SAMHSA's Six Core Strategies to Reduce the Use of S/R. Following that training, the group spent three days together developing a document called "Preliminary Strategic Plan for Reducing / Eliminating the Use of Seclusion and Restraint at Vermont State Hospital." This Preliminary plan was intended to lay the foundation for a longer term strategic plan.

Unfortunately, before the preliminary plan could be implemented, VSH suffered two tragic patient suicides, and VSH was decertified by the Center for Medicaid and Medicare Services (CMS). Shortly after decertification, the U.S. Department of Justice (DOJ) formally initiated a federal Civil Rights of Institutionalized Persons Act (CRIPA) investigation. The DOJ investigation found that VSH failed to adequately protect the civil rights of patients in a number of areas of care. The DOJ specifically cited VSH for numerous instances of failing to protect its patients from harm due to overuse of unnecessary S/R. In sum, the DOJ found that VSH's use of S/R substantially departed from generally accepted professional standards of care and exposed its patients to harm due to inadequate policies and procedures, poor staff training, insufficient behavioral programming, and inadequate documentation and supervision.

DOJ made the following specific findings related to the use of S/R at VSH:

- Over 90% of restraint incidents at VSH involve strapping patients down to a bed in five-point restraints in a seclusion room - the most restrictive and dangerous form of intervention. And that the percentage of patients secluded and restrained substantially exceeds the national average for psychiatric hospitals.
- S/R are repeatedly used as interventions for behaviors where the patient is not an immediate danger to himself or others.
- VSH consistently uses S/R as an intervention of first resort and fails to consider lesser restrictive alternatives.
- VSH also keeps patients in S/R substantially longer than the original incident warrants.
- VSH fails to adequately document its use of S/R – including several instances where records failed to contain any physician order – and fails to provide an appropriate rationale for the restrictive measure

- S/R at VSH is applied without adequate professional assessment and/or supervision, often with significant clinical error, for the convenience of staff, and without appropriate documented rationale.

Since the initiation of the DOJ investigation, with focused leadership and technical assistance, VSH has made significant progress in addressing the areas of concern identified by DOJ. Some of the improvements are:

- VSH developed a new policy that comports with generally accepted standards of care for the use of S/R.
- VSH prioritized the use of S/R for data collection and performance improvement.
- VSH established an Emergency Involuntary Procedures Reduction Program (EIPRP) as part of the new collaboration between the University of Vermont/Fletcher Allen Health Care and the VDH Division of Mental Health. The purpose of EIPRP was to initiate coordinated and comprehensive reform regarding the use of emergency involuntary procedures at the Vermont State Hospital. Consumers, advocates and hospital staff comprised this task force and assumed the responsibility of creating a method for tracking and trending relevant data, identifying training and practice needs and orchestrating and interventions in order to eliminate the avoidable use of restraint, seclusion, and emergency involuntary medication.

However, much work remains to be done.

Over the past two years, VSH's ability to track and trend data on the use of S/R has improved greatly. VSH tracks the use of seclusion, restraint, emergency involuntary medication and constant observation in a variety of ways. On a monthly basis, VSH tracks hours of S/R, hours per 1,000 patient hours, episodes of S/R and the number of individuals secluded or restrained. In addition, on a monthly basis, VSH tracks episodes of emergency involuntary medications, the number of individuals receiving involuntary medications and number of hours, individuals and episodes of constant observation. VSH has the ability to analyze the data from a number of perspectives including: patient demographics, diagnosis, time-of day, staff involved, attending physician, legal status, and length of stay.

In 2006, VSH documented a total of 366 episodes of seclusion with severity ranging from 11 to 60 episodes per month and including documentation of one client repeatedly isolated due to threats of harm toward others. Removing the top two outliers, the mean number of events changes from 30 to 15 per month. During the same year, there were 254 documented episodes of non-ambulatory restraint defined as use of a 4-point or 5-point restraint bed. The mean time restrained was 1.4 hours with a range from 1 to 3 hours. The majority of non-ambulatory restraint episodes occur equally between day shift (41%) and evening shift (43%). The night shift accounted for 16% of these restraint episodes. Emergency Involuntary Medications (EIM) (by definition, another form of restraint) were administered a total of 293 times during 2006. Episodes of constant observation by staff were needed a total of 558 times with a total of 218 patients having at least one 1:1 observation order.

Although much of the work done to date at VSH represents a foundation from which to launch a new strategic initiative to embrace the Six Core Strategies, there is not general agreement among

Vermont's key stakeholders regarding the state hospital's progress to-date. Several stakeholder representatives, including Vermont Protection and Advocacy, have expressed frustration with the state for not implementing the R/S reduction strategic plan developed three years ago, and there have been repeated requests for VSH to update and begin implementing a comprehensive strategic plan to reduce S/R. While the creation of a workgroup focusing on S/R reduction (EIPRP) has coincided with a reduction in the use of S/R at VSH, some stakeholders have been unhappy with its process and outcomes and have stopped attending the group. In addition, some stakeholders believe that VSH currently struggles to comply with a state consent decree, known as Doe v Miller, which was designed to protect patients' basic civil rights relative to S/R. As a result they have limited confidence in the organization's ability to be proactive in this area. Some stakeholders have expressed the need for a broader "culture change" at VSH, including a more comprehensive, transparent process. Many of these concerns are included in several letters of support in Appendix 1 and in the summary of Stakeholder comments below.

While there is not general agreement in the stakeholder community as to where VSH currently is on the continuum of improvement, there is agreement that VSH needs a transparent, inclusive and accountable process to move forward toward the goal of reducing seclusion and restraint. DMH believes that the activities proposed in this grant will address this shared goal.

Retreat Healthcare

Retreat Healthcare (RHC), founded in 1834, is a not-for-profit, regional, specialty mental health and addictions treatment center, providing a full range of diagnostic, therapeutic and rehabilitation services for individuals of all ages and their families. RHC offers individualized, comprehensive continuum of care including inpatient, partial hospitalization, child and adolescent residential, and outpatient treatment .

The population that this project will focus on will be children ages 5-12 and adolescents ages 13-18. Both programs are designed to provide short term, specialized inpatient hospital care for children or adolescents who have serious social, emotional, psychiatric or substance abuse disorders that have led to disruptive and maladaptive behaviors and relationships. As the Vermont state hospital for children and adolescents, RHC specializes in the treatment of complicated psychiatric disorders. The average length of stay is eight to 10 days. Based on their needs, patients may move back and forth along a continuum of care at RHC, from inpatient to residential to partial hospitalization.

The average number of children and adolescents served annually at RHC over the last 4 years was 453. It is anticipated that this will remain the average number served at RHC through the life of this grant. On average, 54% of patients served at RHC are female and 46% are male. Forty-six percent (46%) of the children served are between the ages of 11 and 15, 39% are between the ages of 16 and 19 and 15% are under age 11. Of the 573 total admissions to our Child/Adolescent Inpatient Services in 2006, 95% (543) were voluntary.

Seclusion and Restraint at Retreat Healthcare

In February 2004, the Residential Licensing Unit (RLU) of the Vermont Department of Children and Family Services (DCF), Vermont's state child welfare agency, placed a temporary hold on child and adolescent admissions at RHC. This admissions hold was the result of licensing violations, many of which related to the use of S/R in RHC's residential programs for children and adolescents. Shortly thereafter, RHC and RLU agreed to a corrective action plan and the admissions hold was lifted. The RLU closely monitored the implementation of the corrective action plan to ensure the required improvements in the use of S/R among the children and adolescents served at RHC. Since that point, care has continued to improve.

In 2005, after a number of staff returned from a training on the reduction of S/R sponsored by National Technical Assistance Center (NTAC), RHC established a task force to guide the organization through the Six Core Strategies. The task force, known as TIRRM (Trauma Informed, Resiliency, and Recovery Model) developed a strategic action plan to implement the Six Core Strategies. TIRRM consists of clinical managers from all in-patient and residential programs, members of the executive team, social work staff, therapeutic services staff and several direct care staff from various programs. Other members include the manager of clinical education, director of outreach and education, performance improvement manager and a member from Vermont Protection and Advocacy. This group has met biweekly since April 2005. Through TIRRM, RHC staff has utilized many of the training tools developed by NTAC and NASMHPD. RHC has prioritized TIRRM's philosophy of care and the reduction of R/S has been embraced by the institution from the Board of Directors down to the majority of the clinical staff. Currently the TIRRM task force is reviewing and updating the strategic plan in an ongoing effort to strengthen the organization's commitment to the plan's goals.

Shortly after its inception, the TIRRM task force identified a need for RHC to implement the use of specific S/R reduction tools (Strategy Four) and created a subcommittee focusing on this area. The subcommittee chose to focus on the use of *sensory integration* and *sensory modulation* as key techniques which could aid in the prevention and reduction of S/R (see section B for a full description of sensory modulation), and they began to work with Tina Champagne, a national expert on sensory modulation, to review the organization's facilities and progress to date relating to sensory integration and to make recommendations on how RHC could fully embrace the sensory integration tools and techniques.

Generally, Ms. Champagne's review was very positive. She documented the organizations efforts throughout the facilities to establish sensory rooms and make sensory tools (carts) available to patients / residents. She commented on the commitment and motivation of the staff to use sensory integration techniques in programming. It became clear from Ms. Champagne's review and recommendations that, without further expertise to guide staff, RHC will not be able to experience the full benefits of sensory modulation; RHC has essentially reached a plateau in their efforts to implement sensory techniques. Specifically, without further staff expertise, RHC will not be able to implement the assessment techniques necessary to determine what sensory tools are best suited for each individual's needs and treatment goals.

In consulting with different stakeholders regarding the development of this grant application, there have been some concerns expressed that high turnover among leadership staff at RHC has diluted and slowed RHC's progress toward the implementation of its strategic plan to reduce S/R (see Letters of Support – Appendix 1). As such, some believe there is a need to strengthen stakeholder involvement, re-assess RHC's progress to-date, and revise its strategic plan accordingly.

Similar to VSH, RHC collects data that enables the hospital to track and trend the use of S/R. RHC has relied on data to guide and focus their S/R reduction efforts to date but hopes to maximize the use of data to inform practices through the efforts of this grant. In 2006, the Brattleboro Retreat documented a total of 41 episodes of locked seclusion (patient locked in room w/viewing window in door and staff member on opposite side of door observing and speaking with patient) on all of our inpatient units. Of the 27 episodes of seclusion on the child/adolescent units, 12 of those episodes occurred with one patient. Of the 14 episodes of seclusion on our adult units, 7 of these events involved one patient. The minimum time for a seclusion event was 1 minute, the maximum time was 9 hours 50 minutes. The average time for a seclusion event, including the outliers, was 44.9 minutes. Removing the 2 outlier patients, the average time per seclusion event was 24.48 minutes.

With administrative support and educational programs the clinical staff of the Brattleboro Retreat has strived to improve their therapeutic relationships with patients in an effort to reduce the frequency of "hands on" therapeutic holds that are required to maintain both patient and staff safety. Over the last two years, all units have experienced a downward trend in the numbers of therapeutic holds required to maintain safety.

During 2006, there were a total of 91 episodes of ambulatory therapeutic holds on all of the inpatient units. The average length of a therapeutic hold, including outliers, is 12.02 minutes with a minimum of 1 minute and a maximum of 80 minutes. Removing the 2 outliers, the average hold time is 10.42 minutes with a maximum hold length of 40 minutes. There were 67 therapeutic holds on the child/adolescent units. Of these, 18 were with 3 patients. The remaining 49 were spread among 27 patients. On the adult unit, there were 24 therapeutic hold episodes, 14 of which were with two patients. The remaining 10 were spread over 7 patients. There were 2 documented episodes of non-ambulatory restraint and no uses of 4-point restraints. Emergency Involuntary Medications (EIM) were administered only one time at RHC during 2006.

Additional Stakeholder Assessment of Need

For the preparation of this grant, the Division of Mental Health sponsored a public forum to elicit comments from interested parties regarding how Vermont should focus its efforts to reduce S/R at VSH and RHC. Participates in this meetings included: Vermont Psychiatric Survivors, Vermont Protection and Advocacy, Vermont Legal Aid, the Vermont Chapter of the National Alliance for Mental Illness, the Vermont Council for Developmental and Mental Health Services, and Vermont Department of Corrections, and two individuals who have received treatment at the Vermont State Hospital. The following themes emerged from this public input meeting:

Culture Change

Philosophy

- Approach needs to be broader than simply reducing restraint and seclusion. It should involve a commitment to reducing coercion of all types. It should embrace principles of recovery, respect and self-determination
- Approaches should be trauma-informed and not re-traumatize or penalize patients.
- Program Implementation should focus on prevention of escalating behavior rather than on de-escalation

Myths regarding restraint and seclusion

- Other states have demonstrated that the incidence of restraint and seclusion can be reduced in spite of high acuity level of the served population and lack of or delay in the state's ability to provide involuntary medication to some patients
- Use of restraint and seclusion is largely avoidable, and should not be the result of medicating patients involuntarily

Institutions' readiness to change

- RHC had demonstrated progress in reducing restraint and seclusion in past and both RHC and VSH have demonstrated interest in past but implementation efforts have been derailed or stymied at both institutions by staff turnover (RHC), lack of resources (VSH and RHC), lack of strong leadership (VSH and RHC) and decertification at VSH.
- Vermont Protection & Advocacy has found numerous instances of ineffective de-escalation practices and failure to employ best approaches to de-escalation at both institutions. They have worked closely with staff at RHC and have offered assistance to VSH in improving de-escalation techniques but, to date, help has not been accepted

Leadership and Staff Training

- Leadership must be totally committed to creating a culture change and to leading staff through this change
- Staff need training, demonstrated leadership and an understanding that reliance on historical practices is no longer acceptable. Staff should be rewarded for adopting use of new clinical techniques or sanctioned if they resist
- Differing opinions about proposed project leadership: One participant said statewide Project Director position demonstrates statewide authority, visibility and commitment, while another stated that the champions for implementing this culture change should be working within each institution

Monitoring Progress

- Current EIPRP at VSH not effective structure or process for monitoring incidence of restraint and seclusion. Alternative monitoring process needed.

Alternative Techniques and Physical Environment

- Many questions posed about how to employ sensory modulation techniques with newly admitted agitated patients
- Creation of calm rooms should not eliminate other space equally important to patients
- Green space, outdoor activity space and pets on units can assist in calming patients
- Improved staffing patterns and reduced crowding can reduce escalation episodes

- Brattleboro Retreat has used peers and family members very effectively in calming patients. Use of peers and family members should be integral to any plan to implement alternatives to restraint and seclusion.

Consistency with State Priorities

This application is being submitted by the Vermont Department of Health, Division of Mental Health, which is the State Mental Health Authority. Michael Hartman, Deputy Commissioner for Mental Health at the Department of Health, acts as the State Mental Health Commissioner, and has submitted a letter as part of this application (see Appendix 5 – Letter from State Mental Health Authority) validating that the identified needs are consistent with the priorities of the State. As described in Mr. Hartman's letter, Vermont has consistently hi-lighted the need to reduce coercion within the mental health system over the past ten years. In a 1999 policy paper (Vermont's Vision Of A Public System For Developmental and Mental Health Services Without Coercion, October 1999) then Commissioner Rod Copeland wrote:

> *"...we must measure the success of DDMHS's systems of care by improvements in the wellbeing of our citizens. DDMHS believes that the various forms of coercion are powerful negative forces working against us as we strive to assist citizens to enhance the quality of their lives...Put another way, we do not believe that we can achieve the highest quality of care and supports without paying close attention to the presence of coercion in its various forms in our system of care."*

In addition, in 1997 the Vermont Legislature adopted the following statement of legislative intent regarding their vision of the state's mental health system: "It is the policy of the general assembly to work towards a mental health system that does not require coercion or the use of involuntary medication." 18 VSA §7629(c).

Section B: Proposed Approach

Description of Proposed Project: Purpose, Goals, and Objectives

The purpose of the project will be to improve mental health treatment by reducing the use of seclusion and restraint at Vermont State Hospital and Retreat Healthcare. SAMHSA's Six Core Strategies will guide the development of strategic plans at each hospital, and will help create the culture shift necessary for the use of less coercive measures for ensuring patient and staff safety. The Goals and Objectives of the Project are as follows:

Goal 1: Vermont will strengthen and enhance its oversight, leadership and coordination capacity at the state level and at VSH and RHC to enhance the development of alternatives to restraint and seclusion. As described above in Section A, Vermont has learned a great deal from its past efforts the use of S/R, and recognizes the need to create a more formalized infrastructure to oversee and carry out further reduction efforts. We also recognize the need to increase consumer and other stakeholder involvement and buy-in. To achieve this goal, this project will complete the following objectives:

A. *Designate Key State-Level Leadership to oversee S/R Reduction activities:* At the start of the grant, the Medical Director of the Division of Mental Health, William McMains, will assume the role of Principle Investigator for the grant. He will act as the key leader within the state mental health system to participate in S/R planning activities and ensure grant activities are supported by the State Mental Health Authority. Michael Hartman, Deputy Commissioner for Mental Health, will also provide Administrative Leadership and be actively involved.
B. *Establish a stakeholder steering committee at each institution to oversee S/R Reduction activities.* For both organizations, an existing stakeholder committee that already focuses on S/R reduction will be augmented by additional stakeholder participation and staffing support to become S/R Reduction Steering Committee for this initiative. The committee will include consumers, families, advocates, direct care staff, and key organizational leadership (see Letters of Support – Appendix 1). A nationally-recognized specialist (See Section C) will be hired to guide the committee through the process of assessing organizational needs and developing and implementing a strategic plan. Additional discussion of the two steering committees appears below. As described Section A, some stakeholders have been unsatisfied with the way in which they have been involved in the planning activities to-date (e.g. VP&A), so one of the first tasks of the steering committees will be to re-establish involvement of key participants and set common, agreed-upon expectations and processes for the committees.
C. *Create a state-level position to coordinate S/R Reduction grant activities and assist in the implementation S/R reduction efforts at VSH.* Grant funds will be used to support the creation of a S/R Reduction Project Director that will oversee and coordinate S/R reduction activities. Section C presents an overview of this individual's key role in the project. This position will report directly to the Deputy Commissioner for Mental Health.
D. *Create a "S/R Reduction Coordinator" at RHC to oversee the implementation of alternatives to S/R at that organization.* A description of the duties to be performed by this individual appears in Section c.

Goal 2: Using the SAMSHA Six Core Strategies as a guide, Vermont will develop and implement a strategic plan to complete S/R Reduction efforts at VSH and the RHC.
As described in Section A, there is a need at both organizations to re-assess the strengths and weaknesses of their current efforts to implement alternatives to restraint and seclusion. There is a need to develop a strategic plan that is supported by key stakeholders within Vermont. To achieve this goal, the following objectives will be completed:

A. *Complete Core Training on SAMHSA's Six Core Strategies.* Vermont will work with NAMHSPD to coordinate training on the Six Core Strategies for key staff and stakeholders at VSH and the RHC, including all the members of each organizations' steering committee. This will serve to re-establish common understanding of the core strategies across grant participants.
B. *Complete an Organizational Assessment re: the Six Core Strategies at VSH and the RHC:* Both organizations will complete an assessment using the Inventory of S/R Reduction Interventions (ISRRI) (see Appendix 2) to measure the degree to which the organization adheres to the recommended interventions outlined in SAMHSA's Six Core Strategies. This assessment will serve as a baseline for establishing a strategic plan and will identify areas

that need to be addressed for reach organization. Progress will be measured each year by the ISRRI. For further discussion of the ISRRI, see section D.

C. *Create and Implement a Strategic Plan at VSH and the RHC.* Using the results of the ISRRI self assessment, each organization will work with its steering committee to complete a strategic plan outlining organizational goals and steps to achieve those goals and support the implementation of alternatives to S/R. Both strategic plans will address each of the six core strategies outlined in the RFA for this proposal. The RHC will focus on updating their current strategic plan using the results of the ISRRI and consultation from Tina Champagne. VSH will re-examine its first strategic plan that was created three years ago, and, using the results of the ISRRI, training on the Six Core Strategies, and consultation from Tina Champagne, create a new strategic plan. Based on discussions with both organizations in the development of this grant application, DMH anticipates both organizations' strategic plan will need to speak to the following issues: 1) methods for augmenting current training for staff using SAMHSA's *Roadmap to S/R-Free Mental Health Services,* 2) implementation of improved debriefing techniques for staff and consumers following an incident of seclusion or restraint, 3) development and modification of policies and procedures to support S/R reduction, including the creation of clinical practice protocols, 4) developing improved methods for using consumers to support the prevention and reduction of S/R, and 5) identifying and implementing improved methods for collecting, analyzing and reporting on the use of S/R.

Goal 3: Vermont will implement specific S/R Reduction Techniques (Sensory Modulation) at VSH and the RHC to reduce and prevent the need for S/R. To achieve this goal, Vermont will:

A. *Develop a multidisciplinary Sensory Modulation Team at each organization.* Key members of both institutions would receive intensive training from Tina Champagne, a national expert on the implementation of Sensory Modulation (see Section C), to take on the role of in-house trainers and mentors to support the implementation and support of Sensory Modulation and other S/R Reduction techniques. The team would work with Tina Champagne and the S/R Reduction Project Director/Coordinator to develop a training curriculum for institution staff that is consistent with existing staff training (e.g. NAPPI, MANDT). These team members would also be responsible for working with treatment staff to: 1) complete client-centered assessments using appropriate tools (e.g. the "Sensory Modulation Screening Tool" developed by T. Champagne) to determine clients' "sensory diet" needs and establish specific sensory modulation, 2) develop multisensory treatment goals for each client using cumulative assessment findings and client input and approval, 3) provide specific sensory modulation interventions as directed by a client's treatment goals, 4) document and assess effectiveness of sensory modulation interventions, 5) work with their S/R Reduction Steering Committee to modify and develop specific policies, protocols and clinical practice guidelines to support the use of sensory-based approaches and reduction of S/R. At least one member of Sensory Modulation Team will attend each treatment planning meeting to ensure that the vision and philosophy of client-focused, trauma-informed, recovery-based care is represented in the planning of treatment

B. *Establish Sensory Spaces at VSH and the RHC.* As described below, a key component of sensory modulation in inpatient settings is the creation of "Calm Rooms" and Multisensory

Treatment Rooms. Grant funds will be used to consult with Tina Champagne regarding the conversion of existing space at both institutions into space that supports sensory modulation approaches. Grant funds may also be used to pay for the conversion of the space and purchasing equipment (e.g. weighted blankets, rocking chairs) to stock the sensory modulation space. As described in Section A, consumer input regarding this application also identified the need for more outdoor ("green") and activity space, and so every effort will be made to increase the availability of this kind of space in support of client's sensory needs.

The achievement of these goals will establish a more formalized and better-resourced structure for involving stakeholders, assessing needs at each organization, developing a structured strategic plan, and implementing specific S/R Reduction tools.

Sensory Modulation

Sensory Modulation focuses on assessing and providing individualized-sensorimotor experiences that... "help ground, calm, center, and/or alert individuals" (Champagne, 2004) using collaborative, meaningful, individualized, trauma-informed, recovery-focused and "sensory-supportive" interventions and supports. Implementation of Sensory Modulation includes the articulation and integration of sensory-related assessment tools, integrative therapies, treatment approaches, and program and environmental modifications (Champagne, 2006). This technique is not meant to be used at the exclusion of other assessments or therapeutic activities. Rather, it is used to support enhanced engagement of the entire interdisciplinary treatment team.

The Sensory Modulation approach requires the use of a person-centered, strengths-based, trauma-informed model of care It is essential to assist each client in recognizing not only symptom(s) and problem areas but also their strengths. Emphasizing individual strengths and capabilities supports and encourages the exploration, practice and integration of sensory modulation approaches into daily lifestyle. This is particularly necessary when introducing novel strategies into a habitual repertoire. (Champagne, 2006)

The goals of a coordinated sensory modulation approach include (Champagne, 2006):

- Facilitating the identification of the individual's unique tendencies and preferences, and how these patterns influence self-organization,
- Engaging in the active planning and practice of meaningful sensory modulation activities, and
- Building self-regulation skills and repertoire expansion to continually enhance the use of personal sensory modulation skills.

Sensory modulation approaches include: sensory modulation assessment tools, sensorimotor activities, sensory modalities, the development and use of a sensory diet, a personalized sensory kit and supportive modifications to the physical environment. Sensory modulation activities are used to help prepare for and/or to maintain the ability to actively engage in meaningful life roles and activities.

Examples of sensory modulation techniques include the therapeutic use of self by therapists and direct care staff, grounding, orienting/alerting and relaxation/calming activities, and self-

nurturing and self-soothing practices. Information about the preferences of each client is carefully gleaned from a combination of interviews, questionnaires and checklists. Additionally, "triggers" that set off a series of events such as fear, panic, upset and agitation, are identified along with associated early warning signs of distress. For instance, a client who is triggered by hearing people yell may experience restlessness, agitation, fist-clenching and pacing as early warning signs of a forthcoming crisis. Using this information, client-specific sensory modulation strategies are identified and practiced to manage and minimize stress and interrupt the cycle from trigger to crisis (Huckshorn, 2004).

Individualized sensory modulation interventions serve to reduce S/R, increase self-awareness and the ability to self-nurture, raise self-esteem and contribute to personal resilience. As clients build upon their individual strengths and gain a greater sense of personal control, their ability to engage in self-care activities, social roles and meaningful life roles is enhanced. As a part of the sensory modulation approach, clients learn basic ideas about re-designing their home environment to create sensory space supportive of their needs. Additionally, each individual is taught and encouraged to reflect upon and recognize when their self-identified strategies may be the most useful. Before engaging in any therapeutic program it is important to work with each individual to identify the amount and type of cognitive assistance necessary to support learning and success. Assessment of learning style and cognitive ability is part of the initial assessment process; re-assessment continues throughout the treatment process. Ongoing assessment provides updated information about each client's current learning needs and preferences and enhances meaning.

Multisensory Treatment Rooms

Using Sensory-Based Approaches in inpatient units typically includes the creation of "Calm Rooms" and "Multisensory Treatment Rooms" that are set up to provide a choice of different sensory experiences to help ground, calm, center and/or alert individuals. These specialized rooms are used as a space to reinforce positive coping skills and afford experiential opportunities to enhance self-awareness regarding the influence of the external environment on the internal state. Relaxation, movement, de-escalation, choice and empowerment are among the primary purposes and goals for the use of sensory rooms in mental health settings (Champagne, 2006). Many of these techniques identified, practiced and mastered in a hospital setting, are used by clients following their return to the community to self-calm and maintain self-organization.

Multisensory treatment rooms are typically an appealing, quiet physical space free of external distraction, painted with soft colors and furnished with objects that promote relaxation and/or stimulation (Huckshorn, 2004). Sensory room equipment may include gliding rocking chairs, quiet music, weighted blankets and vests, and aromatherapy. A wide variety of sensory-based interventions are available to increase comfort and relaxation, improve sleep and support self-organization (Walker & McCormack, 2002; Buckle, 2003, Champaign, 2003).

The skilled and responsible use of sensory rooms has been endorsed by Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the Massachusetts State Department of Mental Health (DMH) . The National Technical Assistance Center (NTAC), a division of the National Association for State Mental Health Program Directors (NASMHPD), has been

promoting the use of sensory approaches as one of the instrumental interventions influencing the reduction of restraint and seclusion in mental health care settings since 2003.

Implementation of SAMHSA's Six Core Strategies to Reduce the Use of S/R

Vermont plans to use SAMHSA's Six Core Strategies as developed by the National Technical Assistance Center and does not anticipate any significant additions to or modifications to the model. As described above, Vermont will prioritize the implementation of strategy Four (*Use of Specific S/R Tools)*; however, both organizations will be assessed regarding each of the six strategies using the ISRRI and will develop a strategic plan that addresses needs in all six areas.

Discussion of the Target Population's Language, Beliefs, Norms and Values

Vermont is not considered a culturally diverse state; however, the Vermont State Hospital and the RHC do serve individuals with diverse needs. According to the 2000 national census, Vermont is 96.2% non-Hispanic white, with .9% Hispanic or Latino, .9% Asian, .4% American Indian or Alaskan Native, and .5% African-American. Vermont is also home to small minority communities, including two regions that border Canada that contain and serve both Native Americans and French-speaking individuals, and two urban communities that host a refugee resettlement program that has placed refugees from Eastern Europe, Asia, and Africa. In support of these small groups of diverse individuals, local organizations have developed and will be available to assist in modifying grant activities to address the diverse needs of specific individuals being served at VSH and the RHC. Both institutions will focus on collaborating with these in-state organizations who specialize in supporting individuals with specific diverse backgrounds. For example, the VSH S/R Reduction Steering Committee will consult with the Vermont Refugee Resettlement project when challenged with providing culturally competent services to a patient who is a refugee. The RHC has a history of consulting with the School for International Training to assist staff in understanding culture from which a patient has originated. In addition, both institutions have required their staff to participate in Diversity Training and will continue to do so during the course of this grant.

Vermont has also focused on recognizing the socio-economic diversity which exists within the state and the preponderance of poverty that exists among individuals and families touched by mental illness To address the culture differences which may exist between professional staff, many of whom are middle class, and those who are being served, many of who live at or below the poverty line, Vermont has begun to promote the training "Bridges Out of Poverty," which addresses the cultural aspects of poverty and their implications for providing human services. This training will be made available to VSH and the RHC.

Use of the "Roadmap to S/R-Free Mental Health Services"

Vermont has some familiarity with SAMHSA's "Roadmap." Vermont Psychiatric Survivors has been promoting the curriculum across the state, and it has been provided to a newly opened community residential program that serves individuals who would otherwise be committed to VSH. Based on discussions with stakeholders to date, some feel the curriculum should serve as a core workforce development intervention to help establish common expectations and support

broad culture change at both institutions. If this approach were taken, the Roadmap would be provided to all staff at both organizations at the start of the grant and then at yearly intervals for new hires. Other stakeholders feel that some of the content of the Roadmap is covered by existing training at the two institutions and that components of the Roadmap could be woven into existing training to meet organizational needs. As such, one of the first tasks of the S/R Reduction Steering committees at both organizations will be to review the curriculum in light of existing training (e.g. NAPPI, MANDT) and make recommendations regarding how the training should be provided. Vermont would engage with NASMHPD/NTAC as a consultant to this process. NASMHPD would also be involved in the provision of training on the Roadmap. If grant activities include comprehensive training using the seven modules, we anticipate that Module 5 will be augmented with an in-depth presentation of sensory modulation approaches to S/R reduction. Tina Champagne, OTR/L, will act as the consultant to assist with the design of sensory modulation approaches and curriculum to be included in Module 5.

Forensic Population

As described in Section A, VSH serves both civil and forensic male and female patients. The civil and forensic populations are housed together and there is generally little control over when and how often court-ordered admissions are admitted. As such, VSH's three units approach treatment based on clinical need and do not have separate clinical programming specifically for a forensic population. Consequently, VSH does not feel it will need to develop separate, unique modifications to it's S/R Reductions efforts for forensic patients.

Logic Model

Needs/Goals	Activities/Inputs	Key Short-term Outcomes & Method for Measuring	Long Term Impact
1) Strengthen/ enhance oversight/ leadership/ coordination re: S/R Reduction	• Appoint State-Level Leadership • Create S/R Reduction Steering Committee at VSH/RHC • Create Project Director and RHC S/R Reduction Coordinator	• High satisfaction and involvement among stakeholders with planning and implementation process (ISRRI, Focus Groups) • Successful creation and implementation of strategic plans	Reduced rates of: • Seclusion
2) Develop and Implement VSH and RHC Strategic Plans based on Six Core Strategies	• Core training on Six Core Strategies • Organizational Assessment (ISRRI) • Expert Consultation	• Successful creation and implementation of strategic plans • Increased fidelity to Six Core Strategies at VSH and RHC (ISRRI)	• Restraint • Emergency involuntary medication
3) Implementation of specific S/R Reduction Tools	• Training/Consultation on "Roadmap" • Creation of SM Team at VSH & RHC • Training/Consultation for SM Team • Consultation on development of calm/multi-sensory treatment (MST) rooms	• Development of clinical protocols & procedures re: the use of S/R Reduction tools.(e.g. SM) • Development of patient treatment plans incorporating SM and other S/R Reduction tools • Creation of calm/MST rooms • Development of core training/workforce development practices re: S/R Reduction Tools	• Staff injuries • Staff turnover

*ISR=Involvement and Satisfaction Questionnaire

Advisory Body

For both organizations, an existing stakeholder committee that already focuses on S/R reduction will be augmented by additional stakeholder participation and staffing support to become a S/R Reduction Steering Committee for this initiative. At VSH, the committee will include representatives from Vermont Psychiatric Survivors, Vermont's statewide consumer organization, the National Alliance for Mental Illness of Vermont, and Vermont's Protection and Advocacy Organization. Direct care staff, key VSH leadership, and the grant's principle investigator, William McMains, will also serve on the committee. At the RHC, the steering committee will include representatives from Vermont Psychiatric Survivors, the Vermont Federation of Families - a statewide advocacy and support organization for family members of children with SED, Vermont's Protection and Advocacy Organization, and the state child welfare department (Department of Children and Families). As with the VSH steering committee, direct care staff, key RHC leadership, and the grant's principle investigator, William McMains, will also serve on the committee. For a discussion of key VSH and RHC leadership that will be involved with their S/R Reduction Steering Committee, see section C.

Each steering committee will be responsible for guiding the implementation of the Six Core Strategies at their organization as described in the project approach above. Specific activities will include, but not be limited to: 1) participation in the ISRRI assessment, 2) development of the institution's strategic plan, 3) participation in training and other workforce development activities, 4) review of relevant S/R data reports and other evaluation data re: progress toward project goals. Both steering committees will meet on a monthly basis.

Evidence of Significant State commitment/leadership

Within the current state structure, Michael Hartman, Deputy Commissioner of Mental Health at the Department of Health, acts as the State Mental Health Commissioner. He has been actively involved in the creation of the grant proposal and fully supports the proposed grant initiative. Please refer to Section A of this proposal for a more detailed discussion of his letter of commitment, the controversy it speaks to and Vermont's policy commitment to the reduction of coercive methods of treating in it's mental health system. Mr. Hartman's letter also speaks to some of the concerns raised by state Rep. Ann Donahue. While she is very critical of Vermont's efforts to reduce S/R to-date (see Letter from Rep. Anne Donahue in Appendix 1), her commitment to this issue should help to ensure that state leadership remains committed and is fully supportive of S/R Reduction efforts.

Participating Organizations

To support the reduction of S/R at the Vermont State Hospital and RHC, several other organizations will be involved in support of the grant.

Vermont Psychiatric Survivors (VPS): VPS acts as a statewide consumer organization representing consumers, survivors and ex-patients who have had involvement with the mental

health system. A member of VPS will act as a consumer representative on the steering committee for both organizations (see Appendix 1-Letter of Support). In addition, VPS has and will continue to assist in increasing the role of consumers in the support and evaluation of S/R activities. VPS is currently teaching Wellness Recovery Action Planning, a self-help curriculum designed by Mary Ellen Copeland, at both institutions. The WRAP Program (Copeland, 2000) forms a logical framework which could accommodate the inclusion of sensory modulation approaches. The shift of focus in mental health care from symptom control to prevention and recovery as reflected in the WRAP Program is consistent with the person-centered, recovery-focused elements of an integrated sensory modulation program. The six sections of the WRAP Plan can be enhanced through the use of sensory assessments, creation of a sensory diets, and neuropsychiatric assessments to enhance the data base from which the client and team collaboratively create intervention plans to address client needs. Dovetailing the sensory modulation assessment, planning, intervention and evaluation components with those within the WRAP Plan will enable clients and staff to work with an enhanced palette emphasizing recovery and individual empowerment. VPS will consult with both institutions to determine different ways in which WRAP can be used to support the reduction of S/R. It is important to note that a member of VPS attended the national training on S/R Reduction along with a team from VSH several years ago and was part of the development of VSH's original strategic plan. This same individual, Jane Winterling, is involved in teaching WRAP at both institutions and has been serving on the existing VSH workgroup that focuses on S/R reduction. Her experience and expertise will be crucial in assisting both organizations planning and implementation of S/R Reduction activities.

NAMI-VT: The Vermont Chapter of the National Alliance for the Mentally Ill acts as the statewide advocacy and support program for family members of individuals with mental illness. NAMI-VT will serve on the steering committee at VSH (see Letters of Support – Appendix 1).

Vermont Protection and Advocacy (VP&A): VP&A acts as the state protection and advocacy program for individuals with mental illness. As described in section A, VP&A has been very discouraged recently with Vermont's lack of progress towards the reduction of S/R (See Letters of Support – Appendix 1), and so they will need to play a key role on the two steering committees to identify areas for improvement and assist in the development of a strategic plan that fully addresses anticipated barriers. Despite VP&A's dissatisfaction with recent work in this area, they are committed to working with DMH to re-engage in the planning process in a meaningful way.

Vermont Federation of Families (VFF): VFF acts as a statewide advocacy and support organization for family members of children with SED. VFF will participate on the RHC steering committee (see Letter of Support – Appendix 1) .

Vermont Department of Children and Families: Among its numerous roles and divisions, DCF acts as the state child welfare agency. As described in Section A, DCF has cited RHC for problems relating to the use of S/R in previous years and has committed to participate in the S/R Reduction planning and implementation process at Retreat Health Care (see Letter of Support – Appendix 1).

Stakeholder Involvement

A number of key stakeholders were consulted with in the creation of this grant proposal. DMH consulted with the directors of Vermont Psychiatric Survivors, NAMI-VT, the Vermont Federation of Families, Vermont Legal Aid, and Vermont Protection and Advocacy to inform this application. DMH also hosted an open public forum in which solicited feedback from any interested stakeholders. The meeting was attended by consumers, families and advocates, and included representatives from Vermont Psychiatric Survivors, NAMI-VT, Vermont Legal Aid, Vermont Protection and Advocacy, the Vermont Council of Developmental and Mental Health Services (an advocacy organization representing Vermont's 10 Community Mental Health Agencies), the Vermont Department of Corrections, and members of the Vermont Mental Health Planning Council. Feedback from that meeting was summarized above in Section A and was incorporated in the proposed approach. In addition, because the MH Planning Council did not have a scheduled meeting prior to the due date of the grant, DMH sent out information on the grant application to the members of the Council and received feedback from individual members.

Stakeholder involvement in the planning, implementation and evaluation process at both institutions will be crucial, and the primary vehicle for involvement will be the S/R Reduction Steering Committees at VSH and RHC. The roles and membership of the steering committees are described above (see *Advisory Body).* It is important to note that VPS is already involved in completing consumer satisfaction surveys at VSH, as well as implementing Wellness Recovery Action Plan training at VSH and RHC (see above). We anticipate that the use of consumer satisfaction surveys and WRAP can play a strong role in supporting S/R Reduction efforts.

Expenditure of funds

This program will be administered by the newly created Department of Mental Health, formerly a Division of the Vermont Department of Health (See section C). It will be subject to the same fiscal management and controls as other programs of State government. These include controls on the obligation and expenditure of funds, such as competitive bidding for purchases and approval processes for authorizing payments to vendors. The Department requires that all work hours be positively reported by employees to specific programs and timesheets be reviewed by supervisors. The Department uses a Cost Allocation Plan approved by the Division of Cost Allocation of the Department of Health and Human Services, to allocate its overhead and leave time costs. The Department's Division of Administration provides administrative oversight for the program and fiscal reports are provided to program managers.

Barriers to Implementation

There are a number of anticipated barriers to implementation. As described above, different stakeholders have varying levels of satisfaction and dissatisfaction with current efforts to reduce S/R, and the grant planning process will be severely hampered without broad stakeholder support. We plan to address this in several ways. Through the development of the S/R Reduction Steering committees, we will re-establish expectations and "ground rules" for the planning processes using a consensus-based approach. As evidenced by the letters of support, even those stakeholders who are dissatisfied with the process have expressed a desire to re-

engage in planning under the right circumstances. In addition, by using an established, objective tool (ISRRI) to assess each organization's progress regarding the Six Core Strategies, we should be able to achieve greater consensus. Finally, the use of the *Involvement and Satisfaction Questionnaire (see Section D and Appendix 2)* will allow us to better gauge and track stakeholder satisfaction with involvement and respond accordingly to identified issues.

Another barrier to implementation at VSH (and RHC to a lesser degree), will be the lack of space for the development of calm rooms/multi-sensory treatment rooms. To address this issue, VSH plans to work with Tina Champagne to develop creative solutions to using limited space for multiple purposes; Ms. Champagne has worked with other institutions that have had this issue. One potential solution involves the creation of "sensory modulation carts" that can be easily moved to different spaces to supply consumers and staff with sensory modulation tools.

A third major barrier to implementation will be the challenge of "culture change" among staff at both institutions. While training on specific S/R Reduction Tools can be helpful, staff must fully embrace the belief that their current practice can and should be improved to prevent the need for S/R. Achieving culture change can be extremely challenging, and, based on consultation with Tina Champagne and other states that have faced this issue, we feel that the use of the "Roadmap" training will help to effect this culture change. However, a certain portion of staff will be less likely to fully embrace training from an expert consultant ("She doesn't work here- what does she know?" "That may work in other states, but it won't work here."). The creation of in-house Sensory Modulation teams to serve as champions to promote the use of specific S/R reduction tools should also help with the adoption of this change by diffusing this philosophy and method of treatment throughout the institution. When staff see their colleagues promoting change and providing effective treatment in new and different ways, they are much more likely to adopt that change. In addition, staff are much more likely to embrace change if they feel they are involved and informed regarding the change, so the targeted use of focus groups and the *Involvement and Satisfaction Survey* (see Section D) among staff will provide useful methods for getting input from staff and gauging buy-in.

Improvement of Mental Health Services

The use of S/R on an individual can have a number of negative outcomes, including injury to staff or consumers, traumatization and/or re-traumatization of the consumer and feelings of distrust/anger toward staff using S/R. The implementation of alternatives to S/R will not only help to prevent these negative outcomes, but will also promote self-management of symptoms, empowerment, provision of individualized care and a belief that individuals can be supported in overcoming even the most severe mental health symptoms. Not unlike Wellness Recovery Action Planning, the use of approaches such as Sensory Modulation focus on developing an individualized plan for preventing and managing psychiatric symptoms and avoiding loss of control.

It is anticipated that both VSH and RHC will learn a great deal about how to better provide individualized, trauma-informed, recovery-focused treatment through this process, and Vermont is committed to taking these lessons learned and sharing them with the rest of the mental health system. During the third year of the grant, DMH will ask key staff RHC and VSH to present

"lessons learned" to the four general hospitals that provide inpatient psychiatric treatment and our community mental health providers. Following the completion of the grant, DMH will work with RHC and VSH to make their key staff available to other treatment providers to consult with them regarding the implementation of alternatives to S/R

Continuity and Sustainability

Maintaining program continuity and stability when there is a change in the operational environment (e.g., staff turnover, change in project leadership) will be paramount to ensure the success of this initiative. Vermont's approach to address this issue will focus on three specific strategies: 1) establishing broad stakeholder ownership of the process, 2) establishing a detailed strategic plan with measurable indicators of success, and 3) providing dedicated staffing support to the project. Through the conversion and strengthening of an existing steering committee at VSH and RHC, DMH will strive to create well-informed, empowered committees that have the ability to hold the project accountable to achieving its goals and objectives. By creating steering committees of empowered leaders, specific individuals participating in grant activities may come and go without derailing the overall progress of the project. The creation of a detailed strategic plan will also serve to maintain continuity—as new participants join the process, they will be able to use the strategic plan to ensure that grant activities are implemented and evaluated as planned by their predecessors. Finally, it will be crucial for this project to maintain dedicated staff (i.e. Project Director and RHC S/R Reduction Coordinator) to support the planning and implementation process. Each of the key participants listed in this grant are involved in many different systems improvement initiatives and will find it difficult to devote more than a fraction of their time to this initiative on a weekly basis. Having additional staff dedicated solely to this initiative will allow DMH to collect and provide the necessary information and support to the other participants so their time is used efficiently and effectively.

The ability to sustain improvements made by this project will be a litmus test under which all activities are evaluated. It is commonly said among inpatient units that they must begin discharge planning as soon as someone is admitted to their hospital, and, in similar fashion, this initiative must begin planning for the end of funding as soon as DMH receives the grant award. Some of the improvements made by this initiative will be easy to sustain. The creation of comfort and multisensory treatment rooms, as well as the purchase of specific sensory modulation equipment/tools, will be one-time expenditures and not require ongoing grant funding. Improvements in how S/R data is collected, analyzed and reported will be sustained by standardizing changes in procedures at both institutions and using Information Technology staff to automate reports. Changes in how treatment is provided can be harder to sustain when staff turn over and there are no longer grant funds to provide intensive training and consultation by content experts. This issue will be addressed in a number of ways. Both institutions will work with the expert consultant and its steering committee to develop/modify clinical practice guidelines and protocols for staff. VSH and RHC will also work with expert consultation to incorporate treatment practice guidelines into existing training programs for staff. In addition, through the creation of Sensory Modulation Teams at both institutions, the knowledge and responsibility for training and mentoring other staff will rest with a group of existing staff, so both organizations will have in-house trainers to promote S/R prevention and reduction practices in lieu of relying on expert trainers funded through the grant program.

DMH anticipates that the steering committees at both organizations will need to be sustained following the conclusion of the grant and is committed to funding stipends for consumer and family participants.

It is difficult to predict whether or not the responsibilities of the two grant-funded positions could be passed onto to existing staff at both organizations at the conclusion of the grant funding period. As described above, both positions will be involved in supporting institutional changes (sensory rooms, changes in policies and training) which may or may not be completed at the end of three years. As such, DMH is committed to exploring other funding sources for these two positions should participants in this initiative feel the need to continue funding for the positions at the end of the grant period.

Section C: Staff, Management, and Relevant Experience

Project Timeline	Year 1				Year 2				Year 3			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Form S/R Steering committees at VSH/RHC (DMH/VSH/RHC)	X											
Recruit/Hire Project Director (DMH)	X	X										
Recruit/Hire RHC S/R Coordinator (RHC)	X	X										
Contract with grant evaluator (DMH)		X										
Compete Core Training on *Six Core Strategies* *(NAMHSD/Champagne)*		X										
Complete ISRRI at VSH/RHC (VSH/RHC)			X			X			X			X
Develop/Update strategic plans for VSH/RHC (PD/SRRC & S/R Reduction Steering Committee)			X			X			X			X
Establish Sensory Modulation (SM) Team at VSH/RHC		X										
Intensive Training on SM for SM Team (Champagne)			X	X		X		X		X		X
Begin using SM Team for consultation/practice improvement					X	X	X	X	X	X	X	X
Sponsor "Lessons Learned" Meeting for VSH/RHC (PD, SRRC)						X				X		
Develop plan for development of VSH SM rooms (Champagne/VSH)					X							
Develop plan for development of RHC rooms (Champagne/RHC)					X							
Construction of SM rooms/purchase of SM equipment						X	X	X	X	X	X	X
Develop Plan for use of "Roadmap" training at VSH/RHC (PD, SRCC, Steering Committee)			X									
Implement "Roadmap" Training				X		X		X		X		X
Develop/Finalize Evaluation Protocol (evaluator)		X										
Administer Involvement/Satisfaction survey (evaluator)			X			X			X			X
Establish regular reports on S/R use for steering committees to review (PD, SRRC)		X										
Targeted Focus Groups (evaluator)				X				X				X
Produce final evaluation report (evaluator)												X
Responsible staff/party indicated in parenthesis ( ). Project Director=PD, RHC S/R Reduction Coordinator=SRRC												
Project Milestones indicated in Bold												

Capability and Experience of Applicant and Other Participating Organizations

Applicant Organization

The Vermont Division of Mental Health (DMH) is the applicant organization for this proposal. DMH is organizationally located within the Department of Health, one of four departments in Vermont's Agency of Human Services. As the State's mental health authority, DMH has statutory authority to provide and/or contract for comprehensive mental health Services for Vermont's citizens. DMH directly operates the Vermont State Hospital (VSH) and contracts with ten private, nonprofit designated community mental health agencies (DAs) and five community hospitals to provide comprehensive treatment and rehabilitation services to children, adolescents and adults across the state.

Vermont has a long and well recognized history of effective consumer and family involvement in planning, providing services and in monitoring the effectiveness of public mental health services. Inherent in every activity undertaken by the DMH is the presence of consumer and family participation for input and feedback. To solicit input about this proposal from interested consumers, family members and advocacy groups, DMH held a public forum on May 2, 2007 to invite input from interested parties. Section A. of this proposal presents the themes that emerged at that forum, and letters from stakeholders indicate a range of perspectives on the state's readiness to implement this proposed plan and the varied levels of support that exist among interested parties. Prior to holding the public forum, Division staff wrote and distributed a draft conceptual overview of this proposed project to provide interested parties with a framework for offering perspectives and suggestions. Although some interested parties interpreted this document as a useful way for the Division to demonstrate leadership, others interpreted this as the presentation of a completed process that precluded public input. Although varied opinions exist about the readiness of Vermont to follow a specific methodology for reducing the use of S/R at VSH and RHC, there is common recognition that changes in the ways in which challenging or dangerous patient behavior is managed is long overdue. A significant challenge for the early stages of implementing this proposal will be working with interested parties to move beyond past history and find common agreement about the need to proceed with the planning and implementation of less coercive patient care. DMH believes it can provide the leadership to demonstrate credibility and leadership towards true systems change.

In spite of serving a population generally characterized by a lack of racial diversity, the Vermont Department of Health has demonstrated its commitment to cultural competency by requiring all staff to complete a course on cultural diversity. In addition, an Office of Minority Health exists in the Department, and works with all public health and mental health programs to promote and be a resource for cultural competency. The Department has recently appointed the director of Vermont's 12 local public health offices to develop a plan to infuse knowledge and skills about cultural competence throughout Vermont's public health workforce.

To improve the visibility and importance of mental health services in Vermont and elevate the organization within the executive branch, the Vermont Legislature has passed a bill to create an autonomous Department of Mental Health effective July 1, 2007. The newly created Department

of Mental Health will remain connected to the Vermont Department of Health for operational and business processes such as business, IT and personnel functions. This will enable the new Department to benefit from the rich array of operational functions available at the Department of Health and necessary to effectively manage the mental health provider system. This organizational change will enhance the ability to effectively implement the proposed project because it will provide Vermont's mental health system with Department-level status, Commissioner-level authority and improved access to the Secretary of Human Services. The latter is a key cabinet member who is responsible to the Governor for improving human services so they are delivered in a manner consistent with principles of respect, client-self determination and empowerment. The new Department will retain the legal and mental health research and statistics units that have been essential functions for the provision and oversight of public mental health services in Vermont.

Public-Academic Partnership The Division of Public Psychiatry was created in 2004 as a public-academic liaison between the Vermont Department of Health (VDH) and the Department of Psychiatry, University of Vermont College of Medicine/Fletcher Allen Health Care. The goal was to create a partnership with the University in order to improve mental health services in Vermont, and to facilitate recruitment and retention of high caliber psychiatrists to serve as leaders in the provision of services in the public sector. The Division of Public Psychiatry is dedicated to promoting mental health care as excepted public value with a clear set of expectations related to individuals' health, family well-being, and the public good.

Participating Organizations

Vermont State Hospital. Vermont State Hospital (VSH) is Vermont's only state-run psychiatric hospital for adults with serious mental illness. Section A presents a detailed description of VSH, the demographics of people served and some of the challenges it has faced in implementing systematic alternatives to S/R. As acknowledged and discussed in Section A, some controversy currently exists about the specific strategies that are needed to reduce the use of restraint and seclusion at VSH. Nevertheless, Division of Mental Health Leadership, key staff at VSH, and various advocate and consumer groups stand committed to overcome past thwarted change efforts and collaborate to follow the Six Core Strategies to create a strategic plan and a sustained culture shift at the hospital.

As state employees, all VSH staff are required to complete training courses on cultural competency. In addition, VSH staff must complete a training on age-specific competencies for working with people with mental illness, and pass an annual test on se competencies. The VSH has access to translator services and has an in-house expert who consults on issues related to gender and sexual orientation. Staff needing additional information related to cultural competency have access to the Department's Office of Minority Health as well as the Vermont Refugee Resettlement Program of the Agency of Human Services. With an awareness of the impact of trauma on the lives of many Vermonters served by the Agency of Human Services, the Agency Secretary created a statewide Trauma Coordinator to work with departments for the delivery of trauma-informed services. This coordinator is available to VSH staff for consultation about trauma and strategies for avoiding the re-traumatization of people served.

Retreat Healthcare RCH is a not-for-profit, JACHO accredited, regional specialty mental health and addictions treatment center providing a full range of diagnostic, therapeutic and rehabilitation services for children, adolescents and adults. RHC functions as the Vermont State hospital for children and adolescents, specializing in the treatment of complicated psychiatric disorders. RHC employs the largest staff of specialty-trained child psychiatrists in the region and a range of highly-skilled multidisciplinary professionals committed to improving treatment by reducing coercion. Section A of this proposal presents a more detailed description of this hospital and it past preparations for implementing the Six Core Strategies necessary to create a coercion-free clinical environment.

RHC prides itself on incorporating concepts of cultural competence into its orientations and training programs in spite of serving a primarily homogenous population of white, non-Hispanic origin. In recent years RHC has served some patients who are members of a racial minority, and it has always served patients with non-traditional sexual orientations. The orientation program for new clinical staff addresses diversity, and Retreat managers have all undergone a cultural diversity workshop. More recently, RHC has served children of international births who have been adopted by Vermont families. In an effort to effectively serve these children, RHC has recruited the School for International Training to assist staff in understanding the culture from which these children have originated. More recently, RHC has begun a dialogue with a local community organization, ALANA (African American, Latino, Asian and Native Americans), in an effort to meet the needs of patients in the institution's residential and inpatient adolescent programs who are members of minority groups.

Project Leadership and Staff: Roles, Qualifications, Experience, and Levels of Support.

The statewide leadership and direction for this proposed project will emanate from the newly constituted Department of Mental Health with an identified Principle Investigator for the project and a Project Director, both of whom will report directly to the Commissioner of Mental Health. The project's direct reporting relationship to the Commissioner will ensure support and leadership at the highest level, and a demonstrated commitment to the institutional culture change that will be necessary for creating and sustaining effective alternatives to restraint and seclusion within the two participating institutions. William McMains, MD, Medical Director for DMH will serve as the Principle Investigator (PI) for the project and a Project Director will be hired to direct the program's implementation at VSH and work with RHC to ensure the project's success. The Project Director will be located at VSH and will also assume some coordination duties associated with project planning and implementation at that hospital. DMH proposes to use SAMHSA grant funds to award a planning grant to RHC with which a S&R Reduction Coordinator will be hired. The following will describe the roles, qualifications, experience and levels of effort for the involved DMH staff and the key staff involved in project planning and implementation at each institution.

Project Leadership at the Division of Mental Health

Commissioner of Mental Health When the Division of Mental Health becomes a Department of Vermont state government in July, 2007, it will be led by an Governor-appointed Commissioner of Mental Health. Michael Hartman, MSW, currently Deputy Commissioner for

Mental Health in the Vermont Department of Health, is likely to be appointed to the position of Commissioner, and has been responsible for the leadership associated with the development of this proposal. Michael Hartman has extensive experience in directing public mental health systems and in implementing programs that embrace principles of respect, client-directed services and coercion-free environments. His resume is included in Section G of this proposal.

Principle Investigator William McMains, MD, Medical Director, Division of Mental Health. Dr. McMains has been the Medical Director of the Division since 1991, and works closely with the Commissioner and key staff at Designated Agencies, VSH and RHC to develop statewide standards of care and assure that clinical practice standards are consistent with empirically-based research. Dr. McMains is board certified in general psychiatry, trained in both child psychiatry and administrative psychiatry, and holds clinical appointments as a Professor of Psychiatry at both the University of Vermont and at Dartmouth Medical School. Ten percent of Dr. McMains' time will be devoted to this project as an in-kind commitment to this change process. His CV appears in Section G.

Project Director A Project Director will be hired to oversee the S/R Reduction grant activities, as well as plan and direct the program's implementation at VSH. This individual will coordinate the use of expert training and consultation and will ensure proper collection and reporting of project data at VSH. In addition to overseeing all grant activities for the project, the Director will assume coordination duties associated with project planning and implementation at VSH. The Project Director will oversee the grant award to RHC and work closely with the leadership of that organization to facilitate successful implementation of sustainable changes. This person will have a demonstrated history of change-leadership and successful program implementation experience, and will report directly to the Commissioner of Mental Health. The level of effort will be 100%, and will be supported in its entirety by this grant. A position description outlining the unique qualifications required for this position appears in Section G. Recruitment of this key project leader will begin immediately following notification of the grant award.

Expert Consultant Tina Champagne, M.Ed., OTR/L Tina is a nationally recognized Occupational Therapist who has specialized in developing, implementing and training mental health programs in the area of reducing alternatives to restraint and seclusion. She is widely regarded as an expert in the use of sensory-based approaches such as sensory modulation for reducing coercion in mental health institutions. This proposed project will employ the expertise of Ms. Champagne to work with both VSH and RHC to develop a strategic plan for reducing S/R in each facility. She is knowledgeable about the Six Core Strategies and will use this approach to help leadership create the systems change necessary in each institution to reduce S/R. Ms Champagne has done considerable work with RHC in the past, and her techniques, particularly in the area of sensory modulation, are recognized and respected by the VSH team responsible for implementing change there. Ms. Champagne, whose resume appears in Section G, will provide the equivalent of 20 days of consultation per year to this project, and her involvement will be an essential element of this projects success.

Project Evaluator A project evaluator will be hired on contract to guide the refinement of the evaluation described in Section D. This individual will work closely with key project leaders and the two steering committees to design, conduct, analyze and interpret the findings of the various evaluation methods. The evaluator will have demonstrated experience in both quantitative and qualitative evaluation of programs in clinical settings. This person will also conduct the focus groups and will collaborate with the Independent Evaluator.

Key Project Staff at Vermont State Hospital

VSH Project Principle: Thomas A. Simpatico. MD, Medical Director, The Vermont State Hospital. Dr. Simpatico is an Associate Professor of Psychiatry at the University of Vermont College of Medicine and is the Director of the Division of Public Psychiatry at U.V.M.'s College of Medicine. Sr. Simpatico has a keen interest in the research and application of sensory modalities to assist patients in self-regulating behaviors. Ten percent of Dr. Simpatico's time will be an in-kind contribution to this project..

VSH Executive Director Terry Rowe, LICSW. Ms. Rowe has been the executive leader of VSH since 2004, and is responsible for planning, directing, coordinating and monitoring all operations at VSH including but not limited to strategic planning, development of hospital-wide initiatives, quality assurance and improvement, care and treatment standards, business operations, policies and procedures. It will be her responsibility to lead hospital staff in the development of a strategic plan for implementing the Six Core Strategies necessary to attain sustained culture change at VSH. Ms. Rowe has extensive experience in administration and supervision of residential facilities, including 5 years as the superintendent of a 45-bed correctional facility for female offenders. Ms. Rowe's level of effort for this project will 5%; an in-kind contribution.

VSH Sensory Modulation Team: The following VSH staff comprise the clinical leadership team at VSH and will be working closely with the Project Director, Dr. Simpatico, and Tina Champagne to develop and implement a strategic plan for the use of sensory modulation to reduce S/R.

- **Quality Manager for Clinical Services** R. Scott Perry, R.N., CMHC, M.Ed. Mr. Perry has extensive experience in Quality Management in psychiatric in-patient settings. He manages all quality data for VSH and analyzes these data to identify patterns and trends of, among other things, the use of S/R at the hospital. He also assists with the development of protocols to reduce the use of S/R
- **Director of Nursing** Anne Jerman, APRN, Nursing Ms Jerman's knowledge of the patient, staff and treatment culture will enable her to effectively lead her staff in the changes that this project will require. Anne will be responsible for directing the training and education of VSH nursing staff as they strive to learn and utilize the sensory-approaches for managing challenging behavior. Anne will be a key link between Tina Champagne and the nursing staff.

Key Project Staff at Brattleboro Retreat

Retreat Healthcare Project Principle Linda Rice, MSN, APRN, Vice President of Patient Care at Retreat Healthcare. She has worked at RHC for 10 years during which time she managed the Medical Clinic prior to assuming the role of VP of Patient Care. She has been actively involved in providing leadership to RHC's Senior Clinical Leadership Team in their efforts to implement RHC's S/R activities. In serving as RHC's project Principle, Ms. Rice will exert the leadership necessary to revise RHC's strategic plan for reducing S/R and oversee RHC's implementation of that plan By working closely with the Project Director, Tina Champagne, RHC's Seclusion and Restraint Reduction Coordinator and the RHC Clinical Leadership Team to successfully create that institutional changes identified in this proposal. Her CV appears in Section G. Her Level of Effort will be 10% and will be an in-kind contribution to the project.

S/R Reduction Coordinator A Coordinator will be recruited to coordinate the organizational and clinical changes needed to successfully implement the creation of alternatives to R&S at RHC. The Coordinator will become and will serve as the in-house expert on Sensory Modulation approaches, coordinate staff training and supervision relative to the model, assume responsibility for collecting and reporting all project data and work with staff at all levels of the institution to identify and address barriers to implementation of S/R reduction activities. This individual will have demonstrated experience in leading clinical change efforts and in working with leadership to create the appropriate organizational environment necessary for change. This individual will report directly to Linda Rice and will work closely with the Project Director to ensure that RHC complies with the provisions and plans for this proposal's implementation. This individual will be recruited subsequent to the awarding of the grant, and will be dedicated to and supported by grant funds on a full-time basis. A description for this key grant-supported position appears in Section G.

Retreat Sensory Modulation Team: A highly qualified multi-disciplinary team of Retreat clinical staff will be assigned to work with Linda Rice, the Project Director, Tina Champagne and the S/R Reduction Coordinator to train and supervise RHC clinical staff on the use of sensory modulation techniques. These key clinical personnel and their respective roles are as follows:

- Gregory Miller, MD, MBA Vice President for Medical Affairs
- Tim Jungclaus, BA in Outdoor Recreation/Outdoor Education, CPRP - Certified Parks and Recreation Professional. Mr. Jungclaus is the Director of Retreat's Therapeutic Services Department.
- Gwynn Yandow Flood, LICSW , Director of Social Services

AVAILABLE RESOURCES FOR PROPOSED PROJECT

Vermont State Hospital

In addition to the contribution of the valuable in-kind resources identified above, VSH has committed to working with Tina Champagne to find creative ways to convert limited existing space to accommodate the creation of one calm room each year over the duration of this project. This calm room space will be decorated and furnished with sensory modality supplies that have been empirically demonstrated to calm patients experiencing escalating anxiety and fear. Previously, these behaviors might have resulted in the use of coercive interventions such as involuntary emergency medications, seclusion or restraint. Grant funds will be used to renovate, decorate and furnish these rooms.

Currently, VSH tracks, aggregates and reports data about the use of emergency involuntary procedures using Quantros incident and risk management software. The implementation of this project will involve linking this data with the PsychConsult data system which tracks hospital admissions, discharges and transfers. An essential task will be the development of improved methods for identifying trends of patient incidents, staff involvement and other useful information for understanding patterns of involuntary procedures. Forms and processes for documenting the use of emergency involuntary procedures are currently in place at VSH, but a process to review the completeness and quality of documentation needed to justify the use of these procedures will be necessary.

Brattleboro Retreat

RHC has done the groundwork necessary to finalize and implement a strategic plan for reducing the use of S/R thought it's units. Highly knowledgeable experts at RHC who have been trained in sensory modalities with experts such as Tina Champagne have conducted in-house trainings to raise awareness about the meaning and adaptive nature of patient behavior that might lead to R/S.

RHC is eager to further advance its efforts to create a coercion-free environment and has identified available space for the creation of calm rooms to employ sensory modulation techniques. As with VSH, grant funds will be used to renovate, decorate and supply these three rooms (one per year) with the tools necessary to implement this evidence-based approach to modifying behavior.

Section D: Performance Assessment and Data

Evaluation Plan: Using Data for Continuous Quality Improvement

DMH's evaluation of this grant initiative will be based on a continuous quality improvement approach, (CQI)) in which evaluation data both on the *process* and the *outcomes* of the project will be regularly fed back into the planning process to better inform the implementation of the grant. Our evaluation will attempt to answer the following four questions:

Evaluation Question 1: Did stakeholders feel involved and satisfied with the process?
As described above, this systems improvement process will require meaningful involvement of various stakeholders to ensure its success. As such, the evaluation of this project will include a formalized process to measure participant's level of involvement and satisfaction with the process. In previous consensus-building and systems improvement initiatives, DMH has developed and used a survey called the *Involvement and Satisfaction Questionnaire* (see Appendix 2). This survey consists of 12 items, 11 fixed alternative items and one open-ended comments question that assess if project participants felt involved in the process, if they had the key information to make decisions, and if they were satisfied with the team's process.
DMH will work with a grant evaluator (to be hired) to modify this instrument for the purposes of this grant. This instrument will be distributed and collected at six month intervals among key participants in the grant, including members of the steering committees. Results of the survey will be compiled and reported back to the steering committee, and, based on the results, the steering committee will be empowered to make recommendations regarding needed improvements. In the event that a key participant drops out of the process, that participant will be asked to complete the survey, and the results will be shared with the appropriate steering committee.

Evaluation Question 2: How well were SAMHSA's Six Core Strategies Implemented?
To answer this evaluation question, DMH plans to use the Inventory of S/R Reduction Interventions (ISRRI – See Appendix 2)) to measure progress towards the implementation of SAMHSA's Six Core Strategies. The ISRRI is a tool for measuring, in standardized form, the nature and extent of interventions implemented for the purpose of reducing S/R at a particular facility. The ISRRI is a fidelity scale developed specifically for the evaluation of States' implementation of the Six Core Strategies to Reduce S/R. It measures the extent to which a

program adheres to the guidelines contained within the Six Core Strategies. VSH and RHC will self-administer the ISRRI, with the help of the grant evaluator, and use the results of the survey to establish a baseline from which to measure progress. Results of the survey will be presented to the respective S/R Reduction Steering Committee and will be used in the development of a strategic plan. The instrument will be re-administered again at the beginning of year 2 and 3 to provide evaluation feedback to the project regarding progress. The ISRRI will also be administered at the end of the grant to evaluate progress over the course of the entire grant. The strategic plans for VSH and RHC will set specific, measurable six month and 1 year indicators of success. At six month intervals the steering committee will meet with the evaluator to assess and review the achievement of indicators of success, and the results of that assessment will be used to gauge progress towards the Six Core Strategies. Both organization's strategic plans will need to be updated at six to 12 month intervals, based on the results of ISRRI.

Evaluation Question 3: Was Vermont Able to Reduce the Use of S/R?
As described above, both organizations are currently collecting and reporting on the use of S/R within their institution. Both VSH and RHC regularly produce and review reports on the number of hours of restraint, episodes of restraint, seclusion and emergency involuntary medication, and rates of injury for staff and patients. These numbers are compared with national rates. For the purposes of this grant, the S/R Reduction Steering Committees will review these rates to measure progress towards the reduction of S/R. At the beginning of grant activities, each steering committee will review existing reports and other available data and make recommendations regarding other data that may be useful for measuring progress towards S/R reduction.

Evaluation Question 4: What factors contributed to successful implementation of the Six Core Strategies and the reduction of S/R?
Vermont has had extensive experience with the implementation of evidence-based practices and other systems improvement grants (e.g. COSIG), and with each of these initiatives we have used different methods for documenting what factors contribute to successful implementation. We have found that the most effective method to identify these factors is through the use of targeted focus groups made up of different stakeholders. The improvement of a system or organization is a complex process involving multiple interventions at all levels of the system, and the use of qualitative focus groups have provided us with the most useful evaluation data. Given the small percentage of grant funds available for evaluation, we believe the use of focus groups will be the most cost-efficient method for identifying factors that contributed to successful implementation.

The grant evaluator will conduct focus groups composed of different stakeholders, including institutional staff, members of the S/R Reduction Steering Committee, former patients and advocates to review evaluation data regarding the grant's progress and discuss factors contributing to achievement of grant goals.

The VSH EIPRP committee has been creating and reviewing reports that show the date of specific organizational interventions (e.g. creation of the EIPRP committee, staff training) and how the timing of the intervention corresponds with rates of S/R. For example, a recent report indicated a decrease in the use of S/R following the creation of the EIPRP committee over a six month period. Timelines such as this can be helpful to examine the application of specific organizational interventions and any effect the intervention might have had on S/R use. Dr. Tom

Simpatico, medical director of VSH and originator of the EIPRP, will work with both S/R Steering Committees to produce reports which include key implementation events in comparison with S/R rates. While these types of reports cannot prove causation, they are nonetheless useful evaluation data to include in the quality improvement process and can provide information on what factors may be contributing to successful implementation.

Collection and Reporting of Required Performance Measures

DMH is committed to providing the required GPRA performance measures on infrastructure development to SAMHSA. Vermont is currently implementing a Co-Occurring Disorders State Incentive Grant and has been in compliance with reporting all required performance measures. While we anticipate that all of the evaluation components will contribute to the collection of performance data regarding the domains outlined in the RFA (policy development, workforce development, financing, organizational restructuring, accountability, types/targets of practice, and cost efficiency), we expect that the use of the ISRRI and a well-documented strategic planning process will provide a wealth of data regarding infrastructure development. The grant evaluator will assist in the collection of this GPRA data using data collection instruments developed by SAMHSA. The Project Director and the RHC S/R Reduction Coordinator will be responsible for distributing the SAMHSA-developed workforce development training data collection instruments at any relevant training and the Project Director will be responsible for electronically submitting all GPRA data using the TRAC system. GPRA data reports will also be shared with the VSH and RHC S/R Steering Committees as part of the CQI process.

Independent Evaluator

We anticipate that the national independent evaluator of the S/R Reduction grantees can play a key role in support of Vermont's evaluation efforts. If Vermont's application is funded, the Project Director and Vermont's grant evaluator will work with the national independent evaluator to identify different ways in which the independent evaluator can supplement and enhance Vermont's evaluation plan. Vermont has already consulted with the Human Services Research Institute, the national evaluator for the current S/R Reduction SIG grantees, and discussed several different ways in the national evaluator could assist with Vermont's evaluation. These include: 1) consultation/assistance in administering and analyzing the results of the ISRRI, 2) consultation in determining strategies for achieving goals and tracking progress in achieving goals using indicators of success, 3) provide ongoing feedback on implementation milestones (management support) based on ISRRI, 4) assistance in the development of measures for quantitative information on outcomes of interest, (e.g. monthly S/R rates, GPRA/NOMS measures) to assess the effect of the intervention, 5) assistance in identification of program/contextual factors that may be associated with outcomes, 6) assistance in development of data analysis plan (e.g. time series analysis showing changes in rates of S/R in relation to success in implementing program model), 7) assistance in improving methods for data submission, 9) assistance in development of approaches for and analysis of qualitative assessment (e.g. focus groups) and 10) assistance in analysis of qualitative data (focus groups). We commit to working with whatever organization is chosen to provide whatever information is requested to support cross-grantee evaluation. We also look forward to reviewing the results of any cross-state comparison and will use that data to improve our implementation process.

Section E: Literature Citations

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Cunningham, K. (2004, February). Effects of comfort room use on seclusion and restraint reduction: A pilot study at New Hampshire Hospital. Concord, NH.

Huckshorn, K. (2004). *Creating violence-free mental heath settings: Changing our cultures of Care.* Teleconference. April 6. National Technical Assistance Center.

Roadmap to Seclusion and Restraint Free Mental Health Services. DHHS Pub. No. (SMA) 05-4055. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2005.

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National Executive Training Institute (2006). Creating violence free and coercion free mental health treatment environments for the reduction of seclusion and restraint. Workshop Presentation, Boston, MA. Alexandria, VA: National Technical Assistance Center for State Mental Health Planning.

Walker, D. & McCormack, K (2002). The weighted blanked: An essential Nutrient in a sensory diet. Everett, MA: Village Therapy.

Wilbarger, P. (1984, September). Planning an adequate sensory diet: Application of sensory processing theory during the first year of life. *Zero to three,* 7-12.

SECTION F - Budget Justification/Existing Resources/Other Support
BUDGET - YEAR ONE

Personnel

Job Title	Annual Salary	Level of Effort (FTE)	Salary Requested
Project Director (PG 26)	$ 47,403	1 FTE	$ 47,403
			$ 47,403

Fringe Benefits (30%) **$ 14,221**

Overhead/Admin - Indirect Costs (45% of salaries) **$ 21,331**

Travel

Grant-related travel for grantee meetings in Washington, D.C. for Project Director & S/R Reduction Coordinator		
Airfare ($600/person x 2 people x 1 trips/year)`	$	1,200
Lodging ($200/person x 2 people x 3 nights	$	1,200
Meals & Other	$	250
	$	2,650
Instate Travel for Project Director	$	4,000
		$ 6,650

Equipment

Sensory Modulation Equipment Purchase (e.g. glider rockers, weighted vest/blankets, bubble lamps, carts)	$	10,000 (*in-kind)
**Vermont will use state general fund to pay for this*		**$ -**

Other

VSH Physical Plant Renovations (creation of multi-sensory treatment/calm rooms)	$	20,000 (*In-kind)
**Vermont will use state general fund to pay for this*		**$ -**

In-State Meeting Expense/Other

Steering Committee Meeting Expenses: Stipends/Mileage for Consumer/Family Participants 2 Committees X 4 Participants X $75/Meeting X 8 meetings	$	4,800
Cross-Site Training meetings between VSH and Brattleboro Retreat ($2000/Meeting X 2 meetings/year)	$	4,000

Training materials production and purchase	$	500	
			$ 9,300

Consultant Costs/Other

Tina Champagne			
Consultant fee (20 days @ $900/day)	$	18,000	
Consultant Expense (10 visits @ $500/visit)	$	5,000	
	$	23,000	
Grant Evaluator			
Consultant fee (14 days @ $750/day)	$	10,500	
Consultant Expense (mileage, phone)	$	1,500	
(Less than 20% of the total grant award will be used for data collection and performance assessment)	$	12,000	
			$ 35,000

Planning Grant to Retreat Healthcare

S/R Reduction Coordinator (salary + fringe)	$	50,000	
Sensory Modulation Equipment Purchase (e.g. glider rockers, weighted vest/blankets, bubble lamps, carts)	$	10,000	
Physical Plant Renovations (e.g. creation of multi-sensory treatment/calm rooms)	$	20,000	
	$	80,000	
			$ 80,000
TOTAL YEAR ONE:			$ 213,905

JUSTIFICATION

PERSONNEL

Project Director: A Project Director will be hired to oversee the Seclusion and Restraint Reduction grant activities, plan and direct the program's implementation at both VSH and RHC, coordinate the use of expert training and consultation, ensure proper collection and reporting of project data and coordinate the sharing of project operational successes and challenges between VSH and RHC. The Project Director will have a demonstrated history of change-leadership and successful program implementation experience, and will report directly to the Commissioner of Mental Health. Working closely with Principal Investigator Dr. McMains, the Director will be located at VSH and will also assume some coordination duties associated with project planning and implementation at that institution. In addition, the Project Director will oversee the grant award to RHC and work closely with the leadership of that organization to facilitate successful implementation of sustainable changes. The Project Director's level of effort will be 100%, and will be supported in its entirety by this grant.

FRINGE BENEFITS

The actual cost of fringe benefits (not a fringe-benefit rate) will be reported as a direct cost of the program. The actual cost of fringe benefits varies from employee to employee based on salary, employee choice of health care plan, and employee election of certain other benefits. The usual, major components of this cost are FICA at 7.65% of salary, retirement at 9% of salary, and a portion – 80% for medical, 75% for life and 100% for dental - of the actual costs of the medical, dental and life insurance coverage selected by the employee. The cost of each employee's fringe benefits will be allocated to the program based on hours worked in the program relative to all hours worked by the employee. Based on the current cost of fringe benefits for employees in similar programs, we are estimating the cost of these fringe benefits at 30% of salary.

OVERHEAD /ADMINISTRATIVE COSTS

The Vermont Department of Health uses a Cost Allocation Plan, not an Indirect Rate. This Cost Allocation Plan was approved by the U.S. Department of Health and Human Services effective October 1, 1987. The Cost Allocation Plan summarizes and allocates actual, allowable costs incurred in the operation of the program. These costs include items often shown as direct costs, such as telephone and general office supply expenses, as well as items usually included in an indirect rate, such as the cost of office space and administrative salaries. These costs are allocated to the program based on the salaries and wages paid in the program relative to the total salaries and wages paid in the department overall. Because these are actual costs, unlike an Indirect Cost Rate, these costs will vary from quarter to quarter and cannot be fixed as a percentage of program costs. Based on recent experience with similar programs, we would estimate these allocated costs at 45% of the direct salary ("Personnel") line item.

TRAVEL – Given the responsibilities of the Project Director, he or she will be required to travel extensively from the Vermont State Hospital in Central Vermont to Retreat Healthcare in Southeast Vermont.

EQUIPMENT

In support of the implementation of Sensory Modulation Approaches, Vermont plans to purchase specific equipment that is used with the model to aid patients in psychiatric crisis. This equipment could include bubble lamps, glider rockers, rocking chairs, beanbag chairs, TV/VCR/DVD, CD's and players, ipods, wall murals, therapy balls, weighted vest/blankets, and sound machines, as well as carts for transporting the equipment to different wards at the hospital. The purchase of this equipment will be provided by the Vermont Division of Mental Health

SUPPLIES - None

OTHER

VSH Physical Plant Renovations: To support the implementation of Sensory Modulation approaches, the Vermont State Hospital will consult with a consultant to modify existing space

and create "calm rooms" and multi-sensory treatment rooms. Funds will be used for renovations to existing space. Cost is based on estimates provided by an architectural consultant currently working with the state of Vermont (Frank Pitts – Architectural Plus)

In-state Meeting Expense - Steering Committee Meeting Expenses: Stipends for participation and mileage reimbursement will be provided to consumer participants of the two S/R Reduction Steering Committees

In-state Meeting Expense - Cross-Site Training Meetings: Vermont will host two cross-site meetings between VSH and RHC to share lessons learned and participate in joint training. Funds will cover the cost of the meeting space, food/beverages, and reproduction of training materials (copying, folders, etc.)

Consultant Cost – Tina Champagne: Ms. Champagne will provide expert consultation on Sensory Modulation techniques and the application of SAMHSA's Six Core Strategies to Reduce S/R

Consultant Cost - Grant Evaluator: Vermont will hire an independent evaluator to complete grant evaluation activities.

Planning Grant to Brattleboro Retreat: DMH will provide a planning grant to Retreat Healthcare to fund different S/R Reduction activities. RHC will use the funds to hire a S/R Reduction Coordinator, purchase sensory modulation equipment (described above under "Equipment") and make renovations to their physical plant to create calm rooms and multi-sensory treatment rooms (described above under VSH Physical Plant Renovations).

INDIRECT COST RATE – See OVERHEAD/ADMINSTRATIVE Costs above.

Calculation of Future Budget Periods

	First 12-month Period	Second 12- month Period	Third 12-month Period
Personnel			
Project Director (PG 26) *	$ 47,403	$ 48,351	$ 49,318
Total Personnel	$ 47,403	$ 48,351	$ 49,318
*Assumes 2% Raise in Salary each year			
Fringe Benefits (30%)	$ 14,221	$ 14,505	$ 14,795
Overhead/Admin	$ 21,331	$ 21,758	$ 22,193
Travel			
Grant-related travel for grantee meetings	$ 2,650	$ 2,650	$ 2,650
In-state Travel for Project Director	$ 4,000	$ 4,000	$ 4,000
Equipment			
Sensory Modulation Equipment	$ 10000 (in-kind)	$ 7,000 (in-kind)	$ 4,500 (in-kind)
Other			
VSH Physical Plant Renovations **	$ 20,000 (In-kind)	$ 20,000 (In-kind)	$ 20,000 (In-kind)
**VSH will create one "calm room" per year			
In-State Meeting Expense/Other			
Steering Committee Meeting Expenses:	$ 4,800	$ 4,800	$ 4,800
Cross-Site Training Meetings	$ 4,000	$ 4,000	$ 4,000
Training Materials	$ 500	$ 500	$ 500
Consultant Costs/Other			
Tina Champagne	$ 23,000	$ 23,000	$ 23,000
Grant Evaluator	$ 12,000	$ 12,000	$ 12,000
Planning Grant to Retreat Healthcare			
S/R Reduction Coordinator***	$ 50,000	$ 51,000	$ 52,020
Sensory Modulation Equipment	$ 10,000	$ 7,000	$ 4,500
Physical Plant Renovations****	$ 20,000	$ 20,000	$ 20,000
***Assumes 2% Raise in Salary each year			
****RHC will create one "calm room" per year			
TOTAL COSTS	$ 213,905	$ 213,564	$ 213,777

SECTION G: BIOGRAPHICAL SKETCHES AND JOB DESCRIPTIONS

POSITION DESCRIPTIONS FOR KEY PROJECT STAFF

The proposed project will involve the recruitment and hiring of two key staff described in Section C of the proposal narrative. The following sets out the responsibilities and qualifications for these prospective project leaders.

PROJECT DIRECTOR

The Project Director will oversee the Seclusion and Restraint Reduction grant activities and will serve as a liaison between the Commissioner of Mental Health, the Principle Investigator and the project staff leaders at both VSH and the Retreat. This position will also be responsible for coordinating S/R reduction activities at VSH. This individual will be a state employee, and will be recruited upon notification of the grant award.

Major Job Duties and Responsibilities

- Oversee the planning, implementation and coordination of grant activities
- Work closely with both VSH and the Retreat to guide the development of a strategic plan that incorporates the 6 core Strategies. Both plans should be reviewed and updated annually to reflect project progress and experience
- Work closely with both institutions to develop data collection methods and ensure that routine program data is collected, analyzed and reported.
- Coordinate the expert consultation of Tina Champagne, OTR, to maximize the use of her time to teach and train each institution about effective, empirically-based organizational and clinical strategies for reducing restraint and seclusion.
- Facilitate communication between VSH and the Retreat to share information about project successes, challenges and effective strategies for accomplishing the goals of the project.
- Maintain an effective presence at DMH, VSH and the Retreat to ensure project visibility and stimulate and sustain the engagement of key staff in the change process
- Manage reporting obligations to SAMHSA and communication between the Commissioner's office, the two participating hospitals and interested stakeholders
- Serve as the S/R Reduction Coordinator for VSH

Skills, Qualifications and Experience

- Demonstrated experience as change leader
- Demonstrated effectiveness in program development, implementation and management
- Knowledge of and experience with people with acute severe mental illness
- Understanding of data collection and analysis methods
- Effective verbal and written communication skills

RETREAT HEALTHCARE SECLUSION AND RESTRAINT REDUCTION COORDINATOR

Major Job Duties and Responsibilities

Although located at the Retreat in Southeastern Vermont, this position will report to the Project's Director

- Work with the Project Director, the Retreat Project Principle, and the Retreat's Senior clinical Leadership Team to coordinate the finalization of a strategic plan for reducing Seclusion and Restraint at the hospital.
- Oversee the revision of Retreat protocols, procedures and documentation requirements related to the use of involuntary procedures
- Facilitate and oversee data collection methods and ensure that routine program data is collected, analyzed and reported at the retreat
- Work with S/R reduction Tina Champagne to understand sensory modulation techniques and serve as the in-house expert on these approaches.
- Coordinate Retreat staff training and supervision relative to the model, and work with staff at all levels of the institution to identify and address barriers to successful reduction of S/R
- Facilitate the Retreat S/R Reduction steering committee.
- Work with the Retreat PI and the Project Director to ensure that the hospital complies with the provisions and stated plans for this proposal.
- Identify organizational needs for and operational barriers to successfully reducing the use of involuntary procedures at the Retreat, and communicate these to the Retreat Project PI and to the Project Director
- Actively participate in the preparation and distribution of grant reporting requirements pertaining to this project

Skills, Qualifications and Experience

- Professional training in Occupational Therapy, Nursing, Activities Therapy or other clinical profession
- Experience in the operation of in-patient services to people with severe mental illness
- Demonstrated experience in successful program development, implementation and management
- Knowledge of and experience with people with acute severe mental illness
- Understanding of data collection and analysis methods
- Effective verbal and written communication skills

COMMISSIONER OF HEALTH

(Effective 7/1/07; Formerly Deputy Commissioner for Mental Health, VT Department of Health)

MICHAEL HARTMAN,
M.S.W.
Licensed Clinical Mental Health Counselor
License # 068-0000293
28 Pleasantview St.
Montpelier, Vermont 05602
802-229-4477

EDUCATION

University of Vermont, Burlington, Vermont. Completed Masters of Social Work degree with a concentration in Health/Mental Health 5/98.
Goddard College, Plainfield, Vermont. Bachelor of Arts, Graduated 1982.

LICENSURE

Licensed Clinical Mental Health Counselor 12/19/96 - 1/31/2007 License #068-0000293

EMPLOYMENT

01/07 – Present, Deputy Commissioner for Mental Health, Vermont Department of Health

10/06 –01/07 **Executive Program Director, Collaborative Solutions Corporation,**
P.O Box 69, Montpelier, VT

CSC is a new service provider with the goal of establishing a new 11 bed Community Recovery Residential facility in Williamstown, VT. The targeted population for the program is severely mentally ill adults, many with significant co-morbidity issues and also with co-occurring disorders, who are currently only able to be placed at VT State Hospital. The program is currently being established and will open in late winter '06.

7/00 – 10/06 **Director, Community Rehabilitation and Treatment/Intensive Care Services**
Washington County Mental Health Services, Inc., P.O. Box 647, Montpelier, Vermont.

Program Director for long term care services for adults and acute services for adults, children and families. *(Acute services role is described below)* CRT program serves 450 adult consumers with persistent and severe mental illness. Program includes vocational, residential, recovery oriented, psychiatric, and case management services provided in a co-occurring and trauma sensitive environment within a community setting. Supervise team of 13 middle managers with total staff of 90 care providers. Duties include: clinical and administrative supervision, program development, budget planning/implementation, contracting for third party provision of services, development/maintenance of staff education programs, liaison with state Division of Mental Health Services, and development of community educational services regarding mental health issues.

2/95-6/2000 **Director of Intensive Care Services**, Washington County Mental Health Services, Inc., P.O. Box 647, Montpelier, Vermont.

3/05 – present **VT Behavioral Health Response Disaster Team, Vermont Department of Health, Division of Mental Health,** Burlington, VT.

3/02 – 4/03 **Consultant and visiting clinician, Technical Assistance Collaborative, Inc.** Boston, MA.
3/98 - Present **Adjunct Faculty, Southern New Hampshire University, Program in Community Mental Health, Manchester, NH**

9/80-7/02 **Program Director, Intensive Domestic Abuse Program/DELTA Program, The Institute of Professional Practice, Inc.**, P.O. Box 1249, Montpelier, Vermont.

9/96-5/97 **Intern, Main Street Middle School**, Main Street, Montpelier, Vermont.

9/94-5/95 **Intern, Washington County Mental Health Services, Inc., Children, Youth and Family Services Program**, 9 Heaton Street, Montpelier, Vermont

4/86 - 1/95 **Emergency Services Clinician, Washington County Mental Health Services,**

12/85-4/86 **Child Protective Services Worker, Orange County Department of Public Welfare**, North Madison Road, Orange, Virginia

4/83-7/83 **Day Treatment Clinician, Orange County Mental Health Service**, Box G, Randolph, Vermont.

5/80-4/83 **Assistant Coordinator, 62 Barre Street Group Home**,
Washington County Mental Health Services, P.O. Box 647, Montpelier, Vermont.

PROFESSIONAL DEVELOPMENT, WORKSHOPS AND TRAININGS
Board and Organizational Memberships

2/2006 – present Elected to Board of Directors of the Institute of Professional Practice, Montpelier, VT. IPP is a professional provider of developmental and mental health services in New England, and Maryland.

6/96-present Appointed to serve on Victim Compensation Board of VT Center for Crime Victim Services. Served as Board Chair 1999-2001

9/98-6/01 Member of Advisory Board, VT Deaf to Deaf Project, a community based effort to encourage the development of mental health services for deaf Vermonters.

1/93-1/96 Served one term on Board of Directors, Central Vermont Visitation Center

PRICIPLE INVESTIGATOR - WILLIAM D. MCMAINS, M.D.

Licensure

1991	Vermont, Number 5989
1971	State Boards, Oklahoma

Degrees

1971	M.D. – University of Oklahoma, School of Medicine
1967	B.A. – Oklahoma City University, Biology

Academic Training

1978	Board Certified, General Psychiatry
1974-1976	Residency in General Psychiatry at the Medical College of Ohio in Toledo, Ohio; Chief Resident 1975-1976
1972-1974	Fellowship Child Psychiatry at Yorkwood Center, The Children's Division of Ypsilanti State Hospital, Ypsilanti, Michigan; affiliated with the University of Michigan
1971-1972	Internship – Baylor Medical College, Houston, Texas
2001-Present	Clinical Professor, Dartmouth School of Medicine

Academic Appointments

1991-Present	Clinical Professor, University of Vermont, School of Medicine Burlington, Vermont
1987-1991	Clinical Associate Professor, University Of Rochester, School of Medicine Rochester, New York
1983-1987	Clinical Assistant Professor, University of Rochester, School of Medicine Rochester, New York
1977-1983	Clinical Assistant Professor, Department of Psychiatry, University of Vermont Burlington, Vermont
1976-1977	Instructor, Department of Psychiatry, Medical College of Ohio Toledo, Ohio

Employment

1991-Present	Medical Director, Vermont State Department of Developmental and Mental Health Services Waterbury, Vermont
1985-1991	Chief of Psychiatry, Genesee Hospital; Director, Genesee Mental Health Center Rochester, New York
1984-1991	Medical Director, Residential Treatment Facility, St. Joseph's Villa Rochester, New York
1983-1991	Medical Director, Children's Program, Genesee Mental Health Center, Genesee Hospital Rochester, New York
1982-1983	Clinical Director, Allied Health Services, Vermont State Hospital Waterbury,Vermont Psychiatric Consultant, Group Home and Supervised Apartment Programs, Washington County Mental Health Services Montpelier, Vermont
1979-1982	Psychiatric Consultant to the Vermont State Department of Developmental and Mental Health Services Waterbury, Vermont
1978-1983	Clinical Director, Adolescent Treatment Program, Vermont State Hospital Waterbury, Vermont

1978-1980	State Coordinator for Children's Mental Health Services State Department of Developmental and Mental Health Services Waterbury, Vermont
1977-1980	Medical Director, Giant Step Program (a Program for developmentally disabled adults), Vermont State Hospital Waterbury, Vermont
1977-1980	Director, Youth Treatment Center, Vermont State Hospital, Waterbury, Vermont (residential center for autistic children)
1976-1977	Consulting Psychiatrist, Child Psychiatry, Elizabeth Zepf Community Mental Health Center, Toledo, Ohio
2002-2004	President, Vermont Psychiatry Association

Committee Membership And Organization Activities

1998- 2002	Vermont Psychiatric Association State Legislative Liaison
1998-2000	Vermont Psychiatric Association Deputy Representative National Assembly
	American Psychiatric Association
1998-Present	President-elect Vermont Association of Child and Adolescent Psychiatrists
1994-1996 to	Vermont Program for Quality in Health Care: Mental Health Task Force
	Develop outcome indicators for mental health services
1994-1996	Vermont Community Coalition Planning Committee (Developmental Services
	State Plan)
1993-Present	Vermont Division of Developmental Services Ethics Committee, Chair
1993-1995	Research Committee, Vermont Council of Developmental and Mental Health
	Services and the University of Vermont
1992-1995	Mental Health Advisory Committee to Health Care Authority, State of Vermont
1992-1995	Mental Health Data Advisory Committee to Health Care Authority, State of
	Vermont
1991-Present	Coordinator of Pubic Psychiatry Training at the University of Vermont School of
	Medicine
1991-Present	Vermont Psychiatry Association Executive Committee
1991-Present	Quality Improvement Council, Department of Developmental and Mental Health Services, chair 1999-present
1991-Present	Residency Training Committee, University of Vermont, School of Medicine in Burlington, Vermont
1991	Secretary, New York State Association Of Community Mental Health Center
1988-1991	New York State Office of Mental Health, Children's Mental Health Planning Task Force

EXPERT CONSULTANT

Tina Champagne, M.Ed., OTR/L
Occupational Therapy & Group Program Supervisor
Cooley-Dickinson Hospital, West 5
30 Locust Street
Northampton, MA 01061
Phone: (413) 582-2503
Email: Tina_Champagne@cooley-dickinson.org

Champagne Conferences & Consultation
41 East Street
Southampton, MA 01073
Phone/Fax (413) 527-7913
Email: tina@ot-innovations.com
Web: www.ot-innovations.com

Education

In progress: Creighton University, Omaha, NE
Doctoral Candidate, Occupational Therapy

1998 Springfield College, Springfield, MA
Masters of Education, Occupational Therapy

1996 Springfield College, Springfield, MA
Bachelors of Science, Rehabilitation Services

Occupational Therapy Experience

2000-Present: Cooley-Dickinson Hospital, Northampton, MA
Inpatient Behavioral Health, West 5
Occupational Therapy & Group Program Staff Supervisor

2000-Present: Champagne Conferences & Consultation
Owner, Independent Consultant & International Lecturer

2006-Present: American International College, Springfield, MA
Adjunct Professor, OT Program

2001-2003: Springfield College, Springfield, MA
Adjunct Professor, Master's Level OT Program

1998-2003: Berkshire Medical Center, Pittsfield, MA
Psychiatric Intensive Care Unit
Occupational Therapist & Consultant

Current Professional Memberships:
American Occupational Therapy Association (AOTA)
Massachusetts Occupational Therapy Association (MAOT)
- *Currently, Vice-president of the Executive Board of MAOT*

Society for Chaos Theory in Psychology and Life Sciences

Certifications:
Allen Cognitive Advisor Stage 2, 1999
Allen Cognitive Advisor Stage 3: International Advisor in Cognition, 2000
Therapeutic Listening, 2002
Neurofeedback, 2004
Clinical Aromatherapy, 2005

Awards
2006 Catherine Trombly Award, from the MA State OT Association; Excellence in education, research, practice, administration and political activism
2005 Irene Allard Award; Outstanding Fieldwork Educator

Publications
Champagne, T. (2003, September). Creating Nurturing and Healing Environments for a Culture of Care. *Occupational Therapy Advance*, 19(19) p. 50.

Champagne, T., (2003). Sensory modulation and environment: Essential elements of occupation. Southampton, MA: Champagne Conferences & Consultation.

Champagne, T. (2005, March). Expanding the role of sensory approaches for acute inpatient psychiatry. *Mental Health Special Interest Newsletter, 28,* 1-

Champagne, T. (2006). Sensory modulation and environment: Essential elements of occupation (2nd Ed.). Southampton, MA: Champagne Conference & Consultation.

Champagne, T. (2006, December). Creating sensory rooms: Essential enhancements for acute inpatient mental health settings. *Mental Health Special Interest Newsletter, 29,* 1-4.

Champagne, T. & Stromberg, N. (2004, September). Sensory approaches in inpatient psychiatric settings: Innovative alternatives to seclusion and restraint. *Journal of Psychosocial Nursing*, 42(9), 35-44.

Champagne, T. & McLaughlin, J. (2006, May). Sensory approaches: Seclusion and restraint reduction tools module. In, the *National Executive Training Institute's curriculum for the reduction of seclusion and restraint.* Alexandria, VA: National Association of State Mental Health Program Directors.

Champagne, T., Ryan, J., Saccamondo, H., Lazzarini, I. (In press). A Nonlinear Dynamics Approach to Exploring the Spiritual Dimensions of Occupation. *Emergence: Complexity and Organization.*

Mullen, B., Champagne, T., Krishnamurty, S., Gao, R. & Dickson, D. (In press). Exploring the safety and effectiveness of the therapeutic use of the weighted blanket with adults. *Occupational Therapy in Mental Health.*

Massachusetts Department of Mental Health (In press). *Developing Positive Cultures of Care: Resource Guide*. Boston, MA: Massachusetts Department of Mental Health. *Authored and co-authored several chapters in this manual, to be out in Spring 2007.*

Research: Has participated in numerous research projects. List available upon request.

Consultation Services, Regional, State & International Presentations: List available upon request.

VSH PROJECT PRINCIPLE

Thomas A. Simpatico, M.D.
CURRICULUM VITA
May, 2007

Associate Professor of Psychiatry
Director, Division of Public Psychiatry
Department of Psychiatry
University of Vermont College of Medicine

Director, Fellowship in Public Psychiatry
UVM College of Medicine

Medical Director

The Vermont State Hospital

103 S. Main Street,

Waterbury, VT 05671-2501

Phone: (802) 241-3023
Fax: (802) 241-3001

Email: Thomas.Simpatico@uvm.edu
Born: March 9, 1956
Citizenship: USA
SS# 145-38-3576

EDUCATION

Year Conferred	Institution & Location	Degree	Concentration
1978	Saint Peter's College, Jersey City, NJ	B.S.	Natural Sciences
1984	Rush Medical College, Chicago, IL	M.D.	

Residency

1984-1985	Internship in Internal Medicine, Michael Reese Hospital, Chicago, IL
1985-1988	Residency in Psychiatry, University of Chicago, Chicago, IL

HONORS, AWARDS

1999	Exemplary Psychiatrist Award, National Alliance for the Mentally Ill, Illinois Chapter
2000	United States Department of Justice Public Service Award
2000	Fellow, American Psychiatric Association
2001	Inducted as a member of the American College of Psychiatrists
2002	Distinguished Fellow, American Psychiatric Association

2002	American Psychiatric Association's Psychiatric Services Gold Achievement Award for Outstanding Innovative Program Development (Co-Developer of Cook County Jail Linkage Project with Thresholds, Inc. and Cermak Health Services of Cook County at the Cook County Department of Corrections)
2003	Featherfist Humanitarian Service Award, Featherfist Human Services, Chicago, IL
2005	Award for Excellence in Clinical Education, University of Vermont College of Medicine Psychiatry Residents

MAJOR RESEARCH INTERESTS

Mental health services research
Medicine and the law

EXTRAMURAL SUPPORT

1999-2001	**Co-Principal Investigator & Project Director (Illinois Site), *The Homeless Families Project Multi-Site Study* (Grant # 93-230), United States Department of Human Services, Public Health Service, Substance Abuse and Mental Service Administration (SAMHSA), Center for Mental Health Services (CMHS) and Center for Substance Abuse Treatment (CSAT)** **Award: *$240,000***
2000-2002	**Co-Principal Investigator & Project Director, *Selected Demonstration Project for Reintegration Into the Work Force of High Risk Adult Populations*, United States Department of Labor Capacity Building Grant** **Award: *$90,000***
2001-2004	Principal Investigator & Project Director, *Mental Health Intergovernmental Service System Interactive On-Line Network (MHISSION),* United States Department of Commerce Technology Opportunity Program (TOP) Grant Award: *$540,000*

PRESENTATIONS

Over 150 presentations at regional and national meetings.

PUBLICATIONS

Over 30 peer reviewed journal articles, book chapters and monographs.

OTHER PROFESSIONAL ACTIVITIES

Served on executive boards and as elected officer for numerous professional organizations.

Served as an expert witness for both criminal and civil cases in multiple states.

RETREAT HEALTHCARE PROJECT PRINCIPLE -
Linda Young Rice R.N., M.S.N., APRN, F.N.P.

119 Hosea Fisher Lane (Halifax)
Brattleboro, Vermont 05301
802-257-7982

EDUCATION:

1994	University of Massachusetts, Amherst, School of Nursing Master of Science in Nursing - Primary Care: Family Nurse Practitioner
1992	University of Massachusetts, Amherst, School of Nursing Pre Master's Program
1990	University of Massachusetts, Amherst, School of Public Health Community Health Education (MPH Program)
1990	Comprehensive School Health and Wellness (EDHE 200:5788) University of Vermont Continuing Education Center, Brattleboro
1981	Bachelor of Arts, Social Science with High Honors, Marlboro College Marlboro, Vermont
1969	Diploma in Nursing, Presbyterian School of Nursing, Presbyterian-University of Pennsylvania Medical Center, Philadelphia, Pennsylvania

PROFESSIONAL CREDENTIALS

State of Vermont - Advanced Practice Registered Nurse with Prescriptive Authority - Family Nurse Practitioner #101-0012831 exp. 6/07

State of New Hampshire – Advanced Registered Nurse Practitioner
Prescriptive Authority #053031-23-03 exp. 9/07

American Nurses Credentialing Center - Certification as Family Nurse Practitioner
9/01/94 - 8/31/04 9/01/04 – 8/31/09

American Nurses Credentialing Center - Certification as College Health Nurse
12/01/92-11/30/02

PROFESSIONAL EXPERIENCE

July 17, 2006 – Present
Vice President of Patient Care, Brattleboro Retreat

May 7, 2006 Interim Vice President of Patient Care

Brattleboro Retreat

2005 - 2006 Clinical Manager, Medical Clinic & ECT, Brattleboro Retreat

1986 - 2005 Director of Medical Services, Total Health Center, Marlboro College, Marlboro, Vermont

1994 – 2005 Planned Parenthood of Northern New England, Brattleboro, Vermont
Per diem Nurse Practitioner

1994 -2005 Medical Clinic, Brattleboro Retreat
Per diem Nurse Practitioner

2004–Present Per Diem Nurse Practitioner, Emergency Department, Cheshire Medical Center, Keene, New Hampshire

12/94 - 12/97 West Brattleboro Family Practice, Brattleboro, Vermont

9/94–Present Brattleboro Walk-in Clinic, Brattleboro, Vermont

1969 -1995 Nursing (RN) positions in Vermont, Massachusetts, Rhode Island and Pennsylvania

PROFESSIONAL DEVELOPMENT

Ongoing Annual participation in workshops, training programs, and recertification classes.

PROFESSIONAL ORGANIZATIONS

American College Health Association
Vermont Nurse Practitioner Association
Southeastern Vermont Advanced Practice Group – (Chair 1994-1999)

COMMUNITY SERVICE

2005 – Present National Council of State Boards of Nursing, Advanced Practice Advisory Panel

2002 – 2007 Board of Directors, Women's Crises Center, Brattleboro, Vermont

1999 – Present Vice Chair, Board of Nursing, State of Vermont

1994 – 2003 Brattleboro Hockey Association, Youth Hockey Coach
(certified Level III - USA Hockey)

1997 – 2000 Windham County Safe Kids Coalition

Section H: Confidentiality and Participant Protection Requirements

1. Protection from Potential Risks: Because this grant is focused on improving treatment and implementing recovery-based, trauma-informed practices that have shown effectiveness in other treatment settings, there is increased risk from participating in or evaluating the activities of this grant. It is important to note that individuals may participate in the grant initiative in several different ways. Professionals, consumers, family members and advocates will participate in planning and implementation activities. These individuals will participate on a voluntary basis. Individuals receiving services may fear that access to services might be limited if they criticize the treatment providers they currently work with. Professional staff involved in the project may be concerned that criticisms of the system might jeopardize their employment. To mitigate this real or perceived barrier, facilitators of the planning process will work to create a safe environment for both positive and negative critiques of the system. The purpose of stakeholder involvement, including professional staff, consumers and families is to honestly critique the current system as we implement alternatives to restraint and seclusion.

Because this grant focuses on the reduction of S/R and the implementation of alternatives to S/R, staff at VSH and RHC may experience anxiety and feel less equipped to deal with aggressive or violent behavior if they are instructed to not use S/R without being given alternatives interventions to use. As such, implementation activities will focus on providing staff with new skills and knowledge while implementing a culture change to reduce the use of S/R.

Many of the individuals who are patients at VSH or Retreat Healthcare will be recipients of alternatives to restraint and seclusion, and it is important to note that many of these individuals will be at the institution on an involuntary basis. However, it is anticipated that patients will benefit from grant activities. The use of seclusion and restraint has been described as very traumatizing and always presents a risk of injury, and so the introduction of alternatives should help to improve the treatment they receive.

2. Fair Selection of Participants: Grant activities are designed to include participation from a wide range of stakeholder groups, including representatives across ages, genders, and racial/ethnic backgrounds. Participants will include consumer leaders, family members, advocates, and administrative and treatment professionals, as described in Section C. Individuals with mental disorders, and their family members, will be included in the stakeholder groups because of their ability to speak about the mental health system based on personal experience. No one will be excluded from participation in grant activities.

For individuals who are patients at VSH and RHC, alternatives to S/R will be offered to anyone who may benefit, and no one will be excluded from having access to these alternatives.

3. Absence of Coercion: Participation in the planning and implementation activities will be entirely voluntary for members of each stakeholder group. In addition, participation in any surveys or interviews used to gather information for the project will be voluntary, without any direct or implied coercion.

Many patients at VSH and RHC have been involuntarily committed, and so the very fact that they are receiving treatment from the facility includes some level of coercion. However, the primary focus on implementing alternatives to S/R is to reduce coercive interventions, and so grant activities should help to reduce the level of coercion within the treatment setting.

4. Data Collection: Grant evaluation and continuous quality improvement efforts will rely on data from existing sources as well as information gathered through stakeholder interviews, surveys, and documentation of activities, as described in Section D.

Data collected regarding treatment provided and use of S/R will be compiled using existing VSH and RHC data collection systems. All identifying personal information will be removed prior to compiling data for review by grant planning participants.

5. Privacy and Confidentiality: Acknowledgement of involvement in grant activities in any public or written documentation will be voluntary. Information gathered through surveys or interviews will not include any personally identifying data. Data analyses and reports produced by this grant will not include individually identifiable information. The project will not disclose any information in a manner that would violate the requirements of the HIPPA Privacy Rule.

6. Adequate Consent Procedures: Stakeholders participating in the planning process will be free to participate in grant activities or not, as they desire. Requests to complete surveys will include written explanations, including: (1) completing surveys is voluntary, (2) purpose of surveys, (3) benefits for completing surveys, (4) description of the grant initiative and role of the surveys, (4) no anticipated risks for completing surveys, (7) protections for confidentiality (surveys will be done anonymously), (8) whom to call with questions about the surveys and grant activities, and (9) costs for completing the survey and participants will not be paid.

7. Risk-Benefit Discussion: Because this grant is focused on improving treatment and implementing recovery-based, trauma-informed practices that have shown effectiveness in other treatment settings, we feel the there is great benefit to be had from participating in and/or evaluating the activities of this grant and no increased risk. Professionals, consumers, family members and advocates participating in the planning and implementation activities will do soon a voluntary basis. Individuals receiving services may fear that access to services might be limited if they criticize the treatment providers they currently work with. Professional staff involved in the project may be concerned that criticisms of the system might jeopardize their employment. As such, facilitators of the planning process must work to create a safe environment for both positive and negative critiques of the system. However, because the purpose of stakeholder involvement, including professional staff, consumers and families, is to honestly critique the current system as we implement alternatives to restraint and seclusion, we feel the benefits greatly outweigh the potential risks. The benefits of participation provide a great deal of promise. We expect broad based stakeholder and professional staff participation to result in successful efforts to transform treatment at VSH and RHC.

Because this grant focuses on the reduction of S/R and the implementation of alternatives to S/R, staff at VSH and RHC may experience anxiety and feel less equipped to deal with aggressive or violent behavior if they are instructed to not use S/R without being given alternatives

interventions to use. As such, implementation activities will need to focus on providing staff with new skills and knowledge while implementing a culture change to reduce the use of S/R. In addition, because the use of S/R always has a potential to involve injury to staff, the potential benefits of implementing alternatives to S/R greatly outweigh the risks.

Many of the individuals who are patients at VSH or Retreat Healthcare will be recipients of alternatives to restraint and seclusion, and it is important to note that many of these individuals will be at the institution on an involuntary basis. However, it is anticipated that patients will benefit from grant activities. The use of seclusion and restraint has been described as very traumatizing and always presents a risk of injury, and so the introduction of alternatives should help to improve the treatment they receive.

Protection of Human Subjects Regulations

We do not anticipate that any of our evaluation efforts will require compliance with the Protection of Human Subjects Regulations (45 CFR 46). It is important to note that we consider this project a systems improvement initiative and not a research study in which an unproven treatment intervention is being tested/piloted with a vulnerable population. However, if there are any questions about protection of human subjects, we will submit an application to the Agency of Human Services Institutional Review Board (IRB) to ensure that our activities comply with the requirements. The Agency's IRB has a well developed process, including the requirement that all applicants complete a web-based tutorial program reviewing the Protection of Human Subjects Regulations (www.ahs.state.vt.us/IRB).

GRANTS.GOV™

Grant Application Package

Opportunity Title:	State Incentive Grants to Build Capacity for Alternatives to
Offering Agency:	Substance Abuse & Mental Health Services Adminis.
CFDA Number:	93.243
A Description:	Substance Abuse and Mental Health Services_Projects of
Opportunity Number:	SM-07-005
Competition ID:	
Opportunity Open Date:	03/12/2007
Opportunity Close Date:	05/11/2007
Agency Contact:	Kimberly Pendleton Grants Management Officer Phone: 240-276-1421

This electronic grants application is intended to be used to apply for the specific Federal funding opportunity referenced here.

If the Federal funding opportunity listed is not the opportunity for which you want to apply, close this application package by clicking on the "Cancel" button at the top of this screen. You will then need to locate the correct Federal funding opportunity, download its application and then apply.

This opportunity is only open to organizations, applicants who are submitting grant applications on behalf of a company, state, local or tribal government, academia, or other type of organization.

* Application Filing Name: Alternatives to Restraint/Seclusion

Mandatory Documents

Move Form to Submission List => / Move Form to Documents List <=

Mandatory Completed Documents for Submission

- Application for Federal Assistance (SF-424)
- Project Narrative Attachment Form
- HHS Checklist Form PHS-5161
- Disclosure of Lobbying Activities (SF-LLL)
- Budget Narrative Attachment Form
- Budget Information for Non-Construction Programs (SF-424A)

Open Form / Open Form

Optional Documents

- Faith Based EEO Survey

Move Form to Submission List => / Move Form to Documents List <=

Optional Completed Documents for Submission

- Other Attachments Form

Open Form / Open Form

Instructions

1 Enter a name for the application in the Application Filing Name field.

- This application can be completed in its entirety offline; however, you will need to login to the Grants.gov website during the submission process.
- You can save your application at any time by clicking the "Save" button at the top of your screen.
- The "Submit" button will not be functional until the application is complete and saved.

2 Open and complete all of the documents listed in the "Mandatory Documents" box. Complete the SF-424 form first.

-It is recommended that the SF-424 form be the first form completed for the application package. Data entered on the SF-424 will populate data fields in other mandatory and optional forms and the user cannot enter data in these fields.

-The forms listed in the "Mandatory Documents" box and "Optional Documents" may be predefined forms, such as SF-424, forms where a document needs to be attached, such as the Project Narrative or a combination of both. "Mandatory Documents" are required for this application. "Optional Documents" can be used to provide additional support for this application or may be required for specific types of grant activity. Reference the application package instructions for more information regarding "Optional Documents".

-To open an item, simply click on it to select the item and then click on the "Open" button. When you have completed a form or document, click the form/document name to select it, and then click the => button. This will move the form/document to the "Completed Documents" box. To remove a form/document from the "Completed Documents" box, click the form/document name to select it, and then click the <= button. This will return the form/document to the "Mandatory Documents" or "Optional Documents" box.

-When you open a required form, the fields which must be completed are highlighted in yellow. Optional fields and completed fields are displayed in white. If you enter invalid or incomplete information in a field, you will receive an error message.

3 Click the "Submit" button to submit your application to Grants.gov.

- Once you have properly completed all required documents and saved the application, the "Submit" button will become active.
- You will be taken to a confirmation page where you will be asked to verify that this is the funding opportunity and Agency to which you want to submit an application.

Application Submission Verification and Signature

Opportunity Title:	State Incentive Grants to Build Capacity for Alternatives to Re:
Offering Agency:	Substance Abuse & Mental Health Services Adminis.
CFDA Number:	93.243
CFDA Description:	Substance Abuse and Mental Health Services_Projects of Regional and National Signifi
Opportunity Number:	SM-07-005
Competition ID:	
Opportunity Open Date:	03/12/2007
Opportunity Close Date:	05/11/2007
Application Filing Name :	Alternatives to Restraint/Seclusion

Do you wish to sign and submit this application?

Please review the summary provided to ensure that the information listed is correct and that you are submitting an application to the opportunity for which you want to apply.

If you want to submit the application package for the listed funding opportunity, click on the "Sign and Submit Application" button below to complete the process. You will then see a screen prompting you to enter your user ID and password.

If you do not want to submit the application at this time, click the "Exit Application" button. You will then be returned to the previous page where you can make changes to the required forms and documents or exit the process.

If this is not the application for the funding opportunity for which you wish to apply, you must exit this application package and then download and complete the correct application package.

Sign and Submit Application Exit Application

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424

Version 02

* 1. Type of Submission:	* 2. Type of Application:	* If Revision, select appropriate letter(s):
Preapplication	☑ New	
☑ Application	☐ Continuation	* Other (Specify)
☐ Changed/Corrected Application	☐ Revision	

* 3. Date Received:	4. Applicant Identifier:
Completed by Grants.gov upon submission.	

5a. Federal Entity Identifier:	* 5b. Federal Award Identifier:

State Use Only:

6. Date Received by State:	7. State Application Identifier:

8. APPLICANT INFORMATION:

* a. Legal Name: State of Vermont

* b. Employer/Taxpayer Identification Number (EIN/TIN):	* c. Organizational DUNS:
03-6000274	809376155

d. Address:

* Street1:	108 Cherry St
Street2:	PO Box 70
* City:	Burlington
County:	
* State:	VT: Vermont
Province:	
* Country:	USA: UNITED STATES
* Zip / Postal Code:	05402-0070

e. Organizational Unit:

Department Name:	Division Name:
Vermont Department of Health	Division of Mental Health

f. Name and contact information of person to be contacted on matters involving this application:

Prefix:	* First Name: William
Middle Name:	
* Last Name:	McMains
Suffix:	M.D.

Title: Medical Director

Organizational Affiliation:

* Telephone Number:	Fax Number:
(802)652-2008	(802)652-2005

* Email: bmcmains@vdh.state.vt.us

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424

Version 02

9. Type of Applicant 1: Select Applicant Type:

A: State Government

Type of Applicant 2: Select Applicant Type:

Type of Applicant 3: Select Applicant Type:

* Other (specify):

*** 10. Name of Federal Agency:**

Substance Abuse & Mental Health Services Adminis.

11. Catalog of Federal Domestic Assistance Number:

93.243

CFDA Title:

Substance Abuse and Mental Health Services_Projects of Regional and National Significance

*** 12. Funding Opportunity Number:**

SM-07-005

* Title:

State Incentive Grants to Build Capacity for Alternatives to Restraint and Seclusion

13. Competition Identification Number:

Title:

14. Areas Affected by Project (Cities, Counties, States, etc.):

Vermont

*** 15. Descriptive Title of Applicant's Project:**

Implementation of alternatives to restraint and seclusion

Attach supporting documents as specified in agency instructions.

Add Attachments | Delete Attachments | View Attachments

OMB Number: 4040-0004
Expiration Date: 01/31/2009

Application for Federal Assistance SF-424 — Version 02

16. Congressional Districts Of:

.. Applicant: VT All

* b. Program/Project: VT All

Attach an additional list of Program/Project Congressional Districts if needed.

Add Attachment | Delete Attachment | View Attachment

17. Proposed Project:

* a. Start Date: 10/01/2007

* b. End Date: 09/30/2010

18. Estimated Funding ($):

* a. Federal	213,905.00
* b. Applicant	0.00
* c. State	0.00
* d. Local	0.00
* e. Other	0.00
* f. Program Income	0.00
* g. TOTAL	213,905.00

*** 19. Is Application Subject to Review By State Under Executive Order 12372 Process?**

☐ a. This application was made available to the State under the Executive Order 12372 Process for review on .

☐ b. Program is subject to E.O. 12372 but has not been selected by the State for review.

☑ c. Program is not covered by E.O. 12372.

20. Is the Applicant Delinquent On Any Federal Debt? (If "Yes", provide explanation.)

☐ Yes ☑ No Explanation

21. *By signing this application, I certify (1) to the statements contained in the list of certifications and (2) that the statements herein are true, complete and accurate to the best of my knowledge. I also provide the required assurances** and agree to comply with any resulting terms if I accept an award. I am aware that any false, fictitious, or fraudulent statements or claims may subject me to criminal, civil, or administrative penalties. (U.S. Code, Title 218, Section 1001)**

☑ ** I AGREE

** The list of certifications and assurances, or an internet site where you may obtain this list, is contained in the announcement or agency specific instructions.

Authorized Representative:

Prefix: | * First Name: Michael

Middle Name:

* Last Name: Hartman

Suffix: MSW

* Title: Deputy Commissioner

* Telephone Number: 802-951-1258 | Fax Number: 802-951-1275

* Email: mhartma@vdh.state.vt.us

* Signature of Authorized Representative: Completed by Grants.gov upon submission. | * Date Signed: Completed by Grants.gov upon submission.

Application for Federal Assistance SF-424

Version 02

*** Applicant Federal Debt Delinquency Explanation**

e following field should contain an explanation if the Applicant organization is delinquent on any Federal Debt. Maximum number of characters that can be entered is 4,000. Try and avoid extra spaces and carriage returns to maximize the availability of space.

DISCLOSURE OF LOBBYING ACTIVITIES

Approved by OMB
0348-0046

Complete this form to disclose lobbying activities pursuant to 31 U.S.C.1352

Review Public Burden Disclosure Statement

1. * Type of Federal Action:
- [ ] a. contract
- [x] b. grant
- [ ] c. cooperative agreement
- [ ] d. loan
- [ ] e. loan guarantee
- [ ] f. loan insurance

2. * Status of Federal Action:
- [ ] a. bid/offer/application
- [x] b. initial award
- [ ] c. post-award

3. * Report Type:
- [x] a. initial filing
- [ ] b. material change

4. Name and Address of Reporting Entity:

[x] Prime [ ] SubAwardee

** Name*: N/A

** Street 1*: N/A — *Street 2*:

** City*: N/A — *State*: — *Zip*:

Congressional District, if known:

5. If Reporting Entity in No.4 is Subawardee, Enter Name and Address of Prime:

6. * Federal Department/Agency:

N/A

7. * Federal Program Name/Description:

Substance Abuse and Mental Health Services_Projects of Regional and National Significance

CFDA Number, *if applicable:* 93.243

8. Federal Action Number, *if known:*

9. Award Amount, *if known:*

$

10. a. Name and Address of Lobbying Registrant:

Prefix: — ** First Name*: N/A — *Middle Name*:

** Last Name*: N/A — *Suffix*:

** Street 1*: — *Street 2*:

** City*: — *State*: — *Zip*:

b. Individual Performing Services (including address if different from No. 10a)

Prefix: — ** First Name*: N/A — *Middle Name*:

** Last Name*: N/A — *Suffix*:

** Street 1*: — *Street 2*:

** City*: — *State*: — *Zip*:

11.

Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when the transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

*** Signature:** Completed on submission to Grants.gov

***Name:** *Prefix*: — ** First Name*: Sharon — *Middle Name*:

** Last Name*: Moffatt — *Suffix*:

Title:

Telephone No.:

Date: Completed on submission to Grants.gov

Federal Use Only:

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Standard Form - LLL (Rev. 7-97)

Project Narrative File(s)

*** Mandatory Project Narrative File Filename:** Narrative - Vermont Restraint Seclusion SIG.doc

Add Mandatory Project Narrative File | Delete Mandatory Project Narrative File | View Mandatory Project Narrative File

To add more Project Narrative File attachments, please use the attachment buttons below.

Add Optional Project Narrative File | Delete Optional Project Narrative File | View Optional Project Narrative File

CHECKLIST

OMB Approval No. 0920-0428

Public Burden Statement:

Public reporting burden of this collection of information is estimated to average 4 hours per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC, Clearance Officer, 1600 Clifton Road, MS D-24, Atlanta, GA 30333, ATTN: PRA (0920-0428). Do not send the completed form to this address.

NOTE TO APPLICANT:

This form must be completed and submitted with the original of your application. Be sure to complete both sides of this form. Check the appropriate boxes and provide the information requested. This form should be attached as the last age of the signed original of the application. This page is reserved for PHS staff use only.

TypeofApplication: ☑ NEW ☐ Noncompeting Continuation ☐ Competing Continuation ☐ Supplemental

PART A: The following checklist is provided to assure that proper signatures, assurances, and certifications have been submitted.

	Included	NOT Applicable
1. Proper Signature and Date	☑	
2. Proper Signature and Date on PHS-5161-1 "Certifications" page.	☑	
3. Proper Signature and Date on appropriate "Assurances" page, i.e., SF-424B (Non-Construction Programs) or SF-424D (Construction Programs)	☑	
4. If your organization currently has on file with DHHS the following assurances, please identify which have been filed by indicating the date of such filing on the line provided. (All four have been consolidated into a single form, HHS Form 690)		
☐ Civil Rights Assurance (45 CFR 80)		
☐ Assurance Concerning the Handicapped (45 CFR 84)		
☐ Assurance Concerning Sex Discrimination (45 CFR 86)		
☐ Assurance Concerning Age Discrimination (45 CFR 90 & 45 CFR 91)		
5. Human Subjects Certification, when applicable (45 CFR 46)	☐	☑

PART B: This part is provided to assure that pertinent information has been addressed and included in the application.

	YES	NOT Applicable
1. Has a Public Health System Impact Statement for the proposed program/project been completed and distributed as required?	☐	☑
2. Has the appropriate box been checked on the SF-424 (FACE PAGE) regarding intergovernmental review under E.O. 12372 ? (45 CFR Part 100)	☑	
3. Has the entire proposed project period been identified on the SF-424?	☑	
4. Have biographical sketch(es) with job description(s) been attached, when required?	☑	☐
5. Has the "Budget Information" page, SF-424A (Non-Construction Programs) or SF-424C (Construction Programs), been completed and included?	☐	
6. Has the 12 month detailed budget been provided?	☑	☐
7. Has the budget for the entire proposed project period with sufficient detail been provided?	☑	☐
8. For a Supplemental application, does the detailed budget address only the additional funds requested?	☐	☑
9. For Competing Continuation and Supplemental applications, has a progress report been included?	☐	☑

PART C: In the spaces provided below, please provide the requested information.

Business Official to be notified if an award is to be made

Name: Prefix: Mr. * First Name: Thomas Middle Name:
* Last Name: Ciaraldi Suffix:
Title: Chief Financial Officer Organization: VT Dept of Health
Address: * Street1: 108 Cherry St Street 2: PO Box 70
* City: Burlington * State: T: Vermor
Province: * Country: JNITED S
* Zip / Postal Code: 05402-0070
lephone Number: 802-863-7284
E-mail Address: tciaral@vdh.state.vt.us
Fax Number: 802-865-7754

APPLICANT ORGANIZATION'S 12-DIGIT DHHS EIN (If already assigned)
[ ] – 03-6000274 – [ ]

Program Director/Project Director/Principal Investigator designated to direct the proposed project

Name: Prefix: * First Name: William Middle Name:
* Last Name: McMains Suffix:
Title: Medical Director Organization: VT Dept of Health
Address: * Street1: 108 Cherry St Street2: PO Box 70
* City: Burlington * State: T: Vermor
Province: * Country: JNITED S
* Zip / Postal Code: 05402-0070
* Telephone Number: 802-652-2008
E-mail Address: bmcmains@vdh.state.vt.us
Fax Number: 802-652-2005

SOCIAL SECURITY NUMBER

HIGHEST DEGREE EARNED

PART D: A private, nonprofit organization must include evidence of its nonprofit status with the application. Any of the following is acceptable evidence. Check the appropriate box or complete the "Previously Filed" section, whichever is applicable.

☐ (a) A reference to the organization's listing in the Internal Revenue Service's (IRS) most recent list of tax-exempt organizations described in section 501(c)(3) of the IRS Code.

☐ (b) A copy of a currently valid Internal Revenue Service Tax exemption certificate.

☐ (c) A statement from a State taxing body, State Attorney General, or other appropriate State official certifying that the applicant organization has a nonprofit status and that none of the net earnings accrue to any private shareholders or individuals.

☐ (d) A certified copy of the organization's certificate of incorporation or similar document if it clearly establishes the nonprofit status of the organization.

☐ (e) Any of the above proof for a State or national parent organization, and a statement signed by the parent organization that the applicant organization is a local nonprofit affiliate.

If an applicant has evidence of current nonprofit status on file with an agency of PHS, it will not be necessary to file similar papers again, but the place and date of filing must be indicated.

Previously Filed with: * *(Agency)* on * *(Date)*

INVENTIONS

If this is an application for continued support, include: (1) the report of inventions conceived or reduced to practice required by the terms and conditions of the grant; or (2) a list of inventions already reported, or (3) a negative certification.

EXECUTIVE ORDER 12372

Effective September 30, 1983, Executive Order 12372 (Intergovernmental Review of Federal Programs) directed OMB to abolish OMB Circular A-95 and establish a new process for consulting with State and local elected officials on proposed Federal financial assistance. The Department of Health and Human Services implemented the Executive Order through regulations at 45 CFR Part 100 (Inter-governmental Review of Department of Health and Human Services Programs and Activities). The objectives of the Executive Order are to (1) increase State flexibility to design a consultation process and select the programs it wishes to review, (2) increase the ability of State and local elected officials to influence Federal decisions and (3) compel Federal officials to be responsive to State concerns, or explain the reasons.

The regulations at 45 CFR Part 100 were published in *Federal Register* on June 24, 1983, along with a notice identifying the Department's programs that are subject to the provisions of Executive Order 12372. Information regarding PHS programs subject to Executive Order 12372 is also available from the appropriate awarding office.

States participating in this program establish State Single Points of Contact (SPOCs) to coordinate and manage the review and comment on proposed Federal financial assistance. Applicants should contact the Governor's office for information regarding the SPOC, programs selected for review, and the consultation (review) process designed by their State.

Applicants are to certify on the face page of the SF-424 (attached) whether the request is for a program covered under Executive Order 12372 and, where appropriate, whether the State has been given an opportunity to comment.

Budget Narrative File(s)

* Mandatory Budget Narrative	BudgetJustification - Vermont Restraint and Reduction SIG.doc

Add Mandatory Budget Narrative | Delete Mandatory Budget Narrative | View Mandatory Budget Narrative

To add more Budget Narrative attachments, please use the attachment buttons below.

Add Optional Budget Narrative | Delete Optional Budget Narrative | View Optional Budget Narrative

BUDGET INFORMATION - Non-Construction Programs

OMB Approval No. 4040-0006
Expiration Date 04/30/2008

SECTION A - BUDGET SUMMARY

Grant Program Function or Activity (a)	Catalog of Federal Domestic Assistance Number (b)	Estimated Unobligated Funds		New or Revised Budget		
		Federal (c)	Non-Federal (d)	Federal (e)	Non-Federal (f)	Total (g)
Alternatives to Restraint & Seclusion	93.243	$	$	$ 213,905.00	$	$ 213,905.00
2.						0.00
3.						0.00
4.						0.00
5. Totals		$ 0.00	$ 0.00	$ 213,905.00	$ 0.00	$ 213,905.00

SECTION B - BUDGET CATEGORIES

6. Object Class Categories	GRANT PROGRAM, FUNCTION OR ACTIVITY (1) Alternatives to Restraint	(2)	(3)	(4)	Total (5)
a. Personnel	$ 47,403.00	$	$	$	$ 47,403.00
b. Fringe Benefits	14,221.00				14,221.00
c. Travel	6,650.00				6,650.00
d. Equipment	0.00				0.00
e. Supplies	0.00				0.00
f. Contractual					0.00
g. Construction					0.00
h. Other	124,300.00				124,300.00
i. Total Direct Charges (sum of 6a-6h)	192,574.00	0.00	0.00	0.00	$ 192,574.00
j. Indirect Charges	21,331.00				$ 21,331.00
k. TOTALS (sum of 6i and 6j)	$ 213,905.00	$ 0.00	$ 0.00	$ 0.00	$ 213,905.00
7. Program Income	$	$	$	$	$ 0.00

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Standard Form 424A (Rev. 7- 97)
Prescribed by OMB (Circular A -102)

(a) Grant Program	(b) Applicant	(c) State	(d) Other Sources	(e) TOTALS
8. Alternatives to Restraint & Seclusion SIG	$	$	$	$
9.				
11.				
12. TOTAL (sum of lines 8-11)	$	$	$	$

SECTION D - FORECASTED CASH NEEDS

	Total for 1st Year	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
13. Federal	$	$ 53,476.00	$ 53,476.00	$ 53,476.00	$ 53,476.00
14. Non-Federal	$				
15. TOTAL (sum of lines 13 and 14)	$	$	$	$	$

SECTION E - BUDGET ESTIMATES OF FEDERAL FUNDS NEEDED FOR BALANCE OF THE PROJECT

(a) Grant Program	FUTURE FUNDING PERIODS (Years) (b) First	(c) Second	(d) Third	(e) Fourth
16. Alternatives to Restraint & Seclusion SIG	$ 213,905.00	$ 213,564.00	$ 213,777.00	$
17.				
18.				
19.				
20. TOTAL (sum of lines 16 - 19)	$	$	$	$

SECTION F - OTHER BUDGET INFORMATION

21. Direct Charges:

22. Indirect Charges:

23. Remarks: VDH agrees that no more than 10% of any grant award will be expended for administrative purpose.

OMB Approval No. 4040-0007
Expiration Date 04/30/2008

ASSURANCES - NON-CONSTRUCTION PROGRAMS

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

NOTE: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant, I certify that the applicant:

1. Has the legal authority to apply for Federal assistance and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project cost) to ensure proper planning, management and completion of the project described in this application.

2. Will give the awarding agency, the Comptroller General of the United States and, if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standards or agency directives.

3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.

4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.

5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 19 statutes or regulations specified in Appendix A of OPM's Standards for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).

6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to nondiscrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and, (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of Titles II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally-assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply, as applicable, with provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.

9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally-assisted construction subagreements.

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetlands pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clean Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended (P.L. 93-523); and, (h) protection of endangered species under the Endangered Species Act of 1973, as amended (P.L. 93-205).

12 Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.

13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).

14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead-based paint in construction or rehabilitation of residence structures.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."

18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations, and policies governing this program.

* SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	* TITLE
Completed on submission to Grants.gov	Deputy Commissioner
* APPLICANT ORGANIZATION	* DATE SUBMITTED
State of Vermont	Completed on submission to Grants.gov 5/14/07

Standard Form 424B (Rev. 7-97) Back

Other Attachment File(s)

*** Mandatory Other Attachment Filename:** Letter from Vermont MH Commissioner.pdf

Add Mandatory Other Attachment | Delete Mandatory Other Attachment | View Mandatory Other Attachment

To add more "Other Attachment" attachments, please use the attachment buttons below.

Add Optional Other Attachment | Delete Optional Other Attachment | View Optional Other Attachment

Survey on Ensuring Equal Opportunity For Applicants

OMB No. 1890-0014 Exp. 2/28/2009

Purpose:

The Federal government is committed to ensuring that all qualified applicants, small or large, non-religious or faith-based, have an equal opportunity to compete for Federal funding. In order for us to better understand the population of applicants for Federal funds, we are asking nonprofit private organizations (not including private universities) to fill out this survey.

Upon receipt, the survey will be separated from the application. Information provided on the survey will not be considered in any way in making funding decisions and will not be included in the Federal grants database. While your help in this data collection process is greatly appreciated, completion of this survey is voluntary.

Instructions for Submitting the Survey

If you are applying using a hard copy application, please place the completed survey in an envelope labeled "Applicant Survey." Seal the envelope and include it along with your application package. If you are applying electronically, please submit this survey along with your application.

Applicant's (Organization) Name:	State of Vermont
Applicant's DUNS Name:	8093761550000
Federal Program:	State Incentive Grants to Build Capacity for Alternatives to Restraint and Seclusion
CFDA Number:	93.243

1. Has the applicant ever received a grant or contract from the Federal government?

☐ Yes ☐ No

2. Is the applicant a faith-based organization?

☐ Yes ☐ No

3. Is the applicant a secular organization?

☐ Yes ☐ No

4. Does the applicant have 501(c)(3) status?

☐ Yes ☐ No

5. Is the applicant a local affiliate of a national organization?

☐ Yes ☐ No

6. How many full-time equivalent employees does the applicant have? (Check only one box.)

☐ 3 or Fewer ☐ 15-50

☐ 4-5 ☐ 51-100

☐ 6-14 ☐ over 100

7. What is the size of the applicant's annual budget? (Check only one box.)

☐ Less Than $150,000

☐ $150,000 - $299,999

☐ $300,000 - $499,999

☐ $500,000 - $999,999

☐ $1,000,000 - $4,999,999

☐ $5,000,000 or more

Survey Instructions on Ensuring Equal Opportunity for Applicants

OMB No. 1890-0014 Exp. 2/28/2009

Provide the applicant's (organization) name and DUNS number and the grant name and CFDA number.

1. Self-explanatory.

2. Self-identify.

3. Self-identify.

4. 501(c)(3) status is a legal designation provided on application to the Internal Revenue Service by eligible organizations. Some grant programs may require nonprofit applicants to have 501(c)(3) status. Other grant programs do not.

5. Self-explanatory.

6. For example, two part-time employees who each work half-time equal one full-time equivalent employee. If the applicant is a local affiliate of a national organization, the responses to survey questions 2 and 3 should reflect the staff and budget size of the local affiliate.

7. Annual budget means the amount of money your organization spends each year on all of its activities.

Paperwork Burden Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless such collection displays a valid OMB control number. The valid OMB control number for this information collection is **1890-0014.** The time required to complete this information collection is estimated to average five (5) minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection.

If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: The Agency Contact listed in this grant application package.

Appendix 1: Letters of Support

Vermont State Hospital
Retreat Healthcare
Tina Champagne (Expert Consultant on Sensory Modulation)
Vermont Federation of Families
Mental Health Law Project
NAMI-VT
VAMH
Vermont Council of Developmental and Mental Health Services
Rep. Anne Donahue
Vermont Protection & Advocacy
Vermont Psychiatric Survivors
Department of Children and Families
Sherry Burnette, Vermont Agency of Human Services, Trauma Coordinator

VERMONT

Department of Health
Vermont State Hospital
103 South Main Street, Dale Bldg.
Waterbury, VT 05671-2501

[phone] 802-241-1000
[fax] 802-241-3001
[tty] 802-241-3199

Agency of Human Services

www.healthvermont.gov

Crystal Saunders, Director of Grant Review,
Office of Program Services
Substance Abuse and Mental Health Services Administration
Room 3-1044
1 Choke Cherry Road
Rockville, MD 20857

Dear Ms. Saunders,

On the behalf of the Vermont State Hospital I commit to serve as one of the two psychiatric hospitals in Vermont to participate in the SAMHSA-sponsored initiative to reduce the incidence of seclusion and restraint among our in-patient population.

During the past few years the Vermont State Hospital has invested staff time and training in order to reduce the use of emergency involuntary procedures. The hospital has expended resources into acquiring knowledge about SAMHSA's 6 Core Strategies for creating the culture change necessary to reduce seclusion and restraint. We have created a steering committee (the Emergency Involuntary Procedures Reduction Program) and have developed a draft strategic plan to guide our progress toward our stated goals. The Vermont State Hospital has been committed to and has reduced the incidents of these procedures during the past two years. However, in order to effectively eliminate the use of these procedures, we would need additional resources to implement the plan and to create the environmental modifications necessary to ensure successful alternatives to the use of seclusion and restraint.

The awarding of these funds will not only enable the Vermont State Hospital to proceed with its strategic plan for reducing seclusion and restraint, but it will also enable us to renovate and outfit identified space for the creation of the calm-room space necessary for the use and success of sensory-based calming modalities.

Please be assured that I stand prepared to devote the organizational leadership and in-kind resources identified in the proposal necessary to create the true culture change that is necessary to make this project a success. The Vermont State Hospital is committed to the

provision of quality patient care in a safe environment that would be clearly enhanced by the success with this seclusion and restraint reduction initiative.

If you have any questions about the Vermont Sate Hospital's commitment or readiness to participate in this project, please feel free to contact me.

Sincerely,

Terry Rowe
Executive Director
Vermont State Hospital
Waterbury, Vermont 05671

RETREAT HEALTHCARE

May 11, 2007

Crystal Saunders, Director of Grant Review
Office of Program Services
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road, Room 3-1044
Rockville, MD 20857

Dear Ms. Saunders:

I am pleased to offer our commitment and enthusiasm to serve as one of the two psychiatric hospitals in Vermont to participate in the SAMHSA sponsored initiative to reduce the incidence of seclusion and restraint among our in-patient population.

The Retreat has a long standing commitment to reducing the incidence of seclusion and restraint. In pursuit of this goal, in 2005 we sent a team of managers, educators and, clinical leaders to Baltimore for the NTAC's training in the "Reduction of Seclusion and Restraint." When this group returned we created a "Restraint & Seclusion Task Force" to guide the institution in the adoption of the Six Core Strategies for the reduction of seclusion and restraint. We have invested staff time and hospital resources to acquire the necessary knowledge to adopt a trauma informed model of care. We have developed a strategic plan to guide our progress toward our stated goals and to create the environmental modifications necessary to ensure successful alternatives to the use of seclusion and restraint.

Over the past two years, the Retreat has experienced a significant downward trend in the incidence of "therapeutic holds" and has experienced only 2 "mechanical restraints" in the past year. We have not had the necessary resources to train staff in additional modalities proven effective in de-escalation which we believe would assist us in the further reduction of restraint and seclusion, particularly in our child & adolescent services.

BRATTLEBORO RETREAT
1-800-RETREAT (800-738-7328)
TDD 802-258-3770
Admissions Fax 802-258-3791

ANNA MARSH
BEHAVIORAL CARE CLINIC
802-258-3707
Fax 802-258-3758

PRIMARYLINK
800-320-5895
Fax 802-258-3749

MULBERRY BUSH
EARLY LEARNING CENTER
802-258-3422
Fax 802-258-3797

Anna Marsh Lane P.O. Box 809 Brattleboro, VT 05302 Tel 1-800-RETREAT (1-800-738-7328) Fax 802.258.3782 www.retreathealthcare.org

Receiving this award will enable the Retreat to proceed with its strategic plan for reducing seclusion and restrain by enabling us to further implement Core Strategy #4, and to renovate and outfit an identified space for the creation of comfort-room space necessary for the use and success of sensory-based calming modalities.

Please be assured that I stand prepared to devote the organizational leadership and in-kind resources identified in the proposal to support our ongoing cultural change that will make this project a success. The excellent patient care for which the Retreat has been recognized will be enhanced by the success we are prepared to demonstrate with this seclusion and restraint reduction initiative.

If you have any questions about Retreat Healthcare's commitment or readiness to participate in this project, please feel free to contact me.

Sincerely,

Robert E. Simpson, Jr., DSW, MPH
President & Chief Executive Officer

Tina Champagne, M.Ed., OTR/L
Champagne Conferences & Consultation
41 East Street
Southampton, MA 01073
Phone/Fax: (413) 527-7913
Email: tina@ot-innovations.com
Web: www.ot-innovations.com

5/8/07

To Whom It May Concern,
This is a letter of intent to verify my interest, willingness, availability and commitment to participate in the role of lead consultant with Vermont State Hospital and the Brattleboro Retreat in the seclusion and restraint reduction initiative for the proposed three-year project. This initiative requires the ability to plan, implement and foster the processes outlined in the six core strategies, as defined by the National Executive Institute for which I am a consultant and guest faculty, in addition to the application of sensory modulation, a primary and secondary prevention approach.

I have consulted with a host of mental health organizations in these areas, authored numerous publications on this subject matter, and I am involved in several inter-disciplinary research projects specific to the application of sensory modulation approaches in mental health settings. In this way, my expertise as a leader in these areas will provide the expertise necessary to move forward in this mission. It is with great pleasure that I accept the role as lead consultant, to help guide the process of culture shift across both organizations - among the leadership, staff and consumers of each organization.

Sincerely,
Tina Champagne M.Ed, OTR/L

Tina Champagne, M.Ed., OTR/L

Vermont Federation Of Families

For Children's Mental Health

May 10, 2007

Michael Hartman
Deputy Commissioner of Mental Health
Department of Health
Division of Mental Health
108 Cherry Street
Burlington, VT

Dear Deputy Commissioner Hartman,

I am very happy to write this letter in support of the Vermont Department of Health's application for the SAMHSA State Incentive Grant to Build Capacity to Implement Alternatives to Restraint and Seclusion. This letter is an easy one to write as the Vermont Federation of Families has a great interest in and is already working toward assisting schools and other Vermont programs that work with children, to create alternatives to restraint and seclusion and stronger guidelines on the use of restrictive behavioral interventions.

We offer our strong support for this grant and the opportunity it provides to develop alternatives to seclusion and restraint for children at the Brattleboro Retreat. We hope to be able to expand what is learned from these grant activities to the greater child supporting systems in Vermont

We are happy to collaborate and participate in the planning and implementation activities of the grant and look forward to serving on the grant/project steering committee.

This work is very close to our hearts as our children and those of many families we support are in need of appropriate and positive behavioral interventions and support. Working together we can accomplish so much more and in turn help individuals and families across Vermont who need and/or receive mental health support.

Sincerely,

Kathleen Holsopple

Kathleen Holsopple
Executive Director

P.O. Box 507 Waterbury, Vermont 05676-0507

(802) 434- 6757 * (800) 639-6071 Family Members only * Fax (802) 434-6741 * Email vffcmh@vffcmh.org

MENTAL HEALTH LAW PROJECT

121 SOUTH MAIN STREET
P.O. BOX 540
WATERBURY, VT 05676-0540
802-241-3222 (VOICE AND TTY)
800-265-0660
FAX 802-241-3239

OFFICES:
BURLINGTON
MONTPELIER
RUTLAND

OFFICES:
ST. JOHNSBURY
SPRINGFIELD
WATERBURY

May 9, 2007

VIA FACSIMILE & REGULAR MAIL
(802) 652-2005

Michael Hartman, Deputy Commissioner of Mental Health
Vermont Department of Health
Division of Mental Health
108 Cherry Street
PO Box 70
Burlington, VT 05402-0070
Attention: Nick Nichols

Re: SAMHSA Grant

Dear Michael:

As you know, I am the Project Director of Vermont Legal Aid, Inc.'s Mental Health Law Project ("MHLP") in Waterbury, Vermont, which provides legal representation to patients in Vermont's involuntary mental health system. Our clients include those confined to the Vermont State Hospital and the Brattleboro Retreat, which we believe historically have used seclusion and restraint excessively and improperly. For this reason we share the Vermont Department of Health's interest in developing alternatives to these practices.

MHLP has been involved in efforts to reduce restraint and seclusion for many years. In the 1980's we represented a class of patients who challenged VSH policies and practices on seclusion and restraint, and that litigation resulted in the *Doe v. Miller* settlement which continues to govern the practices of the Vermont State Hospital. Although we continue to have concerns about the implementation of this settlement agreement, I do not doubt that it had the effect of defining the circumstances in which emergency involuntary procedures may be used, reducing the use of these procedures, and formalizing the documentation and reporting of these incidents. The fact that these results have been only partially successful is what motivates us to continue to work on seclusion and restraint issues.

Several years ago the Department entered into a process to reduce the use of seclusion and restraint at the Vermont State Hospital, and MHLP was disappointed by its failure to achieve that end at that time. The concerns have not become less pressing in the ensuing years, and the fact that VSH is on the way to being closed, with its functions transferred to other facilities, suggests that it is important to make strides to reduce seclusion and restraint at VSH and then to expand those changes to the

other hospital psychiatry units in the state. The fact that these changes will require a major change in the culture of these institutions is a reason to take this action now, not a rationale for inaction.

Since we believe the development of alternatives to these practices is both crucial and long overdue, we support the Department's proposed application for a SAMHSA grant to finally bring these changes to bear. Accordingly, MHLP is further willing to agree to participate in the planning and implementation of the activities associated with the grant.

Please feel free to contact me with any questions or concerns you might have.

Sincerely,

John J. McCullough III
Project Director

NAMI – Vermont
National Alliance on Mental Illness of Vermont
132 S. Main St. - Waterbury VT 05676
Toll-free in VT: (800) 639-6480
(802) 244-1396 • (802) 244-1405 (fax)
on the web at: www.namivt.org • *email:* info@namivt.org

May 9, 2007

To Whom it Concerns,

This letter is in support of the Vermont Dept. of Health's application for a State Incentive Grant to Build Capacity for Alternatives to Restraint and Seclusion, SM-07-005. I write as the Executive Director of NAMI-Vermont, a statewide organization representing the interests of 42,000 adult consumers and family members who live with serious mental illness.

NAMI-Vermont's members have a long-standing interest in the reduction of seclusion and restraint in VT's inpatient psychiatric facilities, and thus support the state's commitment to developing additional resources and capacity in this area at VT State Hospital (VSH) and the Brattleboro Retreat. Although not involved in the selection of proposed strategies for this application, we were invited to comment on an early draft, and participated in a stakeholder meeting about this application on May 2.

We are concerned that the current draft does not reflect some of the specific suggestions we offered, including moving some of the proposed staffing from the state agency down to the local level & emphasizing the need for strong leadership at the executive level to promote cultural change. We also agree with some of the concerns raised by VT Protection & Advocacy & others about the state's failure to build upon the plans of the multi-stakeholder group convened in 2003 by SAMHSA to reduce the use of seclusion & restraint at VSH, and that hospital's slow progress towards implementing changes in these practices, pursuant to the terms of its July 2006 settlement of the recent civil rights investigation of VSH by the U.S. Dept. of Justice. Although the primary strategy that will be emphasized in this project may have clinical merit, we do not understand why the Department of Health application does not specifically reference & build upon the plans developed by the 2003 multi-stakeholder group, which were funded & informed by SAMHSA's six Core Strategies to Reduce Seclusion & Restraint.

That said, we are willing to commit to supporting this project, if funded, by encouraging NAMI members to participate in the local stakeholder groups, provided that these groups are offered a meaningful voice in informing and directing the work of this grant project. Whether or not the application is funded, we intend to continue encouraging the VT Dept. of Health to improve the training of front-line staff at the VT State Hospital and other publicly-funded psychiatric inpatient programs in effective strategies that minimize the use of inappropriate seclusion and restraint, and promote a consumer-directed, trauma-informed and recovery-oriented environment there.

Please let me know if I can provide any additional information or support to this important grant application.

Sincerely,

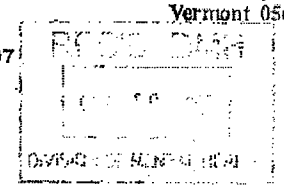
Larry Lewack, Executive Director

VAMH VAMH VAMH VAMH VAMH VAMH

Ken Libertoff, Ph.D., *Executive Director*
Amber Megrath, *Office Manager*

Vermont Association for Mental Health
P.O. Box 165, Montpelier
Vermont 05601

May 8, 2007



Michael Hartman, Deputy Commissioner
VT Dept of Health, Division of Mental Health
PO Box 70
Burlington, VT 05402-0070

Dear Michael,

The Vermont Association for Mental Health strongly endorses the grant request from the Division of Mental Health, soon to be the Department of Mental Health, for a SAMHSA State Incentive Grant to Build Capacity to Implement Alternatives to Restraint and Seclusion.

As a citizen's organization, we remain concerned about the inability of the state of Vermont to develop alternatives to seclusion and restraint for both adults as well as for children. If this grant will enable us to develop the skills, abilities and support for a better care system, then clearly this initiative is a high priority for our state.

Because the Vermont Association for Mental Health is actively engaged in many discussions about the quality of care throughout Vermont's mental health system, and much of our work has focused on the Vermont State Hospital and its shortcomings, we applaud and support the effort of the Division of Mental Health to pursue this important project. Our organization will work collaboratively and cooperatively with you on this important initiative and we look forward to making our state a national model in the reduction of the use of seclusion and restraints both for children and adults.

Sincerely,

Ken Libertoff

Ken Libertoff

Tel.: (802) 223-6263 • 1-800-639-4052 • Fax: (802) 828-5252 • www.vamh.org • E-Mail : vamh1@aol.com

Vermont Council of Developmental and Mental Health Services, Inc.

May 8, 2007

Michael Hartman, Deputy Commissioner of Mental Health
Attn. Nick Nichols
108 Cherry Street
P.O. Box 70
Burlington, VT 05402-0070

Dear Mr. Hartman,

The Vermont Council of Developmental and Mental Health Services promotes a statewide, non-profit system of developmental and behavioral health care services for individuals with developmental disabilities; serious persistent mental illness; substance abuse and severe emotional disturbance. The Council represents fifteen agencies designated by the state to provide a continuum of quality care and services in every community in Vermont.

On behalf of the Vermont Council, I am writing to support the Vermont Department of Health's application for a SAMHSA State Incentive Grant to Build Capacity to Implement Alternatives to Restraint and Seclusion. Our member agencies have a long history of reliance upon and support of the services provided at the Vermont State Hospital and Retreat Healthcare for our clients who require inpatient psychiatry. Our programs interact on a daily basis with both hospitals in the care of patients who are discharged to the community. We have a strong interest in the quality of those services that includes the goal of replacing the use of seclusion and restraint. As you know the efforts to date to achieve that goal have produced mixed results, and we see a need for the kind of resources that this grant would provide in order to identify and implement protocols for more appropriate interventions for both adults and children.

The Council requests participation in the planning and implementation activities of the grant through activities such as evaluation of current practice, review of successful practice models and workforce training.

Thank you for taking this important step toward our shared goal of improving the quality of inpatient psychiatry in Vermont.

Sincerely,

Julie Tessler
Executive Director

137 Elm Street, Montpelier, Vermont 05602 . Telephone: 802-223-1773
Fax: 802-223-6523 Website: www.vtcouncil.org

Vermont State Legislature
State House
Montpelier, VT 05633

May 4, 2007

Crystal Saunders, Director of Grant Review Office of Program Services, Division of Grants Management Substance Abuse and Mental Health Services Administration
Room 3-1044 1 Choke Cherry Road, Room 7-1097 Rockville, MD 20857

RE: Request for Applications (RFA) No. SM-07-005
Application from the Vermont Division of Mental Health

Dear Ms. Saunders:

It causes me great concern to learn that the Vermont Division of Mental Health is applying for a SAMHSA grant for Alternatives to Restraint and Seclusion. The refusal of the current administration to go beyond a superficial pretext of involving consumers in orienting the state's mental health system towards recovery, as demonstrated over the past several years, is epitomized by its attitude towards the issue of restraint and seclusion and by the process in soliciting the grant itself.

The steadfast lack of interest in cultural change by the Vermont State Hospital leadership is a virtual predetermination of failure, since administrative buy-in is fundamental to change. Key areas of concern include:

1. There was no consumer involvement in the conceptualization of this application; what did occur after the program plan application was already drafted, only occurred as a result of demand, not prior intent. The plan as proposed bypasses years of efforts and input from consumers and advocates, and opts for an "innovative intervention" that bypasses fundamentals of trauma-sensitive, recovery-oriented care urged to be addressed. The inclusion of a "comfort room" stragegy belies the fact that the legislature appropriated money three years ago for that purpose, and there is no available space in the already downsized and overcrowded environment to create a comfort room.

2. The VDH already developed an initial strategic plan for the reduction of restraint and seclusion as part of a week-long session hosted by SAMHSA in the summer of 2003 attended by a delegation of 10 persons, including administration, staff, consumers and advocates. That collaborative plan remains unused, and is replaced by a proposal developed behind the backs of those stakeholders, demonstrating a fundamental disconnect with the meaning of consumer-directed, recovery-oriented care.

3. The current VSH medical director has publically stated that he does not need a strategic plan for the reduction of restraint and seclusion because it is "in his head." As the public input summary from the after-the-fact hearing demonstrates, stakeholders believe the alternative structure he created has not been successful, yet this new initiative continues to ignore the existing input. As part of his drive for research at VSH, the proposal requires informed consent and IRB approval, which is not referenced in the application.

4. The Department of Health, Division of Mental Health, has established a repeat track record over the past several years in denying valid consumer participation.

Finally, the Brattleboro Retreat, identified as part of a joint initiative with VSH under the grant, is a private hospital, not run or funded by the state, and is thus not eligible for participation in this grant opportunity. A minimal number of its patients are ever there under the custody or care of the state.

1. Consumer Involvement in the Current Application
In the first public notice of the state's intent to pursue this application, on April 20, 2007, the Department of Health stated:
"In response to a recently released SAMHSA State Incentive Grant Request for Application (RFA), the Division is developing a proposal aimed at reducing the incidence of restraint and seclusion at the Vermont State Hospital and the Brattleboro Retreat. A ***small Division of Mental Health staff writing team has been convened to work with clinical leadership at the two hospitals*** to strategize about infrastructure and procedural changes..." (emphasis added) This is in stark contrast the the SAMHSA guildelines for consumer and family participation (Appendix G) which call for consumers and families to "be involved in substantial numbers in the conceptualization of initiatives;...identification of innovative approaches to address those needs; and development of budgets to be submitted with applications."
On Tuesday, April 24, after a challenge to the process, Deputy Commissioner Michael Hartman acknowledged that the intended process was only to solicit input on a completed draft, and that "feedback on what is already created is not the same as input at the outset of a process." He then indicated an intent to make a public meeting opportunity available; this was later scheduled for May 2, just a little more than a week before the applicantion was due, and certainly not

representing any ability to be involved in "conceptualization" regarding the initiative, or the opportunity to identify innovative approaches to address the needs.
Although the Division claimed that valuable input was received and would be incorporated, it was clear that at such a later date prior to the application deadline, this would be, at best, supplemental input into a completed concept for the purpose of attempting to create the impression of meeting the SAMHSA criteria. The Division refused to share advance work completed by the "small DMH writing team" either before or after the May 2 hearing, despite direct requests. Information identified as available to review on the Division website on April 4 regarding input received was not accessible through the web site, and written input sent to the identified DMH email address was not acknowledged as received. In short, the process for consumer involvement continued a long standing pattern of Vermont's DMH to consider it as an afterthought only, sometimes reflected in minor changes, sometimes ignored, and sometimes accepted and then later discarded without notice, as further described in section 4, below.
Furthermore, tape recorded transcripts from an earlier VSH governing body meeting indicated that a very different approach was intended, and already decided upon -- one that reflected the choice of the Medical Director (see comments below), termed a "sensory modulation program." It is this approach -- not the ignored SAMHSA principles, or the repeated input from Vermont Protection and Advocacy and consumers -- that it now proposes in its application, demonstrating its pre-selection to adopt an approach completely different from that previously developed and that has reduction of restraint and seclusion as an ancillary potential outcome only. See, e.g., definition, "The Sensory Modulation Program, when used by skilled therapists, is a useful guide for the implementation of the use of sensory approaches in general (across levels of care), and it *may also be used* in the efforts to decrease the need for the use of restraint and seclusion in mental health settings." [emphasis added] Such an approach, even if developed with "skilled therapists" in short supply at VSH, does not represent a direct plan to reduce restraint and seclusion, does not address the widespread cultural change necessary, does not require administrative change, and does not include consumer involvement. In short, the proposed plan is hierarchicaly imposed and is not responsive to the key principles reiterated by representatives of Vermont stakeholders at the May 2 hearing.
It is important to note in this regard that the governing body of the Vermont State Hospital was reconstituted under its bylaws in 2004, under different leadership, to include one seat of seven as a consumer seat, and a second seat accessible to a consumer. These two seats have been vacant for between one and two years, not for lack of applicants, but based upon a decision to withhold appointments until the administration decided whether the three community member seats were advisory or formal: a question which arose after information about the Department of Justice investigation was withheld from the public members. In the spring of 2005, the state legislature directed the question of governance to be addressed in dialogue with a planning committee for the future of VSH. Despite repeated requests, that dialogue did not begin until just a few months ago, and has not yet reached resolution; meanwhile, the seats remain empty, cutting off any formal involvement by consumers. As the only body solely responsible for supervision of VSH, this means that any planning funded by SAMHSA would be developed and implemented without consumers having any formal voice in actual decision-making. This directly violates the SAMHSA guidelines on having "consumers and family members...sit on all Boards of Directors, Steering Committees and Advisory Boards in meaningful numbers."

2. Previously Developed Srategic Plan
Regretably, a highly inclusive process already occured in 2003 to begin a strategic plan to reduce restraint and seclusion at VSH without subsequent development. A delegation of some 10 individuals attended a week-long out-of-state working seminar funded by SAMHSA for the specific purpose of planning together to learn strategies and develop a work plan. This group included a cross section of hospital staff, consumers, advocates, and members of the administration. In the four years since then, there has been regular inquiry as to what happenned to that work, but those inquiries have been ignored. It has never been further developed or implemented, despite the full collaboration and support of all involved at the time. In the intervening years, the administration directly refused to develop any written strategic plan. Seeking a grant to begin a new initiative that was not developed collaboratively in place of an existing product already funded by SAMHSA and disregarded by the state administration, would be a misguided appropriation of limited federal dollars. It is also a further demonstration of the current administration's refusal to consider consumer involvement as an importance aspect of initiation, implementation, or outcomes monitoring.
The application notes the failure to implement the 2003 initiative, but offer no explanation for why that plan is not the one being currently proposed for implementation. As noted in the lengthy reports of the Department of Justice in various reviews after the CMS decertification of VSH, fundamental skill sets and basic programming and behavioral supports are missing at VSH. Proposing a plan that bypasses first establishing practices that meet basic standards of care is like trying to build a new building on a crumbling foundation, without an effective plan in place to first repair the foundation. Most of the May 2, 2007 hearing input reflects this exact issue: fundamental issues are raised that are necessary pre-cursors for innovation; lack of adequate and trained existing direct care staff, for example, must be addressed before attempting to create yet another cycle (after repeated policy and practice revisions) of new layers of practice that are intended for highly skilled therapists (a non-existent class of staff at VSH, where basic individual therapy has never been available and where according the the DOJ, there remain an inadequate number of groups, run by inadequately trained staff.) Basic best-practice de-escalation techniques, for example, are not utilized effectively at VSH, and yet, as noted in the public input hearing, offers from Vermont Protection and Advocacy to assist in training in such techniques have not been accepted.
Chronic overcrowding is another fundamental aspect of current stressors contributing to restraint and seclusion at Vermont State Hospital. Creating "quiet rooms" is not a new concept at VSH -- it was urged by advocates for years, but even after funding was appropriated, there was no possible extra space available for such rooms, and there remains no such space. The project was put "on hold" in 2005 pending a census reduction that would free up bedroom space. That reduction has been predicted repeatedly but has never occured. In the meantime, the alternative that is available, and

that is a priority of patients and referenced by stakeholders at the May 2 hearing as well, is the opportunity to get fresh air and have time outdoors. Despite this basic, obvious human need, the administration has refused to commit to any minimum daily access to the outdoors by patients, and has refused to maintain public records on how frequently outdoor activities are cancelled due to lack of adequate staffing. In an environment such as this, the concept of offering a sophisticated new strategy defies common sense.

3. Lack of Leadership Support and Inappropriate Focus on Research

In early 2004, the new Medical Director at Vermont State Hospital was given the responsibility to coordinate planning to reduce the use of restraint and seclusion. He initiated monthly meetings which consisted almost exclusively of data gathering and refinement, revision of paperwork, and later preparatory work towards publishing a paper based upon his data gathering. The primary purpose -- as demonstrated by internal reports -- was to develop the argument that persons who were not medicated were more likely to require the use of restraints and seclusion than those who were medicated, and thus to seek more rapid access to court orders for nonemergency medication. In state-mandated annual reports on involuntary treatment, the data was used to make political recommendations for statutory changes, rather than to develop strategies for behavioral interventions with patients.

In 2005, the Medical Director informed the state Board of Health that there was no need to develop a written stragic plan to reduce restraint and seclusion, because it existed "in my head." The subsequent year, he informed the state Board of Health regarding the same issue that he would be happy to draft a written strategic plan, but he did not know what the term meant.

The current Medical Director, who is clinically responsible for this proposal and is focused on using VSH as a "petri dish" (his words) for research, has been pressing for establishing a research protocol at the hospital, but it has not yet been established. It is clear that by proposing this "sensory modulation" new initiative in lieu of existing recommended best practices, his primary intent is a research initiative. This requires informed consent on the part of patients, Institutional Review Board approval by the IRBs of both the Vermont Agency of Human Services and the psychiatric services provider, Fletcher Allen Health Care (the academic medical center where the Medical Director of VSH hold the position of Director of Public Psychiatry at the University of Vermont medical school), as required under the services contract between the state and UVM. The contract also requires stakeholder involvement and development of internal protocols and policies on informed consent before initiation of any investigational treatment practices. The current application makes no reference to these agreements, yet acknowledges an intent to be exploring a new treatment initiative under the ageis of this grant.

The Department of Justice, which brought an action against the state which is currently under a settlement agreement, identified the lack of behavioral interventions (including in regards to reducing the need for restraint and seclusion) as a problem in a number of its site reviews. The VSH administration -- its comments or acknowlegement of need in the application notwithstanding -- has refused to identify this as a need to address in its performance improvement plan. The lack of acknowledgement of a problem in this critical area suggests both a lack of true buy-in to the need for change, a lack of administrative ability to understand the need, and thus an application based upon intention to use SAMHSA funding for priorities that are not consumer-directed or directed at the necessary cultural change from the top down that is critical to the success of such initiatives.

If significant leadership at the agency and Medical Director level have demonstrated repeatedly a disinterest in serious commitment to this issue, it is highly unlikely that intentions expressed in the application are more than the words of a "writing team" that can use the right language to attempt to secure funds. Again, the depth of the lack of understanding of, and commitment to, the meanings of recovery, consumer-directed planning, and cultural change are embedded within the current leadership, as discussed in section 4. The need for evidence of a very different level of commitment to a comprehensive culture change was noted at the May 2 public hearing.

4. Administrative Disregard of Consumer-Centered and Directed Care

Change must be desired at the upper administrative level if an investment is to be productive. Over the past several years, the administration of Vermont's Agency of Human Services has shown a repeated and ongoing disregard for systems transformation that involves consumer-directed care. The traditional values of Vermont's system of care have been so diminished that an effort to integrate mental health with public health in 2004, through a common Department of Health, was reversed this year by the Vermont legislature. Following the recommendation of its Joint Legislative Mental Health Oversight Committee, a separate Department og Mental Health was restored; it was seen as the only way to allow a public voice for mental health to be restored. A small sampling of other examples of the lack of commitment to a recovery-oriented and consumer-directed system include:

a. The state is involved in a multi-year "Futures" project to replace the services currently provided at the Vermont State Hospital facility. The state legislature set out a process that included multi-stakeholder input, and in 2005, that group made several fundamental recommendations about the plan, including criteria for new inpatient facilities and support for the plan contingent upon the necessary development of expanded outpatient supports. The administration publically adopted the recommendations. Less than a year later, in its formal application for authority to expand planning money, the administration omitted one of the core principles. To this day, despite repeated written requests, the administration has refused to respond to the question of whether the changes made to the plan indicated a formal repudiation of the previously endorsed principles and criteria.

This past month, as part of the ongoing planning process, the administration introduced a new draft of four primary inpatient options. Once again, this narrow outline was produced exclusively by the administration as a product for response and reaction, rather than with consumer collaboration. Lat year, funding that was being used to enable to consumers to travel to participate in project work groups was eliminated, effectively silencing some consumer input.

In addition, instead of meeting commitments to further develop the outpatient support infrastructure to enhance least restrictive and most integrated care, this year's budget submission for the Department actually sought to eliminate two

programs that fell within the scope of areas that were part of the planned expansions integral to the project.
b. In 2006, the Vermont legislature passed new statutory language requiring that transportation of patients use the least restrictive means consistant with safety, superceding language from several years prior that had been ignored. It specifically created public policy against using mechanical restraints/shackling, directed planning to occur for alternative methods of transport than the routine use of sheriff's officers and automatic restraints, and required reporting back to the legislature. The 2007 report, incomplete though it was, suggested that little or no change had occured; did not present a strategic plan to reduce the use of mechanical restraints; and continued to reflect even young children (two in the 5 to 9-year-old age bracket) being transported to the hospital in wrist and ankle shackles with chains.
c. In late 2006, Vermont's Supreme Court ruled that the state's approach to seeking non-emergency involuntary medication orders violated state law requiring that the state to "work towards a mental health system that does not require coercion or the use of involuntary medication." The court specifically ruled that involuntary medication "is an even further intrusion on a patient's autonomy than involuntary commitment."
The court's ruling was in direct conflict with a new Department policy that has prioritized involuntary medication orders on the premise that they were less restrictive than extended hospital commitments. The court also rejected the state's view that individuals who refusal treatment that had been judged to be helpful by a physician was an automatic indicator that the decision was incompetent, supporting instead a recovery perspective that a doctor's recommendation is not a unilateral source for determining competent decision-making for medical treatment. This ruling is consistent with current medical practice, such as both the Consensus Recovery Principles under SAMHSA and the Institute of Medicine's recommendations for quality mental health care, which stress "active patient participation in the design...of patient treatment and recovery plans;" and "patient-centered participation and decision making in treatment..." [IOM, p. 12] The court chided the state for "appearing(ing) to assume that there is only one competent choice a patient could make -- to follow his doctor's advice and accept medication." In fact, it is well established among national psychiatric leadership that treatment referral as a criteria for capacity to make treatment decisions has been long discredited.
At the time of the ruling, the administration said it would "relook" at its assumptions and the "other treatment modalities" that might be available as alternatives in order to achieve greater consumer-directed care. However, to the contrary, the administration submitted a 2007 report to the legislature that articulated the Medical Director's position on increasing the use of non-emergency medication orders. It has thus far rejected the guidance of the Department of Justice which has urged more behavioral treatment supports and psychological services be available, both to enhance treatment and recovery, and to reduce the unnecessary use of restraint and seclusion. Indeed, although behavioral and psychological supports and services at VSH have been cited repeatedly as among its most significant weakness, they have received the least priority as part of any improvement plans.

Grass roots consumers in Vermont have become significantly demoralized by the disrespect for them and their insights over the past several years, with some key consumer leaders resigning from participation in the process as a result of feeling disregard for the value of their participation. As long as the current agency leadership remains unwilling to engage in open dialogue, the hospital's medical leadership remains an avowed opponent of alternatives to medication as fundamental components to reduction of restraint and seclusion and resistant to collaborative strategic planning, without objection or redirection from the governing body, any plan developed under this SAMHSA grant will be likely to be misdirected and contrary to both SAMHSA guidelines and the best interests of patients at VSH.

The Sensory Modulation Program > www.ot-innovations.com The Sensory Modulation Program (Adolescent/Adult version) was created by Tina Champagne, M.Ed., OTR/L at the request of many inter-disciplinary staff in order to help organize the components of the program into a practical and easy to use resource for staff trainings and for use as a therapist guideline. A general outline of the Sensory Modulation Program for adolescents and adults is provided on this web site and more information on this and many other related topics are available in the book Sensory Modulation and Environment: Essential Elements of Occupation (2nd Ed.). Research is currently being implemented on the effectiveness of the Sensory Modulation Program, which utilizes terminology that corresponds with the most current research available on this and related topics.

From: "Nichols, Nick" <nnichols@vdh.state.vt.us>
To: "Rebecca Buck" <rbuck@leg.state.vt.us>
Date: 3/18/2008 1:57 PM
Subject: RE: SAMHSA grant

CC: "Leach, Gary" <GLeach@vdh.state.vt.us>, "Riven, Matt" <Matt.Riven@ahs.st...
Hi Becky--Yes, the letter is from Rep. Donahue. The original letter was sent to SAMHSA, and, at Michael Hartman's request, Rep. Donahue emailed us a copy of the letter to include in the application's appendix. She did not send us a signed copy.

Nick

-----Original Message-----
From: Riven, Matt [mailto:Matt.Riven@ahs.state.vt.us]
Sent: Tuesday, March 18, 2008 1:50 PM
To: Rebecca Buck
Cc: Leach, Gary; Nichols, Nick
Subject: SAMHSA grant

Hello Becky:

You had 2 questions about the SAMHSA grant:

Q1: There is a unsigned letter in the comment-letter packet that appears to be from Rep. Ann Donahue; can we establish that it is hers? In looking at my copy of the document, I assume that it is her letter based on the table of contents for the comment-letter portion, but I cannot verify it 100%. Perhaps DMH can confirm.

Q2: If the letter is indeed from Rep. Donahue, is it the full letter, as there is no signature line? In reading the letter, it seems clear that it is the entire letter. It is 4 pages long, and the last paragraph clearly seems to be the conclusion. But again, if DMH is looking at the original, perhaps they can confirm that as well.

If DMH could please respond to Becky, with a cc to me.

Thanks,

Matt

Matt Riven
Assistant Agency Financial Operations Manager
Agency of Human Services
New phone: 802-241-1049
New e-mail: matt.riven@ahs.state.vt.us
<mailto:matt.riven@ahs.state.vt.us>

Vermont Protection & Advocacy, Inc.
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Email: info@vtpa.org

May 8, 2007

Michael Hartman
Deputy Commissioner
Vermont Department of Health
Division of Mental Health
108 Cherry Street, P.O. Box 70
Burlington, Vermont 05402-0070

Dear Michael,

Please accept this letter as responsive to your request for a letter of support from Vermont Protection & Advocacy, Inc. (VP&A) for the Department of Health's application for a **SAMHSA State Incentive Grant to Build Capacity to Implement Alternatives to Restraint and Seclusion.** VP&A can attest that there is a strong need for the State of Vermont to change its current practices and outdated attitudes towards the treatment of inpatients with mental health issues at the Vermont State Hospital (VSH). It is our belief that the institution does not even meet the legal standards of the existing consent decree that governs emergency interventions in the absence of any outside certification by CMS, or authority such as JCAHO. VP&A has worked extensively with the other 'partner' in this grant application, Retreat Healthcare, a private non-profit psychiatric facility, to reduce seclusion and restraint at that facility.

VP&A, a private non-profit agency, is Vermont's protection and advocacy system, federally funded and authorized to investigate abuse neglect and rights violations of people with disabilities. As such, we have

for years maintained a presence at the VSH, working with individual clients and trying, as well, to influence the "culture" of the institution to move away from its reliance on coercive and violent interventions to a trauma informed model of care of its vulnerable patients.

We rely on more than our own experience in day-to-day advocacy to illustrate the need for change at VSH:

- In 2002, responding to VP&A urging and her own perception of the need, then Commissioner Besio solicited consultation by "*CommunityWorks*" a social system consulting firm with expertise in the reduction of seclusion, restraint and coercion in psychiatric facilities. Their report, titled "A System Under Siege," pointed up major stressors on and in the VSH and painted a picture of an institution on the brink of major breakdown with trauma experienced by patients and staff alike.
- Two suicides in 2003 were investigated by VP&A. In both cases we found evidence of patients treated with interventions that traumatized them and which could have been factors in their demise. Both reports can be found under "VSH" at http://www.vtpa.org/Investigations%20and%20Reports.htm
- Investigation of these suicides led to decertification in late 2003 of the VSH by the Center on Medicare and Medicaid Services (CMS).
- Subsequent elopements precipitated another decertification by CMS in 2004 which is still in effect today.
- Two reports by the US Department of Justice have identified over-reliance on seclusion and restraint among other problems like poor diagnostic and prescribing practices at the VSH and pointed to a culture in need of real change.

This history and an infusion of state resources have yet to lead to real systemic change at VSH. In investigation of more than 20 incidents of emergency interventions in the last two years VP&A finds that the institution has not adhered to the most basic standards for use of seclusion, restraint and emergency involuntary medication. Our reviews of records indicate frequent violation of the Doe V. Miller Consent decree, entered in the 1980s and established as the governing standard for such interventions.

Thus VP&A supports the award of this grant insofar as it may be a tool for new leadership to actually change the direction and orientation at the institution. As the new Deputy Commissioner, we hope that you can draw on the experience and values you relied on in the community mental health system to change the VSH

from being a hold-out of another era to a facility that exhibits the humanity that has changed practices and philosophy in other states' institutions.

VP&A has seen a much greater commitment to reducing seclusion and restraint at the Retreat Health Care. We have been a partner in their efforts but have seen a number of staff changes at levels from the clinical to the management that have appeared to slow their restructuring. We would hope that the SAMHSA grant would help them to regain their very constructive momentum.

Your letter also requested our agreement to participate in the planning and implementation activities of the grant. This we will gladly do as long as these activities evidence change more profound than we have seen in the past. Your application points specifically to the Fourth of the "Six Core Strategies"; VP&A would hold that the most important of the six, and the one most needed in Vermont's current situation, is Number One: Developing leadership towards organizational change. Without that the rest will be little more than meaningless exercises.

Respectfully,

Ed Paquin
Executive Director

Cc.: Crystal Saunders, Director of Grant Review, Office of Program Services
Kimberly Pendleton, OPS, Division of Grants Management, via email
John Morrow, Ph.D., Center for Mental Health Services, via email
Substance Abuse and Mental Health Services Administration

VPS
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Psychiatric
Survivors

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email : vpsinc@sover.net

May 3, 2007

Michael Hartman
AHS/VT Dept of Health/Div of MH
108 Cherry St PO Box 70
Burlington, VT 05402-0070

To Whom It May Concern:

This letter is written in support of the grant application for SAMHSA State Incentive Grant to build capacity to implement alternatives to restraint and seclusion.
As the statewide peer program for Vermont, VT Psychiatric Survivors (VPS) is building peer leadership. VPS has support groups using Mary Ellen Copeland's Wellness Recovery Action Plan (Wrap) as the guide in both the Vermont State Hospital and the Brattleboro Retreat. Peers have also been trained in the Community Links Program that Mary Ellen Copeland and Sheri Mead developed. Peers attend conferences nationally and also have training from the National Technical Assistance Centers.
The reason I mention this is that as an organization VPS wishes to see our recovery movement expand to use our peers to assist in the purpose of this grant, specifically implementing a program as an alternative to seclusion and restraint. In order for this to occur the peer component would need as the professionals training to do the work.
There is mention of the CD "Roadmap to Seclusion and Restraint free Mental Health Services" as well as "Sensory Based Approaches" within the grant. The observation of peers is that both programs resemble much of Mary Ellen Copeland's materials.
If Vermont receives this grant, VPS is willing to:

1) commit time to find peers who wish to become both specialists and peer supporters. The idea will be to assist peers in transitioning to and from the community, provide peer support groups and explore how peer interaction can be supportive in developing the alternatives.
2) Serve on committees and boards
3) Look seriously on the issue of trauma and retraumatization

VPS is always willing to work with DMHS on pilot projects and feel we have a good working relationship.
One crucial piece will be a leader to oversee and coordinate this program at the state level but also in both pilot projects.
Sincerely,
Linda D Cory MS
Executive Director

VERMONT

State of Vermont
Department for Children and Families
Commissioner's Office
103 South Main Street, 5 North Turret
Waterbury, VT 05671-2401
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Agency of Human Services

May 7, 2007

Michael Hartman, Deputy Commissioner
Division of Mental Health
Department of Health
108 Cherry Street
Burlington, VT 05401

Dear Commissioner Hartman,

I fully support the Vermont Department of Health's application for a **SAMHSA State Incentive Grant to Build Capacity to Implement Alternatives to Restraint and Seclusion.** It is my understanding that Vermont would target the development of alternatives to seclusion and restraint (S/R) for adults at the Vermont State Hospital (VSH) and for children and adults at the Brattleboro Retreat.

The Adolescent Residential Treatment Program and the Abigail Rockwell Children's Center are of particular interest to this department. Our Residential Licensing Unit identified a number of concerns, including the use of restraint in 2003. Those concerns included both the modality used and the frequency of use.

In February 2004 a "hold" was placed on the license, preventing further admissions until a satisfactory plan to address this was developed by the Retreat Health Care and approved by licensing. While a plan was agreed upon and the "hold" was lifted on March 5, 2004, this plan has not come to fruition in a timely manner. To this day, the Retreat continues to use a restraint technique that is used by law enforcement and relies on "pain compliance". The delay in retraining all staff in the identified modality of choice has been delayed, according the Retreat Health Care, due to turnover in the administration and lack of the financial means to realize this change.

Brenda Dawson, MSW has agreed to participate in the planning and implementation activities of the grant, should the grant be awarded. Specifically, she has committed to participate on the steering committee that will oversee S/R Reduction activities at the Retreat. Ms. Dawson licenses the Residential Treatment programs within the State of Vermont for the Department for Children and Families and has been, and continues to meet with administrators at Retreat Health Care regularly.

Sincerely,

Stephen R. Dale, Commissioner
Department for Children and Families

VERMONT

Agency of Human Services
103 South Main Street
Waterbury, VT 05671-0203

[phone] 802-241-2234
[fax] 802-241-4461

Operations and Planning

Crystal Saunders, Director of Grant Review
Office of Program Services,
Substance Abuse and Mental Health Services Administration
Room 3-1044
1 Choke Cherry Road
Rockville, MD 20857

May, 10, 2007

Dear Ms. Saunders:

As the Coordinator for the Vermont Agency of Human Services Trauma Initiative, I offer my enthusiastic support for the Vermont Division of Mental Health's application for SAMHSA funds to develop alternatives to seclusion and restraint at Vermont State Hospital and Retreat Healthcare. This proposed project is timely in that it is consistent with the Vermont Agency of Human Services' commitment to develop a system of trauma-informed human services throughout the state:

The Agency recognizes the prevalence of trauma victims that access services through its' departments and offices. The Agency supports the principle that persons who have survived a traumatic event need services that are sensitive to their special needs, and that those services be provided through a trauma-informed system of care (AHS Policy on Trauma-Informed Systems of Care, 2003).

Consequently, we are increasingly aware that many of the individuals and families needing human services are victims of past trauma. Although it is at times challenging, we must be constantly vigilant about designing a system of services that recognizes the vulnerability of people to retraumatizing practices. The use of coercive seclusion and restraint measures to manage the behavior of acutely ill patients in psychiatric hospitals is invariably traumatic to the patient experiencing the coercion, other patients who witness these interventions and staff who are always observing and experiencing the reality of caring for people who may demonstrate threatening behavior.

I am honored to have been asked by Michael Hartman, Deputy Commissioner for Mental Health, to serve on a steering committee for this project. I believe it proposes an excellent process for including consumer and advocacy groups in the development of strategic plans for creating alternatives to the use of coercive and traumatic means of providing care to vulnerable people with mental illness.

I strongly support your endorsement and funding of Vermont's proposal.

Sincerely,

Sherry Burnette, Ph.D.
Vermont Agency of Human Services
Trauma Coordinator
103 South Main Street
Waterbury, Vermont 05671

TOTAL P.02

Appendix 2: Data Collection Instruments/Interview Protocols

ISRRI
Involvement and Satisfaction Questionnaire

Inventory of Seclusion and Restraint Reduction Interventions (ISRRI)

Reviewer's Guide

November 22, 2005

DRAFT: Not for distribution unless authorized by NTAC and/or HSRI
(Coordinating Center: SAMHSA Reduction of Restraint and Seclusion SIG)

U.S. DEPARTMENT OF HEALTH AND HUMAN SERV
Substance Abuse and Mental Health Services Administratio
Center for Mental Health Services
www.samhsa.gov

Table of Contents

What is the ISRRI Reviewer's Guide?

The Reviewer's Guide is designed to assist facilities and agencies in completing the *Inventory of Seclusion and Restraint Reduction Interventions* (ISRRI), a part of the common protocol for evaluation of the Substance Abuse and Mental Health Services Administration Alternatives to Seclusion and Restraint State Infrastructure Grant (SAMHSA SIG) program (referred to here as the S/R Reduction Program) that is to be completed at two points during the grant period. The Reviewers' Guide consists of guidelines, recommendations and worksheets that to produce summary scores entered into the final ISSRI form. When the information needed to complete the ISRRI has been collected using the worksheets, a scoring algorithm will be used by HSRI to convert the items on the worksheets to scores on the ISRRI.

Who should complete the ISSRI Review?

The ISRRI worksheets are designed to be completed by a representative or a team from each facility. Reviewers may be NTAC consultants, staff participating in the S/R Reduction Program, agency staff not directly involved such as Quality Improvement/Quality Assurance staff, local evaluators identified in grantee's SIG proposals, or other agency staff. Although the ISRRI is designed to minimize the necessity of subjective decisions, some degree of this is inevitably required in choosing among response options, thus creating the potential for unconscious bias, especially when the reviewer has a stake in the program's success. When feasible, therefore, the choice of reviewer should be governed by the degree to which the individual's function allows for maximum objectivity. Multiple reviews by a diverse set of reviewers is also a way of reducing bias, and identifying it when it occurs. The guide therefore is addressed to the widest possible range of reviewers (for more discussion of reviewers see Section III, below).

The Guide will supplemented by additional materials posted on the S/R reduction project website.

How should the guide be used?

Following this Introduction, Section II provides background information on the Guide, its relationship to the ISRRI final form, the S/R Reduction model on which the ISSRI is based, and plans for the future. If your interest is in guidance on how to prepare for and conduct the ISSRI, you may wish to go directly to Section III "How to Conduct the ISSRI". Section IV consists of the worksheets themselves, which will allow you to record information about the implementation of the S/R reduction initiative at your facility. Following the guide carefully will ensure consistency and reliability in ISSRI scores across facilities and among raters.

A note on terminology: Program, Intervention and Initiative

Throughout the guide, the SAMHSA S/R Reduction SIG is referred to as "the program." The best-practice model for reducing S/R implemented by the grantee sites with grant funding is described as "the intervention." Activities designed to reduce the use of S/R that are undertaken by the sites independent of, or prior to, the grant-funded intervention are referred to as "initiatives."

II. OVERVIEW

What is the ISRRI?

The ISRRI is a tool for measuring, in standardized form, the nature and extent of interventions implemented for the purpose of reducing seclusion and restraint at a particular facility. It is one of four components of the Common Protocol for evaluation of the S/R Reduction Program, the other being the Facility/Program Characteristic Inventory, the Treatment Episode Data File, and the Seclusion/Restraint Event Data File.

The ISRRI is a type of instrument known as a *fidelity scale.* Fidelity scales are developed to measure the extent to which a program in practice adheres to a prescribed treatment model. Fidelity scales are useful for explaining program impacts, identifying critical components ("active ingredients"), and guiding replication of interventions, as well as for self-evaluation and accountability. The ISRRI is a new scale developed specifically for the SIG project. It differs from some other fidelity scales in that it is designed to capture and assess the relative impact of a wide range of activities rather than an established evidence-based practice with a known set of critical components. Thus, it will serve in the development of the SIG interventions as evidence-based practices.

The ISSRI is also somewhat analogous to an *organizational readiness* checklist, such as the General Organizational Index included in the SAMHSA Evidence-Based Practice (EBP) Implementation Resource Kits[1] or Dr. David Colton's Checklist for Assessing Your Organization's Readiness for Reducing Seclusion and Restraint.[2] These differ from the ISRRI, however, in that they are broader in scope, aiming to collect a wide range of information related to readiness for organizational change, whereas the ISRRI seeks to enumerate the S/R Reduction activities that have been conducted by the facility at the time of the assessment.

What are the ISRRI Worksheets?

The worksheets included in the Guide are to be used by reviewers to obtain the information that will later be used by HSRI for scoring the ISRRI. A scoring algorithm will be used to calculate domain and overall program scores for the final ISRRI. Since the S/R project is still in a formative stage, the primary purpose of the ISRRI is to identify the components of the S/R project interventions that are most successful and also those that present more difficulties in implementation. It is expected that these sub-scale scores for the individual components will be more relevant than the overall ISRRI summary score.

It is not expected that any single facility or program will obtain a perfect score on the ISRRI, which conceptually represents the ideal intervention. For example, few if any facilities collect information on "near-misses" i.e. successful avoidance of an s/r event.

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[1] http://mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits
[2] http://rccp.cornell.edu/pdfs/SR%20Checklist%201-Colton.pdf

This is included, however, because some have noted the value of this information and indicated that such measures are under development.

What is the relationship of the ISRRI to the NTAC Six Core Strategies©?

The ISRRI is intended to be generic and developmental; that is, to be used to identify and measure the hypothesized critical elements or components of any particular seclusion/restraint reduction initiative implemented at the grantee sites, and to support their development as evidence-based practices. Thus the scale is intended to provide information about the individual importance of each of the components (domains) of S/R reduction initiatives. The components of the ISRRI are based on the NTAC Six Core Strategies for Reducing Seclusion and Restraint©, which are based on an extensive review of the literature and best practices in the field. However, the ISRRI is intended for use with other S/R reduction programs as well. For this reason, it includes some additional items in order to capture some potential seclusion/restraint reduction initiatives that may not be included in the Core Strategies, and it varies slightly from the NTAC model in how individual items are classified according to domains. Notably, some elements from the Core Strategies are group together in a separate, additional domain, Elevating Witnessing/Oversight.

What is the structure of the ISRRI?

The ISRRI consists of seven domains, representing individual components of S/R Reduction programs such as NTAC. Each domain has one or more subdomains, for a total of 24 subdomains. Each subcategory includes one to seven specific activities, referred to as items. The Worksheets are designed to facilitate the collection of information about the status of these activities. All domains and subdomains are listed on the following page.

ISRRI Domain and Subdomain Categories:

I. LEADERSHIP
- L.1 State Policy
- L.2 Facility Policy
- L.3 Facility Action Plan
- L.4 Leadership for Recovery-Oriented and Trauma-informed Care
- L.5 CEO
- L.6 Medical Director
- L.7 Non-Coercive Environment
- L.8 Kick-off Celebration
- L.9 Staff Recognition

II. DEBRIEFING
- D.1 Immediate Post-Event
- D.2 Formal Debriefing

III. USE OF DATA
- U.1 Data Collected
- U.2 Goal-Setting

IV. WORKFORCE DEVELOPMENT
- W.1 Structure
- W.2 Training
- W.3 Supervision and Performance Review
- W.4 Staff Empowerment

V. TOOLS FOR REDUCTION
- T.1 Implementation
- T.2 Emergency Intervention
- T.3 Environment

VI. INCLUSION
- I.1 Consumer Roles
- I.2 Family Roles
- I.3 Advocate Roles

VII. OVERSIGHT/WITNESSING
- O.1 Elevating Oversight

What kinds of measures are used?

The activities or individual items within the subdomains consist of a mixture of *structural* and *process* measures, as described in the classic work on quality in health care by Avedis Donnabedian. "Structural" refers to characteristics of the organization or program. Examples of structural measures are the existence of a policy on S/R reduction, a training program for S/R reduction, or the availability of sensory rooms. "Process" refers to actions that are taken in the course of providing treatment services. Examples of process measures are the number S/R events for which a debriefing was conducted as prescribed, or the number of consumers for who risk assessments were made. Process measures are often expressed as a proportion or ratio, e.g. the percent of S/R episodes for which a debriefing was conducted.

Structure and process measures are generally considered to be predictors of outcomes; that is, the degree to which structural elements and processes of care are present is expected to influence outcomes—in this context, reduction in the use of S/R. As the outcomes of the SAMHSA S/R Reduction Program will also be measured by the Evaluation Protocol, it will be possible to test the relationship of structure and process measures to outcomes.

What are the plans for future development of the ISRRI?

The use of the ISRRI for purposes of the SIG grant evaluation represents a field test of the instrument. During the course of the project it will also be reviewed by an expert consensus panel consisting of representatives of NTAC, the National Executive Training Institute (NETI) faculty, S/R Program consultants and others. The reliability and predictive validity of the ISRRI will be tested during the data analysis phase. Using the information about reliability, validity and feasibility obtained through these activities, the instrument will be revised and issued, upon completion of the SIG program as a tested Seclusion and Restraint Reduction Fidelity Scale.

III. CONDUCTING THE ISRRI REVIEW

Who should conduct the review?

Optimally, a fidelity assessment is conducted by someone external to the program or organization, but knowledgeable about relevant issues. In the case of ISRRI, however, this may not always be feasible, in which case it may be necessary for the review to be conducted by someone within the organization. In this situation, it is preferable that the reviewer at least be someone who is not directly involved in, or affected by, the S/R process or the reduction initiative. This is not a matter of ensuring honesty in reporting, but simply to avoid factors that inevitably exert an influence on responses. The ISSRI is designed to be as unambiguous and quantifiable as possible, but some degree of judgment in assigning scores is unavoidable, and the idea of external reviewers is to ensure the objectivity of that judgment.

To the same end, we recommend the use of multiple reviewers (at least two) for each facility, but again this is not likely to be feasible in all cases. However, the Coordinating Center will do all we can to support and enhance the review process. For example, some of the review can be done off-site, such as assessing policy statements and training curricula, and the Coordinating Center with the evaluator, HSRI, would be able to provide some resources for that purpose. An additional advantage of having more than one reviewer is that it will allow for testing inter-rater reliability as a psychometric property of the ISRRI.

We anticipate that, in most cases, multiple reviewers will participate, with the configuration varying by facility. The worksheets will be available on the S/R Reduction Program website and at a minimum will be completed by facility staff to provide a basic repository of implementation information. To the extent possible additional reviewers will independently assess implementation at baseline and again at one and two year follow-up intervals. These may include the technical assistance consultants, the internal evaluators identified in the site proposals, staff of NTAC and HSRI, and others. In some cases multiple reviewers may be able to collect only a part of the information required by the ISRRI. These will serve as data-cross checks to insure accuracy and completeness.

What are the sources of information for completing the ISRRI?

The following table describes the various sources for the information needed to complete the worksheets. Each item on the worksheet provides a space for noting the source of information.

Source of Information for ISRRI Worksheets	
Source	*Description*
Interviews	Consumers, consumer peer-advisors, family members, advocates, direct care staff, nursing staff, CEO, medical director, and other appropriate administrative staff) on-site or by telephone.
Direct observation	Facility tour, observation of meetings, etc.) on-site.
Documents.	State and facility level mission statements, policies and procedures schedules and records of S/R reduction activities, action plans/program descriptions such as S/R reduction, trauma-informed care, recovery-oriented or strengths-based treatment planning
Debriefing reports	Random selection of persons experiencing a S/R event
Other relevant reports	Staff and consumer injuries, etc.
Meeting records	Minutes, agendas, schedules, with participant lists; can be random selection
Training materials	Curricula, course descriptions, course evaluations, schedules, numbers of people trained, numbers eligible
Communication materials	Newsletters, handbooks, posters, etc.
MIS reports relevant to S/R reduction	Information that facilities may gather and report (e.g. other demographic or clinical characteristics).
Chart reviews	Random selection of persons

What is the measurement period?

The initial ISRRI review is to be completed for each facility's status at the beginning of the grant cycle (October, 2004), thus reflecting any S/R reduction initiatives in place prior to the grant. For those items where information is drawn from reviews of randomly selected charts and debriefing reports, the period from which these are drawn should be the month prior to the beginning of the grant cycle, i.e. September 2004. This is to ensure that these reports are representative of current practice.

In addition, the baseline inventory asks for the date of implementation for any initiative preceding the SIG grant intervention. The rationale for this information is that interventions in place for an extended period would be expected to have a greater effect on S/R reduction compared to one implemented only a short time previously. This information will help to understand why S/R rates may vary from one facility to another at baseline.

IV. ISRRI WORKSHEETS

Worksheet Layout

Organization of worksheets:
The worksheets are organized according to the domains of the S/R Reduction initiative: 1) Leadership; 2) Debriefing; 3) Use of Data; 4) Workforce Development; 5) Tools for Reduction; 6) Consumer/Family/Advocate Involvement; 7) Elevating Oversight/Witnessing.

Each of the Domain Worksheets consists of the following elements:

- Name of domain
- Separate subdomains representing specific components of the domains
- Description for domain
- Method to be used (e.g. random selection) for some items as needed
- A check list for specific items, indicating whether or not they are present or have occurred. In some cases this additionally calls for a frequency or percent of that item's occurrence
- The source of information to address the item
- A space to indicate the date of implementation or, if precise date is unavailable, the general time frame of implementation
- A space for comment on any aspect of the information or the collection process.

Template for layout of ISRRI worksheets

DOMAIN NAME: (#) Domain Component
Description:
Method for selecting information source (for some domains)
☐ **Item** (#) (For some items: Number of occurrences in measurement period: ____)
Source of information: Date:__________ *or:* ☐Less than 6 months; ☐6 months to year; ☐more than 1 year
Comment

Worksheet item response categories
It is important to note that the worksheets provide for two types of response options. In some instances, they ask for a simple yes-no check-off (example: "The facility has policy supporting the adoption of the principles of recovery"). Elsewhere, the worksheets call for a count of certain activities occurring within a specified time frame (Examples: "Number of times S/R reduction committee met in the previous year"; "During the measurement month, the number of formal debriefings held within 48 hours."). These items also have a check box which is to be checked if the activity occurred at all, and unchecked if it never occurred or is not part of the reduction intervention at that facility.

Date of implementation
In addition, items ask for date of implementation (preferred) or time period of implementation (if precise date is unavailable). The purpose of this is to determine the length of time that particular practice has been in place, and therefore the extent to which it may have contributed to current rates of seclusion and restraint.

For some types of item, for example a policy, the date would be that at which the policy was implemented. For other types of items, for example the information collected in debriefings, the date may be more difficult to determine precisely, but the response should be the date at which that practice became established: with this example, perhaps the date when the debriefing form was modified to insure that this information is collected routinely.

For the baseline inventory, the date of implementation, if any have occurred, will precede the initiation of the SIG grant project; that is, some states or facilities may have implemented some aspects of the NTAC Core Strategies prior to receiving the grant. For follow up (annual) inventories, the date will indicate at what point during the year the particular practice was put into place, and therefore the extent of its expected effect on seclusion and restraint rates (a practice implemented 11 months previous would be expected to have a greater effect than one implemented only one month previous.) Having this information allows for cross-site comparison of the effectiveness of the S/R reduction initiative, even though some sites may be further along than others in implementing the reduction strategies.

Obtaining support in completing the ISRRI

Any questions or problems in completing the worksheets should be addressed to anyone on the evaluation team at HSRI (see contact information sheet distributed by NTAC). We encourage such contact in order to insure high quality and consistency in the reviews, and will respond rapidly.

We appreciate your contribution to this important effort to assess the effectiveness of interventions to reduce the use of seclusion and restraint in facilities providing mental health treatment.

ISRRI Review Cover Sheet

Facility ID: _____

Name of Facility/Program: _____

State: _____

Start-up Date year (mm/dd/yyyy): _____

Reviewer Name: _____

Title/position: _____

Role:
☐ External Evaluator
☐ Internal Evaluator (e.g. QI)
☐ Staff external to the facility S/R program
☐ Staff part of the facility S/R program
☐ NTAC consultant
☐ Other Consultant
☐ Other (specify):_____

Phone: (____)____---_____

Date Completed ___/___/____

LEADERSHIP (1): State Policy

State DMH Office or relevant state level office directs or supports the reduction of seclusion and restraint in all state run and provider facilities

Description: A developed and communicated statewide mission statement, vision statement and/or action plan that clearly articulates the goal of the reduction of seclusion, restraint or other coercive measures; the development of systems of care that are trauma informed; and a commitment to the principles of recovery including consumer partnerships, assuring safe environments for staff and consumers, peer services and supports, the provision of hope through individualized treatment and full participation in own care; and the promulgation of rules directing or regulating the use of seclusion and restraint that restrict use for safety only and limit S/R orders in concert with CMS or more restrictively.

L.1 Leadership: State Policy	
The state has written policies and procedures that include (check if yes):	
☐	1. A Philosophy Statement (vision statement, action plan, etc.) that specifically identifies goal of reducing seclusion/restraint
	Source of information: _____ Date: __________ *or:* ☐Within 6 months; ☐6-12 mos. ☐more than 1 year
☐	2. A policy providing for a program of trauma-informed care
	Source of information: _____ Date: __________ *or:* ☐Within 6 months; ☐6-12 mos. ☐more than 1 year
☐	3. A policy providing for consumer partnerships, peer services and supports
	Source of information: _____ Date: __________ *or:* ☐Within 6 months; ☐6-12 mos. ☐more than 1 year
☐	4. A policy for ensuring a safe environment for consumers (e.g. a violence prevention program)
	Source of information: _____ Date: __________ *or:* ☐Within 6 months; ☐6-12 mos. ☐more than 1 year
☐	5. A policy providing for comprehensive individualized treatment planning process that includes the full participation of consumers in their own care
	Source of information: _____ Date: __________ *or:* ☐Within 6 months; ☐6-12 mos. ☐more than 1 year
☐	6. A policy restricting the use of S/R to emergencies that reach the level of imminent risk of harm to staff or other consumers only
	Source of information: _____ Date: __________ *or:* ☐Within 6 months; ☐6-12 mos. ☐more than 1 year
Comment:	

LEADERSHIP (2): Facility Policy

Mission statement includes commitment to S/R reduction

Description: Explicitly identifies S/R reduction as a goal or as congruent with principles such as recovery, building a trauma informed system of care, creating violence free and coercion free environments, assuring safe environments for staff and consumers, community integration, or comparable consumer-centered language.

L.2 Leadership: Facility Policy
The facility has written policies and procedures that include (check if yes): ___

☐ 1. A policy identifying S/R reduction as a goal (may be a position or policy statement, vision statement, or action plan)
Source of information: _____
Date: __________ *or:* ☐Within 6 months; ☐6-12 mos. ☐more than 1 year

☐ 2. A policy supporting the adoption of principles of recovery
Source of information: _____
Date: __________ *or:* ☐Within 6 months; ☐6-12 mos. ☐more than 1 year

☐ 3. A policy supporting a trauma informed system of care (for example, including universal trauma assessment upon admission, use of crisis/safety plans, staff training in trauma, availability of EAP services)
Source of information: _____
Date: __________ *or:* ☐Within 6 months; ☐6-12 mos. ☐more than 1 year

☐ 4. A policy providing for creation of violence- and coercion-free environments
Source of information: _____
Date: __________ *or:* ☐Within 6 months; ☐6-12 mos. ☐more than 1 year

☐ 5. A policy providing for safe environments for staff through a violence prevention approach
Source of information: _____
Date: __________ *or:* ☐Within 6 months; ☐6-12 mos. ☐more than 1 year

☐ 6. A policy providing for safe environments for consumers through a violence prevention approach
Source of information: _____
Date: __________ *or:* ☐Within 6 months; ☐6-12 mos. ☐more than 1 year

Comment:

LEADERSHIP (3): Facility Action Plan

Description: 1) Stand-alone plan for reduction, with specific goals, objectives and action steps, assigned responsibility and due dates.). 2) Process for regular review and revision. 3) Indication of senior executive oversight and review.

The facility has:

☐ 1. A stand-alone action plan for reduction that includes (check all that apply):
- ○ Policy statement
- ○ Recovery oriented programming
- ○ Trauma informed care principles
- ○ Violence and coercion free programming
- ○ Violence prevention
- ○ Goals, objectives
- ○ Action steps
- ○ Assigned responsibility
- ○ Due dates

Source of information: _____
Date: __________ *or:* ☐Within 6 months; ☐6-12 mos. ☐more than 1 year

☐ 2. A process for regular review and revision of the action plan.
Source of information: _____
Date: __________ *or:* ☐Within 6 months; ☐6-12 mos. ☐more than 1 year

☐ 3. Indications of senior executive oversight and review of the action plan.
Source of information: _____
Date: __________ *or:* ☐Within 6 months; ☐6-12 mos. ☐more than 1 year

Comment:

LEADERSHIP (4): Leadership for Recovery-Oriented and Trauma-Informed Care

Description: A program that seeks to prevent environmental or staff related triggers for conflict and that follows the principles of a system of care that is Recovery Oriented and Trauma Informed.

L.4 A. Leadership: Recovery Oriented Care
The program includes:

☐ 1. Documented evidence of consumer inclusion in their plan of care, consisting of the following (check all that apply, check box on left if any are present):
- ◎ Training on consumer roles
- ◎ Pre-treatment planning meeting with consumer
- ◎ Training on how to participate
- ◎ Consumer signature in progress notes.

Source of information: _____
Date: __________ *or:* ☐Within 6 months; ☐6-12 mos. ☐more than 1 year

☐ 2. Integrity in informed consent (check all that apply)
- ◎ Communication of risks, benefits, side effects, adverse effects, alternative treatments (all included)
- ◎ Presented in user-friendly, easy to read (non-technical) language
- ◎ Provided in coercion-free, private setting
- ◎ Questions/discussions encouraged

Source of information: _____
Date: __________ *or:* ☐Within 6 months; ☐6-12 mos. ☐more than 1 year

☐ 3. Allowance for choices (for example, Activities of Daily Living, and treatment activities)

Source of information: _____
Date: __________ *or:* ☐Within 6 months; ☐6-12 mos. ☐more than 1 year

☐ 4. Avoidance of unfair rules and regulations that do not respect individual needs and preferences (for example, enforced wake-up, eating or visiting times, mandatory participation in treatment activities)

Source of information: _____

Date: __________ *or:* ☐Within 6 months; ☐6-12 mos. ☐more than 1 year

☐ 5. Predominate use of person first language by staff (for example, in posted notices and verbal communication) (this needs definition)

Source of information: _____

Date: __________ *or:* ☐Within 6 months; ☐6-12 mos. ☐more than 1 year

☐ 6. Predominant use of common courtesies in staff to consumer communication (for example, please and thank you, hello and goodbye, asking and using preferred form of address, introductions to new people)

Source of information: _____

Date: __________ *or:* ☐Within 6 months; ☐6-12 mos. ☐more than 1 year

☐ 7. Clear expectation that all people can self-manage illness (for example, understand illness, monitor symptoms and avoid crises, understand medications and how to manage side effects)

Source of information: _____

Date: __________ *or:* ☐Within 6 months; ☐6-12 mos. ☐more than 1 year

Comment:

L.4 B. Leadership: Trauma-Informed Care
The program includes:

☐ 1. Training for staff in the prevalence and incidence of traumatic experiences in persons served

Source of information: _____
Date: __________ *or:* ☐Within 6 months; ☐6-12 mos. ☐more than 1 year

☐ 2. Use of universal trauma assessment upon admission

Recommended source of information: Chart Review
Source used (if other than recommended):
Date:__________ *or:* ☐Within 6 months; ☐6-12 mos. ☐more than 1 year

☐ 3. Integration of trauma assessment findings in treatment plans

Recommended source of information: Chart Review
Source used (if other than recommended):
Date:__________ *or:* ☐Within 6 months; ☐6-12 mos. ☐more than 1 year

☐ 4. Efforts to encourage staff attitudes, interventions and practices that promote empowerment and inclusion and that do not retraumatize

Source of information: _____
Date: __________ *or:* ☐Within 6 months; ☐6-12 mos. ☐more than 1 year

☐ 5. Access to trauma specific services when needed for persons who demonstrate trauma related symptoms

Source of information: _____
Date: __________ *or:* ☐Within 6 months; ☐6-12 mos. ☐more than 1 year

☐ 6. Access to expert consultation when needed for persons who demonstrate trauma related symptoms

Source of information: _____
Date: __________ *or:* ☐Within 6 months; ☐6-12 mos. ☐more than 1 year

LEADERSHIP (5): CEO

CEO/Administrator participation is active, routine, observable
Description: The CEO/Administrator directs the S/R reduction initiative by: 1) Participating in S/R Reduction Plan meetings; 2) Being perceived by staff as having a central role at a "kickoff" event for the rollout of the initiative; 3) Reviewing progress by means of a standing agenda item for management meetings.

L.5 Leadership: CEO
The CEO or designated leader:

☐ 1. Was present at ____ S/R Reduction Plan meetings in the past year (Enter number or zero; do not check box at left if no S/R meetings held)
Source of information: _____
Date: __________ *or:* ☐Within 6 months; ☐6-12 mos. ☐more than 1 year

☐ 2. Perceived by staff as playing a central role at kickoff
Source of information: _____
Date: __________ *or:* ☐Within 6 months; ☐6-12 mos. ☐more than 1 year

☐ 3. Reviewed progress by means of a standing agenda item for management meeting
Source of information: _____
Date: __________ *or:* ☐Within 6 months; ☐6-12 mos. ☐more than 1 year

Comment:

LEADERSHIP (6): Medical Director

Description: Present at S/R meetings, central role at kickoff event, makes rounds, reviews incidents and data at least weekly, attends debriefing, supervises staff usage

L.6 Medical Director

☐ 1. Was present at ___ S/R Reduction Plan meetings in the past year? (Enter number or zero, do not check box at left if no S/R meetings held)
Source of information: _____
Date: __________ *or:* ☐Within 6 months; ☐6-12 mos. ☐more than 1 year

☐ 2. Perceived by staff as playing a central role at kickoff
Source of information: _____
Date: __________ *or:* ☐Within 6 months; ☐6-12 mos. ☐more than 1 year

☐ 3. Participated in S/R data reviews and analysis every ___ weeks in the measurement year (Data measurement year???)
Source of information: _____
Date: __________ *or:* ☐Within 6 months; ☐6-12 mos. ☐more than 1 year

☐ 4. Attended ___ Formal debriefings in the measurement year
Source of information: _____
Date: __________ *or:* ☐Within 6 months; ☐6-12 mos. ☐more than 1 year

☐ 5. Supervised individual physician usage of S/R on at least a monthly basis
Source of information: _____
Date: __________ *or:* ☐Within 6 months; ☐6-12 mos. ☐more than 1 year

Comment:

LEADERSHIP (7): Non-Coercive Environment

Description: Current, highly visible communication about non-coercive policy to majority of staff through media such as statements in staff meetings, news letters, posters, etc

L.7 Leadership: Non-Coercive Environment
Statements supporting non-coercion issued in the past year by means of:

☐ 1. Staff meetings
Source of information: _____
Date: __________ *or:* ☐Within 6 months; ☐6-12 mos. ☐more than 1 year

☐ 2. Newsletters
Source of information: _____
Date: __________ *or:* ☐Within 6 months; ☐6-12 mos. ☐more than 1 year

☐ 3. Posters
Source of information: _____
Date: __________ *or:* ☐Within 6 months; ☐6-12 mos. ☐more than 1 year

☐ 4. Other: specify: _____
Source of information: _____
Date: __________ *or:* ☐Within 6 months; ☐6-12 mos. ☐more than 1 year

Comment:

LEADERSHIP (8): Kickoff Celebration

Description: A highly visible, well-publicized public event dedicated exclusively to promoting the reduction initiative, open to and attended by a majority of the facility staff at all levels or occasional facility "celebrations" of progress.

L.8 Leadership: Kickoff Celebration

☐ 1. A kick-off celebration has been held (check if yes)

Source of information: _____

Date: __________ *or:* ☐Within 6 months; ☐6-12 mos. ☐more than 1 year

☐ 2. Percent of facility staff attended: ___ (Do not check box, if none held)

Source of information: _____

Date: __________ *or:* ☐Within 6 months; ☐6-12 mos. ☐more than 1 year

Comment:

LEADERSHIP (9): Staff Recognition Program

Description: A formal program for regularly (monthly or weekly) public acknowledgment of the achievements or contributions of individual staff to s/r reduction or related goals such as promotion of recovery or non-coercive treatment environment.

L.9 Leadership: Staff Recognition

☐ Individual contributions to s/r reduction, recovery, non-coercive treatment publicly acknowledged ___ times in the measurement year (do not check box at left if zero)

Source of information: _____

Date: __________ *or:* ☐Within 6 months; ☐6-12 mos. ☐more than 1 year

Comment:

Worksheet 2: Debriefing

DEBRIEFING (1): Immediate Post-Event Debriefing

Description: An immediate post-event debriefing that is done onsite after each event, is led by the senior on-site supervisor who immediately responds to the unit or area. The goal of the post-event debriefing is to assure that everyone is safe, that documentation is sufficient to be helpful in later analysis, to briefly check in with involved staff, consumers and witnesses to the event to gather information, to try and return the milieu to pre-event status, to identify potential needs for policy and procedure revisions, and to assure that the consumer in restraint is safe and being monitored appropriately

Method: Review 5 reports randomly selected from measurement month. If less than 5 review all for the month, and indicate number in comment section.

D.1 Debriefing: Immediate Post-Event

- ☐ 1. Designated mid or senior level clinical staff responded no later than one hour to ____ events in measurement month. (Do not check box on left if no incidents occurred)
- ☐ 2. Immediate Post-Event analyses were held within one hour for ____ events in measurement month. (Do not check box on left if no events occurred)
- ☐ 3. Post-event analysis included direct or indirect input or documented refusal by consumer affected for ____ events in index month. N
- ☐ 4. Post-event analysis included all staff witnessing or participating for ____ events in index month.
- ☐ 5. Post event response includes attention to returning milieu to pre-crisis state
- ☐ 6. Post event response includes assessment and management of potential physical or emotional injury or trauma to consumers or staff
- ☐ 7. Post event response includes documentation staff and/or consumer reports of antecedents to event (such as conflict triggers)

Comment:

DEBRIEFING (2): Formal Debriefing

Method: Review 5 reports randomly selected from measurement month. If less than 5 review all for the month, and indicate number in comment section.
Description: A formal debriefing that occurs within 48 hours of the event or next business day and includes a rigorous analysis (e.g. root cause analysis) or rigorous problem solving procedure to identify what went wrong, what knowledge was unknown or missed, what could have been done differently, and how to avoid it in the future. The formal debriefing includes attendance by the involved staff, the treatment team, the consumer and/or proxy, surrogate or advocate representative, and other agency staff as appropriate.

D.2 Debriefing: Formal

☐ 1. Number of formal debriefings held within 48 hours or next business day (if 48 hour period falls within weekend or holiday)

☐ 2. Number of formal debriefings that were led by credentialed facilitator not involved in event

☐ 3. Number of formal debriefings that include the following: (Identify. Using the debriefing review tool, count the number of debriefings that contain each item.)

- Debriefing Checklist
- Review of assessment and treatment activities with revisions made and/or additional training or supervision provided
- Conflict triggering actions noted
- Timely response documented
- Individual safety crisis plan or other similar individualized options utilized
- Imminent danger threshold reached
- Restraint or seclusion applied safely
- Continuously monitored, face to face for restraint
- ASAP release
- Release criteria reasonable with broken or staff, not poison
- Post debriefing activities carried out
- Learning occurred and is documented
- Follow up recommendations made
- Recommended changes planned for, implemented, and assessed

☐ 4. Number of debriefings that included the following staff:

- Staff involved in event
- Treatment team or consumer involved in event
- Attending physician
- Administration representative

Comment:

Worksheet 3: Use of Data

USE OF DATA (1): Data collected

Description: Standard reports on S/R events that include specified data elements.

U.1 Use of Data: Data Collected
Standard reports include the following items (check if included):

- ☐ [redacted]
- ☐ [redacted]
- ☐ [redacted]
- ☐ [redacted]
- ☐ [redacted]
- ☐ [redacted]
- ☐ [redacted]
- ☐ [redacted]
- ☐ [redacted]
- ☐ [redacted]

Consumer Demographics:

- ☐ [redacted]
- ☐ [redacted]
- ☐ [redacted]
- ☐ [redacted]

Comment:

USE OF DATA (2): Goal Setting

Description: Using data in an empirical, non-punitive manner by identifying facility baseline, setting improving goals and comparatively monitoring use over time.

U.2 Use of Data: Goal Setting

☐ 1. Goals and current S/R rates were communicated to staff (e.g. posted, newsletters)

Source of information: _____

Date: __________ *or:* ☐Within 6 months; ☐6-12 mos. ☐more than 1 year

☐ 2. Benchmarking against self (e.g. baseline) was collected and graphed

Source of information: _____

Date: __________ *or:* ☐Within 6 months; ☐6-12 mos. ☐more than 1 year

☐ 3. Benchmarking against like or risk-adjusted others was collected and graphed

Source of information: _____

Date: __________ *or:* ☐Within 6 months; ☐6-12 mos. ☐more than 1 year

Comment:

WORKFORCE DEVELOPMENT (1): Structure

Description: The appointment of a committee and chair to address workforce development agenda and lead organizational changes in safe S/R application training, and inclusion of technical and attitudinal competencies in job descriptions and performance evaluations.

W.1 Workforce Development: Structure

☐ 1. Number of times S/R Workforce Committee (or taskforce, etc.) has met in the previous year: ____
(Do not check if no committee formed or no meetings held)
Source of information: _____
Date: __________ *or:* ☐Within 6 months; ☐6-12 mos. ☐more than 1 year

☐ 2. Evidence of human resource involvement in S/R reduction initiative (e.g. job descriptions, annual evaluations, etc.) (check if yes)
Source of information: _____
Date: __________ *or:* ☐Within 6 months; ☐6-12 mos. ☐more than 1 year

Comment:

WORKFORCE DEVELOPMENT (2): Training Program

Description: A formal program of training specifically in S/R reduction concepts and techniques, provided at least annually with competency expectations included in performance evaluations, supervisor monitoring and on-the-job mentoring. The measure is the number of people receiving specified training within the measurement year.

W.2 Workforce: Training
☐ 1. Training program in alternatives to S/R exists (check if yes)
Source of information: _____ Date: __________ *or:* ☐Within 6 months; ☐6-12 mos. ☐more than 1 year
☐ 2. Number of people in the *measurement year* receiving training in the following content areas (do not check box at left if no training occurred): Principles of recovery/resilience/strength based treatment: _____ Core therapeutic skills/relationship building: _____ Principles of trauma informed care: _____ Cultural competence: _____ Myths and assumptions re S/R: _____ Involvement of consumer as full time or part time staff members: _____ Role of peer support: _____ Source of information: _____ Date: __________ *or:* ☐Within 6 months; ☐6-12 mos. ☐more than 1 year
Comment:

WORKFORCE DEVELOPMENT (3): Supervision and Performance Review

Description: 1) On-going supervision that supports training philosophy and skill development; 2) Performance reviews that included staff competencies in S/R prevention; 3) Competency demonstrations; 4) Re-training for staff demonstrating lack of competence; and 5) Mechanisms for holding staff accountable for performance (e.g., employment counseling, performance improvement reviews, and/or termination for ongoing resistance to change).

W.3 Workforce: Supervision and Performance Review
The facility has established processes for the following (check if yes).

☐ 1. Ongoing supervision that supports training philosophy and skill development.
Source of information: _____
Date: __________ *or:* ☐Within 6 months; ☐6-12 mos. ☐more than 1 year

☐ 2. Performance Reviews that include staff competencies in S/R prevention.
Source of information: _____
Date: __________ *or:* ☐Within 6 months; ☐6-12 mos. ☐more than 1 year

☐ 3. Competency demonstrations.
Source of information: _____
Date: __________ *or:* ☐Within 6 months; ☐6-12 mos. ☐more than 1 year

☐ 4. Re-training for staff demonstrating lack of competence.
Source of information: _____
Date: __________ *or:* ☐Within 6 months; ☐6-12 mos. ☐more than 1 year

☐ 5. Mechanisms for holding staff accountable for performance (for example, employment counseling, performance improvement reviews, and/or termination for ongoing resistance to change).
Source of information: _____
Date: __________ *or:* ☐Within 6 months; ☐6-12 mos. ☐more than 1 year

Comment:

WORKFORCE DEVELOPMENT (4): Staff Empowerment

Description: The empowerment of staff includes: 1) Formal opportunity to input on rules, policies, and procedures; 2) Satisfaction surveys; 3) Formal process for administration follow-up on survey findings, 4) Process for public recognition of achievements; 5) Individualized scheduling (such as opportunities for mental health days, training days); and 6) Confidential access to EAP or comparable assistance with job-related stress.

W.4 Workforce development: Staff Empowerment
The facility provides for the following (check if yes):

☐ Formal opportunity for staff input on rules, policies, procedures
Source of information: _____
Date: __________ *or:* ☐Within 6 months; ☐6-12 mos. ☐more than 1 year

☐ Staff satisfaction surveys
Source of information: _____
Date: __________ *or:* ☐Within 6 months; ☐6-12 mos. ☐more than 1 year

☐ Formal process for administration follow up on survey findings
Source of information: _____
Date: __________ *or:* ☐Within 6 months; ☐6-12 mos. ☐more than 1 year

☐ Process for public recognition of staff achievements
Source of information: _____
Date: __________ *or:* ☐Within 6 months; ☐6-12 mos. ☐more than 1 year

☐ Individualized scheduling (such as opportunities for mental health days, training days)
Source of information: _____
Date: __________ *or:* ☐Within 6 months; ☐6-12 mos. ☐more than 1 year

☐ Confidential access to EAP or comparable assistance with job-related stress
Source of information: _____
Date: __________ *or:* ☐Within 6 months; ☐6-12 mos. ☐more than 1 year

Comment:

TOOLS FOR REDUCTION (1): Implementation

Description: The use of the following tools for the reduction of S/R: 1) Assessment of risk factors for aggression/violence; 2) Assessment of medical/physical risks for death or injury; 3) De-escalation/safety plans/crisis plans; and 4) Behavioral scale that assists in determining appropriate staff interventions that match level of behavior observed.

T.1 Tools: Implementation

The facility utilizes the following tools (check if yes):

☐ 1. Assessment of risk factors for aggression/violence

Source of information: _____

Date: __________ *or:* ☐Within 6 months; ☐6-12 mos. ☐more than 1 year

☐ 2. Assessment of medical/physical risks for death or injury

Source of information: _____

Date: __________ *or:* ☐Within 6 months; ☐6-12 mos. ☐more than 1 year

☐ 3. De-escalation/safety plans/crisis plans

Source of information: _____

Date: __________ *or:* ☐Within 6 months; ☐6-12 mos. ☐more than 1 year

☐ 4. Behavioral scale that assists in determining appropriate staff interventions that match level of behavior observed

Source of information: _____

Date: __________ *or:* ☐Within 6 months; ☐6-12 mos. ☐more than 1 year

Comment:

TOOLS FOR REDUCTION (2): Emergency Intervention

Description: Policies and procedures for emergency intervention including: 1) Medical risks factors for death or injury; 2) Assessment of risk factors for violence; 3) Safe restraint procedures that include restrictions on prone use; and 4) Safe monitoring that includes continuous observation.

T.2 Tools: Emergency Intervention

Policies and procedures for emergency intervention include the following (check if yes):

☐ 1. Medical Risk factors for death or injury

Source of information: _____

Date: __________ *or:* ☐Within 6 months; ☐6-12 mos. ☐more than 1 year

☐ 2. Assessment of Risk factors for violence

Source of information: _____

Date: __________ *or:* ☐Within 6 months; ☐6-12 mos. ☐more than 1 year

☐ 3. Safe restraint procedures that include restrictions on prone use in policy

Source of information: _____

Date: __________ *or:* ☐Within 6 months; ☐6-12 mos. ☐more than 1 year

☐ 4. Safe monitoring that includes continuous observation

Source of information: _____

Date: __________ *or:* ☐Within 6 months; ☐6-12 mos. ☐more than 1 year

Comment:

TOOLS FOR REDUCTION (3): Environment

Description: Environment of care changes implemented by facilities including: 1) Sensory/comfort rooms; 2) Avoidance of signs of coercion in posters, or other signs; 3) Evidence of signs promoting violence prevention and safe environment of care; 4) Avoidance of overcrowding (e.g. extra beds, insufficient seating in common areas); 5) Avoidance of unnecessary noise (e.g., overhead announcements, bells or buzzers, phones ringing, staffing raising voices unnecessarily); and 6) Process where direct care staff and consumers have opportunity to review institutional rules on routine basis to assure need and effect with evidence of review and resultant change.

T.3 Tools: Environment

The facility is characterized by the following

☐ 1. Sensory/comfort rooms

Source of information: _____

Date: __________ *or:* ☐Within 6 months; ☐6-12 mos. ☐more than 1 year

☐ 2. Avoidance of signs of coercion in posters, or other signs

Source of information: _____

Date: __________ *or:* ☐Within 6 months; ☐6-12 mos. ☐more than 1 year

☐ 3. Evidence of signs promoting violence prevention and safe environment of care

Source of information: _____

Date: __________ *or:* ☐Within 6 months; ☐6-12 mos. ☐more than 1 year

☐ 4. Avoidance of overcrowding (for example, extra beds, insufficient seating in common areas)

Source of information: _____

Date: __________ *or:* ☐Within 6 months; ☐6-12 mos. ☐more than 1 year

☐ 5. Avoidance of unnecessary noise (for example, overhead announcements, bells or buzzers, phones ringing, staff raising voices unnecessarily)

Source of information: _____

Date: __________ *or:* ☐Within 6 months; ☐6-12 mos. ☐more than 1 year

☐ 6. Process where direct care staff and consumers have opportunity to review institutional rules on routine basis to assure need and effect with evidence of review and resultant change

Source of information: _____

Date: __________ *or:* ☐Within 6 months; ☐6-12 mos. ☐more than 1 year

Comment:

INCLUSION (1): Consumer Roles

Description: The full and formal inclusion of consumers in a variety of roles in the organization to assist in the reduction of S/R including: 1) In key executive committees; 2) In paid staff roles with formal supervision; 3) Satisfaction surveys; and 4) Formal follow-up on satisfaction surveys.

I.1 Inclusion: Consumer Roles
The facility provides the following mechanisms for consumer input (check if yes):

☐ 1. Consumers on key executive committees
Source of information: _____
Date: __________ *or:* ☐Within 6 months; ☐6-12 mos. ☐more than 1 year

☐ 2. Consumers in paid staff roles are provided formal supervision
Source of information: _____
Date: __________ *or:* ☐Within 6 months; ☐6-12 mos. ☐more than 1 year

☐ 3. Consumer satisfaction surveys conducted and results addressed
Source of information: _____
Date: __________ *or:* ☐Within 6 months; ☐6-12 mos. ☐more than 1 year

☐ 4. Process exists for formal follow up on satisfaction surveys
Source of information: _____
Date: __________ *or:* ☐Within 6 months; ☐6-12 mos. ☐more than 1 year

Comment:

INCLUSION (2): Family Roles

(Child/Adolescent programs—skip if completing Inventory for Adult programs)

Description: The full and formal inclusion of family members in a variety of roles in the organization to assist in the reduction of S/R including: 1) In key executive committees; 2) In paid staff roles with formal supervision; 3) Participating in treatment planning meetings; 4) Satisfaction surveys; and 5) Formal follow-up on satisfaction surveys.

I.2 Inclusion: Family Roles
The facility utilizes family members in the following ways (check if yes):

☐ 1. Family members on key executive committees

Source of information: _____
Date: __________ *or:* ☐Within 6 months; ☐6-12 mos. ☐more than 1 year

☐ 2. Paid family members provided formal supervision

Source of information: _____
Date: __________ *or:* ☐Within 6 months; ☐6-12 mos. ☐more than 1 year

3. Family members are permitted to attend treatment planning meetings

Source of information: _____
Date: __________ *or:* ☐Within 6 months; ☐6-12 mos. ☐more than 1 year

☐ 4. Family satisfaction surveys conducted

Source of information: _____
Date: __________ *or:* ☐Within 6 months; ☐6-12 mos. ☐more than 1 year

☐ 5. Process exists for formal follow up on satisfaction surveys

Source of information: _____
Date: __________ *or:* ☐Within 6 months; ☐6-12 mos. ☐more than 1 year

Comment:

INCLUSION (3): Advocate Roles

Description: The full and formal inclusion of advocates in a variety of roles in the organization to assist in the reduction of S/R including: 1) In key executive committees; 2) In paid staff roles with formal supervision; 3) Satisfaction surveys; and 4) Formal follow-up on satisfaction surveys.

I.3 Inclusion: Advocate roles

The facility utilizes advocates in the following ways (check if yes):

☐ 1. Advocates on key executive committees

Source of information: _____

Date: __________ *or:* ☐Within 6 months; ☐6-12 mos. ☐more than 1 year

☐ 2. Advocates provided formal supervision

Source of information: _____

Date: __________ *or:* ☐Within 6 months; ☐6-12 mos. ☐more than 1 year

☐ 3. Advocate satisfaction surveys conducted

Source of information: _____

Date: __________ *or:* ☐Within 6 months; ☐6-12 mos. ☐more than 1 year

☐ 4. Process exists for formal follow up on satisfaction surveys

Source of information: _____

Date: __________ *or:* ☐Within 6 months; ☐6-12 mos. ☐more than 1 year

Comment:

Worksheet 7: Oversight/Witnessing

OVERSIGHT/WITNESSING (1): Elevating Oversight

Description: The leadership ensures oversight accountability by watching and elevating the visibility of every event 24 hours a day/7 days per week by assigning specific duties and responsibilities to multiple levels of staff including: 1) On-call observer competent in S/R policies and procedures and familiar with daily operations; 2) On-call supervisor; and 3) Senior staff responding to event.

O.1 Oversight: Elevating Oversight
During the measurement month the following occurred (check if yes):

☐ 1. Formal Executive oversight available on a 24 hour/7 day a week basis was available

Source of information: _____
Date: __________ *or:* ☐Within 6 months; ☐6-12 mos. ☐more than 1 year

☐ 2. On-call observer competent in S/R policies and procedures and familiar with usual and daily operations of facility/units was available. (Denotes use of senior administrator, nursing director, facility manager, clinical director, physician)

Source of information: _____
Date: __________ *or:* ☐Within 6 months; ☐6-12 mos. ☐more than 1 year

☐ 3. Formally designated on-call supervisor was identified and communicated to staff

Source of information: _____
Date: __________ *or:* ☐Within 6 months; ☐6-12 mos. ☐more than 1 year

4. Senior staff responding to event notify executive on call

Recommended source of information:
Source used (if other than recommended):
Date:__________ *or:* ☐Within 6 months; ☐6-12 mos. ☐more than 1 year

Comment:

The Involvement and Satisfaction Questionnaire

The Involvement and Satisfaction Questionnaire is a survey consisting of 10 items: 9 fixed alternative items and one open-ended comments item relating to perceived involvement and satisfaction with the consensus-building and planning process. The possible responses are on a five point Likert scale with values from 1 through 5 ('Never', 'Seldom', 'Sometimes', 'Usually' and 'Always'). Thus, higher scores indicate a higher level of perceived satisfaction and involvement.

The key issues addressed by this survey are: whether committee members felt involved in the process, did they have key information to make decisions, and were they satisfied with the team's process. To answer these questions one Overall scale and two subscales are derived from responses to the survey. The first subscale measures the respondents' perceived Level of Involvement in the planning process and committee meeting structure. The second subscale, Access to Key Information, measures participants' reported understanding of the model and ability to access the materials necessary to make informed decisions in the planning process.

Responses to the fixed alternative questions are entered directly into a computer database for analysis. The ratings for each item are regrouped according to whether they are positive or not.

The Overall scale, measuring involvement and satisfaction with the consensus building and planning process, is based on the responses to all 9 items on the survey. For a rating to be included, at least five of these questions have to be answered. The internal consistency of this scale, as measured by average inter-item correlation (Cronbach's Alpha) is .7994.

The second scale, which measured the Level of Involvement in the committee planning process in Vermont, is derived from responses to five fixed alternative questions:

1. Our team works well together.

2. Meetings are scheduled at a convenient time and place and I am able to attend.

3. When I am NOT able to attend a meeting I feel my ideas and opinions are well represented and shared with other team members.

4. In general, I feel that my opinions and ideas are asked for and considered important in the Integrated Treatment planning process.

6. My questions get answered and I am getting the information I need to participate in this planning process.

For a rating to be included, at least three of these questions have to be answered. The internal consistency of this scale, as measured by average inter-item correlation (Cronbach's Alpha) is: .5464.

The third composite measure, Access to Information, is derived from responses to three fixed alternative questions. The Items that contribute to this scale include:

5. I feel as though I have a good understanding of the Integrated Treatment Model.

6. My questions get answered and I am getting the information I need to participate in this planning process.

8. I feel that the team has a handle on the local issues and potential barriers related to adopting integrated treatment practices statewide.

For a rating to be included, at least two of these questions have to be answered. The internal consistency of this scale, as measured by average inter-item correlation (Cronbach's Alpha) is: .6737.

Appendix 3: Sample Consent Forms

To Be Developed

Appendix 4: Letter to the SSA (if applicable; see Section IV-4 of this document)

N/A

Appendix 5: Letter from the State or county indicating that the proposed project addresses a State-identified priority.

VERMONT

Department of Health
Division of Mental Health
108 Cherry Street, PO Box 70.
Burlington, VT 05402-0070
Healthvermont.gov

[phone] 802-652-2000
[fax] 802-652-2005
[tty] 800-253-0191

Agency of Human Services

May 10, 2007

Crystal Saunders, Director of Grant Review
Office of Program Services
Substance Abuse and Mental Health Services Administration
Room 3-1044
1 Choke Cherry Road,
Rockville, MD 20857

Dear Ms. Saunders

This letter is sent as notice indicating interest by the Vermont Department of Health (VDH), Division of Mental Health, in pursuing the SAMHSA grant application # SM-07-005 to reduce the use of seclusion and restraint at two locations providing inpatient psychiatric care. The decision to apply for this funding is based on the internal assessment by VDH that the next step of improvement for care at both the Vermont State Hospital, our single state operated mental health facility, and The Retreat Healthcare, a private psychiatric facility for children and adults, is to focus on this important area of care.

The Vermont State Hospital (VSH) and The Retreat Healthcare (RHC) are the primary providers of involuntary care for Vermonters, and thus are faced regularly with decisions of if or when to use seclusion and restraint as a method of control when coping with threatening or dangerous behavior. Both facilities have recognized that the occurrences of these behaviors are not unpredictable phenomena. Rather, these events have precursors, which, when recognized, offer opportunities for intervention previous to an outcome of restraint and/or seclusion. Both also recognize that such events are trauma inducing episodes that have a negative impact on patient trust of a provider, and can create new issues of loss of personal control, fear of harm, and embarrassment for both the patient being secluded or restrained as well as patients who observe such interventions.

In the past few years, VSH has struggled through periods of care compromises which resulted in increased use of emergency procedures, loss of certification on two occasions by the Center for Medicaid/Medicare Services and most challenging, the death of two patients. At this time VSH has been able to bring its rate of seclusion and restraint down to a range comparable to national averages. However, the State has yet to regain the momentum of working with consumer advocacy partners in the effort that existed as late as 2004. At that time, VSH and VDH

leadership had committed to a reduction, and were actively working with Vermont Protection and Advocacy (VP&A) and other advocates and consumers on a plan to do so. However, the events mentioned above occurred, and in the ensuing time period momentum was lost. Retreat Healthcare has not experienced the extreme challenges of VSH, but has had management changes which have slowed some important strides toward the reduction of seclusion and restraint. Similar to VSH, the RHC had also committed to change and had worked with VP&A toward a reduction of seclusion and restraint, but subsequent changes in leadership at that hospital had an impact on the momentum there as well.

Thus, as both entities have now stabilized under new leadership, the recognition of the need to continue in the direction that was set out previous to these difficulties has concretized. Vermont's commitment to recovery and self-directed care has now also gained a significant third area of concern in the area of trauma informed care, which requires a new look at the use of coercion and restraint within the system of care. Historically this commitment has been made via legislative and policy initiatives. These are reflected in two primary examples.

The first example is the commitment to addressing coercion in the system of care. As Former Commissioner Copeland stated in a 1999 policy paper (Vermont's Vision Of A Public System For Developmental And Mental Health Services Without Coercion, October 1999) regarding the position of the then Department of Developmental and Mental Health Services,

> "...we must measure the success of DDMHS's systems of care by improvements in the wellbeing of our citizens. DDMHS believes that the various forms of coercion are powerful negative forces working against us as we strive to assist citizens to enhance the quality of their lives...Put another way, we do not believe that we can achieve the highest quality of care and supports without paying close attention to the presence of coercion in its various forms in our system of care."

The paper goes on to describe a range of coercive practices, factors that may lead to coercion and ideas related to its elimination. These ideas included self-directed care, recovery education for providers, best use of informal alternatives and the use of natural supports

The second example is that of commitment by the state of Vermont to reduce involuntary procedures as an aspect of care. In 1997 the Vermont Legislature added a subsection on legislative intent in Title18 of the Judicial Proceeding Chapter 181. This states, "(c) It is the policy of the general assembly to work towards a mental health system that does not require coercion or the use of involuntary medication."

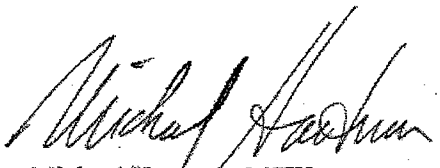
Vermont's system of care has not been able to maximize the strong support of governmental leadership and solidly establish a system without coercion as stated by the former commissioner. In fact, we have struggled to respond to demands made by VP&A and other advocates and consumers to make a strong and solid commitment to this effort. This struggle is evident in the attached letters of support by the VP&A Director, the Vermont - NAMI Director and Rep. Anne Donahue. There are clearly some differing perspectives on the work that VSH and VDH have done in this area in the past four years. It is important to acknowledge, as I believe we do in this application, that the efforts in this area have been insufficient to address the need for establishing new expectations of care and articulating appropriate interactions of staff with patients when collaboration has failed to be established. We offer these letters in our application to be clear and honest about the need for change, and to validate the views of the advocacy community.

At this time, however, the system is ready for this culture change, and will make maximum use of the SAMHSA funds to achieve this goal. The Governor, the Secretary of the Agency of Human Services and the Commissioner of Health have committed to fund and support improvements to the system of care for inpatient psychiatry. This is exhibited not only by increased funding for inpatient and community mental health services during each of the past three years, but also by the support of new residential alternatives such as the recently opened Second Spring program. This program is moving selected VSH patients out of the hospital and into an intensive level of residential care in a community setting. This residential alternative is trauma-informed, consumer centered, and works in partnership with Vermont Psychiatric Survivors to reinforce the principles of recovery based programming.

Since 1999 the Agency of Human Services and VDH have required that all ten mental health service agencies have at least 51% consumer/family representation on their corporate boards. The Agency has supported the creation of 11 consumer advisory groups for adult mental health, one at each of the ten service agencies, and one for statewide issues. In addition, since 2004 the Vermont State Hospital Futures Advisory Committee, a consumer/family/advocate/provider advisory group, has initiated planning in tandem with VDH to develop new replacement services for VSH, an institution with residential units in buildings of between 70 and 115 years old. This group has worked to create not only a preferred plan for a new hospital, but has also spawned three new community programs that now exist. In addition, the group has planned for 2 – 4 other services that will further create community-based treatment options for persons at risk of hospitalization.

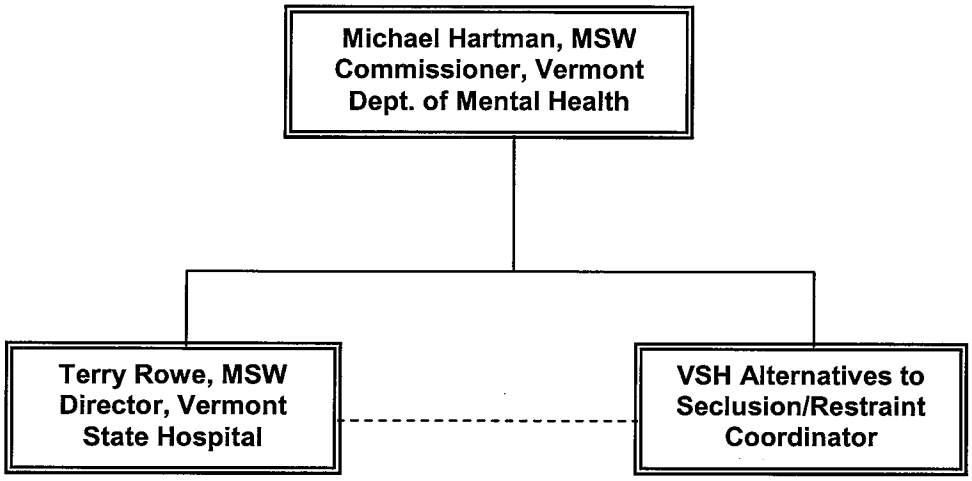
It is with this level of commitment that VDH's Division of Mental Health applies for this funding opportunity. We believe that our work in restructuring VSH and our partnership with the Retreat are of the nature that will make this project highly successful because it affords an opportunity for Vermont to make a significant move ahead in the area of highest quality patient care. We firmly believe our system to be in a state of evolution that can support and make very effective use of this funding opportunity.

Sincerely,



Michael Hartman, MSW
Deputy Commissioner for Mental Health
Vermont Department of Health
Division of Mental Health

Organizational Chart for Vermont State Hospital (VSH) Alternatives to Seclusion/Restraint Coordinator



The VSH Alternatives to Seclusion/Restraint Coordinator will be supervised by Michael Hartman, Commissioner of the Department of Mental Health, but the position will be based at the Vermont State Hospital, and so the position will also work closely with the director of VSH.