History and Scope of Organization

For over forty years, David Lawrence Center has been providing mental health and substance abuse services in Southwest Florida. Established in 1968, David Lawrence Center is a community, not-for-profit 501(c)(3) organization whose mission is to restore and rebuild lives by providing compassionate, highly skilled, affordable mental health and substance abuse services. The Center has five locations throughout Collier County providing specialized treatment programs and services to more than 15,000 individuals yearly. David Lawrence Center currently employs a staff of 235 to administer its programs and services which include:

- Crisis Stabilization Unit (Children and Adult)
- Detoxification Unit (Adult)
- Residential Chemical Dependency Services (Adult)
- Urgent Care and Emergency Services
- Medical Services
- Outpatient Services
- Community Based Services including:
  - Therapeutic Behavioral On-Site Services (Children)
  - Mental Health and Substance Abuse Case Management
  - Juvenile Assessment, Intervention and Education Services
  - Prevention and Education Services

David Lawrence Center has been accredited by the Joint Commission on Accreditation of Healthcare Organizations since 1989 and has been a longstanding member of Mental Health Corporations of America. The David Lawrence Center was also the recipient of the first Negley Award in Risk Management in 1991.

AN INTEGRATED APPROACH TO STAYING SAFE IN AN ACUTE CARE SETTING

Incidents of violence may be preventable and David Lawrence Center has been committed to creating a safe environment, implementation of best practices as related to risk assessment, and the development and implementation of risk reduction measures, especially as related to aggression and violence. The growth trend in the Acute Care setting has demonstrated an increase in admission rates by 13.22% and a 17.78% increase in incidents of aggression in the past year, suggesting increase risk of actual injury related to violence. Recognizing this increase, David Lawrence Center has taken an integrated approach in the development of violence risk reduction initiatives with focus on **Assessment, Community Collaboration, Intervention, Treatment and Therapeutic Environment.** It is notable that staff injuries associated with client aggression have been minimal with "***0***" lost work days. The Risk Management Committee continues to monitor effectiveness of these initiatives.

ASSESSMENT

The Acute Care setting at David Lawrence Center includes the Adult Crisis Stabilization Unit and the Childrens Crisis Stabilization Unit. Every individual admitted to the Acute Care setting is assessed for risk of violence as part of the, Clinical Assessment, Nursing Assessment, and Psychiatric Evaluation which are all completed for every admission. Examples of questions on the Assessment that prompt for assessment of violence includes: *"History of physical aggression?, Recent physical aggression? and Access to weapons?"* Risk factors considered in the assessment process include: gender, previous violence, history of childhood trauma, demographics (i.e. socioeconomic status), diagnosis to include Axis II antisocial behaviors, presence of command hallucinations to hurt others, violent thoughts and presence of anger.

Access To Means **-** As part of the Center's standards for assessment, treatment and discharge planning, policies are in place that require inquiry by the assessing Clinician, Psychiatrist, and Discharge Planning Clinician as to access to any means of harming self and/or others. In addition, local law enforcement officers implement removal of weapons and document this practice routinely in their involuntary documentation statements during a law enforcement initiated admission. Additionally, throughout treatment, the Discharge Planning Clinicians are required to further address risk and access to means, including obtaining collateral information via caretakers, family members, and/or other involved parties,

assisting to evaluate safety in the home and community with a special focus on access to weapons. The practices include documenting the safety plan and actions taken to ensure any access to weapons has been eliminated prior to discharge and this is included as an indicator that is part of the Discharge Summary progress note template. (See attachment # 1)

COMMUNITY COLLABORATION

Collier County shares a very special and effective partnership with local law enforcement with a formal commitment to ensuring the safety of the community. The local law enforcement agency has representation on the David Lawrence Center Board of Directors and participates in quarterly meetings to address best practices for assessing and reducing risk as related to violence/aggression among other factors. Since 2007, David Lawrence Center has partnered with NAMI and local law enforcement in the development and implementation of a proven model of a Crisis Intervention Training (CIT) certification of law enforcement officers. (See attachment #2). Since 2008, David Lawrence Center has hosted seventeen (17) CIT training site visits and provided well over 100 hours of specialized mental health training to law enforcement officers as part of this program. David Lawrence Center's role in the training includes signs and symptoms of mental illness, signs and symptoms of substance abuse, Baker Act (Florida Mental Health Act), and Community Resources training (See attachment #3). Through this collaborative process, the agency recognizes the role of CIT trained officers as first responders in situations where aggression and violence due to mental health and substance abuse issues requires a specialized approach. When indicated, a trained CIT liaison is part of the treatment team for specialized community- based clinical staffing, assisting to ensure the safest and most therapeutic approach to clients with histories of violent/aggressive behaviors. In addition, CIT liaisons and Supervisors share emergency contact numbers and have direct access to one another 24/7 for safety planning and integrated approaches to address safety concerns. The details and testimony to the effectiveness of this process is shared in the letter provided in Attachment #4.

INTERVENTION

Risk Reduction Strategies and Safety Planning: The Center's practices and policies recognize that including and addressing treatment team observations and input is critical. These practices include behavioral health technicians, nursing, clinician and psychiatrist provision of daily and ongoing

assessment, recognizing that client statements versus behaviors observed in the milieu are critical in the assessment process. A prior history of aggression, violence towards others, substance abuse/co-occurring problems, and anti-social personality traits are all key indicators which are incorporated into the various agency assessment tools. Risk Reduction interventions also include scheduling family/significant other meetings with both the psychiatrist and discharge planning clinician. Appropriate prescribing of medications and stressing the benefits of medication treatment, risk of non compliance and risk associated with inappropriate use of medications are all part of the treatment planning process. David Lawrence Center best practices also recognize that there is greater risk for aggression and violence when a co-occurring diagnosis is present. Additionally, consistent and persistent education of the client and significant others as to the identified risk factors, and specifically the safety concern(s) associated with aggression and violence are clearly and directly discussed with all appropriate parties and documented, along with the recommendations from the team as to how to reduce and address these risks and concerns. David Lawrence Center's best practices for discharge planning include addressing the specific recommendations, clarifying the essential services, and includes safety planning, care taker involvement, crisis support, and both telephone and face to face outreach via short term resource coordination/case management, as well as wellness checks post discharge, provided on the same day and/or as needed, sometimes daily, until the follow up outpatient appointment. Wellness checks may include having a trained CIT officer go to the client's home for support and further observation and to ensure the safety of the client and others and include communication with CIT officers regarding history of aggression/violence.

TREATMENT

Special Procedures – From the time of initial client assessment and engagement, staff are trained to identify prior history and/or current risk factors for aggression. This often begins with official communication from CIT/local law enforcement officers that a client has a history or is currently exhibiting aggressive behaviors and/or making threats to hurt others. Communication from local law enforcement prior to admission, while on the way to the mental health receiving facility, are among the effective practices that have been formalized through collaboration with the local law enforcement. Through the assessment and communication process, staff may implement special precautions among the following

levels of observation: one to one, line of site, 15-minute face to face observations, assault precautions or close observations. (See attachment #5) Staff receive communication of the special precautions through physician orders and written and visible alerts are placed on the client information/communication board and walking rounds/observation logs, which are easily visible to staff. Additionally, verbal and written hand-off communication is utilized from shift to shift. Another important practice is that nursing staff considers history and presenting symptoms/behaviors in the determination of appropriate room assignments. Clients with a history of violence/aggression may require more specialized care such as a private room to decrease stimulation and timely offering of appropriate medications. These practices are all part of the existing standards of care.

Special Training Programs - David Lawrence Center has developed a training program that is uniquely designed to target the needs of the population served with the goal of preventing episodes of aggression and improving safety for staff and clients. The training program, C.A.R.E.S. (Communication, Assistance, Respect, Empowerment and Safety) consists of the following components Basic, Comprehensive, Residential Strategies, Special Treatment Procedures (Seclusion, Restraint, Medical Risks) and Sexual Abuse and Trauma. Training compliance rates have consistently exceeded the established target of 90%. C.A.R.E.S. Training content is described in attachment #6.

Safety alerts – David Lawrence Center utilizes "Safety Alerts" as a means of communicating potential threats to staff or persons on the property of David Lawrence Center. Safety alerts include information about the individual, photo when available, as well as the safety plan including notification of 911. Safety alerts are shared through the collaboration with law enforcement which would provide enhanced law enforcement presence on the property in case of an actual event.

ENVIRONMENTAL

David Lawrence Center believes that environmental factors are considered a critical component of violence reduction and that a safe environment can also appear warm, inviting and therapeutic. Access to care and the admission process for individuals in crisis have been designed with the understanding that individuals presenting for services are potentially going to exhibit aggression and violent behaviors. Therefore, the Center remodeled its Emergency Services and Involuntary admission department to include the designation of a distinguished entry way and admission area that also offers enhanced

security and privacy. All assessment and admission areas have visibility so staff or clients are not outside line of vision of other staff. Other environmental enhancements have included use of anti ligature plumbing, lighting fixture coverings, and appliance coverages to reduce availability of items that could be used as weapons. State of the art furnishings include rounded edge furniture and tamper proof hardware. (See attachment #7). In addition the safety practices relating to search and contraband were enhanced during the last year to include use of hand held metal detector devices and a walk through metal detector is current being installed. (See attachment #8). The camera / surveillance system was also expanded with enhanced software to allow desktop monitoring and history files available to Supervisory staff for safety monitoring and incident investigation purposes. Other environmental enhancements include implementation of an emergency alarm system that is available in office locations and portable radios used to facilitate back up from staff from other areas as needed.

Related State Laws / Duty to Protect / Alternative Outpatient - According to Florida Statute 394, The Florida Mental Health Act, information from the clinical record may be released in the following circumstances: *"When a patient has declared an intention to harm other persons. When such declaration has been made, the administrator may authorize the release of sufficient information to provide adequate warning to the person threatened with harm by the patient."*

Prior to making the determination that notification of threat should be made, a clinical multi-disciplinary staffing involving licensed healthcare providers with physician input takes place to outline the criteria and reasons why notification is justified. The client is made aware of the concerns and the notifications and why these are taking place, in addition to evaluating the client's response. Factors that are taken into consideration include, prior history, collateral information, intent, means, co-occurring diagnosis, prior legal consequences to violence, client insight, judgment, support systems, and existence of coping skills.

In conclusion, we believe that this collaborative and integrated approach to "staying safe" in an acute care setting has been effective in reducing client and staff injuries relating to violence. A case presentation is attached as evidence of the effectiveness of this integrated approach to staying safe in an Acute Care setting. See attachment #9.

DAVID LAWRENCE CENTER

Mental Health & Substance Abuse Services

Attachments

Attachment # 1 – Acute Care Progress Note Template

Attachment # 2 – Naples Daily News Article, February 4, 2007

Attachment # 3 – Crisis Intervention Training Curriculum

Attachment # 4 – Letter of Collaboration, Collier County Sheriff's Office

Attachment # 5 – Procedure CLN-42, Special Precaution and Client Observation Guidelines and Procedures

Attachment # 6 – DLC CARES Training Outline

Attachment # 7 – Emergency Services area unit photo

Attachment # 8 – Procedure ACS-306, Maintenance of Safety Standards/Search and Seizure/Contraband

Attachment # 9 – Case Presentation

Attachment # 1

Acute Care Progress Note Template

Progress Note
For Client ID:
For Recorded Service Dates of:

Service Description	Start Date/Time	End Date/Time	Provider Name	Electronic Signed By:	Delivery Method	Place of Servic
Crisis Stabilization					Discharge Date:	

Discharge Planning / Note

Narrative:

RESOURCE COORDINATOR DISCHARGE SUMMARY NOTE

Discharge Placement:

Summary of Caretaker/Supports or rationale for lack of involvement:

Discharge Recommendations:

Essential Services:

Appointment dates/times/locations:

Interventions and Discharge Education:

Does the client have access to weapons?

Address Suicidal/Homicidal Risk Safety:

Attachment # 2

naplesnews.com
Printer-friendly story
Read more at naplesnews.com

Looking for a better way to serve the mentally ill

Mental health leaders, Sheriff's Office attempting to create new crisis intervention team

By RYAN MILLS

Sunday, February 4, 2007

The bang, bang, bang begins just after a visitor steps into the 26-cell medical infirmary at the Collier County jail.

In a cell to the right is a naked man with a flabby midsection, jumping up and down on his bed and pounding on the walls. Members of the jail staff attempt to calm him down, then explain that this particular inmate has a habit of getting excited and masturbating when new people enter the infirmary.

He also has a tendency to write his name on the cell walls with his own feces. Jail staff call this man a "frequent flier," because he's been in and out of the jail for years.

The walls in the jail are painted a pristine white, and a soap dispenser on the wall is telling of a place where cleanliness is of the utmost importance. Most inmates stand or sit at the acrylic glass doors of their cells and stare blankly at anything happening on the other side. For most a deputy walking by or shuffling paperwork is the most entertaining thing they've seen in days, if not weeks.

Seven cells around the corner hold about 15 men and women draped in blue smocks — with no zippers or laces — who are on "strict suicide watch." One man, with a frothy wound around his neck from a recent suicide attempt, inquires as to why he's not allowed outside. Another man, who recently tried to kick out the door to his cell, is shackled to his bed.

The floors inside the claustrophobic cells are shiny and polished. On one side of the cell is a simple toilet and sink, and on the other side is a small cot and mattress. Inmates on suicide watch have no personal items inside their cells, except, possibly, a Bible.

No one is certain how many of the 1,135 inmates at the jail suffer from mental illness, but Chief Scott Salley estimates that the number could be anywhere from 2 to 25 percent. Many of those people, authorities say, don't belong in jail and would be better

served in a mental health facility.

It's a problem that plagues jails across the state, Salley said.

"We're the largest facility for the mentally ill in Collier County," Salley said. "There are people with mental illness that should not be in jail."

In an attempt to help clear the jail of excessive numbers of mentally ill inmates, and to better serve the mentally ill clients that deputies encounter on a regular basis, the Collier County Sheriff's Office is attempting to create a new crisis intervention team, or CIT, on its staff.

The CIT program, Salley said, is a partnership — or bridge — between the Sheriff's Office and the mental health agencies in Collier County in which a team of deputies will be trained with specific skills in how to deal with people who suffer from mental illnesses such as schizophrenia, bipolar disorder, depression, anxiety disorder and panic disorder.

Many of the people who ordinarily would be arrested and sent to jail instead will be taken to the David Lawrence Center where they will receive the treatment they need, organizers say.

"The CIT concept is one that will provide law enforcement with more training in how to identify mental illness issues prior to them becoming a problem and identify a person with mental illness after being called to a complaint," Undersheriff Kevin Rambosk said. "How to de-escalate the problem as opposed to escalate it."

The cost to staff and run the infirmary are significant. Six Collier sheriff's deputies staff the infirmary 24 hours a day, seven days a week, Salley said. Two deputies are required to sit and keep an eye on the suicide watch inmates at all times and record their movements on a paper log every 15 minutes.

On the day after Christmas, Deputy Heather Garduza sat patiently in a chair, watching the inmates' every movement.

"There are a lot of mental health issues and it seems there's nowhere to place these people," Garduza said. "It's sad to see them in this position because there are issues they need help with and unfortunately this isn't the place to give them the help they need."

Building a CIT team

Though the CIT model is new to Southwest Florida, it was first devised almost 20 years ago in Memphis, Tenn.

The Memphis Police Department established the first CIT team in 1988 after a police

shooting left a 27-year-old mentally ill man dead. After implementing the program, Memphis police reported that the number of people officers were putting in jail plummeted and the officer injury rate decreased.

"When we were doing statistics early on we started seeing a significant decrease in the number of people going into the criminal justice system," said Maj. Sam Cochran, the CIT coordinator for the Memphis Police Department.

Since then the CIT model has been praised nationally and has been copied by law enforcement agencies across the country. In Florida, CIT programs have been developed in a number of cities and counties, including Orlando, Jacksonville, Fort Lauderdale, Daytona Beach and Seminole County, north of Orlando.

"It has grown so rapidly and so fast," Cochran said. "We're estimating anywhere from 500 and 600 communities across the country. Chicago would be our largest CIT program. ... It's a movement that is changing and does work, but you have to make sure the community involvement is there."

Kathryn Leib Hunter, executive director of the National Alliance on Mental Illness of Collier County, or NAMI, said her organization first discussed the CIT model with the Sheriff's Office just before the terrorist attacks of Sept. 11, 2001.

The issue fell to the wayside for a few years while Sheriff Don Hunter focused on Homeland Security issues, but in November 2004, Leib Hunter said, NAMI started training 911 dispatchers.

"Our philosophy is we would prefer treatment over incarceration," Leib Hunter said. "One of the myths that we dispel is that a person with a mental illness is more likely to be a victim of a crime than to commit a crime."

CIT training typically calls for a specialized 40-hour training session for select personnel, but the Collier Sheriff's Office decided to take a somewhat different approach, Rambosk said. In January 2006, the Sheriff's Office started providing all road patrol deputies with a two-hour mental health training session.

Those training sessions are ongoing.

The Sheriff's Office also started recruiting deputies who would be interested in the full 40-hour training session. Currently eight deputies have received the full training. Rambosk said he would like to eventually build a 126-member team that would allow for two CIT deputies to be on duty 24 hours a day, seven days a week, at all five Sheriff's Office substations in Collier County.

The CIT deputies would be first responders to any scenario involving a mentally ill person, authorities said.

"It is our intent to continue to train as many officers as we are able to," Rambosk said.

But training deputies can be expensive.

So far, all eight deputies that have been trained in CIT have traveled to Orlando. Though the training, which is conducted by NAMI at a mental health hospital, is free to attend, the costs to the Sheriff's Office are significant, Rambosk said. Not only does the Sheriff's Office lose a deputy for a week, but it also has to pay for travel to and from Orlando, a hotel and per diem expenses for the deputy.

Rambosk said it can cost almost $2,000 to send a deputy for a week.

"It's labor intensive, and anything that is labor intensive costs a lot of money," Rambosk said. "We're looking down the road and we're going to base it on what's needed in our community. We all know it's important."

One solution, Leib Hunter said, would be for NAMI personnel to hold regular training sessions at its offices at 5020 U.S. 41 N. in Collier County.

"If we can get the cooperation and the dedication that they will supply the officers to come to the training, we will do it," she said. "We have the tools and we have the resources."

Leib Hunter said she would like to see at least 25 deputies trained by the end of 2007.

"It's going to be a process," she said. "We don't expect to have 120 people trained in two months."

The CIT model recently has been implemented by law enforcement in Lee County as well, said Ann Arnall, deputy director of Lee County Human Services.

Since May 2005, 31 members of the Fort Myers Police Department, 25 members of the Lee County Sheriff's Office, four port authority officers and three officers from Florida Gulf Coast University have received CIT training in local NAMI training sessions.

"There has been a definite decrease in arrest rates of people with mental health and substance abuse issues," Arnall said. "They've reduced the chance of arrest for people that are having some sort of behavioral health crisis by 63 percent after training."

Not just a law enforcement program

There is more to the CIT model than simply training deputies in how to deal with mentally ill people and assess their needs. If deputies determine that a person they encounter needs to go to a mental health center instead of to jail, there must be a place to take them.

The David Lawrence Center is the only Baker Act receiving facility in Collier County, meaning it is the only place in the county where people can be held involuntarily until they can be evaluated, CEO David Schimmel said. The center only has 14 adult beds, Schimmel said.

"To make crisis intervention training effective, you need to be able to take them and hold that individual for 12 hours to screen and evaluate them," Schimmel said. "Seventy percent of the time we're overcrowded and we could have as many as 19 people in a 14-bed unit."

But Schimmel said the David Lawrence Center is trying to expand. His staff recently requested $2 million from the state Legislature for new construction and extra operations.

"We would like to take those beds and expand them to 24 beds and then to 30 beds," Schimmel said.

The state currently pays for eight of the center's beds, with the rest paid for by the Department of Children and Family Services, Collier County government, donations and client fees. Many clients don't have money to pay for their own services, Schimmel said.

The center also needs to add more caseworkers and longer-term treatment options such as group homes or a halfway house, Schimmel said.

Florida is ranked near the bottom of the country when it comes to spending money on mental health services, Schimmel said. The problem started in the 1950s and 1960s, authorities say, when many of the state mental hospitals were closed, and the problems were passed on to local municipalities.

"We've started the training, but now the ball is in our court and we need to expand the Baker Act receiving facility and add some support services so we can deal with the increased volume of admissions," he said.

In the long run, financially supporting the CIT program and expanding the David Lawrence Center will be cost-effective for the county, and a better solution for mentally ill patients in the county, Schimmel said.

"From a taxpayer's perspective, if we don't do this we're going to be building more county jails, and that's very expensive," Schimmel said. "We want to do everything we can to make sure the people in jail are the people who need to be in jail. ... It's going to make sense in the long run financially and its going to make sense in helping someone overcome their illness."

The CIT program cannot work properly unless the mental health facilities are fully supported, said Cochran of the Memphis police.

"This cannot be a law enforcement program. This has to be a community program," he said. "People get fixated on the training of police officers and miss that this is a community approach. ... It does involve tax dollars, but you're going to pay one way or another."

CIT in action

For the past five years, Cpl. Mike Nelson, a community policing deputy in East Naples, has been working with many of the people who make up Collier County's homeless population. Many within that population suffer from some sort of mental illness, Nelson said.

In September, one of Nelson's superiors explained the CIT program to him and asked him if he'd be interested in going through the 40-hour training. He jumped at the opportunity.

"It actually changed my whole way of dealing with people and talking with people," Nelson said. "It gave me a new way to approach things."

For instance, Nelson said that when dealing with someone who is being hostile, one of the first things he now asks the person is when the last time was they took their medication.

"They'll tell you I got off my meds a couple months ago because I didn't like the side effects," he said. "It's a way of asking without putting them in a box ... of having a mental illness."

Nelson said he also learned not to feed a mentally ill person's delusions and to empathize with the people he encounters.

"You don't make fun of a cancer patient, but everyone thinks its OK to joke about someone with a mental illness," Nelson said. "If you approach them in that manner, they're going to shut down."

Being a CIT officer isn't for everyone, Cochran said.

"We recognized that the CIT officer was a special kind of individual," Cochran said. "It was not just for everybody. It requires a certain heart to be at this level."

Nelson said the CIT model isn't soft on crime, because the people who need to be in jail will be in jail, mental illness or not. The real purpose of CIT, Nelson said, is treating people the way they need to be treated and understanding the root cause of the problem at hand.

"It's in no way a get-out-of-jail-free card," Nelson said. "It's just another set of tools to work with the public at large. It's a different way of communicating and understanding

what might be going on with people that we deal with."

Mike Cipriano, 40, the co-manager of the Sarah Ann Drop-In Center in East Naples, said the CIT program is much needed and overdue in Southwest Florida. Every day, the Sarah Ann Drop-In Center provides services to 15 to 25 people who suffer from some sort of mental illness.

About seven years ago, Cipriano, who has been diagnosed bipolar, had a bad run-in with sheriff's deputies after he was arrested on a DUI charge. He said some deputies at the jail were egging him on, which resulted in a yelling match.

"They tend to agitate you, and they don't just do that with people with a mental illness," Cipriano said. "It just ended up a big mess. ... It ended up I lost my temper. Mania can give you a short fuse."

Other people who work at and visit the drop-in center have had bad run-ins with the law as well, Cipriano said. One drop-in center employee was recently arrested, mistakenly, after his schizophrenic roommate had an outburst, he said.

"I respect the police. They have a tough job," Cipriano said. "If they can look at a person and realize they're sick and not just a bad person, it could help."

Cochran said the CIT model has been a positive step in Memphis, and across the country, in dealing with people with mental illnesses. He wants to see the CIT model continue to expand.

"We all need to unite and ask ourselves, why did we unite as a city or as a county government? Was it not for the people?" he asked. "If we neglect this population, and I think we have across the nation, I think we're doing a tragedy to humanity."

Until the CIT program is implemented, officers are trained, and beds added to receiving centers in Collier County, the county jail's medical infirmary will remain crowded.

Salley said the naked man who jumps on his bed, bangs on the walls and paints the walls with feces is now being held, indefinitely, until a permanent bed opens up for him at a mental health center somewhere in the state. This man, Salley said, is a perfect example of someone who needs help that the jail cannot provide.

As it is, the man, like many others, has become accustomed to life in a jail cell.

"This is the only stability they have in their lives," Salley said. "They become easily institutionalized."

The jail isn't meant to be, nor equipped to be, used as a mental hospital, Salley said.

"My personal goal is to use the jail for what it's intended for, putting criminals away that

need to be detained," he said.

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NAMI
The Nation's Voice on Mental Illness

CRISIS INTERVENTION TEAM TRAINING CURRICULUM

Peacock Center Bldg. C 6216 Trail Blvd. Naples, FL 34108

Time	Monday	Time	Tuesday	Time	Wednesday	Time	Thursday	Time	Friday
8:00 AM	**Introduction and Overview** CCSO/ NPD	8:00 AM	**Baker Act Training** Martha Lenderman	8:00 AM	**PTSD** **Sgt. Leslie Weidenhammer** **Lt. George Welch** CCSO	8:00 AM	**Calm Assess Facilitate** Lt. Brian Garrett Polk County Sheriff's Office	8:00 AM	**Out of the Shadows Video** NAMI of Collier County
Break									
				9:15 AM	**Leave for DLC**				
9:20 AM	**Signs and Symptoms of Mental Illness** Dr. Robert Allan, MD David Lawrence Center	Break							
						Break		Break	
		9:30 AM	**Baker Act Training cont.** Martha Lenderman	9:45 AM	**Tour of DLC** **(3 Groups)**				
						11:15 AM	**Calm Assess Facilitate Cont.**		
Break								9:30 AM	**Community Resources** Kathryn Hunter - NAMI Naples Community Hospital FACT, Youth Haven David Lawrence Center Shelter for Abused Women **Forensic Diversion Programs** Katie Burrough - DLC
				11:15 AM	**Leave DLC for Lunch on Your Own**				
11:45 AM	**Lunch on Your Own**	11:30 AM	**Lunch on Your Own**			Noon	**Lunch on your Own**		
1:00 PM	**Life Interrupted** Panel Family Members	1:00 PM	**Marchman Act** Martha Lenderman	12:30 PM	**Tour of St. Matthews**				
						1:15 PM	**Role Play**		
Break		Break		2:00 PM	**Empathy Training** Lt. Brian Garrett Polk County Sheriff's Office				
								Break	
2:15 PM	**Signs and Symptoms of Substance Abuse** Christine Holmes David Lawrence Center								
		2:15 PM	**Elder Disorders** Steve Edmondson					11:15 AM	**Open Discussion & Evaluations** Discussion Change to Uniform
				Break	**Tour of Sarah Ann Center**				
Break						Break			
		Break							
3:30 PM	**Medication Review** George Drobinski, LMHC Treatment Works			3:30 PM	**De Escalating Children with Autism** Sgt. McDonald, CCSO	3:00 PM	**Role Play Cont.**	Noon	**Graduation Lunch** St. George & The Dragon
		3:15 PM	**Perspectives from People with Mental Illness**						
							Critiques		
Adjourn		Adjourn		Adjourn		Adjourn			

Attachment # 4

Collier County Sheriff's Office

East Naples District Community Policing
Telephone (239) 252-9447 **FAX (239) 252-9438**
10 November 2011

This letter is to explain the Co-operative and mutually supporting partnership that exists between the Collier County Sheriff's office and the David Lawrence Center.

Our partnership is a strong bond that brings a continuity of care and understanding to the citizens of Collier County and the Clients we serve, and unites our efforts to better serve our citizens.

The David Lawrence Center is an integral and important part of our C.I.T. (Crisis Intervention Team) training, from baker act procedures to site tours and question and answer periods they bring the classroom instruction to life, and have become a valued partner with NAMI and the Collier County Sheriff's Office.

The Administration at the David Lawrence Center has furthered their partnership by integration CIT Officers into their Crisis Unit discharge protocol for potentially violent or at risk clients in the community to help clients maintain stability and give their clients reassurance that deputies are allies and can be a trusted source of assistance to them and the community.

CIT Officers are also utilized in the center with clients who exhibit anti-social or violent behaviors, giving the client the opportunity to understand the consequences that their actions could cause and to aid in the clients ability and desire to change these patterns.

It is through this amazing partnership that the Sheriff's Office has created a ground breaking program that provides information to our Officers about our citizens that need assistance with mental health and other issues. This program provides the officers with the knowledge that these citizens have special needs or are at risk so that they, the officers, can respond appropriately to better serve our community.

Respectfully,

Michael R. Nelson
Corporal Collier County Sheriff's Office
DLC Liaison
ID # 2008

Attachment # 5

DAVID LAWRENCE CENTER
OPERATIONAL PROCEDURE

SUBJECT: Special Precaution and Client Observation Guidelines and Procedures	CATALOG NUMBER: CLN-42
AREA: Clinical Management	APPLIES TO: All residential staff

PURPOSE:

1. To provide guidelines for ongoing risk assessment and appropriate levels and types of observation and intervention, in order to prevent injury to self and/or others whenever possible and promote optimal client, visitor, and staff safety at all times.
2. To clarify the role that all residential staff have in assessing client risk for harm to self or others.
3. To define procedures for crisis stabilization unit staff, including CCSU staff in providing appropriate care for clients who have been identified as at risk for harm to self or others.
4. To clarify that roles that all Crossroads and Detox staff have in immediate protection of the client and effecting transfer to a more restrictive environment when such risk is determined.

PART I: **INTRODUCTION TO PRACTICE GUIDELINES:**

1.0 Risk Assessment for harm to self and/ or others is included as part of the Center's Clinical Assessment service and assessment process, as well as for all clients evaluated for admission to a residential program. Risk Assessment is an ongoing process. The Admitting Clinician assesses client risk to self and/or others by completing a formal Risk Assessment and documents client report, family/collateral report/information (as appropriate), client presentation, behaviors, verbalizations, mood, risk factors, and mental status.

1.1 The Clinician utilizes the Risk Assessment prompts from the Clinical Assessment tool to determine level of risk and makes an immediate recommendation to the appropriate in Charge person for implementation of needed special precautions, as appropriate.

1.2 Contracts for safety, including potential clinical consequences and /or interventions based on the established therapeutic/safety contract expectations are utilized as deemed clinically appropriate.

2.0 Assessment for additional risk factors is also performed upon admission to Residential Settings, which includes risk for elopement, assault, fall, withdrawal and seizure, as appropriate.

3.0 Each Residential Program has a varying population and scope of services which may require different levels of observation and supervision, depending on the program and individual needs of the clients served.

3.1 The Crisis Unit is the most restrictive level of care for both adults and children and clients admitted to this level of care require the most intensive level of supervision, based on the client's presentation and assessed needs.

3.2 Clients who are identified as at risk of suicide/homicide may not be appropriate for admission to the Detox or Crossroads programs. In addition, elopement is not routinely a risk factor as these are voluntary programs.

3.3 If a client is determined to be at moderate to high risk or if concerns or questions about the level of risk are identified, then an emergency services clinician may need to be consulted and/or informed of apparent level of risk and asked to complete a face to face evaluation of the client whenever possible.

3.3.1 The ES Clinician will evaluate the client and will help determine the appropriate treatment intervention to ensure the client's safety. This may result in a recommendation for transfer to a more restrictive environment/level of care. (Admission to CSU, CCSU or off-DLC premises), as appropriate.

3.3.2 The client at risk of suicide/homicide will be observed closely by designated staff

until linking to an appropriate level of care is made. The client will not be left alone under any circumstance and, at a minimum, will be under constant visual observation while a formal determination is made as to the appropriate level of care and special precautions to be implemented. The need for an involuntary examination will be assessed as part of the Emergency Services screening/evaluation.

3.3.3 The client in the Crossroads/Detox unit who is physically aggressive and/or potentially assaultive, or based on mental status, , may be considered for transfer to CSU or may be recommended for discharge, based on program rules and procedures.

4.0 The treatment team will plan care for the client who is assessed as at risk for suicide, homicide, elopement, assault, seizure, withdrawals, and/or fall via a multi-disciplinary team approach. The plan of care will be integrated into the Treatment Plan as appropriate.

4.1 Staff who works with the client will be informed of the plan of care for the client.

4.2 Staff is expected to be vigilant for signs and symptoms of distress, increased agitation, or for indication of risk behaviors that may require immediate intervention, in order to prevent an injury or incident and maintain client/staff safety.

5.0 Staff will be alerted to the client's moods and sudden behavioral changes. Staff will keep the following in mind when observing client behavior:

5.1 Suicide attempts are often made in early stages of illness or during the convalescent period.

5.2 Anxiety may easily escalate to agitation and/or aggressive behavior.

5.3 Sudden behavioral changes (e.g., increased symptoms of agitation, emotional distress, psychosis, etc.) may require closer monitoring for suicide, elopement or assaultive behavior.

5.4 Staff must take special care when entering and exiting the residential programs in order to prevent elopement, as applicable

5.5 Monitoring is especially important during change of shift, times of high acuity, and at night when the client has more opportunity to act with potential for less observation.

5.6 Assessment for history and/or risk for seizures, withdrawal, and/or fall will be completed by appropriate staff in accordance with applicable Center Procedures.

6.0 Safety concerns or changes in a client's risk status will be reported immediately to the in charge person.

6.1 The treatment team will be made aware of these observations and take immediate precautions necessary to prevent incident and injury.

6.2 The charge nurse or in charge staff person should consult the physician whenever the risk status changes or when necessary.

6.3 Items of potential harm to self or others will be removed from clients during the admission process according to program procedures. (See Contraband Procedures)

7.0 When a client is placed on any Special Precaution status at least one staff member will be assigned each shift to monitor the client and document as follows:

7.1 The assignment of monitoring the client will be documented on the Special Precautions Log indicating which precaution is being monitored by circling the precaution type on the form.

7.2 The time of initiation of each precaution will be entered on the form in the appropriate section.

7.3 The location of the client being observed will be indicated using the codes and each entry will be initialed by the staff member making the observation.

7.4 A client may be observed simultaneously for more than one precaution.

7.5 If the assigned staff member will be absent from the unit for any reason during his/ her shift, a second staff member will be assigned for replacement.

7.6 Depending on unit acuity, the staff assignment may require that 2 or more staff complete rounds on an assigned caseload of clients to ensure timely completion. For example, on the CSU, assignment of precautions will typically require that 2 staff split the unit census in half to ensure accountability and accuracy in the timely completion of rounds.

8.0 Off Unit privileges (e.g., outings, passes) are generally not permitted for clients on any Special Precaution status, as deemed appropriate by the treatment team.

9.0 Special Precautions procedures, once initiated, will be maintained until a physician order is given to discontinue the precaution.

10.0 When Special Precautions are discontinued, the time the Precaution is discontinued will be entered on the log next to type of precautions as follows: "Discontinued 11:00 am."

PART II: **DEFINITIONS AND STANDARDS FOR CONTINUUM OF PRECAUTIONS**

The Center recognizes that there are varying levels and types of observation that may be required in order to maintain the safety of clients, visitors, and staff. Each program implements general observations, based on the population served, and individual client needs. General observations are often referred to as client rounds or head counts, which are documented on observation logs. Observation intervals vary from the least restrictive to most restrictive, depending on the assessed risk and identified need.

The following levels of observation apply to Acute Care/CSU /CCSU, and at times Detox, as appropriate:

1.0 **15 minute observations (SP II):**

1.1 15 minute observations (SP II) are initiated on all clients admitted to the Acute Care units, including Adult and Child CSU and Detox.
1.2 Upon admission the client is promptly placed on 15 minute observations.
1.3 Staff members are assigned to complete face to face rounds to ensure client safety and status and document observations/rounds on the designated Special Precautions log.

2.0 **Line of Site Observation:** Programs such as CSU and CCSU require clients to be in the line of supervision of the staff, based on medical necessity and client needs. This does not indicate the client is on an arms length one to one. This is a general level of awareness of where client is at all times which is documented via the 15 minute checks/logs and noted in the Progress Notes. Detox clients may be instructed to abide by this level of observation if there is medical necessity for same, such as with moderate to high risk for seizures or falls.

2.1 Staff are required to accompany client when using restroom and client must inform staff when they go to their rooms or outside of the general observation areas of the program.
2.2 Depending on the treatment program structure and/or physician orders, clients may not be permitted to enter into dormitories during waking/program hours without staff permission and or escort.
2.3 Clients may be restricted to certain areas of the program environment.
2.4 Clients may require staff escort from one location to another.
2.5 Clients may be monitored by video when asleep.
2.5.1 The clients SP log will be on designated colored paper to indicate to staff that client is on line of sight.

2.6

3.0 **ONE TO ONE (Special Precautions; SP I):**

3.1 A client may be placed on One to One (SP I) status based on risk assessment determination that the client:

3.1.1 Poses an imminent and/or high risk for harm to self and/or others and/OR
3.1.2 Is at imminent and/or high risk for elopement, assault, fall, or seizure.

3.2 Upon assessment of this status, the client is promptly placed on SP I status.

3.2.1 All of the indicators and approaches outlined for Line of Site as noted in the procedure apply to SP I status. In addition:
3.2.2 The client will be assigned to a specific staff member and be required to stay with the staff member and follow the staff member's directives to ensure safety. (The approach by staff is based on the premise that the client has exhibited behaviors that have shown an inability to make safe decisions without staff approval).
3.2.3 Staff will provide clients with specific safety guidelines, behavioral expectations, as well as outline appropriate boundaries related to the client's treatment needs and client/staff/unit safety.
3.2.4 Special treatment assignments and homework/activities may be implemented in accordance with the treatment plan and client needs.
3.2.5 Staff must constantly maintain a direct arms-length distance 24 hours a day except at night while the client is sleeping and the staff person is at the bedroom door.
3.2.6 The client will UNDER NO CIRCUMSTANCES be left unattended.
3.2.7 The clients SP log will be on designated colored paper to indicate to staff that client is on one to one (SP1).

4.0 Based on the level of unit acuity, the charge nurse or in-charge staff member may attempt to obtain additional staff on the unit to address staffing needs and cover the one to one observation.
4.1 The charge nurse may need to adapt staff assignment to assure that a staff member is assigned to directly monitor the client on SP I status, at arms - length.
4.2 The charge nurse may assist to coordinate staffing needs by contacting additional resources such as other Residential Programs or Program Supervisor/Administrator on call. use of Staffing Coordinator.

5.0 **Additional Definitions or Types of Precautions**:

5.1 Assault Risk: The client exhibits history of assaulting and/or aggressive behavior and current symptoms of agitation, aggression, and/or inability to control impulses. The client may be threatening to act out, harm others, etc., or be unable to contract for safety of others.
5.2 Elopement Risk: The Client is focused on and/or talks about leaving, stays positioned close to doors or makes attempts to follow staff when exiting the unit, has made an attempt to elope and/or talks about elopement. All clients on Jail or DJJ holds will be placed on precaution.
5.3 Fall Risk: Assessed at the time of admission and thereafter in accordance to Fall Prevention Procedure. Fall Prevention Protocol is initiated at time of assessed risk.
5.4 Seizure Risk: Assessed at the time of admission and thereafter in accordance with Seizure Management Procedure. Seizure Prevention/Management Protocol is initiated at time of assessed risk.
5.5 Withdrawal Risk: Assessed at the time of admission via nursing assessment or other appropriate assessment. All Detox clients are monitored for this level of risk. Other programs may require this precaution based on assessment process.

PART III: ADDITIONAL GUIDELINES FOR ADULT and CHILD CRISIS STABILIZATION UNIT

1.0 All Crisis Unit staff are trained and expected to make the assumption that the clients have been admitted to a secure unit for observations and Psychiatric Evaluations due to "harm to self or others" concerns. When they are no longer viewed as a risk to "harm self or others", then a discharge process takes place.

2.0 Based on this assumption, all clients should be observed at all times while in the day room, dining room or the lanai areas, which are considered to be the visual observed areas. Staff should be aware when the client leaves the visual observed area (i.e., going to the bathroom or their bedrooms, etc.).

PART IV: **CSU / CCSU PROCEDURES**

1.0 All clients admitted to the Crisis Unit (Adult and Child) are placed on every fifteen minute observations, twenty-four hours a day, as a general precaution, to ensure patient safety, unless more restrictive monitoring is determined to be necessary.

- 1.1 It is vital that a room check be made, at a minimum, every 15 minutes for any client in their bedroom during the day or night.
- 1.2 A bathroom check is also made, at a minimum, every 15 minutes

2.0 Patient safety is the priority and at least one staff member is assigned to be on the unit at all times with clients in order to maintain the visual observation standard.

3.0 The Admitting/Primary Clinician provides a verbal report to the Charge Nurse, who will also review the Initial Clinical Assessment and admission information to determine if the newly admitted client has been identified as a suicide, elopement, or assault risk, or if the client is in need of close observation due to a marked change in the mental status.

- 3.1 The nurse may also identify the type and/or level of client risk based on the Nursing Assessment and/or other staff recommendation.
- 3.2 A CSU Charge Nurse may recommend a one to one observation, based on the Clinician's report and/or nursing observation/assessment and judgment.

4.0 The Charge Nurse will contact the attending physician to obtain an order for appropriate special precautions. In doing so, the Charge Nurse provides a report to the physician of the client's status, presentation, behaviors, risk assessment findings, etc.

- 4.1 The physician may order additional and/or more restrictive observations at any time, based on the physician's judgment and clinical discretion. Otherwise, the physician may provide an order to approve and authorize the recommended level of precaution(s).

Signatures on file

Rev: 1/01, 8/04, 6/05, 6/06, 6/08, 2/09, 4/10, 2/11

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C.A.R.E.S.

(Communication, Assistance, Respect, Empowerment and Safety)

A therapeutic, recovery oriented treatment approach to strive to eliminate the use of Special Treatment and to ensure the safety of clients and others. C.A.R.E.S. Training components include:

C.A.R.E.S. Basics

- The organization's mission, vision and culture regarding therapeutic approaches to client behaviors
- Recovery oriented treatment approach and principles
- Customer Service Principles
- Understanding DLC scope of services and population served
- Definition and theoretical principles of symptom tolerance
- Departmental Crisis/Safety Planning

C.A.R.E.S. Comprehensive

Effective Communication

- Verbal
- Non-verbal
- Para-verbal

Crisis Prevention & Intervention

- Crisis types
- DLC Crisis Wheel – crisis stages/staff responses
- Crisis Interventions – practical techniques for crisis diffusion and management

C.A.R.E.S. Sexual Abuse & Trauma

- Define sexual abuse and trauma
- Gain a basic understanding of the prevalence and demographics of victims
- Increase awareness of short term and long term effects of sexual abuse and trauma.
- Identify common signs, symptoms and behaviors attributed to trauma and sexual abuse
- Know the procedure for Mandatory Reporting as required by the David Lawrence Center and the State of Florida.

Attachment # 7

Attachment # 8

DAVID LAWRENCE CENTER
OPERATIONAL PROCEDURES

SUBJECT:	Maintenance of Safety Standards/Search and Seizure/Contraband	**CATALOG NUMBER:** ACS-306 / ESAC- 140 / DTX-410
AREA:	Crisis Stabilization Unit (CSU), Emergency Services Assessment Center (ESAC) and Detox	**APPLIES TO:** Acute Care / ESAC Staff
PURPOSE:	To provide staff with guidelines to protect clients and staff from injury and/or accidents, and to clarify search and seizure guidelines.	

PROCEDURE:

1.0 There is a prohibition of specific items on the grounds of David Lawrence Center (DLC) - see safety procedure.

1.1 A law enforcement officer may carry firearms in a motor vehicle as authorized by law and the vehicle must be locked if unattended.

1.2 Although Law enforcement officers are permitted to carry firearms into a client unit, such as the CSU, this is intended for only when necessary to achieve order in an emergency involving the use of a deadly weapon. This should be the exception under dangerous situations, and only with the approval of the charge nurse.

1.3 Staff will request that law enforcement remove their weapons and place them in the designated locked gun box prior to entering the unit. If the officer refuses, the nurse will make a determination of the safety needs and may permit the officer enter the unit with the weapon, but will document the refusal of the officer to place the weapon in the gun box.

1.4 The nurse may also determine to refuse allowing the officer on the unit with the weapon, but client and staff immediate safety needs must be the priority.

1.5 An administrator on call should be notified and an incident report completed when law enforcement is called to intervene in a crisis related to client aggression. The incident report regarding involvement of law enforcement is to also address when law enforcement refuses to remove their weapon.

1.6 Staff members who are not permitted to carry firearms in motor vehicles on the facility grounds.

2.0 Handling of contraband and unit checks.

2.1 The CSU/ESAC will be free from debris, which could be dangerous to the clients and/or staff.

2.2 Razors and scissors may be used by the clients only under strict one-to-one staff supervision upon the approval of the charge nurse on the CSU.

2.3 The CSU/ESAC staff shall take all precautions needed to prevent self-injury by clients (See Special Precautions Criteria procedure).

2.4 All glass bottles, make-up, mirrors, and personal grooming articles are to be kept in locked storage.

2.5 More dangerous articles such as tweezers, nail clippers, knives, scissors, or razors are to be kept in the nurse's /staff work station in a labeled envelope until the client is discharged.

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2.6 Storage areas are to be locked at all times. Articles taken in or out are to be done by a staff member only.

2.7 Utensils meal trays are to be checked and counted before and after meals.

2.8 Safety rounds will be made each shift by the incoming and exiting BHT's.

2.9 Behavioral Healthcare Technicians (BHT) will check the tops of the closets, between and under beds, for dangerous objects while making periodic rounds during their shifts.

2.10 All admitted clients will be observed at regular intervals every 15 minutes at all times. This will be documented on the Safety Rounds. This will be documented on the Special Precautions Log. If a client is on special precautions, such as for elopement or assault, this will be noted on the log and client board.

2.11 Clients on special precautions I will be monitored 1:1 with the staff at arms length at all times while awake. While the client is asleep in room either staff needs to be outside room with direct visualization or via monitor in nursing station.

2.12 Use of personal radios will not be allowed on the CSU. Use of the unit stereo is allowed under staff supervision.

2.13 CSU/ESAC doors leading to the outside of the unit will be kept locked at all times.

2.14 Glass objects such as vases, etc. are not allowed in the CSU/ESAC living area or client bedrooms. Such articles must remain in the nurse's station or other appropriate non-client area until the client is discharged and able to take these articles home.

2.15 All items brought by visitors will be checked. Visitors are to be instructed to check with staff before bringing anything to the client. CSU/CCSU visitors are to be instructed to leave purses and items of value in their vehicles whenever possible. ESAC client may not have visitors while in the ESAC.

2.15.1 Visitors may not bring onto the unit any personal items, to include cell phones, purses, sunglasses, etc. Items such as cell phones, sunglasses and keys may be left in a designated receiving bin in the reception area during visitation if no other means are available to secure the items.

3.0 Search and Seizure:

3.1 All walk- ins will be asked to leave personal items in their vehicles or in a designated locker and empty pockets prior to going into ESAC and/or CSU. Walk-ins may also be subject to use of a metal detector as needed.

3.2 The staff will search all clients being admitted to CSU, CCSU, Detox and any clients to be screened for possible admission in the ESAC. Staff will search clients person for contraband and dangerous items they may have in their possession. Searches must be conducted by staff the same gender as the client. Staff may not leave any unsearched client unattended for any reason. Clients who have not completed the search and seizure process are on a 1:1 precaution until search is complete.

3.3 Clients will be asked to remove any and all jewelry, shoes, belts and any other items observed to be prohibited.

3.4 Clients will be asked to empty their pockets and place items on a flat surface.

3.5 Staff will request that clients open their mouth and stick out their tongue in order to observe

the presence of any oral piercings.

3.6 Clients will be given a gown and asked to step into the restroom and remove their clothes and give them to a staff member who is to be present at the door of the bathroom at all times and able to visually observe the client. The clothing is to be searched by staff with a metal detector and also by hand for any contraband. If appropriate for the unit it may be returned to client. A client may remain in a gown if needed to allow staff adequate time to search clients clothing.

3.7 If there are significant and reasonable concerns with regard to client hiding items that are potentially harmful to client or staff, staff will consider placing client on line of site or one-to-one. If at any point a client is not cooperating with the search and seizure process additional staff may be called to help assist the client. If client is being referred for Detox admission and not willing to comply with search and seizure process the client will not be admitted to the program.

3.8 The search of client's property must be completed in the presence of the client, if possible, and documented in the client's clinical record following.

4.0 Handling Of Contraband Deemed Dangerous And/Or Illegal

4.1 If a dangerous item or items are found, a list is to be completed, and the dangerous items are to be locked in the nurse's station or other appropriate designated area following policy. These items may be returned to the client at the time of discharge, if legally and clinically appropriate. Items that may not be legally or clinically appropriate will be highlighted on client's inventory and the nurse is to be notified of items. Authorization to retain unsafe items is to be obtained from the Physician/designee and/or the Administrator on call.

4.2 Contraband that is considered an illegal substance/ item is to be reported to law enforcement and their procedures will be followed. Copy(ies) of pertinent paperwork completed is to be maintained and an internal incident report filed regarding the disposition of the item(s) via law enforcement. The identity of the client is not to be revealed unless court ordered or required through Executive Leadership/Risk Management for client/staff safety.

5.0 Return Of Contraband Items

5.1 Items deemed appropriate for return to the client will be given to the client/guardian/caretaker at the time of release once transportation has arrived and only at the time the client is being escorting off of the unit/ESAC.

5.2 If the client is being transferred to another agency/facility, the personal belongings and/or contraband will be separated and labeled/ identified as contraband and hand delivered to the receiving responsible entity, such as in the case of a jail hold client, or when a client is being transported to another receiving or treatment facility. In such cases, the belongings and/or contraband shall never be returned to the client. This includes not returning shoe laces, belts or other objects considered contraband.

6.0 Violation Of Safety Standards

6.1 Any violation of safety standards by a client may result in immediate administrative discharge on the Detoxification unit.

6.2 The charge nurse will notify the administrator on call of the issue, and obtain recommendations, as appropriate.

Attachments:

ACS-306A CSU Contraband List

DTX-410A Detox Contraband List

Rev. 2/04, 2/07, 3/09, 6/10, 7/11

DLC INTERNAL USE ONLY

Integrated Approach to Staying Safe in An Acute Care Setting

Case Presentation

Assessment: 44 y.o. unemployed, single, white, male initially referred to Crisis Stabilization unit under CCSO Baker Act for suicidal gesture/statements with superficial cuts to left arm. Clinical, Nursing, and Psychiatric evaluations include review of CCSO sworn statement(s) and written Baker Act. Nursing Assessment, Clinical Assessment, and Psychiatric Evaluation include completion of risk assessment, address precipitating events, client recent MH/SA history, recent legal issues including assault on LEO and prior prison sentences. Assessment documents that client was prescribed psychotropic medications by outside provider which were outlined in medication reconciliation process. Assessment also outlined history of aggression, and current mental status, to include suspicious and agitated behaviors, threatening staff, aggression towards staff, destruction of property upon arrival, and fixation on female in community. Client self-reports anxiety and agitation. Client also presented with past history of cocaine dependence. Psychiatrist further clarifies diagnosis to include: Axis I- Mood Disorder NOS, Rule out Psychosis NOS, Cocaine dependence. Axis II - Rule out Personality Disorder NOS with Cluster B Traits. Axis III- None. Axis IV- Identified stressors are considered triggering factors, i.e., loss of job, relational stressors, financial. Ongoing assessment via milieu management, BHT/Nursing and Discharge Planning Clinician team, and as part of ongoing treatment planning and service delivery leads to an integrated clinical staffing to ensure coordination of care between inpatient, CCSO, and Outpatient services to insure a safety plan. As part of Outpatient linking and services, ongoing assessment process reveals continued agitation and behaviors that appear related to Axis II Personality Traits, but are also considered as part of ruling out other possible diagnosis.

Community Collaboration: CCSO was appropriately involved in community with client due to legal history and behavioral problems in community. CCSO and CIT liaisons worked closely with physician and treatment team to collaborate the most appropriate safety plan to ensure client and community safety. Case required notification under privilege to warn based on later expressed threats to others in the community with prompt notification and wellness checks were provided, in some cases resulting in CIT crisis support and in others resulting in additional Baker Act admissions for safety of client and others.

Intervention(s) / Treatment: Upon CSU admission: Assault Precautions, assignment to private bedroom to decrease stimulation, Emergency Treatment Orders, PRN medication for anxiety/agitation, discontinuation of stimulant (ADHD medication); Psychiatrist consistently offered trial of antipsychotic medications which was refused by client. Initiation of small dosage of anti-anxiety medication. Client engagement with clinical staff while on unit to facilitate development of rapport and transition client towards compliance with outpatient service plan. Clear communication provided via Primary Psychiatrist and treatment team with regard to behavioral expectations, essential services, and medication changes. Referrals made for Individual Therapy and Medication Management.

Discharge Planning: Verification completed and documented as to no access to weapons. ROI's (Release of Information) obtained to include father and friend to assist treatment team in continued discharge planning process. Wellness Checks via Emergency Services post discharge, appointment for follow up Short Term Resource Coordinator Home Visit within 48 hours of Crisis Unit discharge, Medication Management while on unit with follow up appointment within 48 hours of discharge. Integrated agency clinical staffing was held included lead Psychiatrist, Senior Executive Leadership, Case Management, Outpatient Psychiatrist and Outpatient Clinician, and coordination with CIT Liaison. Due to client aggression and threatening behaviors during encounters in Outpatient and Emergency Services, ***Safety Alerts*** were provided as part of safety planning to assist staff with pro-active approach and notification of law enforcement if needed. Clinical Services such as Outpatient Individual and STRC services were provided using buddy system to ensure safety of staff.

Therapeutic Environment: No injury to client or others resulted based on safety planning and the effectiveness of the therapeutic environment.

C.A.R.E.S. Residential Strategies

DLC's Role

- What is our role to the clients we serve
- To families of clients
- To the community

Milieu Therapy & Boundaries

Basic milieu design

- Clear reasonable routine
- Clear program rules
- Sufficient staff

Standards of Boundaries and Conduct

C.A.R.E.S. Special Treatment Procedures

- Seclusion & Restraint
- Policies, Procedures, Standards of Care and Medical Concerns

C.A.R.E.S. DLC Assist & Support

- Determine the purpose and procedures for the appropriate use of physical interaction
- Know and understand emergency responses for seclusion and restraint related emergencies
- Understand the importance of correct application associated with the use of physical intervention skills
- Demonstrate knowledge and understanding of how to monitor, assess, and maintain physical integrity during seclusion and restraint procedures
- Know and understand the nature and risks associated with use of special treatment procedures
- Demonstrate understanding and competence in using each of the physical intervention skills

C.A.R.E.S. Training Components Relating to Prevention of the Risk of Violence

- David Lawrence Center focuses on restoring and rebuilding lives by providing compassionate, highly skilled, affordable mental health and substance abuse services that are available to all.

- Staff members are trained in various theoretical models and techniques for evaluating and intervening appropriately to promote and ensure client/staff safety, dignity and respect.

- The Center's Symptom Tolerance Philosophy is based on the staff's understanding that the clients will have difficulties interacting and that staff will not respond in an overly restrictive or rejecting manner.

- Each Department/Program has a Safety Plan that includes a proactive team approach to a potential crisis with a client.

- Practical techniques are utilized for crisis diffusion and management.

- Each programs' goals include the basic needs of our clients to:
  - feel safe
  - feel secure
  - have time to reflect

- Each DLC staff member who employs physical restraints and seclusion when treating patients undergoes new, more rigorous training to assure the appropriateness of the treatment and to protect patient rights, according to a regulation published in the *Federal Register* by the Centers for Medicare & Medicaid Services (CMS).

- DLC Culture includes that the use of Special Treatment is only in a psychiatric emergency.

- Approved DLC CARES/Assist and Support techniques are part of the DLC CARES program and includes verbal de-escalation, crisis intervention, and physical intervention techniques as a last resort.

- Training also includes special MEDICAL CONSIDERATIONS & CARE OF CLIENTS when using DLC Special Treatment Procedures; and contraindications and Special Treatment Alerts.

- It is the agency's goal to create an environment that reduces the circumstances that may lead to the use of seclusion or restraint and to maximize safety when used, for both clients and staff.