

Mental Disabilities Board of Visitors

SITE REVIEW REPORT

Acadia Montana

Butte, Montana

April 26-27, 2007

GENE HAIRE

Gene Haire, Executive Director

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Mental Disabilities Board of Visitors
Site Review Report
Acadia Montana
April 26 - 27, 2007

OVERVIEW

Mental Health Facility reviewed :

Acadia Montana (Acadia)
Butte, Montana
Catherine Willner, CEO

Residential Treatment Facility

Authority for review :

Montana Code Annotated, 53-21-104

Purpose of reviews :

- 1) To analyze critical areas of concern identified in the following Mental Disabilities Board of Visitors site reviews: August 25 - 26, 2005; September 15 - 16, 2005; October 7, 2005; November 10, 2005; December 16, 2005; January 20 - 21, 2006
- 2) To assess the degree to which the services provided by Acadia are humane, consistent with professional standards, and incorporate BOV standards for mental health services.
- 3) To recognize excellent services.
- 4) To make recommendations to Acadia for improvement of services.
- 5) To report to the Governor regarding the status of services provided by Acadia .

BOV review team :

Staff:

Gene Haire, Executive Director

Board:

Teresa Lewis, LCSW

Consultants:

Bill Docktor, PharmD, BCPS
Pat Frawley, LCSW
Irene Walters, RN
Sheila Smith, LCPC

Review process :

- Interviews with Acadia administrative and clinical leaders, line staff
- Observation of treatment activities
- Review of written descriptions of treatment programs
- Formal and informal discussions with youth
- Inspection of physical plant
- Review of treatment records

Background

The Mental Disabilities Board of Visitors (BOV) conducted six site visits at Kids Behavioral Health (KBH) from August 2005 through January 2006¹. In September 2006, Acadia Healthcare, Inc.² purchased and took over the operation of KBH - now called Acadia Montana³. BOV has met with senior representatives of Acadia Healthcare and with the Acadia Montana CEO several times before and since this organizational change. Acadia Montana has made impressive commitments to improving care and services in the Butte facility. The April 2007 site review was conducted for the purpose of assessing the status of the areas of concern BOV identified in its January 2006 report (see the link at footnote 1 for cross reference):

- I. **Findings** (from the BOV 10/5/05 letter to KBH)
- II. **Primary Causes** of resident-on-resident assaults/aggression, and of the dysfunctional treatment culture
- III. **Recommendations** – from the January 2006 report (BOV selected 11 of the 32 recommendations that are of primary relevance to the current situation at Acadia)

This report organizes BOV's review questions and conclusions under the following headings:

- 1. treatment: environment - safety, modality, structure, physical interventions, abuse/neglect
- 2. staff - training and supervision
- 3. referral screening, admissions, and facility capacity
- 4. leadership

In addition, during this review BOV assessed the cultural competency – specific to the needs of American Indian youth - of Acadia's services, and Acadia's practices related to the use of medications.

¹ BOV's report detailing these visits can be found here >>
http://boardofvisitors.mt.gov/docs/KBH_SR_Report_final.pdf .

² <http://www.acadiahealthcare.com/>

³ <http://www.acadiahealthcare.com/montana/default.aspx>

STATUS of CONCERNS IDENTIFIED in the JANUARY BOV REPORT

Treatment Environment - Safety, Modality, Structure, Physical Interventions, Abuse/Neglect

Does Acadia properly detect, report, or investigate allegations of abuse and neglect?	YES
Is the Acadia treatment environment functional? Does the treatment environment support appropriate treatment?	YES Strengths: The treatment environment has progressed from one that was highly dysfunctional and dangerous to one that is functional and supportive of treatment. This has been brought about through a number of efforts, including bringing in competent executive leadership, limiting the census to a rational level, implementing an appropriate referral screening process, and beginning to develop a well-trained, carefully-supervised, and better-supported staff. The "Primary Therapy" Model appears to have greatly improved the team approach to milieu treatment. Greater communication and coordination among team members has enhanced the treatment environment. The willingness of Acadia to "cap" the resident census at 60 has had a tremendously positive effect on the treatment environment. Acadia appears acutely aware of how the issues of staffing levels and physical space influence considerations of how many youth can be safely and effectively treated in this setting. Environmental factors: 2 beds/room; clean rooms; opportunity for privacy/quiet time for residents; clean, sunny cafeteria; friendly, inviting classroom atmosphere; youth's artwork displayed prominently. The Medical Director's presence, knowledge and experience provides a very strong underpinning for a healthy treatment environment. Concerns: Level system instructions given to residents and written information residents are required to provide in requesting level changes may be too sophisticated for youth with learning disabilities or below average intellectual functioning. The complexity of the new treatment program/level system requires diligent implementation and monitoring by competent individuals on a day-to-day basis; without ongoing vigilance and skilled leadership, the level system structure has potential for punitive implementation (i.e., level systems tend to create power struggles between direct care staff and residents). Recommendation 1: Create a more natural environment by separating the living area from the school area.
Is the Acadia treatment environment humane, safe, calm, and conducive to treatment?	YES Strengths: - Milieu appears calm and more structured; interactions between staff and patients seemed positive and mutually respectful. - Capping the census at 60 is a major factor for improvement in these domains. - Aggressive efforts to remove adolescents with conduct disorders has contributed

	significantly to a sense of calm and order. ▪ ▪ ▪ <u>Physical Plant Concerns:</u> <u>Concern:</u> <u>Suggestion:</u> <u>Recommendation 2:</u>
Are physical interventions used only as a last resort when danger to a resident or other residents in the immediate area is imminent? Are physical interventions used properly?	YES <u>Strengths:</u> ▪ Physical interventions appear to be used only as a last resort, and BOV saw no indications that they were ever used improperly. ▪ Physical interventions have decreased radically. Consequently, the number of injuries has been reduced. ▪ Specialized interventions plans are used. One significant difference now is a slower integration of the resident back into the milieu so that they have time to collect themselves.

Has the violence and "corrections" atmosphere that existed prior to Jan. 2006 been eliminated by Acadia?	YES ▪ The violence and sense the BOV team had previously of being in a corrections facility are almost entirely gone. ▪ Increased presence and visibility of clinical staff on the units, the improved admission and discharge process for youth who pose a risk to the stability of the program, and the reduction the census have had a profound impact.
Are staff in control of the treatment environment?	YES ▪ Direct care staff is better supported; no longer report being left alone to figure out on their own how to respond to problematic behaviors. ▪ Direct care staff appear to feel more confident - they convey this to the youth, and the youth reflect respect back to the staff. ▪ Staff turnover and call offs have decreased since last year.
Is there now a clearly-articulated treatment paradigm at Acadia? If so, what is it, and is it within the accepted scope of treatment approaches for youth with serious emotional disturbances?	YES ▪ The "Primary Therapy" Model is currently the foundation of treatment at Acadia; leadership is currently in the process of developing a level system to introduce in the near future - these efforts represent progress in this area. ▪ The process of evaluating the level system to replace the existing "Today and Tomorrow" program appeared to be inclusive of many staff's opinions. ▪ Effort by Acadia leadership to motivate and support clinicians to pull in the same direction. ▪ Clinical programs fall within the scope of accepted treatment practices. ▪ New groups have been added. The Music Therapist offers informative and insightful groups. ▪ Increased focus on inclusion of families in the treatment process. ▪ A Licensed Addiction Counselor runs a substance abuse group, and is available to conduct substance abuse evaluations after psychiatric consultation and treatment. Concern: ▪ There is not an integrated approach to the treatment of "co-occurring" psychiatric and substance use disorders despite estimates of 70% of residents having substance abuse issues. ▪ Consider more thoroughly integrating treatment for substance use disorders into the overall treatment approach, beginning with focused patient/family education.⁴ ▪ Consider adding one psychiatrist who specializes in addiction medicine – whose duties are exclusively focused on this area of treatment (without other administrative or unit psychiatric duties). Recommendation 3: Expand the inclusion of the MHA's in the development and refinement of the treatment model. Recommendation 4: Increase the emphasis on tracking and evaluating the clinical outcomes of treatment and milieu interventions.

⁴ The Children's Mental Health Bureau is in the process of developing a system-wide plan to address co-occurring psychiatric and substance use disorders.

Does Acadia respond appropriately when a current resident presents an unacceptable level of danger to other residents and staff?	YES Strengths: With referrals for which safe behavior is questionable, arrangements are made before admission for youth to be placed elsewhere if they do not succeed at Acadia.
What is the current approach to the question of 'how many youth can be effectively and safely treated at Acadia'? Is this approach congruent with the physical space, the treatment approach, staff skills, and staffing levels?	YES Strengths: Acadia is aware of how staffing, treatment modality, and physical space play into considerations of how many youth can be safely and effectively treated. To Acadia's credit, it is holding the line at a census of 60. All of these issues and Acadia's experience with this population are being factored into discussion of the possibility of developing a 'low stimulation' unit. Recommendation 5: Hold the line at the current census level, and only increase resident numbers with a corresponding increase in staff and physical space expansion/enhancement.
Does the current program management structure support a cohesive treatment milieu in each unit, and "ownership" among staff in each unit?	YES
Are the educational and mental health components fully integrated? Are educational goals consistent with the mental health treatment goals?	YES - Considerable improvement in this area. - Much better communication and coordination between the educational and clinical staffs. - More involvement and improvement in the <i>quality</i> of involvement by MHAs in the classrooms. - Improved communication and coordination between Acadia and youths' home school districts.
What is the current status with regard to Acadia's efforts to understand events leading up to "incidents" - with a focus on de-escalation and prevention of physical intervention?	- There is a much-improved data collection system to analyze incidents in order to focus on areas of resident-related or staff-related concerns. - The presence of Assistant Program Leads (APL), therapists, Program Manager, and psychiatrists on the units provides critical tools for the direct care staff to learn and understand early intervention in critical incidents.
What is the current status with regard to Acadia's efforts to articulate and implement a coherent treatment approach that integrates individual, group, family, and milieu treatment with the educational and psychiatric services?	- Acadia's current treatment approaches are within mainstream wisdom about how to work with seriously emotionally disturbed youth. - The "primary therapy" model has greatly helped to coordinate teams of treatment. There is frequent therapist presence on the units. This provides a dedicated group of individuals who develop a treatment plan, communicate about results, and adjust it as needed. This model provides more face-to-face time for each resident. Members of the team at all levels seem to be more aware of each resident. This approach has resulted in much-improved integration of all aspects of treatment services. - Acadia is working to implement a new behavioral/level system approach. Staff have been trained and opportunities for youth education are planned. - Teachers are now involved in staffings weekly and consult with the primary therapists.

	Concerns: ▪ The milieu treatment component needs to be further enhanced and better integrated into the overall primary therapist model (in terms of increased MHA involvement and improved congruence between therapy work and milieu activity). ▪ After having “bought into” the previous approach to milieu treatment (<i>Today / Tomorrow</i> - which emphasized a non-confrontational, success-oriented relationship with residents), some staff and youth are concerned that a new level system strategy might be too punitive and may engender an increase in power struggles. Those concerned do, however, appear to have a great deal of respect for their leaders and intend to work to make it succeed.
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Staff - Training and Supervision

Are Acadia staff well-trained? Have significant improvements been made in preparing and supervising direct care staff? Is the approach to staff training dynamic, comprehensive, and ongoing? Are skill deficits identified and remedial training conducted?	Much Improved Strengths: ▪ The Assistant Program Leads (APL) under the oversight of the Director of Programming are now more actively involved in training and supervising the MHA's. This type of “hands-on” teaching and supervising is very helpful to MHA's becoming more treatment savvy. ▪ Therapists assigned to specific units adds to the ability of direct care staff to consult with the therapists regarding resident issues. ▪ The active presence of the psychiatrist on the units and his frequent, incidental interactions with the residents are very positive changes and provide good modeling of treatment and therapeutic interactions for the staff. The psychiatrist is a strong proponent of teaching direct care staff “in the moment”. ▪ The <i>Clinical Employee Training Needs Assessment</i> form is a very good tool for developing training “calendars” and hopefully will be used to address the clinical/treatment training needs of staff. ▪ The initial staff orientation program is very comprehensive and there appears to be a good effort on Acadia's part to implement a formal training program based on employee needs assessments. ▪ There are dedicated staff positions for the education of employees. Concerns: ▪ Formal training still appears too limited in scope for the MHA's; additional education about mental illnesses is needed. ▪ MHA's and their supervisors (APL's) differed on their assessments regarding training. The more experienced MHA staff felt that initial and ongoing training needs improvement. ▪ MHA staff reported that they need more effective de-escalation training to avoid using restraints. ▪ There is one Director of Programming who performs the supervisory duties on day shift that three APLs perform on the second shift. ▪ Ongoing, post-orientation training is minimal. ▪ The primary training that occurs is for new employees and annual training. More could be done to nurture continual development of staff, and to establish a career ladder for direct care staff.
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	<u>Suggestions:</u> ▪ Consider establishing additional APL positions on the day shift. ▪ One MHA proposed the idea of a formal “preceptor” approach with an experienced MHA should be part of the training program - BOV suggests following up on this idea. <u>Recommendation 6:</u> In initial orientation and ongoing education for direct care staff focus more comprehensively on diagnoses, symptoms, and psychodynamics of mental illnesses and serious emotional disturbances. <u>Recommendation 7:</u> Expand the emphasis on professional growth and development of all staff. <u>Recommendation 8:</u> Develop frequent, ongoing, mandatory, scheduled in-service days.
Do direct care staff now have a clearly-defined treatment role?	Much Improved <u>Concerns:</u> ▪ MHA's are frequently not able to be assigned to a specific “Primary Therapy” team due to scheduling difficulties. This, combined with limited training in the areas of specific illnesses and treatment approaches compromises the full inclusion of MHAs in genuine treatment roles. <u>Suggestion:</u> ▪ Explore ways to make scheduling MHA's in a consistent manner on specific units a higher priority.
Are MHA's actively involved in every aspect of treatment?	Much Improved <u>Strengths:</u> ▪ MHAs now appear to have a voice in most aspects of the treatment process. BOV observed this in morning meetings, clinical staffings, and end-of-shift debriefings. This increased treatment role has been and continues to be an ongoing process. ▪ The APLs and Program Manager are great resources for improving direct involvement of MHAs in the treatment process. ▪ Therapists keep the MHAs informed of what is going on with each resident. <u>Concerns:</u> ▪ While management correctly states that MHAs are the backbone of the treatment teams, MHAs are only indirectly involved in some of the critical aspects of treatment - ex., treatment planning and review - through their reports to managerial staff who act as proxies for MHA involvement in treatment planning and review meetings. <u>Recommendations 9:</u> Work with the MHA staff and the psychiatrist to further enhance the active role of MHA staff in every aspect of treatment - addressing the philosophical shift to the belief that MHA's provide important treatment services, not simply behavior management.
Is adequate time allocated outside of milieu responsibilities for supervisors to work with MHA staff – including quality debriefing of incidents?	YES <u>Strengths:</u> ▪ The APL's make a good effort to provide supervision and debriefing for the MHA's. ▪ Debriefing occurs on a weekly basis; supervisors follow up with staff and youth post incident. ▪ Improved debriefing of incidents, and increasing supervisor presence on the units has

	increased the opportunity for more in-the-moment learning. Concerns: ▪ Are weekly critical incident debriefings enough? ▪ Scheduling constraints - and possibly union constraints - create some difficulties for the provision of individual supervision for MHA's outside of the normal work shifts. Suggestion: ▪ Consider debriefing immediately after each incident.
Are therapists adequately supervised?	YES Strengths: ▪ A core of good therapists and good supervisors. Suggestion: ▪ Consider ways for senior leadership to provide more support to clinical staff; allow for more training opportunities, and funding to pay for attendance.
Does the current approach to supervision of MHA and supervisory staff support good skill development, good ongoing decision-making, skillful interactions and interventions with youth, and a quality milieu?	YES Strengths: ▪ The organizational changes and support that Acadia has brought to the program demonstrate a commitment to quality programming. ▪ The expanded APL positions have generated some very positive outcomes. The individuals that function in this role are skilled communicators and are often in the role of mediator, negotiator, and mentor. ▪ APLs provide after-hour supervision. Concerns: ▪ BOV believes that care must be taken to ensure that the new approach on the units (level system) will not devalue skilled communication by making behavioral consequences the only tool staff use. Recommendation 10: Expand the emphasis on improvement of "in-the-moment" and formal supervision and training for the direct care staff to promote skillful interactions and intervention with youth.

Referral Screening and Admissions

Is referral screening and admission decision-making driven by clinical assessment?

YES

Are referrals for whom Acadia does not have appropriate services not admitted?

Does Acadia respond appropriately to referrals of violent, seriously conduct-disordered youth?

Strengths:

- The screening and intake process is better organized with more concern paid to referrals who may pose a risk to resident/staff safety or the program's stability. Clinical decisions about referrals are respected and honored. According to the psychiatrist and clinical staff, there is no pressure to accept referrals who may not be appropriate, and there is support for discharging residents who are too difficult to be treated effectively within the program's structure - or who present behavior that is beyond Acadia's ability to manage.
- Decisions regarding screening and admissions are clinically driven; BOV appreciates that Acadia is realistic and does not try to represent itself as being able to treat every childhood disorder or manage every behavior.

Leadership

Have chain of command issues been addressed?

YES

Are the lines of authority and accountability in both the organizational chart and in practice simple and clear for all staff and lead to a single point of accountability within the Acadia organization?

Strengths:

- Staff are very clear about lines of authority and accountability. Supervisors are responsive and effective.
- The Director of Nursing and the Director of Programming are universally appreciated by staff for their leadership skills. These two senior staff have worked at this facility through difficult changes over many years - their example and persistence is impressive.

Is the leadership – including the CEO - of Acadia now actively involved in the ongoing treatment and aware of and addressing problems that arise?

YES

Strengths:

- Staff interviewed by BOV reported that the new CEO and senior supervisors/leadership are active, aware, knowledgeable, and responsive.
- Staff report that the CEO and other senior staff - with particular emphasis on the psychiatrist - are regularly present in the unit milieu.

Do leaders – including the CEO - place themselves regularly in the milieu?

SENSITIVITY TO CULTURAL, ETHNIC, AND RACIAL ISSUES

Does Acadia ensure that its staff are knowledgeable about cultural, ethnic, social historical, and spiritual issues relevant to the mental health of and provision of treatment of mental illness relevant to all people in the defined community, with a specific emphasis on American Indian people?	YES <u>STRENGTHS:</u> ▪ Acadia staff are sensitive to cultural competency issues. ▪ There is one staff person designated as the Native American Program Specialist. ▪ Acadia provides excellent orientation to new staff that includes information about cultural, ethnic, social, historical, and spiritual issues relevant to American Indian youth. Staff are given a post-test to determine retention of this information, and to plan for future education. <u>CONCERN:</u> ▪ While this staff person is a long-term employee, continuity of the established in-house cultural competency is at risk with no cross-training for other staff. ▪ Acadia has not defined the level of knowledge about cultural, ethnic, and spiritual issues relevant to American Indian people that it expects staff to have. ▪ There is no formal process for ensuring that staff have attained a defined level of cultural competency. <u>SUGGESTION:</u> ▪ Conduct more cross-training of staff throughout Acadia in cultural competency knowledge and skills. ▪ Develop a cultural competency resource book to be kept on each unit. ▪ Identify ways to empower the American Indian residents by providing examples of opportunities specific to American Indians: ➢ provide a list/schedule of pow-wows to American Indian patients/residents ➢ educate the eligible (enrolled) American Indian residents about Indian preference for hiring by introducing them to the Indian Health Service scholarships loan repayment, and employment opportunities ☐ Bureau of Indian Affairs employment ☐ tribal jobs ☐ scholarships ☐ <u>Upward Bound</u>⁵ ☐ Urban Indian activities available ➢ educate American Indian residents about the tribal enrollment process ➢ subscribe to the on-line <u>Native Youth Magazine</u>⁶ (lists many opportunities and resources for American Indian youth) <u>RECOMMENDATION 11:</u> Train interested staff (preferably American Indian staff) to be able to augment and back-up the Native American Program Specialist. If there are no interested American Indian staff, train other interested staff who are committed to American Indian Tradition and sustaining and building excellence in provision of culturally competent mental health care.
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⁵ <http://www.ed.gov/programs/trioupbound/index.html>

⁶ <http://www.nativeyouthmagazine.com/>

	<u>RECOMMENDATION 12:</u> a) Develop comprehensive, ongoing cultural competency training for Acadia staff that includes information relevant to all the Indian tribes in Montana (and others served by Acadia) and their individual cultures – as well as historical factors that affect the mental health of American Indians such as racism, forced migration, boarding schools, and multi-generational unresolved grief.⁷ b) Consult with the <u>Montana-Wyoming Tribal Leaders Council</u> for assistance⁸.
In the planning, development, and implementation of its services, does Acadia consider the needs of, promote specific staff training for, and involve representatives of relevant cultural / ethnic / religious / racial groups, with a specific emphasis on American Indian people?	YES <u>STRENGTHS:</u> ▪ The Native American Program Specialist consults with a Traditional person at the North American Indian Alliance in Butte.
Does Acadia investigate under or over-utilization of mental health services by people in minority cultural / ethnic / racial groups, with a specific emphasis on American Indian people?	YES <u>STRENGTHS:</u> ▪ Long-term Case Managers have long-standing relationships with and are committed to good communication with Montana tribes. They have frequent contact with tribal programs. <u>SUGGESTIONS:</u> ▪ Track number of admissions of American Indian children who were involved in therapy and whose referrals to Acadia were planned and coordinated by the community therapist - versus how many admissions were crisis-oriented and initiated by a local emergency room or law enforcement. ▪ Engage referral sources for American Indian children in a dialogue focused on better understanding the level of pre-admission mental health services, general medical services, and post-discharge support available to American Indian children in their home communities. ▪ Consider arranging for an expert on American Indian cultural competency as it relates to emotional disturbance and mental illness to consult with and present to Acadia staff specifically about the reasons for over-representation of American Indian children in residential treatment.

⁷ see U.S. Department of Health and Human Services. (2001). *Mental Health: Culture, Race, and Ethnicity—A Supplement to Mental Health: A Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services. <http://download.ncadi.samhsa.gov/ken/pdf/SMA-01-3613/sma-01-3613A.pdf>

⁸ www.mtwytlc.com/

Does Acadia employ specialized treatment methods and communication necessary for people in minority cultural / ethnic / racial groups, with a specific emphasis on American Indian people?	YES <u>STRENGTHS:</u> ▪ The Native American Program Specialist (who is also a therapist) provides individual therapy that addresses cultural, ethnic, and racial issues and nurtures an ongoing dialogue with specialized group of American Indian youth in order to keep critical cultural factors in the forefront of their healing (not limited to American Indian youth). <u>SUGGESTIONS:</u> ▪ Consider incorporating specialized treatment goals for American Indian patients/residents into treatment plans to include patients/residents listing what they like/dislike about being American Indian, what their tribal affiliation is, etc . <u>RECOMMENDATION 13:</u> In addition to continuation of the consultative relationship with the American Indian cultural specialist at the North American Indian Alliance, contact the Montana-Wyoming Tribal Leaders Council for assistance in developing specialized treatment methods for American Indian children.
Does Acadia deliver treatment and support in a manner that is sensitive to the cultural, ethnic, and racial issues and spiritual beliefs, values, and practices of all residents and their family members/carers, with a specific emphasis on American Indian people?	YES <u>STRENGTHS:</u> ▪ The Native American Program Specialist offers a specialized group each Friday for all the residents to share in the Native American culture,. ▪ The Native American Program Specialist assists residents to practice smudging each morning. ▪ Acadia supports a culturally sensitive approach to the treatment of co-occurring psychiatric and substance use disorders that includes a very dedicated Licensed Addiction Counselor who understands the significance of integrating appropriate American Indian literature/work books into treatment. <u>SUGGESTION:</u> ▪ Obtain the following book for the Acadia library and incorporate into staff cultural competency training: <u>A Gathering of Wisdoms Tribal Mental Health: A Cultural Perspective by Swinomish Tribal Mental Health Project⁹</u> (includes a section on spirituality that would enhance the Native American Program Specialist's approach in this area.) ▪ Consult the website <u>Traditional Indian Games¹⁰</u> for group activity. ▪ During family sessions utilize family recipes for fry bread into treatment goals for girls. ▪ Utilize the medicine wheel in formulating treatment goals for American Indian children. ▪ Consider emphasizing that the main purpose of the specialized group is to support American Indian tradition and ensure that American Indian youth are the majority in that group.

⁹ Swinomish Tribal Mental Health Project. (1991). *A Gathering of Wisdoms, Tribal Mental Health: A Cultural Perspective*. La Conner, Washington: The Swinomish Tribal Community. For information contact: Swinomish Tribal Community, 950 Moorage, LaConner, Washington 98257

¹⁰ <http://www.traditionalnativegames.org/>

Does Acadia employ staff and develop links with other service providers / organizations with relevant experience and expertise in the provision of treatment and support to people from all cultural / ethnic / religious / racial groups represented in the defined community, with a specific emphasis on American Indian people?	YES <u>STRENGTHS:</u> ▪ The organization has supported attendance at community pow-wows in the past <u>SUGGESTION:</u> ▪ Continue to actively support resident attendance at community pow-wows.
With regard to its own staff, does Acadia monitor and address issues associated with cultural / ethnic / religious / racial prejudice and misunderstanding, with a specific emphasis on prejudice toward and misunderstanding of American Indian people?	YES <u>SUGGESTIONS:</u> ▪ Consider ways to communicate proactively with American Indian residents in a way that will support them in letting Acadia staff know if anyone at Acadia (staff or residents) has treated them disrespectfully because of their race.

MEDICATION

Is the medication prescription protocol evidence-based and reflect internationally accepted medical standards?	YES The medications prescribed are consistent with standard of practice. Although much of the use of medications is outside FDA approved uses, this is necessary in the child and adolescent population since there is little data available for them. The philosophy is to use medications to reduce symptoms as much as possible and address the problems with behavioral and skill development techniques. Medications are used more extensively initially, but tapered as the resident improves to identify which are really needed. Record review confirmed this approach.
Is medication prescribed, stored, transported, administered, and reviewed by authorized persons in a manner consistent with legislation, regulations and professional guidelines?	YES The pharmacist fills medications using a weekly blister card system. Starter dosages are picked from an extensive floor stock which is set up by the pharmacist and which includes an accountability system. There is a formulary committee who determines the needed medications for the facility. The medication room is locked. Controlled substances are locked in cabinets within the med room.
Are residents and their family members/carers provided with understandable written and verbal information on the potential benefits, adverse effects, costs and choices with regard to the use of medication?	YES (it was not determined whether families are given cost information) When a medication is ordered, consent of the parent or guardian is obtained before it is started. When the nurse calls for this consent, she/he explains the use and side effects over the phone. Medication information sheets are provided on admission if they know the medications at that time and at discharge. Medical records mails information sheets otherwise. The medications are explained to the youth at the time of prescription and weekly by the nurses. Medications sheets designed for youth are also given to them.
Are medications administered in a manner that protects the resident's dignity and privacy?	NO The medication cart is taken to the unit. BOV did not observe this, but a more private process may be worth considering.
Is "medication when required" (PRN) only used as a part of a documented continuum of strategies for safely alleviating the resident's distress and/or risk?	PRN medication does not appear to be a planned part of an specialized intervention plan but rather an adjunct to it. If as needed medication is ordered, the determination of it being given is between the patient and nurse.
Does Acadia ensure access for residents to the	YES

safest, most effective, and most appropriate medication and/or other technology?	The psychiatrist described the formulary as adequate and not excessively restrictive.
Does Acadia consider and document the views of residents and their family members/carers and other relevant service providers prior to administration of new medication?	YES
Where appropriate, does Acadia actively promote adherence to medication through negotiation and the provision of understandable information to residents and, with residents' informed consent, their family members/carers?	YES
Wherever possible, does Acadia not withdraw support or deny access to other treatment and support programs on the basis of residents' decisions not to take medication?	YES
For new residents, is there timely access to a psychiatrist or mid-level practitioner for initial psychiatric assessment and medication prescription within a time period that does not, by its delay, exacerbate illness or prolong absence of necessary medication treatment?	YES Psychiatric evaluations are completed within 24 hours of admission.
For current residents, does Acadia provide regularly scheduled appointments with a psychiatrist or mid-level practitioner to assess the effectiveness of prescribed medications, to adjust prescriptions, and to address clients' questions / concerns in a manner	YES On record review, psychiatric progress notes are frequent initially and become less frequent but at least weekly over time. The nurses and treatment team can discuss issues they see with the psychiatrist at any time. Issues with any resident are addressed daily by the team.

that neither compromises neither clinical protocol nor client – clinician relationship?	
When legitimate concerns or problems arise with prescriptions, do residents have timely access to a psychiatrist or mid-level practitioner?	YES
Are medication allergies and adverse medication reactions well documented, monitored, and promptly treated?	YES Allergies are documented several places in the record including the medication administration record. Two of the cases reviewed included side effects which were managed appropriately.
Are medication errors documented?	YES There is a policy and procedure for this. A form is filled out and submitted. The Director of Nursing reviews these forms to identify types of errors and track errors. The most common errors are transcription and missing meds. This is consistent with what is seen at other facilities.
Is there a quality improvement process in place for assessing ways to decrease medication errors?	YES The formulary group reviews all errors at their monthly meeting.
Are appropriate residents screened for tardive dyskinesia?	Acadia medical staff received training on using the AIMS scale just prior to the BOV review; the plan is to start using this tool soon. Other medication monitoring issues: Human Papilloma Virus vaccination, when needed, is referred to family planning. Metabolic parameters and weight were checked and followed in two of the cases reviewed.
Is the rationale for prescribing and changing prescriptions for medications documented in the clinical record?	YES The progress notes and psychiatric evaluation explain the rationale behind medication changes.
Is medication education provided to residents including “adherence” education?	YES Medication sheets are provided to the residents and the nurses do weekly education.
Is there a clear procedure for the use of medication samples?	Samples are not used in the facility.
Are unused portions of	YES

medications disposed of appropriately after expiration dates?	These are returned to the pharmacy and disposed of properly.
Are individual residents' medications disposed of properly when prescriptions are changed?	YES Returned to pharmacy. Home meds are usually sent home with the parent or guardian.
Is there a clear procedure for using and documenting emergency medication use, including documentation of rationale, efficacy, and side effects?	These are ordered by the psychiatrist. None were noted in the records reviewed so documentation was not observed.
Is there a clear procedure for using and documenting 'involuntary' medication use, including documentation of rationale, efficacy, and side effects?	The resident or parent /guardian have the right to refuse medication. Education is used when this is the case.

CONCLUSION

This organization – its staff and its clients – has been through a lot since the summer of 2005. In 2005, the residents were at a high level of risk from ineffectual leadership, the lack of a coherent treatment model, and the unsafe environment. Following the Board of Visitors' and the State Licensing Bureau's intervention in 2005, fundamental changes necessary to address these serious concerns began. As described in this report, the staff are now under competent leadership and the residents are receiving effective treatment in a safe environment. The Board of Visitors commends the veteran staff who have persevered and worked for positive change through this period, and looks forward to a collegial relationship with Acadia Montana as it continues to improve its treatment for the children it serves.

RECOMMENDATIONS

1. Create a more natural environment by separating the living area from the school area.
2. Create more outdoor recreation options on the Acadia grounds.
3. Expand the inclusion of the MHA's in the development and refinement of the treatment model.
4. Increase the emphasis on tracking and evaluating the clinical outcomes of treatment and milieu interventions.
5. Hold the line at the current census level, and only increase resident numbers with a corresponding increase in staff and physical space expansion/enhancement.
6. In initial orientation and ongoing education for direct care staff focus more comprehensively on diagnoses, symptoms, and psychodynamics of mental illnesses and serious emotional disturbances.
7. Expand the emphasis on professional growth and development of all staff.
8. Develop frequent, ongoing, mandatory, scheduled in-service days.
9. Work with the MHA staff and the psychiatrist to further enhance the active role of MHA staff in every aspect of treatment - addressing the philosophical shift to the belief that MHA's provide important treatment services, not simply behavior management.
10. Expand the emphasis on improvement of "in-the-moment" and formal supervision and training for the direct care staff to promote skillful interactions and intervention with youth.
11. Train interested staff (preferably American Indian staff) to be able to augment and back-up the Native American Program Specialist. If there are no interested American Indian staff, train other interested staff who are committed to American Indian Tradition and sustaining and building excellence in provision of culturally competent mental health care.
12. a) Develop comprehensive, ongoing cultural competency training for Acadia staff that includes information relevant to all the Indian tribes in Montana (and others served by Acadia) and their individual cultures – as well as historical factors that affect the mental health of American Indians such as racism, forced migration, boarding schools, and multi-generational unresolved grief.
b) Consult with the Montana-Wyoming Tribal Leaders Council for assistance.
13. In addition to continuation of the consultative relationship with the American Indian cultural specialist at the North American Indian Alliance, contact the Montana-Wyoming Tribal Leaders Council for assistance in developing specialized treatment methods for American Indian children.

FACILITY RESPONSE

Acadia Montana appreciates this opportunity to respond to the recommendations made by the Board of Visitors following our site-visit review.

We find these recommendations to be thoughtful and reasonable, and have indicated our responses below to each recommendation.

1. Create a more natural environment by separating the living area from the school area.

- a. We are looking at expansion plans that would include placing the classrooms in “modular” buildings that would be attached to (or in close proximity to) our main structure, and thus removing them from the resident rooms. The addition of modular buildings is a capital expenditure which will require the approval of Acadia Healthcare’s CEO and Board of Directors. Modular buildings or expansion construction will most likely not be considered by our corporate office until 2009,

We are unable to move classrooms away from our units to other locations at this time given the constraints of our architecture; but are sensitive to both our residents’ needs for privacy and the need to create a natural environment.

2. Create more outdoor recreation options on the Acadia grounds.

- a. We would like to create “experiential” therapy options outdoors such as a ropes course and an equine therapy center. These are also capital budget items, and cannot be assured of funding at this time.
- b. We are looking at “low-cost” recreational options. This Arbor Day our patients planted over 100 trees and many decorative plants and flowers in a garden. The residents are responsible for the care and maintenance of the trees, plants, and flowers to the extent that they are able. They are very proud of their achievement, and had a great time planting. Next year we hope to “start” various vegetables and flowers inside in schoolrooms and transplant them to the garden which is becoming a “living legacy” for our residents.

3. Expand the inclusion of the MHA’s in the development and refinement of the treatment model.

- a. The MHAs were involved and will continue to be involved in the refinement of the treatment model and the level system. We will solicit MHA opinions on on-going changes

to our treatment programs.

4. Increase the emphasis on tracking and evaluating the clinical outcomes of treatment and milieu interventions.

- a. We have identified GAF scores as the measurement for clinical outcomes. We are currently measuring GAF scores at the time of admission, at each treatment plan review, and at discharge. We will review this information quarterly in our Performance Improvement Committee and make appropriate changes based on results. We will also review Satisfaction Survey data from Resident, Family, and Referent Surveys.

We continue to monitor the effectiveness of special interventions and other milieu interventions by both number of interventions, and successfulness of interventions. We even measure the effectiveness of interventions by physician, nurse, and MHA as shown in our MAPS scores.

5. Hold the line at the current census level, and only increase resident numbers with a corresponding increase in staff and physical space expansion/enhancement.

- a. We have done this, and will not increase admissions past 60 without physical plant expansion and appropriately correlated staffing.

6. In initial orientation and ongoing education for direct care staff focus more comprehensively on diagnoses, symptoms, and psychodynamics of mental illnesses and serious emotional disturbances.

- a. We have added education on SED diagnoses, symptoms, treatment, and recovery to our Orientation, and have added specialized in-service SED training topics to our training schedule, such as "Attachment Disorder" based on the results of our staff training survey which identified specific staff training needs and desires. We have a comprehensive two-week mandatory Orientation which includes Mandt Training, and floor training experience with our residents.

Marilyn Warren, CNS, our Clinical Director provides the following course in our mandatory orientation:

Marilyn Warren, NP, Clinical Nurse Specialist, Clinical Director

- 1. Understanding Mental Illness and Treatment Modalities to Include Role of Medications
- 2. Diagnosis
 - a. Review & Score Post Test

Additionally we offer our staff external training external training opportunities as they exist. In March therapist Mary Watson attended Treating Attachment Disorder and Dyadic Developmental Psychotherapy Approach, in May we had 12 attendees for a Web/Telephonic training presented by Dr. Elizabeth Kohlstaedt on Attachment Disturbance and Trauma, In June therapist Mary Watson provided training on Attachment Disorder to Children's unit MHA staff.

7. Expand the emphasis on professional growth and development of all staff.

- a. We have added two-days of paid off-site training time to our Union contract for employees

needing CEUs for licensure. We also provide an extensive Orientation and in-house training program. As of 6/16/07, we have paid for 17,425 hrs. of in-house staff training. As certain diagnosis or mental health treatment issues come up we will coordinate and use knowledgeable trainers either employed by Acadia or from other resources. We also make staff aware of external trainings and encourage their participation. We will continue to evaluate the need for additional diagnosis specific training through patient diagnosis information and employee training needs assessments.

In addition, De-escalation training is now offered every six month as a mandatory requirement.

8. Develop frequent, ongoing, mandatory, scheduled in-service days.

- a. Please see 7.b. We have regularly scheduled mandatory and voluntary trainings. Voluntary trainings are developed directly from a staff training survey which is distributed to all employees.

Our 2007 Annual Training Plan offers training to all staff as outlined below.

Training Types and Requirements-

Training is categorized in the following ways:

- Primary Training- Job Related Clinical Trainings, Management Trainings and Department Trainings.
 - Requirements:
 - Direct Care staff- minimum of one skill based or job related training offered per month.
 - Nurses, Therapists, Activity Services and Teachers- minimum of one job related training every other month.
 - All other Departments- minimum of one job related training every other month.
- External Trainings- scheduled external trainings. The facility encourages external trainings. The facility will pay up to two days of training pay per year for external training attendance those staff requiring licensure or certification with supervisor approval.
- Mandatory Trainings- CPR, Mandt and others
 - Requirements: each mandatory training has a renewal or expiration date.
- Secondary Training- unscheduled mini trainings in department meetings or other venues are highly encouraged
- Orientation- New Hire orientation training.

9. Work with the MHA staff and the psychiatrist to further enhance the active role of MHA staff in every aspect of treatment - addressing the philosophical shift to the belief that MHA's provide important treatment services, not simply behavior management.

- a. This is certainly a goal for us. Our attending psychiatrist, Dr. Killpack, personally works with MHAs to help develop staff's understanding and skill-level with SED residents both formally through in-service training, and informally as situations develop on the unit. We

have also developed “special interventions” for patients when needed that are MHA driven and implemented.

10. Expand the emphasis on improvement of “in-the-moment” and formal supervision and training for the direct care staff to promote skillful interactions and intervention with youth.

- a. Please see 9.a.

11. Train interested staff (preferably American Indian staff) to be able to augment and back-up the Native American Program Specialist. If there are no interested American Indian staff, train other interested staff who are committed to American Indian Tradition and sustaining and building excellence in provision of culturally competent mental health care.

- a. We have a new Native American therapist who is potentially interested in working with Claudia to expand our Sons and Daughters of Tradition specialized programming.

12. a) Develop comprehensive, ongoing cultural competency training for Acadia staff that includes information relevant to all the Indian tribes in Montana (and others served by Acadia) and their individual cultures – as well as historical factors that affect the mental health of American Indians such as racism, forced migration, boarding schools, and multi-generational unresolved grief.

b) Consult with the Montana-Wyoming Tribal Leaders Council for assistance.

- a. Acadia has mandatory Cultural Diversity training that includes information relevant to all of the Indian tribes in Montana, Alaska and other states in the US, Canada, and South America. In addition, we include information on Hispanic, Asian, and Black cultures.
- b. Claudia will consult with the Montana-Wyoming Tribal Leaders Council. She has developed two very comprehensive programs for our Native American patients; the Sons and Daughters of Tradition.

13. In addition to continuation of the consultative relationship with the American Indian cultural specialist at the North American Indian Alliance, contact the Montana-Wyoming Tribal Leaders Council for assistance in developing specialized treatment methods for American Indian children.

- a. See 12 above.

We would also like to take this opportunity to respond to the only area in the survey where we received a “NO” response.

Are medications administered in a manner that protects the resident's dignity and privacy?	NO The medication cart is taken to the unit. BOV did not observe this, but a more private process may be worth considering.
Is "medication when required" (PRN) only used	PRN medication does not appear to be a planned part of an specialized intervention plan but rather an adjunct to it. If as needed medication is ordered, the determination of it being given is

as a part of a documented continuum of strategies for safely alleviating the resident's distress and/or risk?	between the patient and nurse.
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Acadia Montana's Policy and Procedure for the administration of medication had focused primarily on patient safety. Our Policy and Procedure has been changed to include the following to ensure both safety and the residents' dignity and privacy:

"The nurse administering medications must ensure the location of the Med Cart:

1. Limits the ability of the resident to get behind the Med Cart and:
2. Allows medications to be administered in a manner that protects the resident's dignity and privacy."

Acadia Montana's Nursing staff, MHAs and residents will be educated on the changes made to this Policy and Procedure.

PRN medication is part of specialized interventions at Acadia Montana which are directed by the attending psychiatrist with the assistance the Treatment Team. Significant and positive changes in ordering and usage of PRN medications and special interventions have occurred with the addition of Dr. Killpack.