Mental Disabilities Board of Visitors

# SITE REVIEW REPORT

## *MONTANA DEVELOPMENTAL CENTER*

September 28 – 29, 2006

Gene Haire

Gene Haire, Executive Director

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# INTRODUCTION

## Residential Facility Reviewed

Montana Developmental Center (MDC)
Boulder, Montana

Kathleen Zeeck, Superintendent

## Authority for Review

Montana Codes Annotated, 53-20-104

## Purpose of Review

1. To assess the degree to which the services provided by Montana Developmental Center are humane, decent, comprehensive, and of high quality.
2. To recognize excellent services.
3. To make recommendations to Montana Developmental Center for improvement of services.
4. To report to the director of the Department of Human Services and the Governor regarding the status of services provided by Montana Developmental Center

## Review Team

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| Board Members: | Brodie Moll<br>Gay Moddrell<br>Teresa Lewis, LCSW |
| Staff: | Gene Haire, Executive Director<br>Colleen Nichols, Paralegal/Advocate |
| Consultants: | Bill Docktor, Pharm. D., B.C.P.S. - Pharmacology Consultant<br>Jacki Hagen, Pharm. D. - Pharmacology Consultant<br>Gail Baker, L.C.S.W. - Secure Unit Management Consultant<br>Irene Walters, R.N. - Psychiatric Nursing Consultant |

# OVERVIEW

## Service Type

Residential Facility

## Catchment Area

State of Montana

## Review Process

1. Interviews with Montana Developmental Center Staff
2. Informal interactions with residents
3. Review of treatment records
4. Review of written descriptions of treatment programs
5. Observation of treatment activities
6. Inspection of physical plant

## Services / Areas Reviewed

- Social Work
- Communications
- Work Skills
- Health
- Recreation
- Psychology
- Facility Management
- Administration
- Staff Competency
- Abuse / Neglect / Rights
- Treatment / Individual Treatment Plans / Interdisciplinary Team

## Focus / Objective

The Mental Disabilities Board of Visitors' (BOV) primary focus for this review was on treatment provided to residents living in the six cottages; the objective was to determine how successfully treatment is provided to residents.

"Successful" is defined as ***correct treatment interventions consistently carried out by knowledgeable staff under the supervision of involved supervisors under the guidance and authority of clinical professionals.***

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BOV studied the following:

- how original treatment need determinations are made; how periodic reviews are conducted
- how treatment needs are incorporated into the treatment plans
- how treatment plans and staff assignments are communicated to the cottage staff
- how cottage staff attain the knowledge and skills to implement treatment interventions
- how supervisors ensure that cottage staff properly implement their treatment assignments
- how Qualified Mental Retardation Professionals (QMRP) manage the process of implementation of treatment
- the role of the Psychologists in the treatment process
- the role of the resident in the treatment process

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The Montana Developmental Center's services are provided across several physical facilities:

(1) six cottages
(2) units 16 A & B
(3) unit 104 (the "secure" unit)

The six cottages and units 16A & B are licensed under federal regulations as an Intermediate Care Facility for the Mentally Retarded (ICF/NR). This kind of license requires "active treatment", is funded by Medicaid, and is subject to federal review by the Centers for Medicare and Medicaid Services (CMS).

**16 A & B**

This unit is being phased out as part of the Travis D. settlement. The last people now living in this unit will be placed by December 31, 2006, therefore BOV did not review that unit. The BOV developmental disability specialist monitors 16 A & B continually.

**Unit 104**

Unit 104 is licensed under state regulations as an Intermediate Care Facility for the Developmentally Disabled (ICF/DD). This kind of license does not require "active treatment", is 100% state-funded, and is subject to state review by the Quality Assurance Division. This unit was created in 2002 following a review by the Centers for Medicare and Medicaid Services (CMS) in which MDC's ability to protect residents from harm by other residents was cited as being inadequate. The 2003 Legislature created new language in the criminal statutes allowing for the criminal commitment of people with developmental disabilities to MDC – which has exacerbated the challenge.

Unit 104 was established in an unused part of the 16 A & B building – the only place on the MDC campus where residents are housed in older, pre-1990's buildings. Since its inception, the physical environment of unit 104 has been inadequate for provision of "secure" housing and supervision of residents who are deemed to present a danger to others. The 2005 Legislature allocated a one-time $2.5 million appropriation for the construction of a new secure facility on the MDC campus.

BOV conducted an extensive review of unit 104 during its 2002 site review. For this review, BOV consultant Gail Baker returned to assess the implementation of BOV's 2002 recommendations for unit 104.

# ASSESSMENT OF SERVICES

| Organizational Structure and Planning | **Comments / Analysis** |
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| Does the MDC mission statement clearly state its purpose relative to desired outcomes and results for residents?<br><br>Does the MDC mission statement clearly state the activity it will employ (i.e., treatment) in order to accomplish its purpose? | **-NO-**<br>The MDC mission statement says its purpose is "...to meet individual needs...". This is too vague and does not address a problem or condition to be changed or the nature of the change MDC strives to make in this condition or status.<br><br>The MDC mission statement alludes to activity ("to provide quality care and training..."), but this, again, is too vague and does not address the concept of treatment.<br><br>This lack of specificity and clarity in the foundational description of what MDC seeks to accomplish, why MDC exists, and what the ultimate result of MDC's work is leads to ambiguity both on the organizational level and in the understanding that individual staff members have about what their jobs are.<br><br>More specifically, the emphasis on "care and training" is probably outdated and does not adequately acknowledge the increasing prevalence of mental illness among MDC's clientele. |
| Are the lines of authority and accountability in both the organizational chart and in practice relative to the design and implementation of treatment strategies simple and clear for all staff and do they lead to a single point of accountability? | Although there has been recent improvement in the assertion of authority by clinical leaders, the structure of "authority and accountability in both the organizational chart and in practice" relative to treatment needs to be more clearly stated in: (1) written documents (organizational chart, staff training materials, position descriptions, etc), in (2) supervisory relationships between shift managers and line staff, and in (3) the administration's explicit support (both at the divisional and facility levels). |
| Does the structure of MDC promote continuity of treatment for residents across all sites, living units, and programs? | **-YES-**<br>Except for residents who move into and out of the secure unit. The treatment objectives for residents are not clearly defined when they are on the secure unit, and therefore, treatment continuity is interrupted during and after transitions. |
| Does the ***organizational structure*** of MDC reflect a multidisciplinary approach to planning, implementing, and evaluating treatment? | **-YES-** |

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| Does MDC produce and regularly review a strategic plan? | At BOV's request, MDC provided a document titled Montana Developmental Center: Strategic Plan – 2006 – 2011, however, no person BOV interviewed during the site review was aware of this document or had any input into it. It appears that this document may be a draft project at the facility administrative level.<br><br>Most of the Goals and Objectives this document describes are routine functions of MDC.<br><br>Goal 3 appears to be good starting point for a more overarching approach to strategic planning:<br><br>*The Montana Developmental Center in collaboration with facility staff, Developmental Disabilities staff, and Disabilities Services Division staff will continue to expand and develop a continuity of services for persons with developmental disabilities served within Montana.*<br><br>Objectives and Action Steps (labeled with letters under Objectives) appear to be interchangeable; most Objectives appear to actually be "action steps", i.e., address 'what will be done' statements, some of which include target dates; but none include identification of MDC staff responsible (some do identify activities that MDC *residents* will to achieve Goals).<br><br>The idea of proactive, comprehensive, long-range strategic planning - *that includes staff at all levels and other stakeholders* - appears not to be part of the MDC culture. The atmosphere is one of continual reaction to a variety of citations, emergencies, investigations, complaints, funding limitations, and oversight. Despite accomplishments by staff (see **Addendum: Superintendent's Assessment of Success of and Barriers to Consistent Implementation of Treatment Plans and Decisions**) at all levels, the prevailing operational mode of reactivity engenders an ongoing sense of low-level chaos - hence leaders are hampered in their ability to get out in front of existing or developing challenges. One gets the impression that leaders at the divisional and facility level, as well as clinical, supervisory, and line staff are always waiting apprehensively for the next crisis that will require a reaction. Reactivity has become the defacto tactic for implementing responses to crises.<br><br>**Concerns:**<br>▪ The strategic plan document is apparently not the product of a process that includes staff at all levels and other stakeholders.<br>▪ The staff in various 'departments' perceive that they have little or no input into the overall MDC decision-making processes. One result of this is that staff feel that they don't know where MDC is headed, and that they don't have any way to affect the direction of MDC's |

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| | planning or development.<br>▪ One of the central trends and planning issues at MDC has been the increase in the number of residents who are placed at MDC because of criminal behavior - either through adjudication and sentencing, or through non-judicial means.<br><br>If MDC and the Disability Services Division do not assertively and proactively define the evolving mission and develop operational strategies, MDC runs the risk of becoming the defacto correctional facility for criminal offenders with developmental disabilities. While this may be appropriate for part of MDC's role, without good strategic planning, MDC and the Disability Services Division will find themselves continually reacting to outside forces with focus on treatment becoming secondary.<br><br>**Recommendation 1:**<br>Develop – with participation from all levels of the organization – a comprehensive, dynamic strategic plan. This process should include the development of a new mission statement that addresses the purpose, activities to pursue the purpose, and values.<br><br>Good resource:<br>http://www.allianceonline.org/FAQ/strategic_planning |
| Does MDC use a strategic plan as the foundational tool for short and long range planning, and "management by objectives"? | **-NO-** |
| Is the strategic plan developed and reviewed through a process of consultation with staff, residents, family members/carers, and other appropriate service providers?<br><br>The plan includes:<br><br>▪ evaluation of the current MDC mission<br>▪ statement of the role of MDC in the continuum of statewide services for people with developmental disabilities<br>▪ strategy for improving the consistency of the provision of treatment to all residents<br>▪ strategy for the measurement of health and functional outcomes for individual consumers<br>▪ strategy for improving the knowledge and skills of staff at all levels | **-NO-**<br>**see above** |
| Does MDC have operational plans based on the strategic plan, which establishes time frames and responsibilities implementation of objectives? | **-NO-**<br>**see above** |

| Staff Competence, Training, Supervision | Comments / Analysis |
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| Does MDC define minimum knowledge and competency expectations for each staff position providing treatment to residents? | **-YES-**<br>Job expectations are described in position descriptions. |
| Does MDC define specific treatment roles and responsibilities for each staff position providing services to resident? | **-YES-**<br>Position descriptions provide adequate detail relative to direct care treatment role.<br><br>Behavior Treatment Plans describe who is responsible for each aspect of the plan.<br><br>Clinical staff are very clear about their role in treatment. |
| Does MDC have written training material for new staff focused on achieving minimum knowledge and competency levels? | **-NO-**<br>The Training and Development Specialist is developing on-line training to be available in the future.<br><br>MDC is pursuing a contractual relationship with the College of Direct Support: http://www.collegeofdirectsupport.com/ .<br><br>The following training modules do not include any written information provided to pre-service trainees:<br><br>▪ Treatment Program Specialist Introduction<br>▪ Seclusion / Restraint<br>▪ Introduction to 104R<br>▪ Active Treatment<br><br>**Recommendation 2:**<br>Develop a comprehensive written training curriculum for new Psychiatric Aides that includes (1) specific written training objectives referenced to knowledge and skills needed to fulfill treatment responsibilities described in position description; (2) written classroom materials for each topic relating to resident treatment. |
| Does MDC train new staff in job-specific knowledge and skills OR require new staff to demonstrate defined minimum knowledge and competency prior to working with residents? | **-YES-**<br>Two week pre-service Psychiatric Aide training is mandatory.<br><br>The Training and Development Specialist provides general pre-service training including Mandt™ training.<br><br>Departmental Specialists provide pre-service training appropriate to selected criteria.<br><br>Excellent “A Day in the Life of the Other Guy” and “Choice Sensitivity” exercises during pre-service training to help new staff appreciate what it would be like to be a resident |

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| | at MDC.<br><br>Good Power Point presentation on “Client Rights / Abuse and Neglect”.<br><br>Good on-the-job training protocol and check off list.<br><br>**Concerns:**<br>▪ Pre-service and annual training for direct care staff are too rudimentary.<br>▪ New nursing staff are not provided specific training related to developmental disabilities or related treatment; this is done on the job and mentoring form experienced nurses.<br>▪ New professional staff are not provided specific training related to developmental disabilities or related treatment. |
| Does MDC proactively provide staff opportunities for ongoing training? | Annual mandatory and elective training classes are clearly established for all MDC positions.<br><br>Some professional staff are supported to attend trainings around Montana.<br><br>Some classes are now available on-line and can be completed by staff on site when they have the time.<br><br>**Concerns:**<br>▪ Mandatory annual training is oriented to class completion, not demonstration of knowledge and skill attainment or demonstration.<br>▪ Due primarily (but not only) to staff shortages, direct care staff do not have a realistic opportunity to attend required classes.<br>▪ Night shift employees do not have access to classes.<br>▪ Overtime is not available to attend classes outside of scheduled shifts.<br>▪ Opportunities for ongoing, dynamic continuing education for staff at all levels are not in place.<br>▪ The physician identified a need for going to conferences to learn more about this population and to establish a network for consultation. She also mentioned a need for more references available on site. |
| Does MDC consistently assess staff and identify and address knowledge and competence deficiencies? | **-NO-**<br>**Concerns:**<br>▪ The MDC standard is for Psychiatric Aide staff to be evaluated by Shift Managers annually. Performance evaluations do not appear to be used as a dynamic tool to assess staff and identify and address knowledge and competence deficiencies.<br>▪ There appears to be a low percentage of completed performance evaluations. |

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| Does MDC ensure that all staff receive minimum mandatory training? | **-NO-**<br>For MDC staff at all levels who are in a treatment role with residents, the following are the mandatory training completion rates (April – June 2006):<br><br>**56%** have completed **0% - 25%** of mandatory classes<br>21% have completed 26% - 50% of mandatory classes<br>22% have completed 51% - 75% of mandatory classes<br><br>Completion of annual mandatory training at all staff levels does not appear to be enforced.<br><br>**Recommendation 3**:<br>Develop an aggressive strategy to address the unacceptably low mandatory training completion rate. |
| What does MDC do when staff are delinquent in attendance at mandatory training classes? | Nothing.*<br><br>Training completion is tracked, but non-attendance is not addressed.<br><br>*Some supervisors require staff to attend classes if they are not attending on their own. |
| Does MDC provide active formal and informal supervision to staff? | **-YES-**<br>Qualified Mental Retardation Professionals (QMRP) have been placed in the chain of command and therefore more involved with oversight of the programming efforts.<br><br>Unit Coordinators are generally involved more in multi-cottage management than hand-on supervision.<br><br>Shift Managers are very involved and hands on in providing supervision in some cottages and less so in others.<br><br>Psychology Director is playing a much more assertive role in taking direct responsibility for ensuring that programs are being implemented.<br><br>The LPN supervisor does quarterly observations of her staff.<br><br>**Concerns:**<br>▪ Managers spend an inordinate amount of time reviewing and processing incident reports.<br>▪ Quality and diligence of supervision varies by unit and shift.<br>▪ Unit Coordinators and Shift Managers spend a significant amount of time and energy finding coverage for staff shortages. |

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| Are MDC supervisors trained and held accountable for appropriately monitoring and overseeing the way residents are treated by line staff, and for ensuring that treatment is provided effectively to residents by line staff according to their responsibilities as defined in treatment plans? | The Psychology Director has recently become more proactive in ensuring that the Psychiatric Aide staff follow the treatment plans. Though this appears to be effective, it is not supported by the organizational structure of supervisory responsibility.<br><br>Supervisors and other senior staff are committed and diligent in monitoring and mentoring Psychiatric Aide staff.<br><br>**Concerns:**<br>▪ Consistent treatment in the cottages is not happening. MDC has to rely on the personal ethics and accountability of the online staff as there is no formal way to recognize performance. Performance appraisals are not done in a timely manner and have no connection to wage increases. There seems to be no organizational motivators for top performers.<br>▪ Because of staff shortages and staff being pulled to cover in areas where they are not familiar with the residents/treatment, treatment is minimal.<br>▪ Inadequate communication & consistency between staff and shifts limit treatment implementation and efficacy.<br>▪ Some staff understand treatment, some staff just do maintenance.<br>▪ Psychiatric Aides and Shift Managers report that when staff are pulled from their regular assignments to cover other areas, they do not receive adequate training or information regarding expectations related to treatment. |
| Does the Superintendent have the resources and autonomy to ensure that treatment is provided in the way that is necessary to achieve both individual treatment goals and to establish and maintain an appropriate treatment milieu? | While the Developmental Disability Program voices support, it appears that the Superintendent is subject to oversight and administrative strictures that impede her ability to manage assertively in response to immediate situations as they arise.<br><br>Staff shortages have resulted in excessive overtime expenditures and budget overrun; this has created some problems in the Superintendent's problem-solving flexibility.<br><br>The Superintendent acknowledges not having the time to visit the milieu due to administrative responsibilities.<br><br>**Recommendation 4:**<br>Prioritize regular personal visits by the Superintendent to each living and treatment area across all shifts. |

| Assessment, Treatment Planning, Documentation, and Review | **Comments / Analysis** |
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| Does the MDC use a multidisciplinary approach in its treatment planning and review process? | **-YES-**<br>The core team (QMRP, Unit Coordinator, Social Worker, Registered Nurse, and Treatment and Programming Specialist meet with the Psychologist, Recreation Therapist, and others as needed. The physician does not participate unless there are questions about medical issues.<br><br>The psychiatrist participates in team meetings for each resident seen in the psychiatric clinic.<br><br>Advances have been made in some areas comprehensively including and empowering Psychiatric Aides in planning and review (for example: over the past year MDC has developed a cooking program in Unit 4 - Psychiatric Aides were involved with the planning from the beginning.<br><br>**Suggestion:**<br>▪ Evaluate the degree to which Psychiatric Aides are comprehensively involved and empowered in the planning and review process in all treatment areas; solicit Psychiatric Aide input into ways to build on existing role as fully-participating treatment team members. |
| Do MDC assessments: | |
| ➢ identify resident preferences, strengths, and needs regarding safety, food, housing, education, employment, and leisure? | **-YES-** |
| ➢ include assessment of history of abuse/neglect? | **-YES-** |
| ➢ identify factors that place the resident at high risk for suicide, violence, or victimization? | **-YES-** |
| ➢ include detailed family history, including family history of mental illness? | **-YES-** |
| ➢ include detailed description of current family relationships? | **-YES-** |
| ➢ identify family supports available, with specific names, contact, and permission information? | **-YES-** |
| ➢ identify specific ethnic background, including unique cultural, ethnic, spiritual, and language needs relevant to residents and their families, with a specific emphasis on American Indian | **-YES-** |

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| people (including resident identified nation/tribe and relevant tribal contact information)? | |
| ➢ include functional assessment of residents' daily living skills with detailed description of residents' strengths and deficits? | **-YES-** |
| ➢ addresses residents' feelings of hope about the future and their ability to lead a productive life? | **-YES-**<br>The new Personal Support Plan format addresses these subjects in the initial interview. |
| ➢ identify sources of motivation, resources, strengths, interests, capabilities, major problems, and deficits? | **-YES-** |
| ➢ identify coping strategies and supports that have been successful in the past and can be successful in the future? | **-YES-** |
| ➢ address residents' choices regarding services including history of satisfaction and dissatisfaction with services, including medications? | **-YES-**<br>Preferences for medications are in the medical documentation. The residents' medications and treatment are also discussed with them by MD's and staff. |
| ➢ address residents' understanding of their illness, their medications and other treatments, and potential medication side effects? | **-YES-**<br>The physician talks with each individual about his/her medication(s) and diagnoses. |
| When a psychiatric diagnosis is made, does MDC provide to residents and, with the resident's consent, family members/carers with information on the diagnosis, options for treatment and prognosis? | **-YES-**<br>Individual treatment plans identify name of person responsible for interpreting the Individual Treatment Plan results; name of person responsible for interpreting the Individual Treatment Plan result to the resident, and the name of person responsible for interpreting the Individual Treatment Plan results to direct care staff.<br><br>MDC does a good job of including family members in information on treatment. |
| Are residents, and with residents' consent, family members/carers are given a copy of the treatment plan? | **-YES-** |
| Do treatment progress reviews support conclusions with documentation? | **-YES-**<br>QMRP does monthly reviews; the medical charts are wonderfully complete in this way. |
| Do treatment progress reviews actively solicit and include the input of the resident, family members / carers, all facility practitioners - including direct care staff - involved in the resident's services? | **-YES-** |
| Are treatment progress reviews conducted with the treatment team and the resident present? | **-YES-**<br>Quarterly meetings include all members of the team and residents if they want to be present. |

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| Do treatment progress reviews proactively support continuing treatment and support adjustments that will ensure progress, not just maintenance. | **-YES-** |
| When continuation of ongoing treatment strategies is appropriate, does the treatment team clearly address this fact and documents the rationale? | **-YES-** |
| Does MDC document the following to track resident outcomes:<br><br>➢ attainment of treatment objectives?<br>➢ changes in mental health and general health status for residents?<br>➢ changes in behavioral profile?<br>➢ changes in residents' quality of life?<br>➢ resident satisfaction with services? | **-YES-***<br>The Psychologist conducts spot checks.<br><br>The medical and general health is assessed at each contact with the physician. Each resident is seen at least quarterly and as needed. About 60 residents are on psychiatric or behavioral medications; these residents are seen by the psychiatrist in the cottage as needed and on a rotational basis. A few residents undergo a psychotropic medication review each week on a rotational basis.<br><br>Data is tracked on progress toward both mental and general health treatment objectives.<br><br>**Concerns**:<br>*Changes in quality of life and resident satisfaction are not part of any formal tracking. |
| Provision of Treatment | **Comments / Analysis** |
| Are treatment plans and staff treatment assignments effectively communicated to cottage staff? | **-YES-**<br>Line staff awareness of ***individual treatment plans*** and specific responsibilities is spotty, varying by unit and shift.<br><br>Each Psychiatric Aide receives verbal training on every treatment plan in the cottage to which sh/e is assigned; if a Psychiatric Aide is pulled to an unfamiliar cottage, sh/e receives verbal training on every treatment plan in the new cottage.<br><br>Staff are knowledgeable about treatment plans in a general way, and acknowledge that treatment plans are available on the units for review.<br>When staff are pulled to units with which they are not familiar, knowledge of individual and behavior treatment plans approaches zero.<br><br>The psychologist states that staff are knowledgeable about ***behavior treatment plans***.<br><br>**Concern:**<br>Staff shortages have adversely affected treatment. Treatment plan implementation is sometimes not possible due to staff shortages and the need to address milieu safety as a priority over individual treatment. |

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| | MDC has responded to this problem by increasing "minimum staffing" requirements on some units. Staff at all levels are to be commended on their efforts to ensure that treatment takes place despite staff shortages. |
| Do the clinical professionals (psychologists) have the authority to intervene when treatment interventions are not carried out per the treatment plan? | **-YES-**<br>Prior to this site review, ambiguity about the authority of the Psychologists appeared to be a significant problem. Beginning about one month prior to the site review, the Psychology Director began to take assertive action to assume this authority, stating that her position is that for staff not to follow treatment plans as written would be considered neglect. Though this professional initiative is warranted and to be commended, ***organizationally*** these lines of authority continue to be unclear.<br><br>**Concerns**:<br>It appears that on one unit, 'indigenous leaders' among supervisors and front-line staff cooperate only during the presence of the Psychologist. This situation is apparently being addressed administratively. |
| Are individual treatment plans consistently carried out according to the recommendations of the clinical professionals? | Chart reviews indicate that ***behavior treatment plans*** are followed.<br><br>**Concern:**<br>Staff shortages and reassignment of staff to unfamiliar units result in minimal treatment on a regular basis. While staff reported that treatment plans are followed to the best of their ability, it did not appear to the BOV team that treatment was a priority for direct care staff. |
| Are decisions about living assignments, transfers, and other milieu and resident movement considerations made according to the recommendations of the clinical professionals? | -YES-<br>Clinical professionals are part of treatment teams and those decisions seem to be made consensually. Decisions about movement into and out of the secure unit (104) continue to be problematic.<br><br>Until very recently, sexual offenders and people with psychiatric illnesses were housed together. Grouping sexual offenders into a common living unit that allows treatment consistency and uniform staff expertise has been accomplished after years of advocacy by the psychologist in charge of this treatment.<br><br>**Concern:**<br>Clinical recommendations about living assignments, transfers, and other milieu and resident movement considerations are often impossible to implement due to lack of available space in a given unit. |
| Does MDC have enough clinical professionals? | **-YES-**<br>The number of psychiatric, psychological, nursing, and medical staff appears to be adequate - according to interviews with all disciplines, BOV team impressions, and record review. |

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| | **NOTE:**<br>In order for the current number of psychology staff to be effective, ALL psychologists must be assertively involved in monitoring treatment follow-through and ensuring adherence to established treatment plans. |
| Do clinical professionals have the appropriate level of input into and authority over the design and implementation of treatment plans? | **-YES-**<br>Clinical professionals state that management is now supporting their authority over treatment. Recent organizational changes appear to reflect this authority.<br>**Concerns:**<br>▪ It appears that the administration has not been as clear as it should in 'officially' asserting (via policy, memo, and/or directive) that the clinical professionals have the authority to hold staff at all levels accountable for provision of individual treatment as described in treatment plans.<br>▪ The authority of clinical professionals appears more ambiguous on the secure unit (Unit 104) than on other units.<br>**Recommendation 5:**<br>Do the following to reinforce the authority of the clinical professionals to hold staff at all levels accountable for provision of individual treatment as described in treatment plans:<br>(1) develop a written policy;<br>(2) educate staff about the new policy through written directive/memo to all staff and through personal communication by the Superintendent. |
| Do treatment teams defer to recommendations of the clinical professionals? | **-YES-** |
| What are the primary environmental / procedural factors that adversely affect treatment? | Crowded living areas.<br><br>Inadequate budget to allow nightshift staff to attend training.<br><br>Excessive incident management ties up valuable staff resources unnecessarily.<br><br>Staff shortages create a cascade of situations that compromise treatment:<br><br>▪ shift managers spend significant time away from supervisory duties making arrangements for unit coverage<br>▪ staff at all levels of treatment responsibilities forgo required training to maintain minimum staff to resident ratios<br>▪ line staff make judgments to assist residents at risk, temporarily leaving assigned residents unattended<br>▪ cycle of chronic need for overtime - budget-induced overtime caps - need for overtime<br>▪ cumulative morale deterioration |

| Medications | Comments / Analysis |
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| Does MDC medication prescription protocol reflect accepted medical standards? | **-YES-** |
| At MDC facilities, is medication prescribed, stored, transported, administered, and reviewed by authorized persons in a manner consistent with legislation, regulations and professional guidelines? | **-YES-** |
| Are medications is administered in a manner that protects the resident's dignity and privacy? | **-YES-** |
| Is "medication when required" (PRN) is only used as a part of a documented continuum of strategies for safely alleviating the resident's distress and/or risk? | **-YES-**<br>The behavior treatment plan outlines the strategies. These are well documented in PRN protocol forms.<br><br>**Concern**:<br>PRN protocol forms are not kept with the other medical records. It is good that psychology has these forms, but a copy should be in the medical records. |
| Does MDC ensure access for the resident to the safest, most effective, and most appropriate medication and/or other technology? | **-YES-**<br>The physician can always get an acceptable medication. When the one she ordered is not covered by a resident's Medicare Part D or unavailable at the pharmacy, they suggest an acceptable alternative. |
| Does MDC consider and document the views of residents and, with residents' informed consent, their family members/carers and other relevant service providers prior to administration of new medication? | **-YES-** |
| Does MDC provide regularly scheduled appointments with a psychiatrist or mid-level practitioner to assess the effectiveness of prescribed medications, to adjust prescriptions, and to address residents' questions / concerns in a manner that neither compromises neither clinical protocol nor resident – clinician relationship? | **-YES-**<br>Each resident is seen by the medical physician at least quarterly and as needed. The psychiatrist sees all residents on psychotherapeutic medication on a rotational basis and as needed, and does an excellent job of following up with the residents; it is especially good that he visits the cottages. |
| When legitimate concerns or problems arise with prescriptions, do MDC residents have immediate access to a psychiatrist or mid-level practitioner? | The physician is not local nor present every day. During off hours or days, she is available by phone. The nursing staff assesses the situation and calls the psychiatrist or medical director if needed. The emergency department at St Peter's Hospital in Helena is also used on occasion. |
| Are medication allergies and adverse medication reactions well documented, monitored, and promptly treated? | **-YES-**<br>There is better documentation of adverse effects than the BOV consultant has seen in any other facility. |
| Are medication errors documented? | **-YES-** |

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| Is there a quality improvement process in place for assessing ways to decrease medication errors? | **-YES-**<br>The medication error form goes to the Director of Nursing and is discussed at the pharmacy committee meetings which includes the physician. This group reviews each error looking for system issues. |
| Are appropriate residents screened for tardive dyskinesia? | **-YES-**<br>A DISCUS scale was present in the charts of each resident on antipsychotic agents. |
| Is the rationale for prescribing and changing prescriptions for medications documented in the clinical record? | **-YES-**<br>Both the medical physician and psychiatrist document the rationale and use of medications well. |
| Is medication education provided to residents including "adherence" education (based on each resident's ability to understand)? | **-YES-**<br>Residents are educated on what prescribed medications are for and any possible side effects they should watch for. |
| Is there a clear procedure for the use of medication samples? | Samples are not used at MDC. |
| Are unused portions of medications disposed of appropriately after expiration dates? | Not assessed. |
| Are individual residents' medications disposed of properly when prescriptions are changed? | Not assessed. |
| Is there a clear procedure for using and documenting emergency medication use, including documentation of rationale, efficacy, and side effects? | **-YES-**<br>Medications are only given secondary to an order from a physician. There is a stock of medications on site that need to be started immediately upon a physician order, such as antibiotics. Other orders are faxed to the pharmacy and delivered the next day. |

# Secure Unit (104-R)

| 2002 Observations and Recommendations; MDC response | 2006 Comments / Analysis |
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| **2002 OBSERVATION 1:**<br>The staff and residents in 104-R feel "cut off" from the MDC administration. Staff fears residents and feel unappreciated. Staff outside of the unit resent the high intensity staffing level in 104-R, especially when staff must be pulled from other units to meet the one on one supervision level. Within the unit direct care staff are also struggling with how to manage the residents, with some giving residents whatever they demand to avoid confrontation and others following policies and then struggling with resident resentment for following policies.<br>**2002 RECOMMENDATION 1:**<br>A representative from the administrative level should conduct a weekly walk-through of the units.<br><br>This "management by walking around" method will reassure staff and residents with a sense of "buy in" by allowing their concerns to be heard. It will increase communication between the units to have issues clarified and rumors eliminated on a regular basis, and can be used as an opportunity to reinforce to staff the importance of following policies in Unit 104-R.<br><br>**2002 MDC RESPONSE:**<br>Shift supervisors, Unit Coordinators, and Client Services Directors are in the unit daily. | The 2002 recommendation for an administrative level walk through weekly was intended to be in reference to upper management team members' involvement and interaction in the unit. Staff reported in 2002 that they felt unappreciated and 'cut off'.<br><br>Staff interviewed in 2006 reported that they felt more involvement on the part of management team members. |
| **2002 OBSERVATION 2:**<br>The current staff to resident ratio is 1:1, except for the 10:00 p.m. to 6:00 a.m. shift, when the ratio drops to 2:3. The 1:1 daytime ratio does not include the Treatment Program Specialist. Staffing levels never drop below 2 in the unit, this was observed in practice.<br><br>A primary concern with staffing is the cost to the facility- both monetarily and in pulling "flex" staff from other units. "Flex" staff presents a risk if they have not been specifically trained. The residents in Unit 104-R are unique to MDC. The residents take advantage of inexperienced staff and this presents a dangerous situation. Residents dictate when they will go to town or to activities outside of the unit, necessitating the need to have three staff in the unit so that one can escort resident to various activities on demand. During times of resident inactivity, staff tends to congregate and remain idle between periods of 15-minute resident observation.<br><br>**2002 RECOMMENDATION 2-A:**<br>Reorganize resident activity schedules and staffing so that a 2:3 ratio is maintained except during times of planned increased resident activity.<br>• If a resident refuses to attend an activity at a designated time, log this refusal and do not allow the resident to do the activity until the next scheduled opportunity. | 1:1 ratios are observed in practice but on the male side of the unit, staff are not interacting with residents, observing them but not engaging with them in 1:1 direction- again bringing to mind the usefulness of having 1:1 staffing.<br><br>On the female side, residents were observed attending to activities and hobbies; they were cheerful and engaged with staff.<br><br>**Concern:**<br>There is much tension in the male unit, residents wander aimlessly and lay on the floor in front of the staff desk area. Residents appear bored and listless; one was observed engaging in a debate with a staff member that was meaningless - he continued to escalate in his response the longer the staff member argued with him about the issue. |

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| There is no need for one-on-one supervision when residents are inactive. Each resident should have a regular schedule as a part of his/her Individual Treatment Plan. A third staff member could be assigned only for times of planned high activity, such as scheduled activity/escorts outside of the unit. It is far safer to have two trained/experienced direct care staff in the unit than it is to utilize inexperienced "flex" staff to meet the 1:1 ratio.<br><br>**2002 RECOMMENDATION 2-B:**<br>Require that at minimum one person with specialized training supervise all interactions between residents and inexperienced "flex" staff.<br><br>**2002 MDC RESPONSE:**<br>Permanent staff are always assigned, 1:1 staffing ratio is necessary. | |
| **2002 OBSERVATION 3:**<br>There have been challenges related to taking 104-R residents on off-grounds outings and other "desirable" activities. MDC has struggled with the traditional belief that such activities should be predicated on "good" behavior or the absence of "bad" behavior. This approach has not yielded good results with this population due to the nature of residents' cognitive deficits and other clinical issues.<br><br>**2002 RECOMMENDATION 3:**<br>Make all off-grounds trips and other activities a part of each 104-R resident's INDIVIDUAL TREATMENT PLAN. Ensure that the approach to these activities and their relationship with residents' behavior is individualized and consistently enforced by the treatment team.<br><br>Implementation of this recommendation should ensure at a minimum that the resident is being given an earned privilege as a part of an incentive-based behavioral management program that is commensurate with cause-and-effect time frames that make sense for each resident, and that there have been no behaviors within the immediate time frame that should reasonably preclude the activity or that indicate an immediate danger to the community. If the resident refuses to participate in an activity or has not been allowed to go on an activity due to recent unacceptable behaviors, then the opportunity should be lost and should not be "made up" at an unscheduled time or upon demand.<br><br>**2002 MDC RESPONSE:**<br>It is believed that residents in question do not have the cognitive abilities to make a connection between behavior and consequences. | Clinical staff reported a belief that direct line staff were refusing resident's planned activities in response to behaviors but not as a sanctioned part of the individual behavior management plan. In practice, it was observed that residents were encouraged by line staff to attend their scheduled activities.<br><br>Daily schedules were available for each resident, but activities were limited and allowed for late morning/afternoon (5 hours in the day) without any structure-hence the listlessness of the residents in the unit during these times.<br><br>On the female side, when residents became bored they were offered suggestions and directed to hobby activities.<br><br>**Recommendation 6:**<br>Conduct team building with QMRP, Unit Coordinators, and Psychology Department to engage residents on the men's side in meaningful activity in the unit as well as out of the unit. |
| **2002 OBSERVATION 4:**<br>Staff expresses fear and concern for their safety in Unit 104-R. They express helplessness in their ability to stop the acting out behaviors that have been exhibited by the residents. There have been numerous dangerous incidents and assaults on staff in the unit. Staff are unclear about how to manage difficult interactions with residents. The inconsistency between shifts in following policies creates tension in the unit, allowing further inconsistencies.<br><br>Two of the three residents meet the criteria for a DSM-IV-TR™ Axis II diagnosis of Antisocial Personality Disorder. The third resident has a long history of impulsive and destructive acts "without provocation", although he | BOV consultant did not observe the use of Cognitive Principles and Restructuring (CP & R), nor was it seen on lesson plans for staff.<br><br>Staff reported that when a resident acts out, he or she is offered a thinking error report. |

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| was able to identify a prolonged "feeling" (frustration/anger) that preceded the acts of violence.<br><br>**2002 RECOMMENDATION 4-A:**<br>Send staff working in Unit 104-R to a one-day training session in the concepts of "Cognitive Principles and Restructuring" (CP & R), to include antisocial personality traits and associated behaviors.<br><br>**2002 RECOMMENDATION 4-B:**<br>Implement resident involvement in CP & R training as a part of each 104-R resident's individual treatment plan (ITP).<br><br>It is possible to identify the cycle of aggression/assault for each resident, enabling staff to understand how behaviors escalate, and giving them a tool to de-escalate destructive behaviors. The Department of Corrections utilizes a program called "Cognitive Principles and Restructuring" (CP & R). Staff can be taught this program so they may recognize each resident's cyclical/escalating behaviors.<br>The psycho-educational program is behavioral based and can be provided to residents by a trained staff member. Staff can reinforce the concepts in interactions with residents, correcting dysfunctional thoughts before they escalate to actions.<br><br>**2002 MDC RESPONSE:**<br>**MDC concurs with this recommendation** | **Concern:**<br>Staff was unable to locate the thinking error report form and residents were not able to identify any of the concepts in CP & R when interviewed, nor was it observed as a program or class on any resident schedules.<br><br>Most recently, DBT or Dialectical Behavioral Therapy has become available in the state. It has been used successfully in a modified format in the treatment of impulsive acting out or self harm behaviors for people with developmental disabilities in the community. It teaches basic skills related to emotion regulation and distress tolerance. Both the CP & R and DBT programs could be used in conjunction to address the needs of the population in the unit.<br><br>**Recommendation 7:**<br>Implement Recommendations 4 A and 4-B from the 2002 BOV report:<br><br>**2002 Recommendation 4 A:**<br>Send staff working in Unit 104-R to a one-day training session in the concepts of "Cognitive Principles and Restructuring", to include antisocial personality traits and associated behaviors.<br><br>**2002 Recommendation 4 B:**<br>Implement resident involvement in "Cognitive Principles and Restructuring" training as a part of each 104-R resident's individual treatment plan (ITP).<br><br>**Recommendation 8:**<br>Implement Dialectical Behavioral Therapy training for staff, and inclusion of Dialectical Behavioral Therapy in each 104 resident's treatment plan. |
| **2002 OBSERVATION 5:**<br>Larry LeRoux, Resident Services Director, and Terry McFadden, Treatment Program Specialist, have made significant policy changes recently. They are to be commended for these efforts. Change is difficult for both staff and residents. Some discussion was held with Larry regarding implementing new policies and policy revisions in a manner to avoid escalating resident behaviors, such as giving residents a means by which to provide feedback, allowing their concerns to be expressed ("venting"). Another method is to | Given the active use of the restraint chair, video taping its use will provide training material and protection from liability. Debriefing use of force/restraint incidents also can be incorporated in policy and in formalized training procedures. A policy for the use of the restraint chair was reviewed and is well |

set a time-line for implementation, such as 30 days after the policy is presented, giving both staff and residents time to adjust to the change and allowing time for staff training.

Further policy changes are recommended within this report. To implement security procedures and training regarding policy changes, staff may attend Department of Corrections training at minimal cost. Training is held regularly at the Montana Law Enforcement Academy in Helena, staff could be sent to particular modules of this training program. Further training is available in other locations throughout the year.

The most pressing issue related to training is that only 24 of 170 staff have received self-defense training.

**2002 RECOMMENDATION 5-A:**
Ensure that at least one staff member assigned to Unit 104-R on each shift is trained in the following:

- Searches
- Antisocial personality traits
- Non-Violent Crisis Intervention ("CPI")
- Report Writing
- Interpersonal Communication
- Restraints (if the decision is made to utilize restraints, see Recommendation Eleven)
- Emergency Response Procedures
- Crime Scene/ Evidence Preservation
- Security Inspections

**2002 RECOMMENDATION 5-B:**
Ensure that all staff assigned to Unit 104-R receive formalized orientation and on-site training, prior to working in the unit, to include:

- Antisocial Personality Disorder traits
- Suicidal Behaviors and Mental Health Issues
- Self Defense Tactics (as prescribed in MANDT or another appropriate program)
- Emergency response, key control, tool control, safety issues
- Stress Management/Wellness/Healthy Boundaries
- A review of each resident's ITP
- Policies specific to the unit
- Post orders developed for the unit, as recommended in Observation Number Nine.

Some of these modules are already being offered as voluntary in-service training provided by both the Psychology Department and by Terry McFadden in the unit. The unit has some new policies, including "Resident Interaction Guidelines", that begin to address healthy boundaries and manipulation tactics by residents. With some technical assistance, these existing policies can be utilized in the training modules. The on-site training can reduce staff resistance by explaining manipulation tactics and why such issues as personal disclosure are a security/safety risk.

The Department of Corrections is available to provide technical assistance in coordinating with MDC staff for scheduled training and developing lesson plans for on-site and orientation training.

drafted.

The facility now has a permanent crime investigator. A formal policy needs to be in place to protect evidence and chain of custody for all evidence. The Client Protection Specialist Manager reported there was discussion of a policy and that he was informally training staff regarding evidence preservation. He has developed a storage system to address chain of custody concerns, a more formalized policy for evidence preservation can be obtained online at: http://www.cor.mt.gov/resources/POL/3-1-28.pdf

It should be noted that some training is not being documented, such as the review of resident behavior management plans by Connie Orr with individual direct care staff. This time could be appropriately credited as training specific to the unit and special needs of residents in the unit.

There remains a disparity in staff mandatory training, with only 33% of staff on Unit 104 having completed minimal mandatory training. (see Recommendations 3, p.11 - **Staff Competence, Training, Supervision**)

**Recommendation 9:**
Implement recommendations 5-A and 5-B from 2002 BOV report (excluding "Non-Violent Crisis Intervention [CPI]" – MDC trains all staff in the use of Mandt):

**2002 RECOMMENDATION 5 A):**
Ensure that at least one staff member assigned to Unit 104-R on each shift is trained in the following:

- Searches
- Antisocial personality traits
- Non Violent Crisis Intervention ("CPI")
- Report Writing
- Interpersonal Communication
- Restraints
- Emergency Response Procedures
- Crime Scene/ Evidence Preservation
- Security Inspections

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| **2002 MDC RESPONSE:**<br>**Training already available, will consider additional topics in the future.** | **2002 RECOMMENDATION 5 B:**<br>Ensure that all staff assigned to Unit 104-R receive formalized orientation and on-site training, prior to working in the unit, to include:<br>• Antisocial Personality Disorder traits<br>• Suicidal Behaviors and Mental Health Issues<br>• Self Defense Tactics (as prescribed in MANDT or another appropriate program)<br>• Emergency response, key control, tool control, safety issues<br>• Stress Management/Wellness/Healthy Boundaries<br>• A review of each resident's ITP<br>• Policies specific to the unit<br>• Post orders developed for the unit, as recommended in Observation Number Nine.<br><br>**Recommendation 10:**<br>Develop a formal policy addressing protection of evidence and chain of custody for all evidence.<br><br>Suggestion:<br>Begin to video tape the use of the restraint chair. This would be helpful for both training purposes, and to address potential liability concerns. |
| **2002 OBSERVATION 6:**<br>Admissions criteria are vague and discharge criteria are not complete for Unit 104-R. It is unclear whether individual residents who are placed on 104-R are there temporarily with a planned return to their "home" residence, or whether some will remain on 104-R as the appropriate ongoing treatment and residential environment.<br><br>**2002 RECOMMENDATION 6-A:**<br>Establish a protocol for determining whether each individual placed on 104-R is being placed there temporarily with a planned return to his/her "home" residence, or whether he/she will remain on 104-R as the appropriate ongoing treatment and residential environment.<br><br>**2002 RECOMMENDATION 6-B:**<br>For individuals who are placed on 104-R temporarily, add a specific treatment completion component to discharge criteria from Unit 104-R, such as completion of the CP & R program, or another specific cognitive-behavioral based performance measure for treatment.<br><br>**2002 RECOMMENDATION 6-C:**<br>For individuals who are placed on 104-R temporarily, establish incentive-based measures, such as a set time without destructive behaviors toward | Policy has been implemented and was reviewed by this reporter. Discharge criteria are now directly linked to treatment team and individual treatment plans.<br><br>**Concerns:**<br>▪ It is unclear as to final authority in admitting and discharging residents.<br>▪ There is a concern regarding the conceptualization of treatment for residents in the unit, notably the purpose of the unit as a specialized treatment area verses a punishment or isolation area.<br>▪ Several files reviewed identified residents as having a bipolar disorder diagnosis, but not being treated with a mood stabilizer. Medications may be more effective for some residents, especially those with bipolar disorders, than any |

self, property or others as part of the discharge criteria.

**2002 RECOMMENDATION 6-D:**
Establish behaviorally specific goals for each resident to reach; eliminate the generic term "as decided" or "as determined by the Interdisciplinary Team" - these are too difficult to measure and are open to individual staff subjectivity.

**2002 RECOMMENDATION 6-E:**
Incorporate the following clinical components into a more specific admission criteria:

1. An Axis II diagnosis of Antisocial Personality Disorder or Borderline Personality Disorder; OR
2. Any Axis I diagnostic code that includes a behavioral disturbance; Conduct Disorder, Oppositional Defiant Disorder, Disruptive Behavior Disorder Not Otherwise Specified, Explosive Disorder, Impulse Control Disorders or sexual paraphilias (severe), as listed in DSM IV-TR™, as the focus of clinical attention; OR
3. Any Axis IV diagnostic code that includes physical abuse or sexual abuse with the focus of clinical attention on the perpetrator. (When these problems become the principal focus of clinical attention, they are listed on Axis I). These V-codes from DSM IV-TR™ would include: V61.21; V61.12; V62.83; V71.01; OR
4. An additional condition that could warrant admission to Unit 104-R would also include non-compliance with treatment, V15.81, when the problem is sufficiently severe to warrant independent clinical attention for maladaptive personality traits or coping styles. This category can be used when the focus of clinical attention is noncompliance with an IMPORTANT aspect of treatment for a mental or general medical condition, such as:
    - Refusal to comply with a special diet for a medical condition, resulting in stealing or running away to obtain the food, when the behavior represents a significant danger to self as a result; or with Obsessive Compulsive Disorder (poor insight) when compulsive behaviors are a danger to self, warranting more intensive supervision, or with a psychotic/manic episode if the resident becomes a danger to self or others.

By making admission criteria clinically based as well as behavioral based, the Unit is more clearly identified as an intensive treatment unit, with behavior based specific measures/incentives for discharge (for those who are placed there temporarily), while at the same time separating these residents from potential victims in the vulnerable population. The intensive treatment component is additionally addressed in the recommended training for 104-R staff. Making every interaction with a resident a "teachable moment" will happen when staff begins to feel more confident/safe with learned behavioral management techniques.

It should be noted that these entrance criteria could be incorporated with the currently utilized Psychological or Mental Status Report, an assessment instrument utilized in the admission process already.

**2002 MDC RESPONSE:**
MDC agrees in principle to these recommendations and will develop appropriate criteria in the near future.

amount of training or traditional therapeutic interventions for impulse control, conduct or disruptive problems.

- MDC's mission and philosophy statements note that the program is directed toward preparing residents for ultimate discharge to an appropriate program in a community setting. It is unclear how this philosophy is applied to practice in Unit 104.
- The residents and staff in unit 104R lack direction regarding the purpose of the unit; the policy is vague except for a generalized statement:

"*Individuals admitted to MDC ICF-DD do not necessarily meet the definition of being in need of active treatment as defined by federal regulation….The identified treatment needs of the residents admitted to (the unit) generally include the need for highly structured environments which may include up to the need for an environment with a high level of security for the protection of the resident and others*."

**NOTE**:
One resident refuses medications, yet remains a long term resident in the secure unit based on his risk of harming himself or others; it appears that this resident's competence to make a decision to refuse medications is a valid question that should be pursued.

**Recommendation 11:**
Develop specific descriptions of purpose, goals, and objectives for the secure unit.

**Recommendation 12:**
Designate clinical professionals as having the final authority for admission to and discharge from the secure unit.

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| **2002 OBSERVATION 7:**<br>The Unit was clean and in good repair, except for recent damage by a resident to ceiling tiles and fire extinguisher boxes.<br>**2002 RECOMMENDATION 7:**<br>Based on the individual clinical needs and cognitive limitations of each resident, incorporate reimbursement for property destruction into the ITPs for 104-R residents who intentionally destroy property on a regular basis.<br><br>It would be a good behavioral management tool to extinguish his destructive behaviors by making reimbursement a part of his ITP. This is not suggested as a punishment, but as a method of treatment to assist residents in regaining control of their behaviors through accountability for their actions. It reinforces anti-social personality traits to NOT hold them accountable. It is also escalating their destructiveness. Some 104-R residents have a great sense of accomplishment and enjoys bragging about their behaviors, telling "war stories" about the things they have destroyed/damaged. It is a disservice to residents not to aid them in improving these behaviors. It is also extremely dangerous to continue to let these behaviors escalate.<br><br>**2002 MDC RESPONSE:**<br>The 104-R team will assess the ability to pay and the validity of this method as a teaching tool for an individual on a case by case basis. | There is a policy in place that sets forth provisions in applying consequences for destructive behaviors. It is unclear if this has been effective as a teaching tool for the residents in the unit. |
| **2002 OBSERVATION 8:**<br>The nurses station or main staff staging area is not secure. Residents "hang out" in this area, observing shift change over, entrance procedures, security procedures, chatting with staff, and listening to all discussion regarding Unit operations.<br><br>**2002 RECOMMENDATION 8:**<br>Implement the following procedures to establish a secure “control center”, to discourage residents from "hanging out" in this area, and to eliminate the availability of sensitive information to 104-R residents:<br>• Encourage staff to conduct interactions with residents in the day room instead of the hall.<br>• Conduct shift exchange outside of the unit, allowing a more extensive/confidential exchange of information.<br>• Create a closed-in staff communication area OR keep residents away from the entrance door/main staff “staging” area by painting a line on the floor.<br>• Encourage staff to avoid congregating in this area.<br>• Staff should not discuss unit procedures, operations, personal disclosures, or complaints about the unit or MDC in the presence of residents.<br>• Ensure that unit logs entries are made regarding important issues for the next shift to know about, and that new shift review all log entries for the prior shift upon assuming their duties.<br><br>**2002 MDC RESPONSE:**<br>MDC concurs with this recommendation. | Residents are discouraged from going behind the nursing station counter but constantly attempt to do so. BOV consultant observed staff congregating in this area.<br><br>On the female side, residents were offered options for redirection when they came to the desk area, or they had a need that staff immediately responded to with an engaged and pleasant demeanor.<br><br>Staff no longer participate in a formal shift exchange, but review the logs when they come onto their shift and demonstrated sensitivity to anything they spoke of in front of the residents.<br><br>**Concern:**<br>On the male side, residents were observed lying on the floor in front of and beside the desk area for most of the BOV consultant’s observation time. |

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| **2002 OBSERVATION 9:**<br>Staff and residents had much confusion regarding resident schedules and unit procedures.<br><br>**2002 RECOMMENDATION 9:**<br>Implement "post orders" (detailed description of what is done when) that entail the following:<br>• Overall resident schedules for activities that staff can follow in detailed 1/2-hour increments to determine what should be offered or completed at each time of the day.<br>• An individual post order for each resident so the staff member assigned to that resident can follow it.<br>• Guidelines for enforcement of each resident's schedule and for planned/controlled movement of residents through the campus or into town.<br>• Documentation of the scheduled activities and opportunities for activities that may be refused (see **Recommendation 2-A**).<br><br>Post orders will give residents a sense of stability and staff a sense of routine/predictability more specific then a general policy. Previously recommended was a set schedule for each resident, enforcing that if they refuse an activity, the opportunity for the activity will not be offered again until scheduled. The Department of Corrections can provide technical assistance in developing post orders.<br><br>**2002 MDC RESPONSE:**<br>MDC believes that individual resident schedules and staff schedules serves this purpose. | Resident schedules and staff schedules were reviewed and were current. The philosophy behind this recommendation was to encourage staff to interact and engage with residents with detailed descriptions of staff duties/responses to residents, and general outlines of procedures. The behavioral management plans give this detail and are adequate as detailed and directive for staff in interactions.<br><br>In the female unit, the behavioral management plans were readily located and in a place that allowed ease in location and reference.<br><br>**Concern:**<br>In the male unit, two staff members were unable to locate the behavioral management plans when asked. They were located in a drawer eventually. |
| **2002 OBSERVATION 10:**<br>There are no search policies related to body searches, room searches, or area searches. An attempt has been made to implement the practice of room searches. A resident acted out and assaulted two staff prior to having his room searched. A pair of 12-inch scissors was found under his mattress.<br><br>**2002 RECOMMENDATION 10:**<br>Develop policy and procedure for both routine unit safety searches as well as for searches of individual residents.<br><br>Routine unit safety searches should entail the following:<br>• Inform the residents that it will be happening.<br>• Implement a planned transition into the routine.<br>• Do not allow acting out behaviors to deter from the process.<br>• Provide training for staff that will be doing searches.<br>• Require weekly common area searches and room searches.<br><br>Individual resident searches should take into account the following:<br>• Defining methods for assuring that a resident does not have or bring into the unit any item that could pose a danger. These could include minimally intrusive methods such as asking a resident to empty his/her pockets and more intrusive methods such as "pat" searches and strip searches – according to assessment of each individual situation.<br>• When dealing with resident rights it is imperative that staff obtains proper training prior to doing searches and diligent supervision. | Policies and procedures are in place to address these areas.<br><br>It is important to note that an evidence preservation policy (noted in observation 5) has a direct correlation with a search policy regarding procedures, evidence handling and preservation.<br><br>**Concern:**<br>Electronic wands are locked in the Crime Investigator's Office, in their original boxes, and have never been used. He reports they are awaiting policy development to implement use. Policy recommendations would include: http://www.cor.mt.gov/resources/POL/3-1-17.pdf |

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| • Some considerations include cross-gender pat searches, techniques to ensure items are not concealed on the body, and resident rights related to privacy and property. Area and room searches should be documented.<br>• Realizing that body searches would be difficult and extreme measures in the MDC setting, perhaps a "trail of evidence" could be accumulated for a specific resident during room searches. The evidence would document and justify the need to conduct a strip or pat search on a resident who consistently obtains items not allowed.<br><br>The Department of Corrections has already provided a documentation form and policy to MDC regarding area searches. DOC can also provide training in this area.<br><br>**2002 MDC RESPONSE:**<br>Searches will occur on a case by case basis; electronic wands will be purchased so that body searches are less invasive. | |
| **2002 OBSERVATION 11 :**<br>(Observation and Recommendation 11 apply to 104-R and other residences at MDC. These also are related to Observation 4.)<br>MDC has taken the admirable initiative of discontinuing the use of mechanical restraints in managing resident behavior. This bold action has forced the treatment culture at MDC to adapt other more humane and effective interventions when residents present challenging behaviors. However, MDC staff report that two to three "physical interventions" continue to be implemented weekly. These interventions include such actions as teams of staff forcibly taking dangerous items away from residents and holding/escorting residents as well as asking for police intervention and their use of handcuffs. There is no policy related to these interventions, except for reliance on MANDT procedures. When a resident is acting out to the point of requiring physical intervention, staff leaders direct the interventions according to the MANDT system. The philosophy of MDC appropriately focuses on protecting and preventing injury to residents. It appears that MDC does not fully address the additional need to protect and prevent injury to staff. Staff will feel more comfortable and will be better able to protect residents if procedures are in place that also maximize staff protection.<br><br>**2002 RECOMMENDATION 11:**<br>Determine when it is realistic to use force in defense and/or protection of persons, property and community. Develop and implement policies and procedures that guide the use and documentation of all physical interventions, with an emphasis on individual treatment planning when applying physical interventions.<br><br>The Department of Correction has provided MDC with a copy of a use of force and restraints policy, including a continuum for responding to escalating behavior. (This is in some ways similar to the MANDT "graded system of alternatives" approach.) It is not suggested that MDC necessarily follow this policy but that response training *appropriate to MDC's management of 104-R* and other situations requiring physical intervention be developed for staff, utilizing the DOC continuum as a reference for how to incorporate the use of physical interventions in policy. | Since its 2002 response, MDC has implemented the use of a restraint chair. The draft policy the BOV consultant reviewed was adequate; refer to training recommendations and videotaping suggestion under **2002 Observation 5 Observation 5** above. |

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| The current situation in Unit 104-R is dangerous in that behaviors are not controlled and are escalating. There is a liability issue if a resident hurts himself without an effort made to stop him. The duty to protect <u>does</u> extend to other residents, community, and staff. Local law enforcement cannot always respond in a timely manner and if a resident obtains a weapon, such as the 12-inch scissors found during a search (see **Observation 10**), there is risk and intent for deadly harm to self or others. After consultation with legal counsel, MDC may choose to seek technical assistance from the Department of Corrections to implement a policy and procedures. To implement such a policy, there will be many other issues to consider, including training, protective equipment, sanitation of equipment, inventory of equipment and storage. It is a complex and complicated issue that will require planning and forethought. *A planned use of physical intervention is less likely to result in injuries than if behaviors continue to escalate until a reactionary/defense situation occurs.*<br><br>**<u>2002 MDC RESPONSE:</u>**<br>MDC does not feel the use of restraints should be incorporated at this time. | |
| **<u>2002 OBSERVATION 12:</u>**<br>Key control policy and procedures are "loose". There are too many keys on a ring, making it difficult for staff to identify which key goes to which lock, or for staff to identify if any one key is missing. Three of four staff members tested did not have the new key to the fire extinguisher boxes, although they had several keys on their rings that previously were used for this purpose. A spare set of keys is kept in a locked wooden box in the staff operations area- a resident broke this box the week before this review during an assault. If staff locks themselves in a closet or room for protection, a resident could get access to them by accessing these keys. *A staff member was observed showing a resident which keys went to which doors, "because he asked and wanted to know".*<br><br>**<u>2002 RECOMMENDATION 12:</u>**<br>***Immediate and priority issue***: develop and implement a key control system with technical assistance from the Department of Corrections.<br><br>Key control is a critical component of any security system or locked unit. There are numerous examples of failed key control systems in secure/locked facilities that have resulted in death and injury. As a critical component of this security system, ***the spare set of keys in the unit should be relocated to a designated and secure location outside of the unit immediately.***<br><br>**<u>2002 MDC RESPONSE:</u>**<br>MDC concurs with this recommendation. | There were adequate key control practices observed, in accordance with policies and procedures. |
| **<u>2002 OBSERVATION 13:</u>**<br>MDC recently implemented tool control measures for staff and property restrictions for residents. This is a difficult area as residents claim they have a right to items that could be used as weapons. The facility has a start in the right direction, but staff and residents expressed confusion regarding both property allowances and tool control. The current policy related to "Unit Security" is specific regarding what staff brings into the unit and how they account for it. It is made clear in the policy what expectations are for staff and the policy is being enforced. | There is an adequate property policy in place, and consistency between shifts and units was observed.<br><br>**<u>Concern:</u>**<br>It should be noted that the male unit was barren and severely limited in property. BOV consultant was told that residents destroy anything they are |

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| **2002 RECOMMENDATION 13:**<br>Implement a property policy for residents in 104-R, and stick to it *with no exceptions*.<br><br>The policy needs to specifically state what is not allowed. It is understood that property rights are a contentious issue, but the nature of behaviors that bring residents into the unit justifies reasonable restrictions for all residents in the unit in the interests of security and safety. It is suggested that the policy be *for the unit instead for each resident individually* because if one resident is allowed to have certain items, it gives every resident in the unit access to said items. The policy needs to be a part of the admission process because it is difficult to take things away once they've been allowed. The "rights restriction form" could be filled out to justify restrictions as a part of the safety/security of the residents in the unit and as a part of the intensive treatment/behavioral modification aspect of the unit.<br><br>The Department of Corrections has found success in litigation defense regarding property rights by storing "unallowable" property, so the person being denied said property can have it back when leaving the secure setting. This works as an incentive for the resident to earn more privileges with a less secure setting. An inventory of each resident's property has been completed; follow up searches and inventories will aid in identifying unallowable property and tracking how it comes into the unit. These inventories should be completed upon admission to the unit in the presence of the resident to explain why certain items are not allowed and how they will be secured until the resident discharges from the unit. Incoming packages should be opened in the presence of staff to ensure the item is allowable and is added to the inventory.<br><br>**2002 MDC RESPONSE:**<br>MDC concurs with this recommendation. | allowed to have, even puzzles on the wall or any hobby projects they were offered. When BOV consultant asked a resident why he had no property available, even music such as a walk-man, he reported he could check one out but that he had no batteries and no money to purchase batteries.<br><br>Even on the high side of the Montana State Prison, inmates are allowed basic property and it was confusing as to why this area was so limited on the male side. |
| **2002 OBSERVATION 14:**<br>The window in 104-A was not secured. The door between one resident's bathroom and the observation/suicide room in 104-R was not locked (the resident demonstrated this). A Safety Officer completes safety inspections, but there has been no emphasis on security inspections to identify such issues.<br><br>**2002 RECOMMENDATION 14:**<br>Develop and/or improve existing policy and procedures for conducting thorough security inspections.<br>• Obtain training for the Safety Officer to include what to look for and how to conduct a thorough security inspection.<br>• Conduct security inspections weekly in Units 104-R and 104-A.<br><br>A policy and documentation form was provided to MDC as a resource for developing a policy/procedure for documenting the process.<br><br>**2002 MDC RESPONSE:**<br>Security inspection at the beginning of each shift. | Policy is in place and was observed in practice. |

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| **2002 OBSERVATION 15:**<br>The outdoor recreation area fence could be easily and quickly scaled.<br><br>**2002 RECOMMENDATION 15:**<br>Add chain link or wire mesh as a ceiling to the outdoor recreation fence to make it more secure.<br><br>Best practice would be to have concrete footing at the base of the fence so it cannot be dug out for a planned escape. With one-on-one supervision, it can reasonably be expected that a resident would not have time to dig out the base of the fence without being observed. Staff should be aware that this is a common means of escape from locked units, and security inspections should include the fencing and base of the fencing to ensure this is not happening over a period of time.<br><br>**2002 MDC RESPONSE:**<br>Not fiscally able to accommodate physical fencing recommendations, included in security inspection policy. | Fencing is currently being installed and a new unit will be built in a few years; this does not meet National Institute of Corrections standards for perimeter security but with 1:1 supervision and inspections current practice is adequate. It should be noted that there is a rise in criminally convicted residents; most are managed in the less secure units so it is irrelevant if the fencing meets standards. |
| **2002 OBSERVATION 16:**<br>Staff wears alarm buttons. The receiver for the alarms is located in an un-manned station in Unit 16. The alarm was tested in my presence. The ambient noise level on Unit 16 is loud, acoustics are poor, and staff is busy. It is possible that a distress call could be unobserved or not heard for some time. Response is unofficial, procedure is for random available staff to assemble and go into the unit to render aid. This is dangerous, as it is unknown what situation staff will be going into without protective equipment or formal response protocols. Policy states that all staff will carry a walkie-talkie for communications, this was not observed in practice.<br><br>**2002 RECOMMENDATION 16:**<br>Correct deficiencies in the alarm system 104-R staff use to request assistance in an emergency.<br><br>Address the following:<br>• Increase the volume of the distress alarm receiver.<br>• Implement procedures that absolutely ensure that when staff on 104-R activate the alarm, help is on the way immediately.<br>• Establish procedures for responding staff to follow.<br>• Implement specialized training to prevent injuries.<br>• Provide and store protective equipment in the closet outside of the unit, readily available if needed for an immediate response.<br>• Develop procedure for maintenance, inventory and sanitation after use of protective equipment.<br>• Implement a procedure for the exchange of walkie-talkies during shift exchange, or if this communication method is not to be implemented, this should be removed from policy.<br>• If walkie-talkies are to be used, implement a procedure for testing, inventory, and maintenance of this system.<br><br>**2002 MDC RESPONSE:**<br>"We will review our system – at this time we do not feel that protective equipment for staff is necessary." | In the female unit, staff members carried the alarm buttons on their person.<br><br>**Concerns:**<br>▪ The alarm system was tested on two occasions with no response.<br>▪ In the male unit, the alarms were locked in a box.<br>▪ Protective equipment has been purchased and is locked in an office, never having been used.<br>▪ For lack of development of an appropriate system for obtaining assistance during emergency situations, staff has developed their own emergency response system by programming personal cell phone numbers into their personal cell phones. They call one another for assistance when situations are escalating. They report they trust certain staff members to bring a rapid and effective response in this manner.<br><br>**Recommendation 13:**<br>Abandon the unused and problematic alarm system - it is inadequate and creates the illusion that an adequate emergency response system is in place. |

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| | **Recommendation 14:**<br>Develop a formal crisis response team, with five specially trained (with documentation) members, under the supervision of the experienced criminal investigator. (There is already such a team in place on an informal basis. When asked who they called when in crisis, direct care staff named the same five staff members each time, who are also trained in the use of the restraint chair.)<br><br>**Recommendation 15:**<br>Develop emergency response policies and procedures. |
| **2002 OBSERVATION 17:**<br>There is no policy related to hostage situations.<br><br>**2002 RECOMMENDATION 17:**<br>Develop and implement a policy addressing hostage situations.<br><br>The following formalized policy statement will discourage hostage situations: "Any employee taken hostage is without authority regardless of rank." Incorporate this statement into a formal policy available to staff and residents:<br><br>**2002 MDC RESPONSE:**<br>MDC will incorporate this into current policy | Policy has been revised and does include the appropriate language regarding hostage situations. |
| **2002 OBSERVATION 18:**<br>Residents are confused about policies, rules and regulations in the unit.<br>**2002 RECOMMENDATION 18:**<br>Develop a formal, consistent means to orient residents to 104-R. This process should include a written checklist and possibly a handbook for staff to use in order to ensure consistent orientation.<br><br>An orientation handbook can include policies that pertain to residents, or can be a written overview of expectations. It is best practice to separate staff procedures from policies related to resident rules/regulations and then incorporate policies related to residents within this handbook. At admission to the unit, a formal orientation session should be held with the resident to verbally go over the rules and to provide an opportunity to answer resident questions. This will alleviate resident anxiety and clarify behavioral expectations. The orientation process can additionally include the ITP and discharge criteria for the resident, if he/she is on the unit temporarily.<br><br>**2002 MDC RESPONSE:**<br>Verbal explanation, including entrance and exit criteria | Residents are not able to identify the exit criteria for the unit. They are able to articulate basic rules. |
| **2002 OBSERVATION 19:**<br>There is a formal grievance system, but residents claim staff withhold the forms when they request one or that staff "rip them up" when they are given to them. | The facility has a written policy that is orally explained. Residents interviewed demonstrated a basic understanding of grievance procedures. |

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| **2002 RECOMMENDATION 19:**<br>Adjust the resident grievance process as follows:<br>• Remove unit staff from the grievance process (best practice).<br>• Make grievance forms available at all times in a common area (such as the day room).<br>• Provide a secured box so residents can submit grievance forms without fear of staff interference in the process and to ensure confidentiality around the issue.<br>• Designate a person from outside of the unit to check the grievance submission box twice a week and process the request. This designated person could also allow verbal reports for those residents who are less literate, providing assistance in the grievance filing process.<br><br>Formalizing this internal due process system can alleviate constant litigation. The courts look favorable upon an internal due process system for residents.<br>**2002 MDC RESPONSE:**<br>MDC will implement this procedure. | |
| **2002 OBSERVATION 20:**<br>Cell phone abuse by residents has been an issue in the unit. The policy that cell phones are pre-paid by the resident has not been enforced. One resident needs behavioral management related to phone usage/abuse as he is refusing all activities outside of the unit and using the phone to solicit jobs, apartments, place wants ads, and order advertised products that he cannot pay for. The log reflecting his phone usage shows that this is the only activity he is engaged in, and it is not beneficial to his treatment to allow this extensive and constant use to continue.<br><br>**2002 RECOMMENDATION 20:**<br>Adjust the telephone use policy as follows:<br>• Eliminate the use of cell phones by residents on 104-R (see **Recommendation 13**).<br>• Allow unlimited access to unit "land-line" telephones, with pre-paid phone cards for long distance calls.<br>• Implement individual resident telephone use restrictions as determined to be clinically indicated with all necessary documentation and review in the ITP.<br>**2002 MDC RESPONSE:**<br>MDC will follow ITP recommendations when problems occur with cell phone usage; only prepaid cell phones allowed. | The grounds-wide phone policy was observed as consistently applied in the unit and in accordance with policy. |
| **2002 OBSERVATION 21:**<br>Activity logs and record keeping are excellent in the unit, including the sign-in and sign-out system. One issue is the policy of 15 minutes checks on residents. Log entries are only made every 1/2-hour. When something is not documented, it is difficult to prove it was done. (Further recommendations regarding logging behaviors are addressed in **Recommendation 26**.)<br><br>**2002 RECOMMENDATION 21:**<br>Consistently log the occurrence of the 15-minute checks.<br><br>**2002 MDC RESPONSE:**<br>MDC concurs. | This practice was observed in policy, practice, and by log entries reviewed in the unit. |

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| **2002 OBSERVATION 22:**<br>There are two suicide observation areas - one in Unit 104-A and one in Unit 104-R. Staff was unable to identify the location of a rescue knife. Hanging is the most common form of actual attempted suicide in locked facilities. When a hanging is attempted, it is extremely difficult to release the resident from the noose as it tightens around the skin. It is critical to get the noose off of the neck as quickly as possible. There are some case findings related to facility duty to respond and remove the noose in a timely manner.<br><br>**2002 RECOMMENDATION 22:**<br>Purchase a rescue knife, place it in a secure area, and train staff regarding the location of the instrument and what the purpose of it is so it may be accessed quickly in an emergency.<br><br>(This is an instrument specifically designed for secure facilities, considered non-dangerous as the blade is contained within the hook.)<br><br>**2002 MDC RESPONSE:**<br>MDC does not believe this is necessary given the 1:1 staff ratio and observations. | **Concern:**<br>A rescue knife is not available on the secure unit.<br><br>Hanging is the most common form of suicidal gesture and it is very difficult to rescue someone effectively in a hanging attempt without the appropriate tool.<br><br>**Recommendation 16:**<br>Implement Recommendation 22 from 2002 BOV report:<br><br>Purchase a rescue knife, place it in a secure area, and train staff regarding the location of the instrument and what the purpose of it is so it may be accessed quickly in an emergency.<br><br>***The cost is cheap in comparison to the cost of loss of life when rapid rescue is imperative.*** |
| **2002 OBSERVATION 23:**<br>Given the history of the residents in the unit and trends in the make up of the MDC resident population in the past 10 years, there may come a time when criminal charges against residents on 104-R will need to be pursued. Policy needs to be created to preserve evidence and crime scenes so that staff does not unintentionally impede the investigation.<br><br>**2002 RECOMMENDATION 23:**<br>Develop policy and training specific to the issue of criminal charges against residents on 104-R.<br><br>The Department of Corrections can provide technical assistance in this matter.<br><br>**2002 MDC RESPONSE:**<br>This issue will be addressed at the division level | There is policy related to criminal activities at the facility. A criminal investigator has been hired who has the proper training, experience, and relationships with local law enforcement. |
| **2002 OBSERVATION 24:**<br>Residents use MAP representatives as a manipulation tool and a form of power and control over unit operations. One resident stated, "…I like to use my powers of intimidation to get what I want. If that doesn't work, I go to MAP and they do the intimidating for me."<br><br>**2002 RECOMMENDATION 24:**<br>Make every attempt to adjust communication between MAP and MDC so that it can become proactive and so that residents cannot manipulate MAP and MDC against one another.<br><br>MDC can open the lines of communication with MAP to be proactive instead of reactive. Pending policy changes can be e-mailed to each resident's MAP representative with an explanation/justification. A response can be invited within a set time limit and the response can then be considered prior to the | There continues to be communication problems between residents, family, staff, and advocates. MDC recognizes the critical component MAP plays in advocating for residents; it is unclear how communication breaks down when both sides believe they have the best interests of residents at heart. MDC often cites MAP as a reason they are unable to apply effective policies or treatment. |

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| implementation of the policy. In the least, this will allow MAP to be aware of pending issues that the resident may be calling about. The MAP representative can be enlisted as a member of the team to aid in de-escalating situations by reassuring the resident that MDC is working in their best interests.<br><br>**2002 MDC RESPONSE:**<br>'A bone of contention', has improved. | |
| **2002 OBSERVATION 25:**<br>Staff shared many resident comments/behaviors with me that were not documented. Threats or threatening behaviors especially need to be documented with date, time, statement made, and witnesses.<br><br>**2002 RECOMMENDATION 25:**<br>Implement procedures, training, and supervision that ensure that *every* pertinent resident communication and behavior is documented properly.<br><br>Many of the statements made by a resident can be addressed as a part of cognitive restructuring. Documenting statements can aid in treatment of thinking errors. Most importantly, it documents the behaviors that keep the resident from discharging from the unit, measuring progress and justifying the placement in the locked unit. Documenting will additionally aid in stopping the inconsistencies between shifts. Statements such as, "the other shift let me do it", need to be documented. Logging the statements or behaviors with details is sufficient and allows the next shift to review what went on in the previous shift. Over time, the logs will show a pattern that will aid in enforcing policies between shifts, identify escalating behaviors, and show progress in behaviors relevant to discharge.<br><br>**2002 MDC RESPONSE:**<br>MDC concurs | Policies for the unit have been revised to document all behaviors and responses. There is a clear record of use of physical interventions; it is applied to meet federal standards. |
| **2002 OBSERVATION 26:**<br>(RE: Unit 104-A - Observation Unit)<br>There is no admission/discharge criteria for Unit 104-A, an observation room. Staffing the "unit" is labor intensive, requiring that two staff members be pulled from other areas. The room is not secure. The window opens with no obstructions to keep residents from exiting through the window. The bed is not an appropriate furnishing for the purpose of the room, it is flimsy and pieces could be broken off for use as a weapon to harm self or others. It is unclear why the room is used, except as a form of voluntary isolation for residents.<br><br>**2002 RECOMMENDATION 26-A:**<br>Replace the bed in 104-A with a secure box frame design.<br><br>**2002 RECOMMENDATION 26-B:**<br>Secure the window in 104-A with strong wire mesh.<br><br>**2002 RECOMMENDATION 26-C:**<br>Implement security inspections on 104-A so that prior to any resident going into the room, it is inspected as specified and the inspection documented. | Unit 104-A no longer exists. An observation room has been incorporated into unit 104-R. Policies regarding observation are appropriate, including the exclusion of actively suicidal residents in the use of the room as a therapy tool. The room is inspected before and after resident usage. |

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| **2002 RECOMMENDATION 26-D:**<br>Develop a logging system for 104-A documenting resident visitors and resident behaviors.<br>**2002 RECOMMENDATION 26-E**<br>Implement the following admission and continued stay criteria for 104-A:<br>• Use the current generic admission criteria for Unit 104-R, "danger to self or others".<br>• Conduct and document an assessment by a licensed mental health clinician, RN or MD within 24 hours of placement on 104-A.<br>• Unit 104-A should be used only for brief intensive supervision purposes. A resident who is in crisis for longer than 24 hours either needs stabilization with medication, or a behavioral management program, further investigation into the issues, and to have the issues addressed in an individualized treatment plan.<br><br>**2002 MDC RESPONSE:**<br>MDC concurs | |
| **2002 OBSERVATION 27:**<br>(RE: Criminal Commitments)<br>There is one resident in "general population" (i.e., not on 104-R) at MDC who was committed as a criminal commitment rather than a civil commitment. Mixing criminal commitments with civil commitments is a litigious issue.<br><br>**2002 RECOMMENDATION 27:**<br>Begin development of a means of classification or assessment for criminal commitments to document an attempt by MDC to protect prey from predators. Such documentation should consider:<br>• The severity of the charges<br>• Prior history of assault (convictions only) for the last 5 years only<br>• Escape history for the last three years<br>• Extent of alcohol/drug abuse<br>• Pending court proceeding, warrants and detainers and severity of charges<br>• Prior felony convictions for the last 5 years only<br>• Resident actions and staff reports<br>• Stability factors (age - under 26; employment and education)<br><br>As criminal convictions to MDC are rare, it would be sufficient to document a review of these issues and consideration of these factors when placing the resident in general population.<br><br>**2002 MDC RESPONSE:**<br>"If more criminal convictions become a reality, this recommendation will be incorporated" | There are now six criminally convicted residents at MDC.<br><br>Keith Reeder also demonstrated a global positioning system, tracking with an ankle bracelet, for residents at the facility. **MDC should be applauded for proactively working toward keeping their trusting relationship with the community.** The anklet is less restrictive then a lock down unit yet ensures protection of the grade school and high school students located next door. There are criminally convicted sex offenders at the facility and as this population continues to expand, the community will be assured that the facility is taking every precaution in protecting predator from prey. It is hoped that advocacy programs will understand this issue as the population continues to change.<br><br>**Recommendation 17:**<br>Implement Recommendation 27 from 2002 BOV report:<br><br>Begin development of a means of classification or assessment for criminal commitments to document an attempt by MDC to protect prey from predators. Such documentation should consider:<br>• The severity of the charges<br>• Prior history of assault (convictions only) for the last 5 years only<br>• Escape history for the last three years |

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| | • Extent of alcohol/drug abuse<br>• Pending court proceeding, warrants and detainers and severity of charges<br>• Prior felony convictions for the last 5 years only<br>• Resident actions and staff reports<br>• Stability factors (age - under 26; employment and education)<br><br>Reference policy for standards may be obtained at: http://www.cor.mt.gov/resources/POL/4-2-1.pdf<br><br>Another consideration regarding lock down units and mental health treatment includes: http://www.cor.mt.gov/resources/POL/3-5-3.pdf |

# Incident Management

As a result of a sincere and exhaustive attempt to comply with both the requirements of the Centers for Medicare and Medicaid Services and the expectations of the Montana Advocacy Program, MDC commits extraordinary amounts of staff time and resources to responding to and resolving allegations of resident abuse, neglect, and injuries. This system for investigating "incidents" - in BOV's opinion - has come to dominate an unreasonable portion of its staff's time and resources.

The increased awareness of situations that may indicate abuse, neglect, or mistreatment of residents is excellent - and has shifted the culture at MDC positively in this regard. Diligent observation and meticulous reporting are good; MDC acknowledges that tracking what may appear singly to be innocuous events can sometimes disclose larger patterns that need to be addressed.

However, BOV believes that the threshold for determining that an incident is at the "critical incident" level [1], and therefore requiring mobilization of the full spectrum of investigative processes and resources, has been set unnecessarily and inappropriately low.

This approach appears to have taken on a life of its own, is overwhelming staff resources, and has resulted in a disproportionate and unjustified shift toward an obsession with "safety" to the detriment of focus on treatment.

MDC is working with the Developmental Disabilities Program, the Montana Advocacy Program, and the Quality Assurance Division to develop more effective and streamlined policies and practices to address the issue of investigations of allegations of abuse and neglect.

**Recommendation 18:**
Rapidly complete the process of reassessing and redefining the threshold that triggers full incident investigations, so that appropriate – but not excessive – resources are devoted to incident investigations.

[1] By policy, all incidents related to allegations of abuse, neglect, sexual abuse, mistreatment, and exploitation of residents are automatically considered "critical incidents".

# Review of PRN Medication

BOV contracted with two pharmacology experts to review the use of medications administered PRN (Pro re nata – or "as needed") to residents of the Montana Developmental Center. This review was conducted within the broader context of BOV's September 2006 site review objective (to to determine how successfully treatment is provided to residents) to ascertain the role that PRN medications play in treatment.

Drs. Hagen and Docktor reviewed a total of eight cases in detail, based on data from MDC for residents who are frequent recipients of PRN medication.

**Objective 1**: Determine whether or not PRN medications are being used in lieu of programming and treatment.

**Assessment**: No evidence that PRN medications are being used in lieu of programming and treatment was found. There is good documentation in Incident Reports and completed Crisis Situation Forms of the staff following each resident's treatment plan. Where indicated, treatment plans specify when the use of PRN medication is appropriate. The staff used PRN medications when necessary, and in accordance with PRN protocol.

There is some question about the relationships among: (1) the settings/locations in which PRN medications are used, (2) the level of treatment plan-directed resident activities, and (3) the frequency of the use of PRN medications. In order to thoroughly assess this question, observation of residents over time and across settings would be necessary; this was outside the scope of this review.

**Objective 2**: Determine whether or not PRN medications are being used excessively.

**Assessment**: No evidence that PRN medications are being used excessively was found. The charts reviewed were chosen based on the use of PRN medications for certain clients.

In some cases, the heavy PRN medication use is clearly related to brain injury that is simply not going to change.

**Objective 3**: Determine whether or not PRN medication protocols are appropriate and whether are being used before PRN medication is administered.

**Assessment**: PRN medication protocols are appropriate. In all cases reviewed, non-medication interventions specified in the behavior treatment plans and the PRN medication protocol were used. Treatment plans are well described and detailed.

**Conclusions:**

It appears that the use of PRN medications is appropriate. The behavior treatment plans are well developed and require a progression of non-medication interventions before a medication is used. In the one case where the prn protocol and behavior data was reviewed, it appears that this process is followed. The incident reports often also state that the protocol was followed.

Documentation indicates that MDC strives to identify underlying causes of problematic behaviors before increasing PRN medication dosage or adding medications.

**Concern:**

The PRN medication protocol and behavior data is not part of the chart; the Psychology Department maintains this information. This data should be maintained as part of the main charts in the Medical Records Department.

**Recommendation 19:**

Incorporate individual resident PRN medication protocol and behavior data into the main charts in the Medical Records Department.

# Addendum: Superintendent's Assessment of Success of and Barriers to Consistent Implementation of Treatment Plans and Decisions

## Successes

A Management Team Which Works Effectively and Cooperatively Together
The Montana Developmental Center has developed a dynamic team which represents the breadth of services provided at the facility. This team has demonstrated the ability to come together effectively without personal agendas and protection of territory to address the many challenges which have presented themselves.

Access to a Highly Qualified, Accessible Physicians
Both Dr. Jean Justad and Dr Robert Caldwell have been dynamic members of the facility staff. They are consistently available to the treatment teams for consultation and are actively interested in providing the persons at the Montana Developmental Center with the best services available. In addition, the previous dentist and the current dentist Richard Warner and Christopher Mast have provided exceptional service to the persons served at MDC. The contracted physicians who provide additional services have also been exceptional. MDC is fortunate to have such dedicated healthcare professionals available to serve the persons at the facility. Dr. Justad, in particular has expressed an interest in providing follow-up and consultation services for persons after they have been placed into community services.

Dedication and Commitment to Quality by Facility Staff.

When viewed as a whole, the staff at the Montana Developmental Center exhibit a high level of dedication to the work that they do. In the face of very difficult challenges both internally and externally, they consistently strive for the best that they can give to the people they work with. They exhibit a high level of commitment to doing their best each day. They see the work they do as work worth doing. They are resilient and accommodate crises with pragmatism and a spirit of willingness to try to solve the problems presented to them.

Consistent Support from Executive, Department, Division and Program Level Staff

The Montana Developmental Center currently receives a great amount of support for the continued functioning of the facility from upper management staff on the Executive, Department, Division and Program level. This support is communicated through a willingness to take an active role in communicating the need for the services provided by
the Montana Developmental Center and its role in the continuum of services for persons with developmental disabilities in Montana. This support has been particularly apparent in response to the recent difficulties that MDC has experienced in our survey process and budgetary difficulties.

Improved Communication and Coordination of Services Across the Developmental Disabilities Program

The Montana Developmental Center has, in the past, been held separate from the community service system for persons with developmental disabilities. This separation, while still apparent at times, has significantly improved during the past five years. The facility has participated as a partner in the development of a continuum of services for persons with developmental disabilities

and has participated in the development of strategies to better serve this population. In addition, improved communication and participation in the transition of persons into and out of the facility has benefited those who have been served.

Excellent Recreational Services

The Recreation Department consistently provides the persons living at the Montana Developmental Center with a broad array of opportunities to learn leisure and recreation skills. This department is especially skilled at including the persons served at the facility in community activities such as races, concerts, camping, fishing, and many more activities. In addition, the Recreation Department actively teaches the persons served at the facility to participate in activities to which they have not been exposed.

Improved Skills of Professional Staff

The Professional staff at the Montana Developmental Center currently includes professionals who have been specifically trained in the provision of services to the population currently served at MDC. The Psychology Department staff in particular currently provide services which are high quality and have been found to demonstrate the current best practices in treatment of dual diagnosis and offending behavior. In addition, professional staff have been provided with increased opportunities to consult with peers in many disciplines from other areas of the country. This has improved the knowledge and skill level of the staff which has resulted in the development of treatment to better address the needs of the persons served at MDC.

## Barriers

Insufficient Resources to Manage Demands of the System

The Montana Developmental Center has a consistent shortfall of resources to address the demands of the various demands made by the oversight and governmental system we have to deal with. Areas of need are:

- Increases in required documentation -

  Fewer and fewer staff are available to produce more and more documentation. The facility has been required to provide more frequent and more in-depth documentation of most aspects of our services. There has been due to more intensive scrutiny of what we do by the entities who provide oversight. Documentation that in the past required a single entry in a file, now requires completion of multiple forms. In addition, MDC maintains two separate facilities – the ICF-MR and the ICF-DD - under the umbrella of MDC. Whenever a person moves from one facility to the other, a completely new set of treatment documents must be developed including assessments, treatment plan and supporting documentation. This has been extremely labor intensive. Additionally, due to the Travis D Lawsuit, the management staff has been required to respond to a multitude of requests for responses included in documents from the Montana Advocacy Program.

- Shortfalls in technology and data management systems –

  As there have been increased demands for more in-depth documentation, the facility has not kept up technologically. The facility has improved its computer systems and has improved data management in some aspects, but, access to computers and data management systems is far behind the norm which is expected in an operation of this type. There continues to be a limited number of computers available for entry of data and documentation, consequently, this is done by only a limited number of staff who transcribe hand-written reports and forms.

- Staffing shortages resulting in fewer staff doing the required work -

  In preparation for the closure of 16AB, facility supervisory and professional staff have frequently been expected to "double up" on job duties in order to prevent Reduction In Force from occurring as the facility downsizes. This has also occurred to enable the facility to meet required vacancy savings, and to cover budget shortfalls.

  Budget shortfalls have occurred due to need for excessive overtimes due to direct care vacancies and a lack of depth within the organization to enable staff to use earned time. Direct care staff frequently work with minimum staffing levels despite the facility having hired large numbers of overtime staff. When staffing levels fall to minimum, staffing is often not adequate to provide all the scheduled treatment, to provide for staff training, or to spread staff and clients out to better reduce stress and crowding. While supervisory, support and professional staff have been used to provide coverage, there is frequently a lapse in the work that needs to be completed by these persons such as program and policy development, review and implementation. A common criticism of this facility has been the lack of in depth trend analysis. This can be attributed in great part to the overloading of duties upon existing staff.

- Facility limitations

  Due to the fact that facility design has often been based upon practices and philosophy current at the time of the design, the current physical plant of the Montana Developmental Center does not provide an optimal environment to support current treatment practices.

  This facility was not designed to serve a concentration of persons who exhibit significant destructive or aggressive behaviors. The current residences were designed to house larger numbers of persons than is currently recognized as best practice. There are limited options to allow for personal choice in living environments such as where to live, who to live with, and space for a person to make his/her own.

The current residences were constructed to a residential standard rather than a standard which accommodates hard usage. Residences are consistently at capacity with persons who have serious behavioral issues and it is difficult to structure the environment to support the skills which the people are taught in their sessions and treatment. Privacy and areas to be alone are not provided within the residences of the current facility. MDC has limited capacity to move persons to protect them or others when a situation is identified as placing persons at risk.

Montana Developmental Center is currently designing and building a unit to house the persons considered to be the most aggressive and dangerous persons at the facility. This unit also must house persons who are sent to the facility for fitness to proceed evaluations pending criminal proceedings. This unit will only house twelve persons within three houses. The current unit, which houses only 8 persons, was intended only to be for temporary use and has been used for four years. While referred to as a secure unit, does not meet good practices in providing security and is not an environment conducive to treatment. MDC is currently remodeling this area to increase the capacity and space within the unit and make the unit safer. This remodel is also expected to be temporary until the completion of the new unit.

<u>Difficulties recruiting and maintaining quality direct care staff</u>

As other service provider agencies, the Montana Developmental Center continues to have difficulty recruiting and maintaining high quality direct care staff. The physical location of the facility makes it challenging to recruit staff, especially during these times of rising gas prices with many staff needing to drive long distances to and from work. In addition, Boulder has

two other human service facilities and a number of home health and group home services competing for the available labor pool. This has been particularly difficult during the summer construction season.

Low staff morale and negative image of the facility

Due to the efforts of some persons and organizations within the state, the facility has been subject to a great deal of criticism and negative press. It has been the firm position of many within the disabilities community that facilities such as MDC are not needed and, in fact, prevent the full participation of persons with developmental disabilities. This position has resulted in a devaluing at times of those whose life work has been the improvement of the services that MDC provides. The staff of the Montana Developmental Center have a great deal of pride in the work they do. Many have been instrumental in providing a better life for many of the persons with developmental disabilities in Montana. In addition, the organization of the survey process is not to find positive aspects of the facility, but to find areas of failure. This has resulted, especially among the some of direct care staff in low morale and frustration. In addition, MDC has implemented a more strict incident management and abuse prevention system. This has been very difficult for the staff, as staff are placed onto administrative leave during the investigation and the stress of having been accused and investigated has taken a toll on the morale of the staff. Finally, work providing direct services to persons who are limited in their ability to care for themselves is frequently not a high status job.

# RECOMMENDATIONS

**Recommendation 1:**
Develop – with participation from all levels of the organization – a comprehensive, dynamic strategic plan. This process should include the development of a new mission statement that addresses the purpose, activities to pursue the purpose, and values.

Good resource: http://www.allianceonline.org/FAQ/strategic_planning

**Recommendation 2:**
Develop a comprehensive written training curriculum for new Psychiatric Aides that includes (1) specific written training objectives referenced to knowledge and skills needed to fulfill treatment responsibilities described in position description; (2) written classroom materials for each topic relating to resident treatment.

**Recommendation 3**:
Develop an aggressive strategy to address the unacceptably low mandatory training completion rate.

**Recommendation 4:**
Prioritize regular personal visits by the Superintendent to each living and treatment area across all shifts.

**Recommendation 5:**
Do the following to reinforce the authority of the clinical professionals to hold staff at all levels accountable for provision of individual treatment as described in treatment plans:
(1) develop a written policy;
(2) educate staff about the new policy through written directive/memo to all staff and through personal communication by the Superintendent.

**Recommendation 6:**
Conduct team building with QMRP, Unit Coordinators, and Psychology Department to engage residents on the men's side in meaningful activity in the unit as well as out of the unit.

**Recommendation 7:**
Implement Recommendations 4-A and 4-B from the 2002 BOV report:

> **2002 Recommendation 4-A:**
> Send staff working in Unit 104-R to a one-day training session in the concepts of "Cognitive Principles and Restructuring", to include antisocial personality traits and associated behaviors.
>
> **2002 Recommendation 4-B:**
> Implement resident involvement in "Cognitive Principles and Restructuring" training as a part of each 104-R resident's individual treatment plan (ITP).

**Recommendation 8:**
Implement Dialectical Behavioral Therapy training for staff, and inclusion of Dialectical Behavioral Therapy in each 104 resident's treatment plan.

**Recommendation 9:**
Implement recommendations 5-A and 5-B from 2002 BOV report (excluding “Non-Violent Crisis Intervention ["CPI"] – MDC trains all staff in Mandt):

**2002 RECOMMENDATION 5-A):**
Ensure that at least one staff member assigned to Unit 104-R on each shift is trained in the following:

- Searches
- Antisocial personality traits
- Non-Violent Crisis Intervention ("CPI")
- Report Writing
- Interpersonal Communication
- Restraints
- Emergency Response Procedures
- Crime Scene/ Evidence Preservation
- Security Inspections

**(2002 RECOMMENDATION 5-B):**
Ensure that all staff assigned to Unit 104-R receive formalized orientation and on-site training, prior to working in the unit, to include:

- Antisocial Personality Disorder traits
- Suicidal Behaviors and Mental Health Issues
- Self Defense Tactics (as prescribed in MANDT or another appropriate program)
- Emergency response, key control, tool control, safety issues
- Stress Management/Wellness/Healthy Boundaries
- A review of each resident's ITP
- Policies specific to the unit
- Post orders developed for the unit, as recommended in Observation Number Nine.

**Recommendation 10:**
Develop a formal policy addressing protection of evidence and chain of custody for all evidence.

**Recommendation 11:**
Develop specific descriptions of purpose, goals, and objectives for the secure unit.

**Recommendation 12:**
Designate clinical professionals as having the final authority for admission to and discharge from the secure unit.

**Recommendation 13:**
Abandon the unused and problematic alarm system - it is inadequate and creates the illusion that an adequate emergency response system is in place.

**Recommendation 14:**
Develop a formal crisis response team, with five specially trained (with documentation) members, under the supervision of the experienced criminal investigator. (There is already such a team in place on an informal basis. When asked who they called when in crisis, direct care staff named the same five staff members each time, who are also trained in the use of the restraint chair.)

**Recommendation 15:**
Develop emergency response policies and procedures.

**Recommendation 16:**
Implement Recommendation 22 from 2002 BOV report:

> Purchase a rescue knife, place it in a secure area, and train staff regarding the location of the instrument and what the purpose of it is so it may be accessed quickly in an emergency.

**Recommendation 17:**
Implement Recommendation 27 from 2002 BOV report:

> Begin development of a means of classification or assessment for criminal commitments to document an attempt by MDC to protect prey from predators. Such documentation should consider:
> - The severity of the charges
> - Prior history of assault (convictions only) for the last 5 years only
> - Escape history for the last three years
> - Extent of alcohol/drug abuse
> - Pending court proceeding, warrants and detainers and severity of charges
> - Prior felony convictions for the last 5 years only
> - Resident actions and staff reports
> - Stability factors (age - under 26; employment and education)
>
> Reference policy for standards may be obtained at:
>
> http://www.cor.mt.gov/resources/POL/4-2-1.pdf
>
> Another consideration regarding lock down units and mental health treatment includes:
> http://www.cor.mt.gov/resources/POL/3-5-3.pdf

**Recommendation 18:**
Rapidly complete the process of reassessing and redefining the threshold that triggers full incident investigations, so that appropriate – but not excessive – resources are devoted to incident investigations.

**Recommendation 19:**
Incorporate individual resident PRN medication protocol and behavior data into the main charts in the Medical Records Department.

# MONTANA DEVELOPMENTAL CENTER
# RESPONSE TO SITE REVIEW REPORT

**Recommendation 1:**
Develop – with participation from all levels of the organization – a comprehensive, dynamic strategic plan. This process should include the development of a new mission statement that addresses the purpose, activities to pursue the purpose, and values.

Good resource: http://www.allianceonline.org/FAQ/strategic_planning

***The administration of the Montana Developmental Center agrees that there is need for a comprehensive, dynamic strategic plan for the facility. MDC has begun the process of development of a Strategic Plan. This process, to be done well, is expected optimally to take approximately nine months to a year. It is essential to note, however, while MDC is dedicated to establishing a proactive plan regarding the future role and function of the facility, much of the future role of the facility is determined by entities outside the facility. The Montana Developmental Center, as a program of the Developmental Disabilities Program of the Disabilities Services Division, has been participating in Strategic Planning Across Montana II. This process is expected to set direction for the Program as a whole and is expected to provide the facility with guidance regarding its future role and function.***

**Recommendation 2:**
Develop a comprehensive written training curriculum for new Psychiatric Aides that includes (1) specific written training objectives referenced to knowledge and skills needed to fulfill treatment responsibilities described in position description; (2) written classroom materials for each topic relating to resident treatment.

***The Staff Development Specialist will continue to develop more opportunities for hands-on competency-based in-residence training for front line staff. This training will identify and prioritize specific skills needed on a daily basis as identified within the position description of the staff. The facility will continue to develop alternative training opportunities for the staff, including on-line, structured training using audio-visual materials which can be offered at flexible times, and alternative scheduling of training. It is also the intent of MDC to provide on-line training for direct care staff through the College of Direct Support, (CDS.com). This training will be coordinated with the Instructor Led training already in place at MDC to prevent conflicting information and redundancy. A written curriculum containing a written syllabus for all classes and copies of classroom materials will be maintained by the Staff Development Specialist. This curriculum will be maintained on the MDC shared drive as a reference.***

***Each professional discipline will be expected to provide recommendations and input into training needs of those in the discipline at MDC. The facility will research options regarding continuing education opportunities for professional staff by participation in relevant professional organizations. Training opportunities will be provided which specifically address the competencies and training needs identified by these disciplines. In addition, Professional staff at the Montana Developmental Center will be accountable for providing both formal and ongoing informal training to facility staff regarding treatment issues related to their discipline.***

**Recommendation 3**:
Develop an aggressive strategy to address the unacceptably low mandatory training completion rate.

***The current level of staffing in the residences has resulted in difficulties in the facility's ability to relieve staff especially on night shift to attend training without high levels of overtime. Efforts have been made to schedule training to occur during periods when staff are present to provide relief. MDC also is examining its training curriculum to streamline the training provided and to offer training in a wider variety of media. This will include participation in the College of Direct Care, an online treatment curriculum designed for direct care staff. In addition, the facility will work to develop creative solutions to address the difficulty of providing frequent training to night staff.***

***The Staff Development Specialist and Unit Coordinator staff have been working to address low staff attendance at training. Improvement has been seen, but there is still room for continued improvement. All supervisory staff will be accountable for ensuring that staff attend scheduled training. The Montana Developmental Center will incorporate reporting of staff assignment and completion of in-service training into daily supervisory shift reports. Staff Development will publish reports of staff completion of training at least quarterly. In addition, under Montana State Pay Plan 20, incentives can be provided for completion of training. These incentives are based upon regular performance evaluation. The percentage of required and optional training that has been completed would be reported and a predetermined percentage would have to be reached to qualify for the incentive. The facility will work with the unions representing our workers to put these incentives into place.***

**Recommendation 4:**
Prioritize regular personal visits by the Superintendent to each living and treatment area across all shifts.

***It is the intent of the Superintendent to make personal visits to the facility milieu a high priority and to resume regular 'walk throughs' of the facility to observe treatment and to discuss services with those served and the facility staff.***

**Recommendation 5:**
Do the following to reinforce the authority of the clinical professionals to hold staff at all levels accountable for provision of individual treatment as described in treatment plans:
(1) develop a written policy;
(2) educate staff about the new policy through written directive/memo to all staff and through personal communication by the Superintendent.

***The Montana Developmental Center will more clearly outline the expressed authority by the clinical professionals in policy and improve communication of this authority to facility staff. The administration of the facility has supported the authority of the clinical professionals, but has not been as effective in enforcing this authority as desired. It is the intent of the facility to step up enforcement of the consistent provision of treatment as developed by its clinical professionals and hold facility staff accountable for their actions.***

**Recommendation 6:**
Conduct team building with QMRP, Unit Coordinators, and Psychology Department to engage residents on the men's side in meaningful activity in the unit as well as out of the unit.

***The 104 Treatment team has developed guidelines and directives for the residential staff regarding appropriate activities for the 104 men's area. Steps have been taken to allow for more personal property in the unit. Secure stereo and television cabinets are being constructed for the unit. Additional storage will be made available when the new secure unit is constructed. Staff have been directed to not use the desk area of the residence unless they are completing paperwork and that no more than one staff is to be in the desk area at one time. Persons are to be worked with consistently and to be provided alternatives throughout the day when not scheduled into regular activities. Schedule options will be placed onto a posted unit schedule daily and staff will be directed to document the person's response when activities are offered. MDC will continue to emphasize collaborative problem solving techniques when interacting with out of control behaviors.***

**Recommendation 7:**
Implement Recommendations 4-A and 4-B from the 2002 BOV report:

> **2002 Recommendation 4-A:**
> Send staff working in Unit 104-R to a one-day training session in the concepts of "Cognitive Principles and Restructuring", to include antisocial personality traits and associated behaviors.
>
> **2002 Recommendation 4-B:**
> Implement resident involvement in "Cognitive Principles and Restructuring" training as a part of each 104-R resident's individual treatment plan (ITP).

***Representatives from the Montana Developmental Center Staff Development, the 104 Treatment Team and other clinical and professional staff are scheduled to attend a training session of Non-violent Crisis Intervention during February and Cognitive Principles and Restructuring in March. Upon completion of this training, the MDC staff who have received this training will determine how to best use this information in providing services to persons served at MDC in coordination with current MANDT crisis prevention and crisis management techniques.***

**Recommendation 8:**
Implement Dialectical Behavioral Therapy training for staff, and inclusion of Dialectical Behavioral Therapy in each 104 resident's treatment plan.

***The Psychology Department at the Montana Developmental Center has researched Dialectical Behavioral Therapy and how it could be applied at MDC. It is the position of the Psychology Department that it is not in the best interests of those who are served at MDC to limit all treatment to one specific therapeutic approach. Rather, a variety of treatment paradigms may be applied, as effective, to the treatment of individual persons. While the literature does contain documentation that many persons have benefited from DBT, it is considered doubtful that all persons treated would benefit solely from this therapeutic approach.***

**Recommendation 9:**
Implement recommendations 5-A and 5-B from 2002 BOV report:

**2002 RECOMMENDATION 5-A):**
Ensure that at least one staff member assigned to Unit 104-R on each shift is trained in the following:

- Searches
- Antisocial personality traits
- Non-Violent Crisis Intervention ("CPI")
- Report Writing
- Interpersonal Communication
- Restraints
- Emergency Response Procedures
- Crime Scene/ Evidence Preservation
- Security Inspections

**(2002 RECOMMENDATION 5-B):**
Ensure that all staff assigned to Unit 104-R receive formalized orientation and on-site training, prior to working in the unit, to include:

- Antisocial Personality Disorder traits
- Suicidal Behaviors and Mental Health Issues
- Self Defense Tactics (as prescribed in MANDT or another appropriate program)
- Emergency response, key control, tool control, safety issues
- Stress Management/Wellness/Healthy Boundaries
- A review of each resident's ITP
- Policies specific to the unit
- Post orders developed for the unit, as recommended in Observation Number Nine.

***It is the intent of the Montana Developmental Center to provide training to all facility front line staff in the issues recommended. The facility administration believes that it is essential to provide this training to 104 unit staff, but also, because unit staff is often supplemented from other areas of the facility, it is also essential to train those staff. MDC is currently anticipating enrolling our staff in the College of Direct Supports which will provide training in issues such as report writing, interpersonal communication, and stress management. In addition, facility staff are in the process of development and revision of policies which will provide the structure for the training of staff in issues such as searches, crisis intervention, restraint, emergency response procedures, security of keys, the facility, tools, and persons and related topics. Issues of evidence are covered within the facility investigations policy, which is currently being revised. In addition, the recommended information is integrated into the individual Behavior Treatment Plans (BTP) and this information is discussed as it applies to the specific person when the staff are trained on the BTPs. Training will be supplemented throughout the year by formal and informal training by the facility supervisory and professional staff.***

***While the facility agrees that an effective system of communication is needed for the smooth running of the unit, the traditional concept of "post orders" is not advisable at MDC. Posting schedules and client information in public areas is a violation of the right to privacy and confidentiality. Information will be kept in a centrally located area which also maintains the confidential nature of the information and is more normal in application than posting the information on the wall. This information can also be individualized to make it available to each person in the unit.***

**Recommendation 10:**
Develop a formal policy addressing protection of evidence and chain of custody for all evidence.

***Policies 205.4 and 205.5 currently has been written addressing protection of evidence and chain of custody. These policies are currently being revised to better address this issue.***

**Recommendation 11:**
Develop specific descriptions of purpose, goals, and objectives for the secure unit.

***The 104 Treatment team has developed goals and objectives for the secure unit and for those who live in it. These goals and objectives are adhered to as much a possible, but, due to the influx of persons requiring the use of the unit and changing interpersonal dynamics of the unit, these goals frequently need revision and it can be difficult to always consistently meet these goals prior to placement out of the unit. Even though the treatment team does establish exit criteria which are considered when making discharge decisions, the availability of space within the unit is often also an overriding consideration in these decisions. It is hoped that the new unit being built will alleviate many of these difficulties.***

**Recommendation 12:**
Designate clinical professionals as having the final authority for admission to and discharge from the secure unit.

***While the decision to admit or discharge a person from the secure unit is made by the Treatment Team, the approval of the clinical professionals is always obtained before admitting or discharging a person from the secure unit. There may be disagreement within the clinical professionals regarding this matter, however, and the opinions of the other members also need to be expressed and documented.***

**Recommendation 13:**
Abandon the unused and problematic alarm system - it is inadequate and creates the illusion that an adequate emergency response system is in place.

***Currently, the batteries in the alarms have been replaced and are being tested at the beginning of each shift. It is the opinion of the treatment team that many alarm systems are too correctional or easily triggered. The Montana Developmental Center is currently consulting with security firms to develop improved security at the facility. MDC is in the process of building a new unit to replace the current secure unit. Security systems are being built into this unit. In the time until the new unit is opened, the facility will investigate development of an improved system in the current areas.***

**Recommendation 14:**
Develop a formal crisis response team, with five specially trained (with documentation) members, under the supervision of the experienced criminal investigator. (There is already such a team in place on an informal basis. When asked who they called when in crisis, direct care staff named the same five staff members each time, who are also trained in the use of the restraint chair.)

***It is the intent of the facility to enlarge the list of persons who would be able to respond to a crisis, as well as to implement a notification system to immediately alert staff to the need for assistance. A crisis response team, along with alternates (to cover for days of, etc.), will be organized with staff members who are trained in the necessary skills in order to respond to immediate crisis situations in the secure area. A call system will also be***

***developed in order for those people to be notified when their assistance is required. Policies will be developed identifying the conditions for activation, the overall purpose of the team, as well as their specific duties when in a crisis situation.***

**Recommendation 15:**
Develop emergency response policies and procedures.

***See comments at Recommendation 14.***

**Recommendation 16:**
Implement Recommendation 22 from 2002 BOV report:

> Purchase a rescue knife, place it in a secure area, and train staff regarding the location of the instrument and what the purpose of it is so it may be accessed quickly in an emergency.

***Rescue knives have been ordered.***

**Recommendation 17:**
Implement Recommendation 27 from 2002 BOV report:

> Begin development of a means of classification or assessment for criminal commitments to document an attempt by MDC to protect prey from predators. Such documentation should consider:
> - The severity of the charges
> - Prior history of assault (convictions only) for the last 5 years only
> - Escape history for the last three years
> - Extent of alcohol/drug abuse
> - Pending court proceeding, warrants and detainers and severity of charges
> - Prior felony convictions for the last 5 years only
> - Resident actions and staff reports
> - Stability factors (age - under 26; employment and education)
>
> Reference policy for standards may be obtained at:
>
> http://www.cor.mt.gov/resources/POL/4-2-1.pdf
>
> Another consideration regarding lock down units and mental health treatment includes: http://www.cor.mt.gov/resources/POL/3-5-3.pdf
>
> ***Currently, triage is done by the clinical treatment staff as soon as documentation regarding the reasons for commitment of an individual is received. Policies will be developed using the recommended information provided by the Board of Visitors. This classification will be better documented on treatment plans.***
>
> ***At this time, the Montana Developmental Center does not have the resources available within the facility to separate criminally committed persons from civilly committed persons. It is hoped that this will improve when the new secure unit is completed.***

**Recommendation 18:**
Rapidly complete the process of reassessing and redefining the threshold that triggers full incident investigations, so that appropriate – but not excessive – resources are devoted to incident investigations.

***The Montana Developmental Center agrees that demands of the current Incident Management Policy have placed unreasonable demands on the resources available to the facility. MDC has revised the application of this policy and has rewritten our policies in an attempt to address this problem. In addition, MDC has been in communication with the Developmental Disabilities Program regarding the difficulties which the facility is experiencing. Adjustments have been made, but it is felt that it is important for all parties who are engaged in the application of this policy provide input into the problems experienced in implementation of the policy in order to identify communal problems and determine needed revisions. The facility has discussed establishing a workgroup with community providers and state office personnel to review the current policy and make needed adjustments.***

**Recommendation 19:**
Incorporate individual resident PRN medication protocol and behavior data into the main charts in the Medical Records Department.

***PRN psychotropic medication profiles have been added to the master client files in the Client Records Department.***

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## Additional Comments

***The Montana Developmental Center is grateful to the Board of Visitors for the assistance and information offered to us in this report to assist us in better managing the facility.***

***The current Superintendent prior to assuming her position had been primarily responsible for provision and monitoring of treatment of persons at the Montana Developmental Center and \had limited experience in managing a facility. She has, over the period since assuming her position, endeavored to develop the skills to manage effectively and assertively at this level. She has received strong support and assistance from those above her and below her in developing these skills. It is anticipated that her skills will continue to improve. It is important to acknowledge that, due to limitations regarding budget, governmental policy and regulation and formal agreements, it has been challenging to operate with the flexibility and creativity needed to assertively manage.***

***The Montana Developmental Center administration agrees that the recent levels of direct care staffing has placed a very difficult strain on the facility. It was anticipated that this situation would be short term and would be relieved by the closing of unit 16AB. As the closing of the unit has been delayed, this has continued to place stress upon the system. Since the site review of the facility by the Board of Visitors, this has been relieved somewhat due to moving staff into positions as the population of 16AB has decreased. Full realization of the planned realignment of staff is not anticipated to occur until March of 2007.***

***Due to changing demands upon the facility and staffing and budgetary challenges, MDC has needed to resort to overtimes and pulls to adequately staff the facility in order to provide treatment and protection to those served. The administration recognizes that this has had a cost to the quality of services at MDC due to unfamiliar staff working with individuals and to the level of staff training that has been completed. This situation has improved, but is still problematic. It is anticipated that this situation will improve once***

***Residence 16AB closes and staff can be redistributed. Legislation has been introduced into the current Legislative Session to provide additional funding to address the budgetary limitations at this time. However, due to limitations beyond the control of the facility, such as the limitations in the number of authorized FTE positions, difficulty in recruitment of staff, or high level needs of the population served at the facility, stable assignments of staff may be difficult to provide at times.***

***The Montana Developmental Center is currently converting to Montana State Pay Plan 20 which allows supervisory staff to work with those supervised to establish monetary incentives to reward notable employee action. The facility will be working with the staff and unions to establish these incentives. It is anticipated that this will assist in formalizing recognition of above average workers and to provide incentives to complete training. In addition, Pay Plan 20 is predicated upon regular performance evaluations in order to determine if these incentives have been earned. This will place pressure on the staff at MDC to complete evaluations in a timelier manner.***

***As has been noted, MDC does not have control over the numbers of persons committed to the facility. As a result, there have been times when the facility has been at capacity. This results in crowded conditions in which it becomes a challenge to group persons to best support their treatment. Increased efforts by MDC and the Developmental Disabilities Program to place persons once they no longer are in need of services at MDC has shown positive results and is anticipated to relieve this overcrowding.***
***The treatment staff at The Montana Developmental Center are very concerned about issues of quality of life, life satisfaction, and effective communication of treatment goals. MDC recently adopted the Personal Supports Planning (PSP) process. The PSP incorporates a variety of people chosen by the person to participate in the planning of his/her vision. Direct Care staff are encouraged to participate in meetings involving the people who are served at MDC. This has appeared to encourage many of the direct care staff to participate more fully in meetings involving their clients. MDC has obtained the Consumer Satisfaction Survey which is used in community programs to assess consumer satisfaction. It is intended to implement this survey or modify it to suit the needs of those served at MDC.***

***In addressing the concern of the Board of Visitors regarding the treatment regime of those diagnosed with bipolar disorder, it is noted that in prescribing psychotropic medication for the persons served at MDC, the psychiatrist makes use of the nationally recognized Texas Algorithm. In addition, the use of psychotropic medications at MDC has been reviewed by several oversight groups and national consultants, including Drs Robert Fletcher and Jarrett Barnhill, MD from the National Association for Dual Diagnosis who have validated the psychiatrist's pharmaceutical regimes.***

***Regarding the recommendation of the Board of Visitors to require restitution when a person destroys the environment, it is the practice of this facility that, due to the limited resources of the majority of the persons served at the Montana Developmental Center, restitution is to be used rarely as a consequence of a behavioral outburst. When it is used, the person clearly needs to understand that the consequence is linked to the actions. If the person, in the opinion of the treatment team, can make the connection between his actions and the consequence, the person may be required to pay a reasonable portion of the costs associated with the destruction of property. In all cases, the behavior of property destruction is addressed through treatment of the causes of this action.***

***The Montana Developmental Center continues to confront rapidly changing demands within the treatment system. Persons coming to the facility are demonstrating much different needs than those the system was designed to meet even five years ago. The facility continues to be dedicated to providing treatment and not incarceration for those it***

***serves, but recognizes an obligation to provide protection from harm to the persons served and to the community at large. Determination of what constitutes appropriate treatment is often a great challenge and it often takes time to determine effective treatment strategies. At times, this challenge can be overwhelming; especially when resources available are limited and regulatory systems do not change rapidly to respond to the changing needs of the population served. The facility has received a great deal of support and direction from consultation with nationally recognized experts in this treatment, but it must be noted that treatment of persons with co-existing developmental disabilities, mental health and criminally offending behavior is continuing to develop. It is essential that MDC continue its communication with others involved in the development of best practices in these services. The facility must have the ability to respond creatively and flexibly to the challenges that confront it.***