

Eastern
Montana
Community
Mental Health
Center
Sidney/Glendive

October 6, 2011

2011

A Site Review Report of the Services Provided by Eastern Montana Community
Mental Health Center at offices in Sidney and Glendive

Mental
Disabilities
Board of
Visitors Site
Review

Overview

Mental Health Facility Reviewed:

Eastern Montana Community Mental Health Center
Sidney and Glendive

Authority for the Review

Montana Code Annotated, 53-21-104

Purpose of the Review

1. To learn about the outpatient services provided through EMCMHS in Sidney and Glendive Montana;
2. To assess the degree to which the services provided by EMCMHC Sidney and Glendive are humane, consistent with professional standards, and incorporate Board of Visitors Standards for mental health services;
3. To recognize the role of the services provided through EMCMHC Sidney and Glendive in the continuum of services in eastern Montana;
4. To make recommendations to EMCMHC for improvement of services based on the Standards; and,
5. To report to the Governor regarding the status of services provided by EMCMHC.

Site Review Team:

Staff:

Alicia Pichette
Craig Fitch
Leigh Ann Holmes

Board:

Betty N. Cooper

Consultant:

Mary Chronister, Ph. D

Review Process:

- Interviews with staff in Sidney and Glendive
- Observation of treatment activities
- Review of treatment plans
- Informal discussions with clients of those EMCMHC services
- Inspection of the physical plant at both locations
- Review of medication records
- Review intake and discharge process

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SUMMARY

Eastern Montana Community Mental Health Center was last reviewed in 2008 and the recommendations from that review are included in this document. This Site Review was limited in scope and time. The review was limited to one day with the Review Team observing 2 offices – Sidney and Glendive. Like most of the communities in Montana each city was unique in the service needs and individuals served. Glendive is home to the VA Community Based Outpatient Clinic and the Eastern Montana Veteran's Nursing Home and serves many Military Veterans whose service needs may be different from those individuals served in other communities in the region. Sidney's offices are in a new building that is provided through collaboration with the Richland County Commission.

Services in Sidney and Glendive are delivered primarily on an outpatient basis with an emphasis on case management, day treatment and medications management. The service area is large and is designated as 'frontier' for health care purposes. Staff at both offices were engaged with the clients, and showed genuine empathy for them. Long term clients are fondly spoken of, the day treatment centers felt like home, and there was evidence everywhere of good care – from cooking, shopping, cleaning, quilt making, and outings to farmers market. Day treatment programs at both centers were welcoming, comfortable and supported peer-to-peer interaction. Individuals interviewed at both programs asked for access to NAMI peer-to-peer training programs.

The economy of the region has been based on agriculture production until recently. Communities are small and remote. Individuals who have mental illness access services through EMCMHC but rely heavily on family supports for day to day needs. The community is currently experiencing growing pains and change is coming to the region with the boom in oil and gas development east of Sidney, as a result of expanded production of the Bakken oil and gas deposits in North Dakota. Interviews with staff, clients, and other service providers in the region all pointed toward a rapidly changing landscape for service needs. Housing for clients and staff is difficult to find in Sidney and Glendive, Section 8 vouchers are available and going unclaimed; landlords can rent properties for much more than the vouchers pay. Recruiting staff for the Mental Health Center is challenged, because wages for direct care mental health workers cannot compete with the salaries paid to laborers for the oil and gas production companies.

Demand for mental health services, medical care, schools, law enforcement, and housing are increasing as the demographics of the region change. Anticipating the needs of this changing constituency will prove challenging for the EMCMHC leadership. Some staff interviewed at the Glendive program had low morale and expressed frustration with the stigma they have encountered in the community toward mental illness and the services the center provides. Glendive staff expressed hope that having a new building will reduce stigma about mental health services so the program can attract new clients.

Services provided by the agency are adequate to meet the needs of individuals currently identified and currently receiving services. Whether the current level of services can meet the needs of the influx of individuals who might attempt to access services in the future is a goal for the Mental Health Center to address through the agency's strategic/operations planning process.

Director Lane and other staff interviewed mentioned services provided to Military Veterans and the training EMCMHC staff has received to provide services to individuals for the treatment of PTSD and other mental illnesses related to active duty service. The staff also estimated that 11% to 13% of the individuals served by the agency are Native American/American Indian people. The diverse culture of these two groups when added to the range of clients served from childhood through elderhood by the program tests staff training and competencies.

QUESTIONS – STANDARDS

Organizational Planning and Quality Improvement

Planning:

Does EMCMHC develop a strategic operational plan through a process of consultation with staff, clients, families, community stakeholders and other service providers? Does the planning process also establish the operational plan for the agency to address the service needs of the community each office of the agency serves?

Strengths/Observations:

When asked, staff at both Sidney and Glendive offices responded that they were not aware of a planning process; nor were clients interviewed aware of a planning process or plan. Most responded that they assumed that the Associate Directors would be involved with upper management to develop a process for the agency to meet the evolving service needs of these communities. When the Site Review Team asked for a copy of the agency Strategic Plan/Operational Plan the agency Service Plan was provided for review.

The Service Plan is a good snapshot of the services EMCMHC currently provides to the 17 counties it serves. It does not contain projections for anticipated changes that are likely to occur in the future as a result of increased population and mental health services needs. The region is in the early years of a boom in oil and gas development that is projected to last 20 or more years. The Service Plan does not address the potential for operational changes that will be needed to address the changes that will occur in the rural communities served by EMCMHC as a result of the boom.

Suggestions:

Sidney and Glendive are just two communities in this large region. The needs of these communities are changing quickly, making continued collaboration with all other service providers in these counties crucial to assure quality and integration of services in response to the changing needs. The agency provides services at the VA Community-based Outpatient Clinic, Glendive Medical Center, and Eastern Montana Veteran's Home and is responsible for counseling, medication consultations and crisis services at the Dawson County Regional Prison in Glendive.

Recommendation:

Open strategic planning/operations planning to include all members of the staff at some point during the process – either through a staff survey or focus meetings to bring ideas forward to agency leadership.

Quality Improvement:

Is staff knowledgeable about the quality management, assurance, and improvement plan/process used by EMCMHC to evaluate and improve all of its activities related to services to Center clients and their families? Does the staff participate in the process?

Strengths/Observations:

Inquiries of staff indicated that most staff considered the services provided to be good quality, but most were unable to describe the process used to evaluate the quality of services provided. Staff interviewed thought the quality improvement plan was monitored by individuals in the Miles City offices, but beyond naming the CEO as responsible for the quality management activities, didn't have a clear picture of the process to evaluate and improve activities related to clients and their families.

By observation the team members concluded that the services are adequate to the needs of the individuals served by the program. Staff appears to enjoy working with the clients and have good relationships with the clients served. Training to quality standards established through a process of evaluating existing services and striving for continuous quality management through a quality improvement plan/strategic plan were not evident.

Suggestions:

A strong quality assurance process/planning structure is needed to ensure that all the pieces of the program work smoothly together and provide opportunities for all staff concerns to be brought to the attention of leadership for the purpose of discussion and resolution. If this is occurring now, direct care staff in the satellite offices does not know about the process. Staff has great confidence in the Associate Director's leadership. She may be representing the interests of all staff during agency management meetings, if not, then the agency would become stronger if a more representative and transparent planning process would occur. The National Committee for Quality Assurance¹ or the Council on Accreditation² may provide helpful information.

Recommendations:

Open the membership of the agency's quality assurance committee to include representatives of all members of the (direct care/clerical/professional) in addition to agency leadership to direct the quality management planning process.

Does EMCMHC promote, encourage, and provide opportunities for client and family member participation in strategic plan process, quality improvement process, advisory groups, peer and staff education and training, family and client peer support?

Strengths/Observations:

The site review team members did not see any indication that families and clients were involved with either the strategic planning process or quality improvement process. Some clients do meet at the Local Advisory Council/Service Area Authority (LAC/SAA) level to share information about services but these clients self-select and those clients who aren't 'joiners' may have suggestions/recommendations for improved services.

Suggestions:

Provide more opportunities for client/family engaged involvement in the agency's planning processes for organizational/quality improvement planning.

¹ <http://www.ncqa.org/tabid/451/Default.aspx>

² <http://www.coastandards.org/standards.php?navView=private>

Rights, Responsibilities, and Safety

Rights, Responsibilities:

Does EMCMHC define the rights and responsibilities of and provide verbal and written information about those rights and responsibilities to clients and family members when an individual enters services? Is access to independent advocacy services actively promoted?

Strengths/Observations:

This information is provided to clients in a one page document provided during intake/admission interview. The therapist, is generally the first person to meet one on one with the client and will review the rights and responsibilities information with a new client. The client will then sign a copy of the rights and responsibilities for the agency file and can request a copy to keep.

The team did not observe information about independent advocacy services being provided to consumers. Information about the Board of Visitors, Mental Health Ombudsman and Disability Rights Montana was not part of the new consumer packet information provided to the team. Staff and consumers in both Sidney and Glendive asked members of the site review team to explain the role of the Board of Visitors and other advocacy groups to them during the site review visit.

An outdated BOV poster was posted in the waiting area in Sidney. Team members provided updated contact information for all three advocacy groups, and informational brochures for the Board of Visitors and the Mental Health Ombudsman were left in the waiting areas at both offices.

Suggestion:

Staff would benefit knowing about advocacy services during new staff orientation/training and during regular training updates so all offices have current information about the Mental Disabilities Board of Visitors (BOV), the Mental Health Ombudsman and Disability Rights Montana.

Recommendation:

Include information about advocacy services in the new consumer information packet/handout. Urge the agency to post informational posters with contact information for the Board of Visitors, the Mental Health Ombudsman and Disability Rights Montana in reception/waiting areas of all the EMCMHC offices.

Include information about the advocacy role of the Mental Disabilities Board of Visitors, the Mental Health Ombudsman and Disability Rights Montana during new employee orientation and staff continuing education.

Does EMCMHC have an easily accessed, responsive, and fair complaint / grievance procedure for clients and their family members to follow?

Strengths/Observations:

The review team asked staff and clients about the complaint/grievance process and policy/procedures and could not determine a clear procedure. BOV was provided with a grievance policy/procedure/form that appears to be for reporting HIPAA violations. However, staff in both offices confirmed that this was used as the grievance form. The Associate Director, reported that the form is sent to Miles City and her involvement ends there. She did not know if clients receive responses directly from the administrative offices, or if clients are satisfied with the responses they do receive (she noted that there were very few grievances filed).

Suggestions:

Clients may not have complaints/grievances, but they would benefit from having the process/procedure explained to them in writing.

Recommendations:

Develop a clear policy and procedure for managing complaints and grievances that identifies the individual responsible for responding to a complaint/grievance; includes timelines for review; and describes follow-through and an appeal process.

Safety:

Does EMCMHC protect clients from abuse, neglect and exploitation by its staff or agents and had EMCMHC fully implemented the requirements of 53-21-107, Montana Code Annotated (2011) with regard to reporting on and investigating allegations of abuse, neglect and exploitation?

Strengths/Observations:

EMCMHC has a policy on abuse and neglect, but it is geared towards what staff would do if they suspected abuse or neglect of a child, reporting requirements, and the role of staff. Staff appears to be knowledgeable about the policy and what their role would be in reporting and providing the children served by the agency protection from harm.

The information provided to the BOV before the site review visit indicated that there were NO allegations or reports of abuse, neglect or exploitation of any client filed during the past year. The policy/procedure provided to the BOV seemed incomplete and was not specific to the reporting requirements under 53-21-107 MCA.

Recommendations:

Update the policy/procedure for recognizing, identifying, and reporting suspected incidents of abuse, neglect or exploitation of clients – children and adults – to benefit staff and clients of the Center. Include the reporting requirements under 53-21-107, MCA in the policy/procedure and include those requirements in staff training.

Is staff of the EMCMHC trained to understand and to skillfully and safely respond to aggressive and other difficult client behaviors?

Strengths/Observations:

This topic seemed strange for staff as if this was not something that happens in either Sidney or Glendive. Staff reported that they would call the police and move the other clients from the area. Training certificates provided to the BOV before the site review visit included certificates of MANDT training. It was difficult to tell from the certificates how regularly the staff receives training, and if all members of the staff have been trained to respond to this type of situation.

Suggestions:

Well trained staff would have responded that MANDT training would be useful in a situation like this to respond to aggressive/difficult client behaviors before contacting law enforcement.

Recommendations:

For the safety of the staff and clients of the Center, update training for staff at all levels so they can skillfully and safely respond to difficult behaviors.

Does the EMCMHC give clients access to staff of their own gender?

Strengths/Observations:

Between the Glendive and Sidney offices the site review team met just one male staff – a LCPC in Glendive. The staff roster indicates that most of the staff members in this corner of the EMCMHC region are female, so clients are unlikely to have access to staff of their own gender. The site review team recognized the how challenging it is for the agency to recruit qualified staff that can also provide gender balance in each community in the region.

Suggestions:

This may be an area where using peer-to-peer support could provide gender balance. NAMI has peer-to-peer training programs. If the trainings are not available in the EMCMHC region, NAMI may provide written materials that could be put to use by the SAA/LAC groups to promote peer-to-peer support and gender balance.

Client/ Family Member Participation

Does EMCMHC identify in the service record client family members and describe the parameters for communication with them regarding client treatment planning and for their involvement in treatment, support and discharge/exit planning?

Strengths/Observations:

Notes in the electronic record specify who was authorized to receive information about clients. Family involvement is dependent on the client's authorization for release of information. It appeared that when therapeutic, family involvement was encouraged in treatment sessions. Therapy and medication management are very strong in both Glendive and Sidney offices. The APRN and Therapists spend time with clients and are thorough with regards to diagnoses and treatment options. Staff reports that treatment plans are shared with family members if the client agrees, and the family requests copies. This sharing of information is not done routinely.

Discharge planning for clients to exit services is done at the time the treatment plan is created and is updated on a regular basis. Treatment plans reviewed showed limited family involvement in the treatment planning process and follow-up support to clients by family/peers when exit plans are created. Staff interviewed noted that a majority of the clients served are identified as having chronic SDMI, and have limited family support. Some have closer relationships with peers than family. Peers have a valuable role to encourage wellness and NAMI online chat groups are used to support peers and clients.

Suggestions:

Family/peer involvement is an important component for a client to successfully exit services. The site review team encourages staff to actively promote family/peer of choice involvement in the treatment planning, treatment plan reviews and exit planning process.

Does EMCMHC promote, encourage, and provide opportunities for client and family member participation in the evaluation of components of the center's services, client satisfaction with services, effectiveness of communication with clients and families and that treatment outcomes are measured? Does EMCMHC have written descriptions of these activities?

Strengths/Observations:

The Center did not provide the site review team with information to answer this question. Family involvement in the evaluation of services was not observed. Client and family satisfaction regarding treatment outcome measure were not reported to the BOV. Written descriptions were not provided. Clients interviewed did comment that they were comfortable with the day treatment services; but noted that support for Veterans in particular PTSD programs was very limited. The VA counselor is only in the area once a month and that trained peer support would be helpful.

Suggestions:

The team encourages the agency to promote stronger family/peer involvement to evaluate services and treatment outcomes.

Cultural Effectiveness

Does EMCMHC have a Cultural Effectiveness Plan – developed with the assistance of recognized experts - that includes defined steps for its integration at every level of organizational planning and that specifically emphasizes working with American Indian people?

Strengths/Observations:

Staff didn't recognize a need for cultural training or planning although each staff member could readily identify a number of American Indian clients they were working with, and estimated that 11% to 13% of center clients are Indian people. The VA Clinic in Glendive serves Veterans with combat related illness many of whom are American Indian. Glendive and Sidney, and the counties in this corner of the region, face unprecedented economic and demographic expansion which will include an increase in new people with different cultural backgrounds.

Staff interviewed acknowledged that treatment plans should take into account individually-identified cultural issues; and that cultural competency is not limited to serving Indian people. Information provided to members of the site review team by EMCMHC indicated that the center does provide information about its services to Indian Health Services at Fort Peck and Northern Cheyenne, but the information did not indicate whether a reciprocal exchange of information occurs at those meetings.

Of the staff interviewed at both offices none identified as being a Native American. Cultural competency for providing services to Indian people was not evident.

Suggestions:

Staff training designed to a cultural effectiveness plan will promote staff competence and confidence to effectively address client therapeutic needs – no matter what culture is identified.

SAMHSA³ and NAMI⁴ have resource guides available to help organizations develop a plan for cultural competency. Indian Health Services⁵ also has information about cultural competency.

Take advantage of EMCMHC informational meetings at Fort Peck and Northern Cheyenne to gather information about the cultural perspectives of providing mental health care to Indian people. Continue working to establish good working relationships with the two prominent Tribal communities at Fort Peck and Northern Cheyenne.

Recommendations:

While EMCMHC has recently focused on becoming proficient in the culture of military veterans, at this time staff still demonstrates an overall lack of cultural competency in general, (a SAMHSA requirement) or to address specific need for heightened cultural competency related to American Indians in Montana (a state government requirement). BOV recommends EMCMHC create a cultural competency program to include a plan for staff education and training, and create a list of potential contacts/trainers for each nearby reservation. Access the cultural education resources available through Tribal government social services and health offices for the treatment of mental illness and chemical dependency.

Prepare for population boom of ethnic people of color with mental health needs and recognize benefits to staff and clients for the agency to have strong cultural competencies to serve those needs.

³ <http://captus.samhsa.gov/access-resources/elements-culturally-competent-prevention-system>
<http://www.cmhsrp.uic.edu/nrtc/starcenter.asp>

⁴ http://www.nami.org/Content/NavigationMenu/Find_Support/Multicultural_Support/Cultural_Competence/Cultural_Competence.htm

⁵ <http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=11>

Staff Competence, Training, Supervision, and Relationships with Clients

Competence and Training:

Does EMCMHC define minimum knowledge and competence expectations specific to working with people with mental illnesses for each staff position providing services to clients?

Strengths/Observations:

No, other than the professional staff and their credentials, team members did not note knowledge and competence expectations specific to working with individuals with mental illness for staff. Some staff indicated that they sought out information about mental illnesses on their own. When one staff member was asked about access to mental illness specific training/knowledge her response was “Google is my friend”. Staff members interviewed expressed a desire for more training specific to mental illness, and staff and clients asked for access to NAMI family-to-family and peer-to-peer training.

Is training for new staff focused on achieving optimum knowledge and competence specific to working with individuals who have mental illness? Does the program effectively utilize the expertise of staff to provide staff training?

Strengths/Observations:

Associate Directors do provide staff training, other members of the staff are trained to provide MANDT training, and the privacy requirements under HIPAA. EMCMHC uses staff to provide new staff orientation training and continuing education to stretch resources. Training does not appear to be established on an ongoing schedule, it appears that the center takes advantage of training that is provided through DPHHS, is easy to attend (or comes to the region), and is affordable. Staff interviewed asked for more training specific to mental illness, medications, current issues related to recovery, Wellness Recovery Action Plan (WRAP) and Illness Management and Recovery (IMR). The information provided about training included certificates for WRAP and IMR, staff interviewed indicated an interest in accessing additional training also.

Does EMCMHC periodically assess current staff and identify and address knowledge and competence deficiencies?

Strengths/Observations:

Staff interviewed confirmed that the Associate Directors do assess staff regularly, it was unclear to the team if staff training and knowledge were linked to these assessments. The team could not answer whether training is sought out to strengthen staff knowledge and competencies or if training is limited to what is available, didn't require significant travel and when the agency can afford to provide it.

Recommendation:

The previous site review included a recommendation for staff training to include:

- Defining minimum knowledge and competency expectations for each staff position providing services
- Based on those expectations develop a written training curricula for new staff including basic information about all major mental illness
- Train new staff in job-specific knowledge and skills OR require new staff to demonstrated defined minimum, knowledge and competence prior to working with clients.

This report includes the same recommendation.

Supervision:

Does EMCMHC train supervisors and hold them accountable for appropriately monitoring and overseeing the way clients are treated by line staff? Are supervisors held accountable for monitoring, overseeing and ensuring that treatment and support is effectively provided to clients?

Strengths/Observations:

The Associate Director who supervises both Glendive and Sidney offices has excellent management skills, staff report regular interactions and access to her. Staff meetings are held regularly, and training does occur at these staff meetings. Reports of abuse/neglect and complaint/grievances are rare. The team observed staff interactions during lunch at the day treatment program and clients appeared to be comfortable with the staff. Clients were open in discussions with site review team members and appeared to be satisfied with the relationships with staff at the center as a whole. Treatment teams meet weekly and all team members are engaged in the implementation of the plan.

Treatment plans reviewed did not appear to have connections with day treatment or case management, making observations about the supervision difficult.

Suggestions:

None

Relationships and Active Engagement with Clients:

Does EMCMHC staff demonstrate respect for clients by actively engaging; demonstrating a positive demeanor; expressing empathy, and calmness; and, validating the wishes of the clients in every applicable environment?

Strengths/Observations:

The staff at both offices appeared calm and were comfortable with the clients. Clients appeared to trust the staff and have good interactions with staff. Facilities in both Glendive and Sidney were clean and comfortable and the atmosphere, both in day treatment and in the office spaces was welcoming. The facility in Glendive is old and does not meet ADA requirements. The agency applied for and received a grant to build a new facility that will begin construction this fall to be completed early next year (weather permitting). The work involved in this undertaking demonstrates EMCMHC's commitment to providing quality mental health services and should be of great benefit to the community of Glendive and surrounding areas.

Is the professional staff present and interacting with direct care staff and clients teaching, modeling, and reinforcing healthy, constructive, respectful interactions? Do supervisors and staff ensure that clients are engaged in consistently positive, recovery-oriented interactions?

Strengths/Observations:

The team observed that staff at both locations were positive, modeled and reinforced healthy interactions and were respectful of the clients. Day treatment, case management and supported employment do not seem to be overly oriented toward evidence-based recovery. The Associate Director reported that people graduate out of their services all the time, the work program is limited – some clients have jobs cleaning businesses.

Suggestions:

Establish a stronger partnership with business leaders (Chamber of Commerce) to create a more formalized supported employment program.

Treatment and Support

General:

Is a written treatment plan in place and being implemented for every client receiving service from EMCMHC?

Strengths/Observations:

Treatment plans are in place and are implemented. EMCMHC transitioned to an electronic record keeping system called Credible this past year, Treatment plans are filed on Credible and staff can access the records online. Team review of treatment plans did not find written discharge plans in place for each client.

For all new or returning clients, does EMCMHC ensure that a thorough physical / medical examination has been performed within one year of the client entering / re-entering the service?

Strengths/Observations:

Physical exams are not performed at either of the offices. The Associate Director and APRN reported that they have excellent relationships with the hospital and medical clinics in both communities and attempt to ensure that all clients have regular primary care check-ups. The APRN stated that she attempts to rule out medical conditions responsible for presenting psychiatric symptoms.

Evidence-Based Services:

Does EMCMHC provide treatment and support to adults that incorporates the following SAMHSA-identified evidence-based practices: Illness Management and Recovery, Assertive Community Treatment, Family Psychoeducation, Supported Employment, Integrated Treatment for Co-occurring psychiatric and substance use disorders?

Strengths/Observations:

The team interviews indicated that some staff are trained with IMR and some with ACT, Family Psychoeducation training was not mentioned, Supported employment is a challenge for the staff. One staff member noted that since so many individuals served by the Center have chronic mental illness, life skills are fundamental then recovery oriented treatment comes later.

Co-Occurring Psychiatric and Substance Use Disorders:

Has EMCMHC fully implemented the protocols established by AMDD for treatment of people who have co-occurring psychiatric and substance use disorders?

Strengths/Observations:

Like other agencies, EMCMHC is striving to become 'co-occurring capable', two staff members at the two offices visited are working toward dual licensure. The APRN indicated that the clients with substance abuse disorders utilize telehealth at the hospital to access SA support groups and treatment. The frontier nature of the region does make access difficult. The team noted however that the Center does not host 12 step programs or open the facility after hours for support groups to meet.

Suggestion:

One possible strategy to pursue that might reduce stigma in the community about mental illness and co-occurring substance abuse would be to open the Centers to support groups, NAMI, and 12 step programs for meetings after business hours.

Medication:

Is the medication prescription protocol evidence-based and reflect internationally accepted medical standards?

Strengths/Observations:

This appears to be a strength of the organization. The APRN is very conscientious about medication use and follows standards of care with regards to prescribing.

Is medication prescribed, stored, transported, administered, and reviewed by authorized persons in a manner consistent with laws, regulations, and professional guidelines?

Strengths/Observations:

Medication is only prescribed at EMCMHC, not administered or transported. As noted, the APRN is very conscientious about medication use and follows standards of care with regards to prescribing.

Are clients and – with consent - family members provided with understandable written and verbal information about the potential benefits, adverse effects, and costs related to the use of medication?

Strengths/Observations:

The APRN spends 1 hour with each client for an initial visit and ½ hour on subsequent visits and she speaks at length with the clients during these visits about the medications. She is a strong advocate for clients regarding the price of medication and provides samples when necessary to help clients “get through difficult times.” While options are limited for medical second opinions about medications and treatment, the APRN will attempt to gain access for those opinions if a client should ever make the request.

For new clients, is there timely access to a psychiatrist or mid-level practitioner for initial psychiatric assessment and medication prescription within a time period that does not, by its delay, exacerbate illness or prolong absence of necessary medication treatment?

Strengths/Observations:

New clients are seen almost immediately by the APRN who will even complete new client intake in the absence of a therapist in the office.

Does EMCMHC actively promote adherence to medication through negotiation and education? When legitimate concerns or problems arise with prescriptions, do clients have immediate access to a psychiatrist or mid-level practitioner?

Strengths/Observations:

The APRN spends 30 minutes with clients for follow-up appointments. She indicated that different clients have different needs so they are seen at different intervals. She talks at length with the clients during the visits about the medications and provides education and is available and on-call to respond to problems with medications.

Are medication allergies, side effects, adverse medication reactions, and abnormal movement disorders well documented, monitored, and promptly treated?

Strengths/Observations:

Yes. The APRN does a very thorough job of assessing clients and intervening as necessary. She is also very cautious in her prescribing – start low and go slow approach is used. Rationale for prescribing and changing prescriptions is well documented in the clinical record.

Are clients taking antipsychotic medication monitored according to the consensus guidelines of the American Diabetes Association and American Psychiatric Association?

Strengths/Observations:

The team noted that the APRN is very conscientious about antipsychotic use. 1 client is on Zyprexa after numerous trials of other medications; decision made with the client that benefit of quality of life outweighs the risk of metabolic syndrome and diabetes.

Is there a clear procedure for the use of medication samples?

Strengths/Observations:

Medication samples are used. The team was not provided with a formal procedure for the use of samples.

Emergency/involuntary medications use does not occur and unused medications are the responsibility of the client and are not disposed of at the Center.

Suggestion:

Write a formal procedure for the use of samples.

Are there procedures in place for obtaining medications for uninsured or underinsured clients?

Strengths/Observations:

During interviews with clients, the APRN spends time discussing medications during appointments, if medication costs are an issue she can provide samples as needed.

Access and Entry

Is EMCMHC convenient to the community and linked to primary medical care providers? Does EMCMHC inform the community of its availability, range of services, and process for establishing contact?

Strengths/Observations:

Programs in both Sidney and Glendive are convenient, although the facility in Glendive is not ADA accessible. Links to hospitals and community public health are in place. EMCMHC uses the agency web page as advertisement for the services it provides. The communities of Sidney and Glendive appear to be aware of the services available through EMCMHC, case managers at EMCMHC work with community resources to assist center clients so the program is known.

Is an appropriately qualified and experienced staff person available at all times - including after regular business hours - to assist clients to enter into mental health care?

Strengths/Observations:

EMCMHC does have a crisis line for clients of their program, which may be all the community needs. When asked the staff responded that although the crisis line is for clients of the program, when a non-client calls they will be referred to the program for services as soon as possible. Therapy is good and is handled professionally.

The center provides crisis services to the detention center in Glendive, but those services have been largely unreimbursed and the clinician interviewed suggested that that access would end. Unreimbursed services would not continue.

Does EMCMHC ensure that clients and their family members are able to, from the time of their first contact with EMCMHC, identify and contact a single mental health professional responsible for coordinating their care?

Strengths/Observations:

When the team asked this question of the intake staff she indicated that therapists are direct contact and will share information with families if the client agrees. Again, family members involvement is limited, the question remains does the MHC actively attempt at every opportunity to involve families – does the center regularly check to see if clients want to involve family.

Does EMCMHC have a system for prioritizing referrals according to risk, urgency, distress, dysfunction, and disability, and for commencing initial assessments and services accordingly?

- *Who makes intake decisions?*

Strengths/Observations:

After initial intake interview is completed an appointment is scheduled with the therapist, the wait is not long, usually less than 2 weeks. If the individual seems to be urgently in need of an appointment the therapist may complete a brief visit and schedule an appointment as soon as possible.

Suggestions:

The intake seems a bit informal, in the absence of complaints though the team determined that the existing process is apparently workable.

Continuity of Services Through Transitions

Does EMCMHC review the outcomes of treatment and support as well as ongoing follow-up arrangements with each client and - with consent - family members prior to their exit from the service?

Strengths/Observations:

One staff member interviewed said that time was short and often treatment outcomes were not reviewed regularly to establish the exit strategy. This was reported in the context that the largest number of individuals being served is long-term, has chronic mental illness and does not transition between services and plans are ongoing. The Associate Director indicated that individuals do transition/exit services but did not explain follow-up services.

Suggestions:

Always review and develop transition planning, and include consultation with any staff who have been involved with the client during services.

Does EMCMHC provide clients and their family members with information on the range of relevant services and supports available in the community when they exit from the service?

Strengths/Observations:

Case managers interviewed did respond with a list of programs they might access to help clients while they are in services. The assumption was that individuals exiting services would already be receiving all available services.

When the site review team requested a list of relevant services in the area near the 2 programs visited that would serve Native American people the team was told that no services specific to Indian people existed. The team questioned if the staff meant that no services exist outside of those provided through the BIA, Indian Health Services and Tribal Social Services.

Suggestion:

Develop a listing of services available in the communities served by the Sidney and Glendive offices for to provide to clients/families when exiting EMCMHC services.

Does EMCMHC ensure that clients referred to other service providers have established contact following exit from EMCMHC?

Strengths/Observations:

The staff knows the communities and follow-up adequately as time permits.

Suggestions:

Staff may not need to formalize the follow-up but a tickler file for follow up would assure that follow up occurs in specific time frames (30 days 6 months, etc.)

If a client was receiving community mental health services prior to an inpatient or residential treatment admission, does the community mental health center assume primary responsibility for continuity of care between inpatient or residential treatment and community-based treatment?

Strengths/Observations:

EMCMHC works closely with the ADRT team at the State Hospital to coordinate the discharge planning when a client returns to EMCMHC services in the region.

RECOMMENDATIONS

Recommendation #1:

Open strategic planning/operations planning to include all members of the staff at some point during the process – either through a staff survey or focus meetings to bring ideas forward to agency leadership.

Recommendations #2:

Open the membership of the agency's quality assurance committee to include representatives of staff (direct care/clerical/professional) in addition to agency leadership to direct the quality management planning process.

Recommendation #3:

Include information about advocacy services in the new consumer information packet/handout. Post informational posters with contact information for the Board of Visitors, the Mental Health Ombudsman and Disability Rights Montana in reception/waiting areas of all the EMCMHC offices.

Include information about the advocacy role of the Mental Disabilities Board of Visitors, the Mental Health Ombudsman and Disability Rights Montana during new employee orientation and staff continuing education.

Recommendations #4:

Update the policy/procedure for recognizing, identifying, and reporting suspected incidents of abuse, neglect or exploitation of clients – children and adults – to benefit staff and clients of the Center. Include the reporting requirements under 53-21-107, MCA in the policy/procedure and include those requirements in staff training.

Recommendations #5:

For the safety of the staff and clients of the Center, update training for staff at all levels so they can skillfully and safely respond to difficult behaviors.

Recommendations #6:

Create a cultural competency program to include a plan for staff education and training and produce a list of potential contacts/trainers for each nearby reservation. Access the cultural education resources available through Tribal government social services and health offices for the treatment of mental illness and chemical dependency.

Prepare for population boom of ethnic people of color with mental health needs and recognize the need for a staff with strong cultural competencies to serve those needs.

Recommendation #7:

The previous site review included a recommendation for staff training to include:

- Defining minimum knowledge and competency expectations for each staff position providing services
- Based on those expectations develop a written training curricula for new staff including basic information about all major mental illness
- Train new staff in job-specific knowledge and skills OR require new staff to demonstrate defined minimum, knowledge and competence prior to working with clients.

This report includes the same recommendation.

EMCMHC Response to 2011 Site Review Report

January 19, 2012

Alicia Pichette, Executive Director
Mental Disabilities Board of Visitors
PO Box 200804
Helena, MT 59620-0804

Dear Alicia:

Please accept this as my response to the BOV site visit report to the Glendive and Sidney offices. I would like to thank you for your patience throughout this process as it was slowed down thru the holidays and my health problems. I also appreciate you meeting with me on January 10 to discuss the report.

The BOV team was correct in their observation that Glendive and Sidney are undergoing some rapid changes. These changes have drastically changed western North Dakota and if published predictions are correct, the same can be expected for Eastern Montana.

The Board dedicates some interest in the report to long range planning for the coming changes and one of the recommendations is that the staff be involved in the long range planning process. Rest assured that when we know what to plan for and where to plan for it, the staff will be involved thru the monthly management meetings in which each office is represented. EMCMHC faces the same problem as every other human service provider in that none of us has a crystal ball. County governments, city governments, Departments of state governments, not-for-profit health care providers, fire departments and police departments are all faced with a big unknown with very few specifics being offered for public knowledge. I have yet to see a comprehensive completed document from anyone that successfully predicts and plans for the next 10 years.

Our staffs in Sidney and Glendive were totally involved in the planning for the new facilities and service deployment for those counties. The management team solicits and regularly receives feedback for management consideration.

Client enrollment packets will include information about advocacy services and updated posters will be posted in all waiting rooms. I would appreciate it if the BOV could supply us with updated versions whenever they change.

Our grievance policy does include timelines, persons responsible for handling complaints but we will update it to be in total compliance with 53-21-107.

All staff is trained each year in MANDT and de-escalation techniques for "difficult" situations. While the term difficult is undefined and open to interpretation, the staff is trained to call the police when issues of personal safety for staff or clients are imminent.

EMCMHC is privileged to have 1 Native American and 1 Latino as full time

service providers on its staff. Additionally, our doctorate level LCPC in Rosebud County lives in Lame Deer and is married to a Native American lady. He has lived for decades in Indian country. One of our LACs in Glasgow has spent his entire career working on Indian reservations. He serves Wolf Point and Poplar to those Natives who choose not to access their services thru HIS. His wife also happens to be a Native American lady. Both of these professionals are a valuable resource to the rest of the staff when issues of cultural understanding evident.

While it is true that EMCMHC has devoted much of its training efforts in the past few years to learning to treat veterans, our next area of emphasis as a corporation will be devoted to becoming a organization that provides state of the art trauma informed care. Research shows that up to 90% of the people who present for mental health and chemical dependency treatment have suffered major trauma in their life. A trauma informed care provider emphasizes history and treatment of trauma at the beginning of care and doesn't wait for it to surface (maybe) during the course of treatment. This seems like a natural progression for corporate learning given the changing economic and cultural environment that may be coming. This is an evidenced based practice that is being emphasized by SAMHSA.

The minimum competency expectations for staff positions is defined by the licensing rules that are promulgated by the Dept. of Commerce and when we are site visited for licensure, we are held very strictly to those requirements. Since the site visit by the BOV, we have developed a packet of required reading for paraprofessionals whose minimum educational may not be set by licensure rule. The packet is based upon a nationally recognized educational curriculum for paraprofessionals.

I hope I have addressed all of the recommendations in the report.

If you have any further questions, please feel free to call.

Sincerely,

Frank L. Lane, Executive Director
Eastern Montana Community Mental Health Center

Recommendations from 2008 Report with Responses

1. Actively promote consumer/family member/carer access to independent advocacy services by:
 - providing written information about independent advocacy services at time of admission
 - displaying posters and/or brochures in day treatment and residential programs that promote independent advocacy services
 - providing written information about assistance available from the Mental Disabilities Board of Visitors in filing and resolving grievances

EMCMHC Response: *"Will do."*

2. Develop an in-house grievance procedure for consumers and family members to use when they have a complaint.

EMCMHC Response: *"Will do."*

3. Revise abuse and neglect policy as follows:
 - develop guidelines for detecting abuse/neglect
 - include time frame for required initial reporting to BOV
 - develop guidelines for determining validity of allegations of abuse/neglect
 - develop mechanisms for reporting allegations of abuse/neglect that do not deter or discourage individuals from reporting the allegations.
 - develop guidelines for avoiding conflict of interest, including criteria for deciding when to use outside investigators
4. Develop a consistent, proactive procedure for identifying interested family members and formally reaching out to and including them as active partners in consumers' services.

EMCMHC Response: *"We always involve family members in the direct treatment with the adult consumer's permission and we involve parents or responsible parties in the treatment of all children."*

5. Define expectations for staff knowledge about cultural, ethnic, social, historical, and spiritual issues relevant to the mental health of and provision of treatment of mental illness relevant to all people in the community, with a specific emphasis on American Indian people.

EMCMHC Response: *"No way to train. Most of our professional staff are native Montanans and understand the culture of Eastern Montana very well. We are very sensitive to the cultural sensitivity of Native Americans and are very successful in our treatment of them. We have never received a complaint of inappropriate actions of staff towards any consumer. We have Native Americans, Latinos, lesbian, and people of Caucasian heritage on our staff. EMCMHC is now engaged in the learning of being culturally competent in the treatment of combat veterans. We have spent thousands of dollars to train all staff in being knowledgeable and sensitive to the special needs of veterans. Priorities for training monies have to be set. We cannot train staff to be culturally sensitive to "ALL" people. We believe this recommendation to be unwarranted and poorly worded. Rest assured; we will provide cultural sensitivity training to staff for special populations when needed."*

BOV NOTE: BOV has removed the word "all" from this recommendation. (see p. 14)

6. Provide staff training conducted by recognized experts that enables staff to meet expectations for knowledge about cultural, ethnic, social, historical, and spiritual issues relevant to the provision of mental health treatment to all people in the community, with a specific emphasis on American Indian people.

EMCMHC Response: *"Not needed. As special populations needs become identified, we seek training for staff as quickly as possible. Whether it is learning to treat the affects of farm/ranch stress on our farmers and ranchers, treatment of combat vets, community response to adolescent suicides, WRAP training, or cultural sensitivity to races, we have provided that special training over the years. On the day of this writing, we have 7 clinicians attending training about treating returning vets and evidence based treatment interventions for those vets that are casualties of combat. In point of fact, a business can train itself into bankruptcy. We do provide training to staff as the budget will allow."*

BOV NOTE: BOV has removed the word “all” from this recommendation. (see p. 14)

7.
 - a) Define minimum knowledge and competency expectations for each staff position providing services to consumers.
 - b) Based on minimum knowledge and competency expectations, develop written training curricula for new staff focused on achieving minimum knowledge and competency levels. This training should include basic information about all major mental illnesses.
 - c) Begin to train new staff in job-specific knowledge and skills OR require new staff to demonstrate defined minimum knowledge and competence prior to working with consumers.

EMCMHC Response: “Will try to do.”

8. Arrange with NAMI-Montana to conduct provider training for EMCMHC staff.

EMCMHC Response: “Will not do. We do have staff scheduled to attend the illness management training that is coming up. As stated previously, we had a number of staff and consumers attend the WRAP training sessions. Prior discussions with representatives of NAMI in the past have proven to be unsuccessful towards setting up a good time that fit into the schedule of all concerned. We have not planned this training in the training schedule in the immediate future because of the impact on staff time, of the illness management trainings, combat vets training and other specialized trainings that clinicians have scheduled because of perceived need for further knowledge. As budget funds become tighter and inflation eats away available monies we all must become more aware of the need to utilize teleconferencing as an efficient means to train staff. As the economy weakens we all must be more careful about how we spend available dollars.”

9. Begin to routinely give a copy of the treatment plan to each consumer and, with permission, to involved family members.

EMCMHC Response: “Will be done.”

10. Use the SAMHSA information to develop Illness Management & Recovery, Psychosocial Education for Families, Integrated Treatment for Co-Occurring Disorders, and Supported Employment components.

EMCMHC Response: “We have accessed the SAMHSA site and will integrate those facets of evidence based practices that we currently aren’t doing. As I travel the region to do HIPPA [sic] training for staff, we will also include, as part of the training, a discussion on the implementation of components of the SAMHSA guidelines. Each of our offices presents a special challenge of logistics and the guidelines will have to be tailored to fit and meet the need of each particular community. We are certainly committed to providing the most efficacious and meaningful treatment practices as we can.”

11. Revise the medication calendar program as follows:
 - a) change the staff role to one in which assistance is provided to consumers in filling their own medication calendars;
 - b) ensure that this assistance is provided by someone licensed to handle medications (pharmacist or nurse);
 - c) develop this assistance component into an educational part of the treatment program for consumers;
 - d) incorporate into each consumer’s treatment plan.

EMCMHC Response: “Will be done.”

12. Implement monitoring of patients on antipsychotic medication according to the consensus guidelines of the American Diabetes Association and American Psychiatric Association.

EMCMHC Response: “Done.”