

Mental Disabilities Board of Visitors

SITE REVIEW REPORT

Montana State Hospital
Warm Springs, Montana

June 17 – 18, 2010

Gene Haire

Gene Haire, Executive Director

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**Mental Disabilities Board of Visitors
Site Review Report
Montana State Hospital
June 17-18, 2010**

OVERVIEW

Mental Health Facility reviewed:

Montana State Hospital (Montana State Hospital)
Warm Springs, Montana
John Glueckert - Administrator

Authority for review:

Montana Code Annotated, 53-21-104

Purpose of review:

- 1) To learn about Montana State Hospital services.
- 2) To assess the degree to which the services provided by Montana State Hospital are humane, consistent with professional standards, and incorporate BOV standards for mental health services.
- 3) To recognize excellent services.
- 4) To make recommendations to Montana State Hospital for improvement of services.
- 5) To report to the Governor regarding the status of services provided by Montana State Hospital.

BOV review team:

Staff:

Gene Haire, Executive Director

Board:

Joan-Nell Macfadden

Consultants:

Jacki Hagen, PharmD
Curt Chisholm
Jack Hornby, MD
Bill Snell
Patrick Wayne
Irene Walters, RN

Review process:

- Interviews with WMMHC-B staff
- Observation of treatment activities
- Review of written descriptions of treatment programs
- Informal discussions with patients
- Inspection of physical plant
- Review of treatment records

ASSESSMENT OF SERVICES

Medical / Psychiatric Services

STRENGTHS:

- Physicians all seem very encouraged with the addition to the MSH team of the new Clinical Director and new Administrator.
- Highly committed physicians (both medical clinic physicians and psychiatrists) who are very available to patients and staff, and who provide a high level of professional medical/psychiatric care.
- Several innovative programs are evolving such as the 'metabolic syndrome' clinic held quarterly involving dieticians and pharmacists.
- Clinical pharmacists are involved in medication profile review, and have authority to order labs/drug levels if necessary.
- Strong interdisciplinary teamwork.
- Medical Clinic:
 - Physicians interviewed by BOV are enthusiastic, innovative, and are continually working to improve medical clinic services.
 - Work well with outside specialists and other community providers; work hard to stay current on general medical information.
 - Work well in conjunction with the psychiatric staff and appear to respect and to be well-respected by staff as well as patients.
 - Have brought in new equipment and needed procedures (ex: indirect ophthalmoscope, routine Papanicolaou tests (Pap smear) performed by a female Medical Clinic physician), and have other plans for improvement of care.
 - There is a new atmosphere of optimism, engagement, and enthusiasm in the Medical Clinic, and respect for the Medical Clinic throughout MSH.
- Psychiatrists appear optimistic and creative in their efforts in the face of a burgeoning patient population and complexity/severity of presenting illnesses.
- Physicians express a feeling of close collegial relationships with one another.
- The two Nurse Practitioners interviewed by BOV appear particularly outstanding, dedicated, and well informed in their areas of expertise.

OBSERVATIONS:

- In some situations, psychiatrists appear to be handicapped by insufficient admission information from community providers, making it difficult to know what treatments have been tried successfully or failed.
- Physicians report that state budget constraints preclude reimbursement for participation in training and meetings in urban centers where much of the most current information is being communicated.
- MSH medical staff report that there have been a number of patients who have arrived at MSH from various settings (community hospitals and other) with unstable medical conditions.

SUGGESTIONS:

- Consider re-establishing the telemedicine contacts between MSH and community psychiatrists.

Nursing Services (Registered Nurses, Licensed Practical Nurses, Psychiatric Technicians)

STRENGTHS:

- New employee training is standardized and augmented to address specific needs for each unit where a staff person may be assigned. For example, Spratt staff are trained to strengthen knowledge about substance use and personality disorders; D Unit staff are trained to strengthen skills in calming and responding during critical incidents and aggressive behavior.
- MSH is a significant teaching facility for nursing students from a number of nursing schools.
- Psychiatric Technicians generally appear clear about their responsibilities for patient treatment and the mission and purpose of MSH.

OBSERVATIONS:

- Nursing staff report that there is a need for better computer access for charting and accessing information. There is some concern that some units have better access to technology than others. As MSH moves closer to a paperless system, computer access will become more and more important for people to do their jobs efficiently.

Psychology**STRENGTHS:**

- Psychologists are highly respected by their peers, well trained, clinically-focused, and creative in contributing to their units' efforts to provide excellent patient care.

OBSERVATIONS:

- Since 2006, the number of doctorate level psychologists has been reduced from 7 to 2 ½ FTE. This appears to have resulted in demands on time and expertise that are difficult to meet, limited time available for work on other units, and little time for psychological testing.

SUGGESTIONS:

- Consider ways to maximize psychologists' clinical expertise in designing the treatment mall concept.

Social Work**STRENGTHS:**

- Social Workers interviewed by BOV are thoughtful, compassionate, hard working, and conscientious.
- With significant turnover in recent years, there is now a good blend of seasoned and new social workers with new ideas; veteran social workers are invaluable in providing mentoring and training.
- Discharge satisfaction surveys have been developed and are being used with good results.

Therapeutic Learning Center**STRENGTHS:**

- Energetic, enthusiastic, creative Program Manager with progressive goals for the Therapeutic Learning Center (TLC) including plans to recruit staff trained in recovery-oriented concepts.
- The TLC is a "hive" of activity with patients participating in a variety of experiential learning activities - including activities to enhance employment potential; physical exercise; exploration of ways to use leisure time, art and other creative expression; and social engagement all available.
- The two Peer Support Specialists attached to the TLC are well-respected and have a significant role in supporting patients.
- The TLC has a gym and stage which patients and staff use sports, skits, and talent activities which enhance the physical health and self-esteem of the patients.
- The TLC library has many resources available, and as part of the state library system has access to all the resources any city library could have.

OVERVIEW of TREATMENT

GENERAL STRENGTHS:

- The new Director of Treatment (on board since January 2009) and the new CEO (on board since February 2010) have created a new leadership atmosphere; positive new initiatives are being explored, and new standards of excellence are being put into place.
- Dedicated conscientious, experienced staff at all levels; positive staff presence; caring atmosphere provided by Psychiatric Technicians on the units.
- Majority of staff have a strong sense of teamwork; all staff interviewed by BOV expressed a deep interest in the patients' well-being and quality of care.
- Staff have confidence in their training and protocols for treatment; staff remarked that there has been improvement in unit training for critical incident response.
- New, higher level of awareness of the importance of family involvement; staff working to increase active involvement of family members in treatment and discharge planning.

GENERAL OBSERVATIONS

- Chronically high census - not enough space for number of patients served.
- High recidivism rate.
- Tendency toward problematic intermix of psychiatric/behavioral presentations across units.
- Shortages in some staff positions.
- High percentage (50% - 60% of all admissions) of patients entering the mental health system for the first time at the MSH level.
- Ongoing inconsistencies in effectiveness of engagement with community providers for treatment and discharge planning.
- Emergency detention patients moved to MSH without prior psychiatric assessment and/or adequate information.
- Patients arriving at MSH with unstable medical conditions.
- Slow, archaic electronic record system (TIER).

B Unit - Adaptive Living Skills (ALS) Pathway

STRENGTHS:

- Patients receive excellent medical care.
- Staff and supervisors have greatly improved the ongoing awareness and monitoring of patients who, because of behavior related to dementia or other disorders, have the potential for and/or history of being aggressive toward other patients.

OBSERVATIONS:

- The unit appears overcrowded and noisy; there is little room on the unit to sit and visit with privacy.
- There appears to be a particular stress associated with working on this unit due to staff shortages, and the severity and acuity of co morbid medical/psychiatric issues.

SUGGESTIONS:

- Consider assigning a full-time Program Manager and full-time Nurse Manager to B Unit.
- Because of the acute medical needs on this unit, consider ways to reduce the variety of mental illness diagnoses served.
- Consider ways to provide some form reach outreach/training to community nursing homes to help reduce stigma and to increase their willingness and ability to serve elderly people with mental illnesses.

D Unit - Management of Legal Issues (MLI) Pathway

STRENGTHS:

- Staff are well-trained, supervised, and expert in working with forensic patients whose behaviors often present significant challenges to the safety of staff and other patients.
- Staff development for staff assigned to D Unit includes intensive training to address aggressive behaviors.
- Staff were actively interacting with every patient the entire time BOV was visiting; both staff and patients appeared comfortable with each other.
- Patient and staff safety are top priorities on the forensic unit, where risk is higher than the population in other parts of the hospital; safety and being proactive is part of ongoing team discussion; awareness of cues to possible behavior escalation is acute.

OBSERVATIONS:

- As MSH staff and administration are well aware, D Unit is chronically overcrowded.
- At the time of this review, Pintlar Lodge was just opening as a “step down” for forensic patients.
- Staff report that the collaborative working relationship between MSH and MSP has improved.

Spratt Building - Coping and Co-Occurring Pathway**STRENGTHS:**

- There seems to be an increasing awareness of the need for Psychiatric Technicians to be circulating throughout the milieu interacting with patients.
- The improvements that Spratt staff requested from Administration and which were made (new patient entrance; removal of a nursing station) have resulted in an increased ability of staff to monitor patients and an increase in staff-patient interactions.

OBSERVATIONS:

- Situations in which patients require 1:1 staffing, and escorting off the unit creates challenges for appropriate staffing levels.
- The excessively diverse patient population on Spratt appears to be a major contributing factor to the chaos on the unit that BOV perceived and that staff and patients report.
- The physical environment appears antiquated, stark, unappealing, and not conducive to fostering growth and progress; the layout of the building increases the potential for dangerous situations.
- Updating certain aspects of the building is in the design phase, but even with the planned changes, the interior design may still be compromised in critical areas such as staff ability to have clear line-of-sight throughout building, insufficient number of secure “safe” rooms, and excessive distances throughout building.
- Spratt tends to be the ‘overflow’ unit for MSH. Along with the concentration of patients with personality disorders and co-occurring psychiatric and substance use disorders on one unit, the overflow from other units creates a confusing ‘mishmash’ of presentations (mood disorders, thought disorders, personality disorders, substance use disorders, and geriatric patients). Added to this intermix are a significant number of vulnerable patients with histories of abuse and patients with histories of victimizing others.
- When staff escorts patients off unit to meals, court hearings, therapeutic learning center, etc., the unit is often left short-staffed.
- At the time of this review Spratt’s Social Workers were short-staffed, causing longer patient stays and creating more stress and tension among staff and patients.
- Senior MSH staff tend not to “bid” on openings on Spratt which skews the staffing toward a more inexperienced level of care.

SUGGESTIONS:

- Reconsider the current approach to patient placement on Spratt; make every attempt to reduce the untenable diversity of the patient mix.
- Prioritize incident review on Spratt; analyze incident occurrence/risk compared to other units; use conclusions to develop strategies to reduce chaos and risk factors, to make patient placement and staff assignments, and to develop specialized staff training specific to the needs of this unit.
- Consider ways to address the tendency for a concentration of newer, less experienced staff on Spratt; consider engaging the union in discussions about the position bidding process; consider creating a pay differential for Spratt staff.
- Consider additional ways to empower Psychiatric Technicians and to bring them into a more direct role in active treatment.

Transitional Living**STRENGTHS:**

- Positive environment that teaches living skills in the least restrictive environment possible on the MSH campus; an environment that is more comparable with structured living settings many patients will be discharged to in the community.

MENTAL DISABILITIES BOARD of VISITORS STANDARDS

Organizational Planning and Quality Improvement

Does MSH produces and regularly review a strategic plan?

Strengths:

- A strategic planning process was initiated during the summer of 2009. The Administrator, Director of Treatment, and unit management staff are actively engaged in developing a strategic plan; it is clear that this process and the creation of a dynamic plan is a high priority for all.
- MSH leadership describes a process through which the strategic plan will evolve with specific, measurable goals, defined responsibilities, and time frames for achievement of goals.
- The document titled *Montana State Hospital Strategic Plan, July 1, 2009* describes the MSH mission, vision, and guiding principles and overarching statements about the hospitals priorities: Safety, Clinical Quality, Communication, Culture, and Community.

Suggestions:

- Consider development of "sub plans" specific to each treatment unit based on the overall MSH strategic plan.

Is the strategic plan of MSH developed and reviewed through a process of consultation with staff, patients, patients' family members, other community stakeholders?

Strengths:

- Each person interviewed expressed confidence that the strategic planning process would be inclusive. The senior management team is collecting and considering recommendations offered by staff.
- Senior management is working to engage patients - through the Resident Council - in the strategic planning process.

Observations:

- It appears at this point that the strategic planning process is primarily internal.
- Input of line staff in the strategic planning process is accomplished through unit managers.

Suggestions:

- Consider:
 - ways to maximize communication between all staff and management during the strategic planning process
 - ways to solicit and incorporate the input of families and other stakeholders into the strategic planning process
 - ways to include representatives from line staff and all staff disciplines - in addition to management staff - in the strategic planning process

Does MSH use a process of continuous quality improvement to evaluate and improve all of its activities related to treatment services?

Strengths:

- A document titled, *Montana State Hospital Organizational Performance Improvement Plan* was developed for fiscal year 2010; this document builds on the nascent strategic plan by describing the Performance Improvement Plan's scope, values, model, process, and general goals. This is an excellent beginning of a performance improvement process. ***The positive change represented by MSH efforts moving forward in strategic planning and quality improvement cannot be overstated.***
- MSH staff at all levels appear to be aware and supportive of efforts that are underway to establish quality standards and a system to monitor and improve adherence to these standards.

Suggestion:

- Flesh out the nine objectives of the Performance Improvement Plan by: (1) following up each objective with a statement that describes **how** the objective will be achieved (for example: "Montana State Hospital incorporates performance data into decision-making activities ... **by (a) defining performance data to be measured, (b) collecting this data, (c) distributing collected data to managers, (d) ensuring that data is integral to discussions directly leading to decisions.**", and (2) adding "who will do what by when" statements – establishing specific accountability and time frames.

Are designated staff of MSH accountable and responsible for the continuous quality improvement process?

Yes - Senior management and the Quality Improvement Director.

Is MSH able to demonstrate a process of continuous quality improvement that directly affects health and functional outcomes for individual patients?

The development of continuous quality improvement at MSH has not yet achieved the ability to track patient outcomes.

Strengths:

- MSH is working very hard to develop a process of continuous quality improvement in a way that makes sense to everyone and is effective.
- Discharge surveys have identified that patients want greater involvement in planning their discharges; QI staff is including this in the 2010 Performance Improvement Plan.

Rights, Responsibilities, and Safety

Does MSH define the rights and responsibilities of and provide verbal and written information about rights and responsibilities to patients and family members?

Yes

Does MSH actively promote patient access to independent advocacy services by:
 > providing verbal and written information to patients and patients' family members?
 > prominently displaying in all of its facilities posters and brochures that promote independent advocacy services including the Mental Disabilities Board of Visitors, the Mental Health Ombudsman, and Disability Rights Montana?

Yes

Strengths:

- The patient handbook describes advocacy services including assistance available from the BOV.
- As a part of the package on admission, advocacy services information is reviewed with new patients; patients report having an understanding of BOV and its services.

Observations:

- Telephone numbers for BOV and other advocates do not appear to be consistently available on all units.
- The Patient Handbook does not include advocacy groups or phone numbers.
- It is unclear whether or not family members are provided information about independent advocacy services.

Suggestion:

- Include phone numbers for BOV, Mental Health Ombudsman, and Disability Rights Montana in the Patient Handbook

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

Yes

Strengths:

- MSH has a grievance committee consisting of MSH staff and a Peer Support Specialist. A BOV representative participates in Grievance Committee meetings as a support for the patient's point of view and to provide oversight for the process.
- Every Grievance Committee decision results in a letter to the patient and treatment unit Program Manager.
- MSH staff receive training specific to assuring the grievance policies are well communicated to patients when they are admitted, and to involved family members.
- Patients appear aware of the grievance process, how to access it, and reported to BOV that they feel their complaints are taken seriously.

Does MSH protect patients from abuse, neglect, and exploitation by its staff or agents?

Yes

Strengths:

- Protecting patients from abuse and neglect is a top priority for MSH leadership.
- MSH leadership has taken decisive steps to improve the way in which allegations of abuse/neglect are responded to, the thoroughness of in-house investigations, acknowledgement of events and actions that precede incidents - including those that result in abuse/neglect allegations, clarifying for all staff what leadership's expectations are for treatment of patients. When warranted, MSH leadership has demonstrated a new willingness to more assertively implement corrective action.
- There has been an increase in regular training and ongoing incidental supervision regarding proper treatment of patients.
- The camera system has become a great tool, allowing clear identification of problematic interactions with patients including instances when abuse clearly has occurred, providing graphic support for training, and providing objective evidence when allegations are not substantiated.

Has MSH fully implemented the requirements of 53-21-107, Montana Code Annotated for reporting on and investigating allegations of abuse and neglect of patients?

Yes

In investigations of allegations of abuse, neglect, or exploitation of patients by its staff or agents, does MSH thoroughly analyze the events and actions that preceded the alleged event – including actions and/or non-actions of its staff or agents?

Yes

After an allegation of abuse, neglect, or exploitation of a patient by MSH staff is determined to be substantiated, does MSH debrief all related circumstances – including all staff and supervisory actions or non-actions that could have contributed to the abuse, neglect, or exploitation – in order to decrease the potential for future recurrence?

In instances of alleged abuse in the past year the matters have been reviewed in accordance with MSH Policies.. The incidents have been reviewed with all concerned and discussed to explore alternatives that may have delivered care more safely. The addition of our video system for review and investigation has been beneficial in educating and training staff. It is our hope that this effort decreases the potential for future recurrence.

Are staff of MSH trained to understand and to skillfully and safely respond to aggressive and other difficult patient behaviors?

Yes

Strengths:

- All staff are trained in Mandt®¹.
- Staff Development focuses intensely on training related to identifying “predictors” of escalating behavior, verbal de-escalation, and non-violent intervention when necessary.
- Security staff are available for backup in situations that involve higher levels of risk.
- There is a strong commitment by MSH administration to keep patients safe under all conditions.

Are patients of MSH given access staff of their own gender?

Yes

Does MSH use special treatment procedures that involve behavior control, mechanical restraints, locked and unlocked seclusion or isolation, time out, etc. in a manner that is :

- > clinically justified?
- > properly monitored?
- > implemented only when other less restrictive measures have failed?
- > implemented only to the least extent necessary to protect the safety and health of the affected individual or others in the immediate environment?

Yes

Strengths:

- Seclusion and restraint is considered only when patients pose an imminent risk of harming others or themselves and no other less-restrictive intervention is possible.
- MSH reports that its use restraint is lower than the state hospital average nationally.
- MSH is starting to use data on seclusion and restraint to identify trends and make decisions for improvement.
- Process policies are well defined and consistent with federal regulations.
- There is a strong intent by MSH leaders to reduce/eliminate the use of restraint and seclusion.

Does MSH debrief events involving special treatment procedures, emergency medications, aggression by patients against other patients or staff, and patient self-harm; retrospectively analyze how such events could have been prevented; and support staff and patients during and after such events?

MSH does debrief the events listed above to analyze how such events could have been prevented or avoided. Staff involved in the debriefing include LIPs, Nurse and Program Managers, and Administrative Staff including DON, Treatment Director, Quality improvement Director and Administrator. The focus has been on improving and

preventing future occurrences. The process could be improved to provide better support to staff and patients as part of this process.

In addition to debriefing, we have expanded what was the Seclusion and Restraint Review Committee to broaden the function and purview of the committee. The new Committee is referred to as the Patient Safety Committee and includes Nurse Managers, MDs, Program Managers, Administration, Quality Improvement and others as needed. The focus is on learning, prevention and care and safety improvements.

Patient / Family Member Participation

Does MSH identify in the service record patients' family members and describe the parameters for communication with them regarding patients' treatment and for their involvement in treatment and support?

Inconsistently

Strengths:

- Staff is open to including family members in the treatment and discharge planning if patient consent is given.

Observations:

- Staff shortages have made it difficult for Social Workers to engage family members effectively.

Suggestions:

- Consider establishing – as part of the admission process - identification of interested family members and a description of the parameters for communication with them regarding each patient's treatment.

Do MSH assessments, treatment and discharge planning, and progress reviews proactively include the participation of patients and with consent patients' family members?

Inconsistently

Strengths:

- Contingent on ability, patients are always involved in their treatment and discharge planning.
- Social Workers attempt to reach out to families to participate in discharge planning.
- The E Unit psychiatrist calls interested family members - with patient permission - and discusses diagnosis and planned treatment.

Suggestions:

- Consider ways to be more consistently proactive about reaching out to interested families and including them in the treatment and discharge process.

When a diagnoses is made, does MSH provide the patient and with consent the patient's family members with information on the diagnosis, options for treatment and possible prognoses?

Yes

Does MSH proactively provide patients, and with consent patients' family members a copy of the treatment plan?

Inconsistent

Observations:

- It does not appear that patients are consistently given a hard copy of their treatment plan.
- It does not appear that MSH is proactive in providing patients' treatment plans - with permission – to interested families.

Suggestions:

- Consider ways to routinely provide hard copies of treatment plans to all patients.
- Consider ways to be more proactive about identifying families who are interested in having a copy of their family member's treatment plan, and then provide them.

Does MSH promote, encourage, and provide opportunities for patient and family member participation in the operation/evaluation of its services? Examples:

- 'customer service'
- effectiveness of communication with patients and family members
- measurement of health and functional outcomes of patients
- participation in developing the strategic plan and plan for continuous quality improvement?
- advisory groups?
- interviews and selection of prospective staff?
- peer and staff education and training?
- family and patient peer support?

Does the service has written descriptions of these activities

Yes – but limited

Strengths:

- MSH deserves much credit for establishing two part-time Peer Support Specialist positions; these individuals as well as the Resident Council are actively involved in supporting patients and bringing the patient point-of-view into MSH decision-making.
- Service evaluation feedback is sought through discharge planning satisfaction surveys and inpatient satisfaction surveys. This information is tabulated and shared with the Quality Improvement Committee and the rest of the hospital.

Suggestions:

- Consider ways to regularly inform patients and their families of conclusions drawn from survey evaluation information and of improvement plans based on these surveys.
- Consider creating a "family advisory council" of engaged family members of current or former patients to MSH who might serve in an advisory capacity.

Cultural Effectiveness

Note: *At the time of this review, approximately 10% of the patients at MSH census were American Indians.*

Does MSH 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?

No

Strengths:

- All staff interviewed were supportive of the possibility of a formalized Cultural Effectiveness plan.

Does MSH define expectations for staff knowledge about cultural, ethnic, social, historical, and spiritual issues relevant to the mental health treatment of the people served, with a specific emphasis on American Indian people?

No

Strengths:

- The position description for Psychiatric Technician mentions cultural awareness (Psychiatric Technician – Sec. II, Major Duties or Responsibilities - Subsection A, r.).
- Both formal and informal contact between MSH staff and the BOV Cultural Consultant revealed interest in and desire to gain additional knowledge in this area; staff appear enthusiastic about learning more about American Indian issues relevant to mental health treatment that would enable staff to more effectively support patients.

Does MSH 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 the people served, with a specific emphasis on American Indian people?

Strengths:

- MSH provided BOV with a list of a number of trainings that had been provided to staff, some of which were relevant to cultural issues in general and American Indian people in particular.

Observations:

- Cultural training is not formalized or required.

Do MSH treatment plans take into account individually-identified cultural issues, and are plans developed by a culturally competent clinician or in consultation with such a clinician?

No

Strengths:

- Rehabilitation staff appear to have a good grasp of the meaning of the “kinship system” and the importance of “belonging” in American Indian culture.
- Most staff are aware of the importance of individualized treatment and in addressing patient-expressed concerns regarding cultural issues.
- The TLC provides culturally-oriented art and craft activities for American Indian clients who wish to participate.
- The TLC has established a “cultural night” in coordination with the American Indian Alliance in Butte; patients are transported to Butte for these activities.
- The computer lab and library provide a good resource for patients to access information about their heritage, and about current events regarding their tribes.
- Treatment plans address spiritual and cultural needs of individual patients including tribal affiliation and Indian names.
- MSH staff make an effort to ensure that individuals have the opportunity to practice various religious activities including American Indian ceremonies such as ‘smudging’.

Observations:

- Even though there is good effort made to address culturally-relevant issues in working with patients, there is no formal process for capturing *in treatment plans* specific cultural issues relevant to treatment.
- There is no on-site culturally-competent clinician; there is no ongoing consultative relationship between MSH and a culturally-competent clinician.

Has MSH developed links with other service providers / organizations that have relevant experience and expertise in the provision of mental health treatment and support to people from all cultural / ethnic / religious / racial groups in the community, with a specific emphasis on American Indian people?

Yes

Strengths:

- Although not formalized, MSH works closely with referring agencies such as Indian Health Services (IHS), tribal courts, Indian centers, and federal and tribal social services. The TLC provides services such as “cultural night trips” in collaboration with the Native American Indian Alliance in Butte and other community integration activities.
- Rehabilitation staff work closely with the federal TRIO² program in Butte.

Observations:

- It appears that the momentum of developing linkages and collaborative partnerships is important to most MSH staff, however the demands of their duties and responsibilities limits the time available to work on them.

Suggestion:

- Consider developing a directory that can be used for quick reference to resources available from other service providers.
- Develop an informal sustainable relationship by “trading” or “reciprocating” expertise between MSH staff and other Agency staff. This could include training, brief and general consultation on mental health issues, cultural considerations.
- Consult with the Montana-Wyoming Tribal Leaders Council³ for assistance in identifying service providers / organizations that have relevant experience and expertise in the provision of mental health treatment and support to American Indian people.

Does MSH have a plan for recruitment, retention, and promotion of staff from cultural/racial/ethnic backgrounds representative of the community served with a specific emphasis on American Indian people?

No

Observations:

- Few applicants with minority ethnic backgrounds apply for employment. This is particularly true for American Indians.
- No special considerations are made for retaining ethnic staff.

Suggestion:

- Consider adding the following language to job vacancy announcement: “Ethnic or minority applicants are encouraged to apply”.
- Consider placing job vacancy announcements in tribal newspapers, at tribal colleges throughout Montana, and at Montana State University and the University of Montana.
- Consider establishing specific skill sets such as ‘bilingual speaker’ and other specialized cultural skills within several MSH position descriptions so that recruitment and compensation for cultural expertise can be formalized.
- Consider establishing one ‘Cultural Specialist’ position at MSH.

With regard to its own staff, does MSH monitor and address issues associated with cultural / ethnic / religious / racial prejudice and misunderstanding, with a specific emphasis on prejudice toward and misunderstanding of American Indian people?

Yes

Does MSH analyze the cultural / ethnic / religious / racial demographics of its catchment area with a specific emphasis on American Indian people?

No

Strengths:

- Many of the MSH staff understand the special challenges to “reentry support” of clients back into their communities, especially those faced by American Indians.

Observations:

- No data is collected to analyze referral source trends, tribal affiliation, or other demographic profiles.

Suggestion:

- Consider conducting American Indian patient data analysis by region, tribe, and community to enhance understanding of the ‘flow’ of American Indian patients to and from MSH, with emphasis on (1) understanding the relationship between availability of community mental health services in Indian communities and MSH admission rates, and (2) the particular challenges that American Indian patients face when returning to home communities.

Recommendations:

1. Develop a Cultural Effectiveness Plan - with the assistance of recognized experts that includes defined steps for integration at every level of organizational planning.
2. Define expectations for staff knowledge about cultural, ethnic, social, historical, and spiritual issues relevant to the mental health treatment of MSH patients, with a specific emphasis on American Indian people.
3. Develop and provide 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, with a specific emphasis on American Indian patients.
4. Formalize a section in the treatment plan that captures relevant information concerning cultural issues such as whether a patient is bi-lingual, the degree of assimilation into mainstream culture, tribal enrollment/affiliation, etc.
5. Develop a working relationship with one or more clinicians who are qualified to assist in ensuring that treatment plans – in particular plans for American Indian patients – are culturally relevant.

Staff Competence, Training, Supervision, and Relationships with Patients

Does MSH define optimum knowledge and competence expectations specific to working with people with mental illnesses for each staff position providing services to patients?

Job Profiles’ for the following positions were reviewed: Psychiatric Technician, Licensed Practical Nurse, Registered Nurse, Nurse Manager, Treatment Unit Supervisor, Social Worker (Bachelor level), and Recreation Therapist.

Strengths:

- The Job Profiles for Psychiatric Technicians and Social Workers have good specificity regarding expectations for knowledge about mental illnesses and working with people with mental illnesses. This description of the knowledge MSH expects Psychiatric Technicians to have is particularly good:

“Knowledge of ... the principles, practices, and methods of treatment, rehabilitation and recovery for individuals with severe and persistent mental disabilities [sic]; the effects of stigma and discrimination on the lives of patients and their families; major consumer advocacy groups; Montana State statutes concerning treatment of patients at Montana State Hospital; patient rights; hospital’s mission, vision, and guiding principles...”

Observations:

- Knowledge expectations in the Job Profiles of Nurse Manager and Treatment Unit Supervisor are less specific, but do address “major psychiatric illness”:

“Thorough knowledge of treatment/rehabilitation techniques and modalities currently being utilized to treat adults with major psychiatric illness within a public inpatient behavioral health setting.”

- Knowledge expectations in the Job Profiles of Licensed Practical Nurse and Registered Nurse more vague:

"Thorough knowledge of [principles and skills/nursing process] as it applies to the provision of medical, geriatric, and psychiatric services to adult individuals in an [inpatient/inpatient psychiatric] setting."

- Knowledge expectations in the Job Profile of Recreation Therapist do not address working with people with mental illnesses at all.

Suggestions:

- Consider revising Job Profiles for the above positions so that they are consistent and modeled after the Psychiatric Technician profile.

Does MSH have a written training curriculum for new staff focused on achieving optimum knowledge and competence expectations specific to working with people with mental illnesses defined for each position providing services to patients?

Strengths:

- There is a comprehensive training curriculum for newly hired Psychiatric Technicians; training includes initial and annual update Mandt, basic mental illnesses and working with patients, cultural awareness, charting, responding to difficult and aggressive behavior, and reporting requirements for abuse/neglect; 12 hours of annual continuing education are required.

Does MSH train new staff in job-specific knowledge and competence OR require new staff to demonstrate defined optimum knowledge and competence specific to working with people with mental illnesses and emotional disturbances prior to working with patients?

Strengths:

- MSH has a strong and dedicated Staff Development department, and continually strives to expand and improve training offerings.
- New employee training programs train to MSH general requirements then to unit specific services needs.
- New nurses complete a 3-4 week orientation including education on psychiatric medications (taught by the pharmacy) and Mandt®, followed by placement on a unit for 5-6 days with an experienced RN.
- Staff interviewed appeared well trained and when asked had no reluctance to say if they needed or wanted training specific to serve people on a specific unit or with a specific medical/psychiatric health need the training would be available.

Observations:

- Since the specificity of expectations varies across job positions, and the relationship between the training curriculum and the knowledge and competence expectations is unclear, the degree to which training results in staff achieving defined expectations is also unclear.

Suggestions:

- Work toward establishing direct relationships among knowledge/competence expectations, the training curriculum, and training provided.

Does MSH provide staff opportunities for ongoing training including NAMI-MT Provider Training, NAMI-MT Mental Illness Conference, Mental Health Association trainings, Department of Public Health and Human Services trainings, and professional conferences?

Yes

Strengths:

- Staff attend a variety of trainings both off and on campus.

Suggestions:

- Consider ways to increase inclusion of Psychiatric Technicians in off-campus training including the annual NAMI-Montana conference

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

Yes - via annual performance appraisals.

Does MSH train supervisors and hold them accountable for appropriately monitoring and overseeing the way patients are treated by line staff?

Yes

Does MSH train supervisors and hold them accountable for appropriately monitoring, overseeing, and ensuring that treatment and support is provided effectively to patients by line staff according to their responsibilities as defined in treatment plans?

Yes

Strengths:

- Both Psychiatric Technicians and supervisors interviewed were focused clearly on the primacy of treatment plans as the guide for decisions and daily work with patients.
- BOV team members who interviewed D Unit staff and supervisors were particularly impressed with the degree to which all staff there have input in treatment planning and intervention decision-making, and are integrated into ongoing unit communication and problem-solving across shifts.

Observations:

- Some professional staff indicated that Psychiatric Technicians would benefit from more supervision and training specific to understanding patients' illnesses and treatment plan goals as the basis for their responsibilities in working with patients.

Suggestions:

- Continue to push toward increased integration of Psychiatric Technicians in all facets of treatment.

Do mental health service staff demonstrate respect for patients by incorporating the following qualities into the relationship with patients:

- active engagement?
- positive demeanor?
- empathy?
- calmness?
- validation of the desires of patients?

Yes

Strengths:

- The strategic plan includes guiding principles and key priorities that focus specifically on the dignity of the patients and the way all staff are expected to interact with patients.
- Throughout the two-day review, staff-patient interactions observed by BOV team members were calm, respectful, and positive.

Active Engagement with Patients:

Do MSH direct care staff demonstrate proactive, assertive, supportive, engagement with patients in every applicable treatment environment?

Yes

Observations:

- In the Spratt building, building design and staff shortages appear to significantly compromise both the frequency and quality of staff engagement with individual patients.

Are MSH professional staff consistently present in all treatment environments interacting with direct care staff and patients teaching, modeling, and reinforcing healthy, constructive, respectful interactions?

Yes

Strengths:

- During this two-day review, BOV team members observed significant constructive presence of professional staff in treatment milieus.

Observations:

- Professional presence in the milieu varied from unit to unit.

Treatment and Support

Is a written treatment and discharge plan in place and being implemented for every patient receiving services from MSH?

Yes

Strengths:

- MSH has been moving toward significant increase in the active participation of patients in treatment and discharge planning.

Observations:

- MSH has increased the percentage of treatment plans and discharge plans which are done within 10 days of admission as required by 53-21-162(2), MCA and 53-21-180, MCA, however MSH is not always consistent in meeting this statutory requirement.

Does MSH perform a thorough physical / medical examination or ensure that a thorough physical / medical examination has been performed within one year of the patient entering / re-entering the service?

Yes

Strengths:

- Each patient receives a physical/medical examination within 48 hours of admission; patients are followed closely for recurrent medical problems; acute problems appear to be promptly being addressed.
- Over the past several years, MSH has increased its emphasis on the general physical/medical health and wellbeing of patients.

Does MSH provide patients with ongoing primary health care?

Yes

Does MSH proactively rule out medical conditions that may be responsible for presenting psychiatric symptoms?

Yes

Strengths:

- The Medical Clinic works closely with psychiatrists in identifying co morbid conditions that could be causing or compounding psychiatric conditions.

Does MSH ensure that patients have access to needed dental care?

Yes

Strengths:

- MSH patients receive prompt and comprehensive dental care; much better access to dental care than is generally available in community settings.

Does MSH 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?

Observations:

- MSH leadership is actively pursuing development of the 'treatment mall' concept.
- MSH participates in AMDD's project to implement SAMHSA evidence based practices.

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

The Addictive and Mental Disorders Division has established an expectation, defined in Administrative Rule, that all mental health and substance use service providers are "co-occurring capable". The expectation is that when a person presents for treatment with either a mental illness or a substance use disorder, the presence of the other disorder is explicitly identified or ruled out; and if identified, the other disorder is explicitly addressed.

Strength:

- MSH policy# ADM-05⁴ states that *"All treatment programs are co-occurring capable in that substance abuse treatment needs will be appropriately addressed concurrently with other treatment the patient requires. This program is designed to address the needs of people who have severe substance abuse problems concurrent with a mental illness."*

Observations:

- There are two Licensed Addiction Counselors on MSH staff – one assigned to the Spratt unit, one assigned to A Unit.
- The degree to which MSH services meets the expectation of co-occurring capability is inconsistent from unit to unit.

Recommendation:

6. Assess the degree to which services on each unit are inconsistent with the AMDD expectation of co-occurring capability; develop a plan with defined time frames to meet this expectation.

Medication:

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

Yes

Strengths:

- Medication prescriptions reviewed by BOV all had evidence supporting their use for the diagnoses of the patients; dosing and titration was appropriate; clinical pharmacist interventions were noted for dosing and titration recommendations.

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

Yes

Strengths:

- Pharmacists rotate on-call responsibility for new admissions after hours.
- Regulated by an in-house pharmacy, which has expanded its hours to 7am-9pm M-F and 9am-5:30pm Sat and Sun.
- Medications are appropriately stored and logged within the pharmacy; medications are kept in a locked medication room in a locked medication cart; there is a locked refrigerator for medications requiring refrigeration.
- Schedule II narcotics and PRN schedule III-V narcotics are bubble packed and kept separate; a continuous log is kept for these medications and they are counted and double signed at each shift; schedule III-V medications that are to be given on a scheduled basis are placed in the medication carts with other meds and documented via the medication administration record (MAR).
- Non-narcotic PRN medications are placed in the cart with other medications and noted with a bright orange sticker.
- Each unit also has an emergency box regulated by pharmacy; B Unit has a crash cart for medical emergencies.
- In the pharmacy, orders are received by fax and inputted on a computerized MAR; pharmacy fills medication carts 2 times / week and makes 5 deliveries per day for new orders.
- The pharmacy has a certified IV hood to make IV medications when necessary.
- The transitional care houses keep medications in a locked room where monitored self administration is supervised by an RN.

Observations:

- Administration of medication on treatment units is not done with a sufficient level of privacy/confidentiality. The BOV consultant did not observe a medication pass, but it appears that patients line up at the medication room door en mass and are given their medications in an open setting. It was reported to BOV that - particularly in the Spratt building - some patients have been "bullied" for their medications by other patients.

Suggestion:

- To fix the privacy issue temporarily, consider requiring patients to stand back a certain distance until it is their turn to receive their medication.

Recommendation:

7. Develop an appropriately private/confidential process for administering medications to patients across all treatment units.

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

Yes

Strengths:

- Medication education is provided by psychiatrists and nurses individually and in group medication education classes on units.
- The pharmacy uses pharmacy students and clinical pharmacists to provide monthly medication education classes to reinforce medication adherence and compliance as well as answer any questions the patients may have.
- When patients are discharged, they are given medication information packets.

Observations:

- It was reported to BOV that many patients decline to give permission for their families to be included in communication about their treatment.
- In this treatment setting, it may be unrealistic for families to participate in medication education.

Is "medication when required" (PRN) only used as a part of a documented continuum of strategies for safely alleviating the resident's distress and/or risk?

Yes

Strengths:

- When PRN medication is given, the purpose and effectiveness is recorded in the MAR. The continuum of other strategies leading up to the necessity of the PRN is recorded in the progress notes.

Does MSH ensure access for patients to the safest, most effective, and most appropriate medication and/or other technology?

Yes

Strengths:

- MSH does not have a strict formulary; physicians are free to prescribe what they feel is best for the patients.

Observations:

- Upon discharge, access to more expensive medications - especially for patients on MHSP - is limited. The discharge team does everything it can to provide vouchers and other assistance to obtain medications.

Does MSH actively promote adherence to medication through negotiation and education?

Yes

Strengths:

- The pharmacy provides a monthly class and nurses and psychiatric technicians are also educated about medications, so they can educate patients on a daily bases.

When legitimate concerns or problems arise with prescribed medications, do patients have immediate access to a psychiatrist or mid-level practitioner?

Yes

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

Yes

Strengths:

- Abnormal Involuntary Movement Scale⁵ (AIMS) assessments are conducted.
- RNs and psychiatric technicians are trained to observe for side effects.
- Abnormal movements are well documented by nursing staff.
- Easy access to psychiatrists and nurse practitioners.
- Allergies are recorded on patient MAR.
- Potential problematic medication interactions are identified via the pharmacy computer system and are addressed by a pharmacist.

Are medication errors documented?

Yes

Strengths:

- Medication error forms are filled out when an error occurs. This form goes to the Nursing Director and the pharmacy; the Quality Improvement team meets periodically to review causes of medication errors and to implement changes needed to prevent/reduce medication errors.

Observations:

- It was reported to the BOV consultant that most medication errors occur at administration; and that this may be due to the frequency of “flex” LPNs from off unit to administer medications without knowing the patients; it was reported that medications have been given to the wrong patients in some instances.

Suggestion:

- Consider ways to address the specific issue of “flex” LPNs and medication errors; identify this issue in quality improvement strategies. *MSH Comment: MSH has systematized medication error reporting and follow-up so that we can track specific staff performance, determine need for systematic improvements and determine root causes.*

Is there a quality improvement process in place for decreasing medication errors over time?

Yes

Strengths:

- See above.
- Computerized Physician Order Entry system is being developed - which will help prevent medication errors on the pharmacy end (misread prescriptions).

Is the rationale for prescribing and changing prescriptions for medications documented in the clinical record?

Observations:

- This varies among physicians; some write very good progress notes describing their rationale, while others make changes with very little if any documented rationale.
- Progress notes from all disciplines are on the same pages of the same section of the chart, making it difficult to clearly see documentation for prescriber rationale for medication changes.

Suggestion:

- Consider ways to ensure more consistent documentation of rationale of medication prescription and changes.
- Consider creating a separate section in the progress note section of the chart for each discipline's documentation.

Are unused portions of medications and expired medications disposed of appropriately after expiration dates using when resources are available the protocols described in SMAR_xT DISPOSAL^{TM 6} or similar protocol?

Yes

Strengths:

- Unused/expired medications are placed in sharps containers by the pharmacy; sharps containers are sealed when full and taken to one of the nearby hospitals where they are disposed of via the hospital's policy.

Is there a clear procedure for using and documenting emergency medication use, including documentation of rationale, efficacy, and side effects?

Yes

Strengths:

- Documentation is similar to PRN medications. Most emergency medications are available in the emergency medication box on each unit.
- A prescriber is always available to give an order for an emergency medication; pharmacy enters the order for records.

Is there a clear procedure for using and documenting 'involuntary' medication use, including documentation of rationale, efficacy, and side effects?

Yes

Strengths:

- If a physician believes that a patient is a candidate to receive medications against his/her wishes, the Involuntary Medication Review Board process^{7, 8} is followed.

When a patient who is transitioning to another service provider is taking psychotropic medications, does MSH proactively facilitate the seamless continuation of access to those medications by ensuring that: (1) the patient has an appointment with the physician who will be taking over psychotropic medication management, (2) the patient has enough medications in hand to carry him/her through to the next doctor appointment, and (3) the patient's medication funding is established prior to the transition?

Yes

Strengths:

- This always a challenge and the procedure tends to be very individualized.
- The patient usually leaves with a prescription; if it is thought that there will be a delay until the prescription is filled, the MSH pharmacy provides the patient with a 3-7 day supply of medications.
- Discharge forms are given to the patient and faxed to the post-discharge community provider.
- Social workers are involved in making post-discharge medication appointments, and coaching the patient in how/when to contact the community provider.
- Medication vouchers are given to patients as needed and other medication access assistance is provided.

Continuity of Services through Transitions

General comment:

MSH works hard to gather necessary information for each patient on admission and to coordinate with community providers on discharge. For many patients, this process works well on both ends. However, for a number of patients, this process is less than optimal. BOV believes that there needs to be a clearly-defined written protocol for communication and coordination between community providers and MSH providers, and that this protocol needs to be followed for each patient admitted to MSH.

For the purposes of treatment/discharge planning and continuity of services, patients admitted to MSH are in one of two categories:

- (1) Those who are engaged in mental health services in the community prior to admission to MSH.
- (2) Those who are not engaged in mental health services in the community prior to admission to MSH⁹.

Admission Communication/Coordination:

For patients in category (1), BOV believes that admission and treatment planning conversations need to take place between the community provider and MSH at the time of admission. BOV believes that the community provider has the responsibility to initiate this conversation. ([53-21-162\[2\], MCA](#) requires a treatment plan to be in place within 10 days of admission.)

For patients in category (2), BOV believes that MSH should begin the process of identifying and engaging with a community provider who will provide services to the patient post discharge, and that this effort should begin within one week of admission. ([53-21-180, MCA](#) requires a discharge plan to be in place within 10 days of admission.)

Ongoing Communication/Coordination:

For patients in categories (1) and (2), BOV believes that ongoing treatment conversations need to take place between the community provider and MSH periodically throughout the patient's stay at MSH. BOV believes that MSH has the responsibility to initiate these conversations.

Discharge Communication/Coordination:

For patients in categories (1) and (2), BOV believes that discharge planning conversations need to take place between the community provider and MSH within one week of admission, and periodically throughout the patient's stay at MSH. These conversations need to be oriented around specific discharge logistics no later than two weeks prior to the planned discharge date. BOV believes that MSH has the responsibility to initiate these conversations.

BOV believes that both the community provider and MSH should proactively engage interested family members – with patients' permission – in all of these conversations.

Recommendation:

- 8. The Addictive and Mental Disorders Division and Montana State Hospital should work with community providers to establish a clearly-defined written protocol for communication and coordination between community providers and MSH providers relative to admission and discharge of MSH patients.

STATUS of IMPLEMENTATION of 2006 RECOMMENDATIONS

May 27, 2010

Gene Haire, Executive Director
Mental Disabilities Board of Visitors
P.O. Box 200804
Helena, MT 59620-0804

Re: *Status of Implementation of Report Recommendation – May, 2010 update*

Dear Mr. Haire,

As you requested in your site visit announcement I am providing an update to the recommendations made by the Board during the December, 2006 Site Review of Montana State Hospital. Updates were previously provided in December, 2007 and September 2008. This letter is to provide further information and comment concerning these recommendations.

RECOMMENDATION 1:

Quickly identify "guilty but mentally ill" patients whose primary diagnosis is not an Axis I major mental illness, who present an unstable risk to other patients and staff and transfer them to prison sooner.

Response

Action to be taken: Implementation

December, 2007 update

A Memorandum of Understanding between Montana Department of Corrections and Montana Department of Public Health and Human Service has been signed off on by both agencies on 10/26/07. The two departments intend to treat these offenders the same with regard to sentence calculation, victim notification and tracking their status through the criminal justice system regardless of which department has custody of the offender. The DOC will ensure fingerprints and photographs have been collected from each offender prior to transport to DPHHS custody. Additionally, a (A0) number will be assigned and initial offender information will be entered into the DOC database with offender status and placement. Lastly DOC will complete standard intake at MSP or MWVP as appropriate, to include preliminary classification of the offender.

GBMI patients have been registered with the Montana Department of Justice as of 12/14/07 for sexual and violent offenses. Administration and the Forensic treatment team are looking at a policy change that would involve prohibiting people convicted of violent or sexual crimes from participation in community outings until they are very close to parole eligibility.

Other Correctional Release / Placement Options have been discussed for movement of GBMI patients. These are:

- Montana State Prison
- Montana women's Prison
- Treasure State Correctional Training Center
- Pre – Release Centers (Missoula, Butte, Billings, Great Falls, Helena, Bozeman)
- Intensive Supervision Program
- Warm Springs Addiction Treatment and Change (WATCH)
- Connections Corrections Program (Warm Springs and Butte)
- Elkhorn Treatment Center (Boulder)
- Nexus Correctional Treatment Center (Lewistown)
- Interstate Compact
- START (Warm Springs)
- BASC (Billings)
- MASC (Missoula)

Contact Person: Ray McMillan, D Unit Program Manager

September, 2008 update – We continue to work closely with staff at Montana State Prison to identify people who might be more appropriately served in a correctional facility and to carefully plan transfers when indicated.

May, 2010 update - We continue to work closely with staff at Montana State Prison to identify people who might be more appropriately served in a correctional facility and to carefully plan transfers when indicated. The MOU that we have operated under for the past several years is currently under review and updating.

RECOMMENDATION 2:

- a) Take decisive action to establish clear expectations for direct care staff, supervisors, and professional staff regarding ongoing, active engagement with patients in the context of a dynamic therapeutic milieu.
- b) Require professional staff to be consistently present on units teaching direct care staff about and modeling for direct care staff healthy and constructive interactions with patients.
- c) Require supervisors to insist and ensure that direct care staff spend most of their time in the milieu with patients in consistently positive, recovery-oriented incidental interactions based on intervention strategies described in treatment plans as well as general guidelines for appropriately engaging with people with mental illnesses.
- d) Direct the Program Managers, Psychiatrists, Nurse Managers, and Clinical leaders to identify staff who are not functioning in a way that actively contributes to the mission of the Pathway/Unit or to the recovery of individual patients. Immediately address job performance problems of these staff in formal, written performance evaluations.

Response

Action to be taken: Partial implementation

December, 2007 update

Providing active treatment to patients at MSH remains the highest priority on all treatment units. Program Managers are responsible for ensuring that this is happening. An audit tool to monitor active treatment on each unit has been developed and is being used on a weekly basis to provide feedback to the Psychiatrist, adjust individual schedules and monitor group attendance. While it is not a perfect program, we continue to revise it and train staff in its use.

To further the endeavor of providing active treatment, as professional positions become open, each position is reviewed to determine the hours and days off that will best support not only active treatment but also provide more support to the nursing staff on evening and week-ends. Program Managers have met with representatives from the Independent Union and the Professional Union to discuss group coverage and expectations for providing active treatment.

The hospital has developed a "Safety and Security for Preventing Violence and Responding to Incidents" class which is provided on a monthly basis. MANDT training continues to be offered on a monthly basis. Several Program Managers and Nurse Managers are trainers in this program. The goal is to have all Program Managers and Nursing Managers receive advanced training in this program. Other training that has taken place in the past year include team building, active treatment, person centered care, boundaries, empathy and cultural training to mention a few. Managers on the individual units work closely with the Staff Development Department to address the training needs on their individual units.

High census and unfilled positions, despite our attempts to recruit, remains a barrier to implementing all the training and strategies we would like. The goal of everyone is to provide a safe environment for our clients and our staff.

Contact Person: Helen Amberg, A Unit Program Manager

September, 2008 update – We are aware that the Board has continuing concerns in this area. We have asked supervisory personnel to continue their efforts to make improvements in patient-staff communications and coordination of care on our treatment units.

May, 2010 update - MSH is keeping critical positions filled and providing more active treatment. We have modified our staffing complement by decreasing psychologists and adding four treatment specialists. This has allowed us expand active treatment to evening and weekend hours. Vacancy rates for our critical positions are at the lowest levels in recent memory. Psychiatric Technician treatment unit job assignments have been revised to include scheduled therapeutic assignments in day halls interacting with patients and therapeutic training has been provided to LPNs and psych techs throughout the hospital.

RECOMMENDATION 3:

- a) Adopt an objective classification system such as the following: Montana Department of Corrections Offender Classification Procedures, Policy 4-2-1.pdf >>> <http://www.cor.mt.gov/resources/POL/4-2-1.pdf>.
- b) Utilize the classification system defining security levels described in Guidelines for Development of a Security Program.
- c) Place any person who scores higher than a MEDIUM classification rating in prison until he/she has received a classification rating below MEDIUM.

Response

Action to be taken: Do not implement recommendation as stated; research alternative classification systems specific to forensic psychiatry

December, 2007 update

Virginia Hill, M.D. attended a meeting of State Forensic Mental Health Program directors in September, 2007 and brought back the following information;

The following states do not have any classification system but have level systems similar to the one used at Montana State Hospital.

Maine, West Virginia, Arkansas, Tennessee, Georgia, Oregon, Hawaii, Idaho, Pennsylvania, Wisconsin, Nevada, Utah, New Jersey, and Texas.

Classifying offenders higher than a MEDIUM classification and transferring them to prison would only lengthen their recovery period from mental illness. Montana State Hospital is the best place to recover from mental illness where observation and treatment can go on 7 days a week and Montana State Hospital has a wealth of professionals to enhance the recovery process.

Before GBMI patients can advance in the level system they are evaluated over a period of time by the Forensic Treatment Team. Compliance with mediations and involvement in "prescribed therapy" groups are taken into account before an offender can advance. Offenders can only advance past Level 3 if they have shown that they are actively involved in treatment and have a resolve to make further progress. They are taken to a panel of Psychiatrists, Director of Nursing, Social workers, Nurses, Psychologists, and the CEO of the hospital who must agree with the treatment team that it would be in the best interest of the patient to move into the higher levels. The FRB board looks at the treatment history and the crime along with any victims that there may be and makes an informed judgment as to the higher levels. This process has been in place for many years and has served MSH well.

Contact Person: Ray McMillan, D Unit Program Manager

September, 2008 update – No specific action has been taken to implement a specific classification system modeled after those used in correctional settings. Our approach is to use a detailed level system and individualized treatment planning managed by unit treatment teams.

May, 2010 update – The September, 2008 update continues to reflect current status.

RECOMMENDATION 4:

Immediately address problems with the chain of command that cause confusion during critical incidents.

Response

Action to be taken: Implementation

December, 2007 update

Training on the chain of command during critical incidents continues on an ongoing basis. 100 Staff to date have completed a two-day training program on Safety and Security which included roles and responsibilities including following the chain of command when responding to emergency situations. Dates for the class have been set up through March and will continue until all the direct care staff has completed the training.

Contact Person: Connie Worl, Director of Quality Improvement

September, 2008 update – We continue to provide safety and security training and to review critical incidents after they occur to identify things that could be improved upon.

May, 2010 update – The chain of command in critical incidents is clearly outlined in the MSH Fire, Emergency and Disaster Plan(FEDP). This plan is reviewed and updated annually. All staff complete FEDP mandatory training annually and all new employees are trained on FEDP during orientation.

RECOMMENDATION 5:

Develop and implement training in crime scene investigation, evidence preservation, and incident reporting to improve the ability to support prosecution for criminal behaviors.

Response

Action to be taken: Do not implement recommendation as stated. Continue to work cooperatively with local and state law enforcement agencies.

December, 2007 update

Staff training regarding providing information to law enforcement during critical incidents is included in a two-day training program on Safety and Security. 100 staff members have attended the class thus far and the class is scheduled on a monthly basis. A meeting was held with the County Attorney and Sheriff of Anaconda Deer Lodge County to enhance communication. Leadership staff was trained on the information needs of the country and this information is discussed with the unit staff on an ongoing basis.

Contact Person: Connie Worl, Director of Quality Improvement

September, 2008 update – We have updated Hospital policy on reporting incidents to Law Enforcement Authorities and have reviewed it with supervisory personnel. The County Attorney has told us this is an excellent policy that covers the relevant issues. She has asked us to reinforce the need for staff to follow the prescribed procedure.

May, 2010 update – We met with local law enforcement and the County Attorney on April 22, 2010. At the meeting the County Attorney reiterated her support for our policy and process for communicating with local law enforcement in emergency situations. In addition, all Security Officers have been trained in crime scene investigation and preservation, and all employees are trained in incident reporting. The training was done through a educational program published through the Security Guard Management Co of Maryland. All officers were tested on the material and passed with a score of 80% or more.

RECOMMENDATION 6:

Amend the MSH sentinel event review policy so that it replicates the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) JCAHO Sentinel Event Policy and Procedure.

Response

Action to be taken: Do not implement recommendation as stated; review incident review procedures.

December, 2007 update

MSH closely follows JCAHO standards when completing sentinel event reviews. Our Sentinel Event Policy outlines the steps that are taken when a sentinel event occurs. We conduct extensive reviews in attempt to determine the root cause of the event. MSH also conducts event review when seclusion and or restraint is utilized or an act of violence occurs. While these procedures do not warrant sentinel event reviews, events leading up to the procedure or act are reviewed to determine antecedents. The person served is included in the review in attempt to avoid the use of the procedure in the future.

Contact Person: Connie Worl, Director of Quality Improvement

September, 2008 update – We continue to make every effort to review incidents thoroughly and commensurate with the nature of the event.

May, 2010 update – Our significant event policy is currently under revision. Root cause analyses have been completed on two significant events since the time of the last visit.

RECOMMENDATION 7:

- a) Reevaluate all Montana State Hospital policies and procedures that address emergency response, patient safety, and management of the treatment environment; review the standards of the Joint Commission on Accreditation of Healthcare Organizations in these areas and use in revising Montana State Hospital policies and procedures.
- b) Develop a stronger security presence with more comprehensive training.
 - Option 1: A minimum of two security staff with training specific to emergency response and incident command authority.
 - Option 2: One Security Manager with an appropriate background with forensic populations who could develop policies, supervise and train a crisis intervention team, focus on emergency response, investigate incidents, triage issues to report to law enforcement, and provide consultation to all units to ensure safety.
- c) Incorporate the expertise of security specialists in decisions affecting and policies and procedures (including staff training) for D Unit.

Response

Action to be taken: Partial implementation

December, 2007 update

The hospital has security officers on duty 24/7. These individuals' responsibilities include but are not limited to maintain a safe and secure environment. The security officers are not trained as law enforcement personnel. They do receive extensive training in crisis response. They also receive training in therapeutic interventions including de-escalation and the safe management of escalated persons. They are expected to interact in a therapeutic manner with all served and they take a proactive approach to managing escalating persons.

D Unit has taken several internal steps to increase the safety and security on the unit, for example, visitors are not allowed to bring any items with them when they visit. People served are limited to the amount of items they can have in their rooms.

Contact Person: Connie Worl, Director of Quality Improvement

September, 2008 update – We continue to try to provide effective safety and security setting in a treatment setting. Some organizational changes to enhance security are under consideration. This includes possibly reclassifying positions to increase the number of security officers or to differentiate duties assigned to psychiatric technicians on D Unit.

May, 2010 update – Training for all Security Officers is ongoing, and training on emergency response, incident command and crime scene investigation is completed annually. Two additional security officers have been hired since the 2006 site review. This brings our security workforce up to seven full time officers.

RECOMMENDATION 8:

Develop detailed policies and procedures that are specific to the specialized needs of this unit/population; transcribe the guidelines contained in the 11-22-06 memo into formal policies and procedures.

Response

Action to be taken: Implementation

December, 2007 update

A detailed security policy was drafted and sent to the Hospital Administrator for review and approval. The Administrator has approved the policy.

Contact Person: Ray McMillan, D Unit Program Manager

September, 2008 update – In general, we believe that security procedures in place on the unit work well. We would appreciate feedback if you or your staff believe otherwise.

May, 2010 update – Since the time of the last BOV visit, D Unit has added security tools that significantly augment our security policies and practices. The new tools include a video system in all public areas on the unit and the addition of a metal detection system.

RECOMMENDATION 9:

Conduct background checks of visitors; establish an approved visitor list for each patient; limit visitors to those with an approved background check. (reference: <http://www.cor.mt.gov/resources/POL/5-4-4.pdf>)

Response

Action to be taken: Do not implement recommendation as stated; consider other alternatives to enhance security during visits

December, 2007 update

The following provisions are included in the Forensic Unit Security Policy:

1. Visitors will not be allowed to bring any items for patients into the visiting room. Coats and handbags must be stored in provided lockers or left in cars.
2. Patients who return from the visiting room will be pat searched and put through the metal detector.
3. Visitors can put money into patients' accounts and may leave phone cards and clothes as long as the amount of clothes does not exceed the limit. No food items may be sent in. Patients with level four and above privileges may eat in the visitation room.
4. Level one and level two patients will have non-contact visits by camera.
5. Level three through level eight may have contact visits in visitor's room. Level nine and level ten may have contact visits on campus.
6. Inappropriate behavior, such as, aggression, sexual contact, alcohol and drug use, or any threatening or aggressive behavior will result in termination of visit.
7. The treatment team reserves the authority to deny a visit for safety or treatment reasons.

Contact Person: Ray McMillan, D Unit Program Manager

September, 2008 update - We believe that procedures in place to supervise visits are working reasonably well and have not recently experienced any significant problems on the forensic unit.

May, 2010 update – The policies and procedures in place have greatly improved security. The hospital is updating D Unit visiting policies and considering the addition of having all visitors pass through the metal detector in order to visit. In the revised policy, staff would be subject to random, unannounced metal detection.

RECOMMENDATION 10:

Incorporate the following language into visitation policy:

- "Patients may NOT use restroom without a search by staff prior to use." (This is a primary means of introducing contraband into secure areas). "Visitations will be directly observed at all times."
- "Visitations will be directly observed by designated staff at all times."
- "Patients may not sell OR GIFT items to other patients."

Response

Action to be taken: Do not implement recommendation as stated; evaluate alternatives to provide security in a hospital setting

December, 2007 update

The following provisions are included in the Forensic Unit Security Policy:

1. Visitors will not be allowed to bring any items for patients into the visiting room. Coats and handbags must be stored in provided lockers or left in cars.
2. Patients who return from the visiting room will be pat searched and put through the metal detector.
3. Visitors can put money into patients' accounts and may leave phone cards and clothes as long as the amount of clothes does not exceed the limit. No food items may be sent in. Patients with level four and above privileges may eat in the visitation room.
4. Level one and level two patients will have non-contact visits by camera.
5. Level three through level eight may have contact visits in visitor's room. Level nine and level ten may have contact visits on campus.

6. Inappropriate behavior, such as, aggression, sexual contact, alcohol and drug use, or any threatening or aggressive behavior will result in termination of visit.
7. The treatment team reserves the authority to deny a visit for safety or treatment reasons.

Patients returning to the unit

1. Patients will not be allowed to bring anything back to the unit after an off unit activity.
2. Patients need to clear the metal detector at all times. If not able to get through the detector, the hand held detector must be used. Patients may be pat searched at any time.
3. Staff must be present at the metal detector to observe patients returning to the unit.

Purchases

1. Patients may make purchases from vendors which must be sent directly by the vendor to the unit. Purchases that are sent to a family member and then sent to the patient will be returned at the patient's expense. If a package comes in from a family member and there are items that the patient cannot have they will be returned at the expense of the patient. If the patient does not have money to return the item it will be considered "abandoned property" and will be destroyed.

Bathrooms for visitors on D wing are in the main rotunda and it would be impossible for staff to search the bathroom before each visit and is not necessary because the visits for D wing patients are in the visiting room between the two doors off of D wing. The visiting room has a camera installed in the room as you have noted. Also as noted we do not allow selling or gifting items to other patients.

Contact Person: Ray McMillan, D Unit Program Manager

September, 2008 update – Again, we believe that procedures in place to supervise visits are working reasonably well and have not recently experienced any significant problems on the forensic unit.

May, 2010 update - The policies and procedures in place have greatly improved security. The hospital is updating D Unit visiting policies and considering the addition of having all visitors pass through the metal detector in order to visit. In the revised policy, staff would be subject to random, unannounced metal detection.

RECOMMENDATION 11:

Develop a hostage policy that conforms with standards described in Guidelines for Development of a Security Program.

Response

Action to be taken: Do not implement recommendation as stated; consider alternatives for emergency response training and procedures

December, 2007 update

The staff at MSH has been trained to call law enforcement if a hostage incident would occur. The Hospital's emergency response plan will be revised to include protocol for hostage situations. The training will focus on providing pertinent information to law enforcement and the chain of command during the situation.

Contact Person: Connie Worl, Director of Quality Improvement

September, 2008 update – We believe that security procedures in place on the unit work reasonably well. We would appreciate feedback if you or your staff feel otherwise.

May, 2010 update – A hostage situation policy is under review and consideration at MSH.

RECOMMENDATION 12:

Develop a strategic plan in consultation with staff, patients, family members, and community service providers.

Response

Action to be taken: Partial implementation

December, 2007 update

MSH efforts in this area continue through DPHHS and AMDD planning and budget development procedures. MSH also has a number of committees involving staff and patients that look at programs within the organization and policy changes.

Contact Person: Ed Amberg, Hospital Administrator

September, 2008 update – The Hospital Administrator is giving further consideration to how this recommendation may be accomplished. The Hospital is seeking to add additional administrative staff which will provide additional support and may allow sufficient time and resources for this type of planning process to occur.

May, 2010 update – A strategic planning process was initiated in the summer of 2009. The process is young and needs further development. The focus at this point is to have Senior Leaders utilize the process. Some have shared it with their direct reports.

RECOMMENDATION 13:

Develop specific criteria for bringing in outside investigators in abuse/neglect cases; address conflict of interest and other issues that would require outside investigators.

Response

Action to be taken: Implementation

December, 2007 update

MSH recently updated its policy/procedure regarding investigation of abuse and neglect allegations. Input was provided by the MDOV attorney. MSH is also seeking to provide additional training to staff who are assigned responsibilities for completing investigations. MSH has discussed with AMDD staff circumstances when outside investigators would be used, which would be when an obvious or perceived conflict exists. A source of outside investigators has not been identified, but MSH would work cooperatively with law enforcement agencies or other state agencies who may be assigned to conduct an investigation.

Contact Person: Susan Beausoleil, R.N., C., Director of Nursing

September, 2008 update – MSH is in the process of hiring for a new position that will have primary responsibilities for overseeing investigation processes. The investigator may use other personnel within the Hospital to assist with investigation processes, but will have overall responsibility for ensuring that investigation procedures are thorough and complete. Investigation findings will be reported directly to the Hospital Administrator. The Hospital Administrator can request additional assistance from the DPHHS Director when outside resources are needed to complete an investigation. In this instance, the Director would authorize use of other personnel within DPHHS or request assistance from other agencies within state government, or use an independent contractor. An outside investigator will be requested when it appears that the scope of an investigation requires resources beyond those available at the state hospital or technical expertise unavailable at the Hospital, or when a substantive conflict of interest exists that could compromise the objectivity of the investigation.

It is important to recognize that investigations conducted by outside personnel are usually slow to begin and often take significantly longer to conclude. Outside investigators are usually unfamiliar with Hospital policy and procedure and have difficulty making arrangements to meet with personnel who work afternoon or night shifts or are off during weekdays. We recognize that outside investigators do offer a perspective that may be helpful in some circumstances. After giving this issue careful consideration over the last year and inquiring about how investigations are conducted in other state psychiatric hospitals, we have concluded that the best policy for Montana is to normally use personnel on staff to report investigation findings directly to the Hospital Administrator and allow the Hospital Administrator to confer with the AMDD Administrator, and the DPHHS Director about whether an outside investigator may be needed under certain circumstances. Because of the wide range of issues concerning patient abuse allegations, we believe it is better to allow the exercise of some judgment on this matter than to try to hold to specific criteria in a written policy. However, we would appreciate any information the Board may have on criteria for using outside investigators found in policies of other mental health facilities in the state.

May, 2010 update – We have not developed criteria for when we would select an outside investigator. We have cooperated with the DOC on a joint investigation this year and, as noted in previous status reports, if an outside investigator is needed DPHHS would allow us to call upon outside investigators.

RECOMMENDATION 14:

- a) conduct a thorough analysis of the status of the project to reduce or eliminate the use of seclusion and restraint at MSH;
- b) develop an approach that brings all staff into the process as active partners;
- c) develop comprehensive orientation and training for staff at all levels to accomplish this.

Response

Action to be taken: Implementation

December, 2007 update

MSH continues to see positive results from the reduction of seclusion and restraint use. Staff and patient injuries related to violence are also decreasing in correlation to the reduction of seclusion and restraint. The Safety and Security Training has been addressing the reduction of the use of seclusion and restraint on the national level. The staff is being education about the New Freedom Commission of 2002 and changing CMS regulations. In addition, staff is being education regarding the physical and psychological risks associated with the use of these procedures. Topics including therapeutic communication, trauma informed care and role recovery are being covered. The staff is engaging in open and supportive communication regarding the initiative. Staff at all levels is speaking positively about the efforts to reduce the use of these procedures. Event reviews are conducted after each procedure. The participants of the reviews are seeing the process as beneficial. The leadership team continues to review all incidents of seclusion and restraint and appropriate feedback is offered to the staff involved. While some staff continue to express concerns that safety on our treatment units has been adversely affected by reductions in the use of restraint and seclusion, more and more people are speaking favorably of the effort and recognizing the risks and limitations of these interventions. The Hospital's experience with staff concern and resistance has mirrored the experience in similar facilities across the country.

Contact Person: Connie Worl, Director of Quality Improvement

September, 2008 update

Montana State Hospital continues to sustain significantly lower rates of restraint and seclusion use than was the case several years ago. MSH benchmarks its rates with other state psychiatric hospitals and finds that utilization is consistently below published national rates for these interventions. As time has passed, staff seem more comfortable with this change in practice. We continue efforts to train staff in effective intervention procedures.

May, 2010 update – We continue to look seriously at each and every seclusion restraint episode to learn and seek areas of improvement. Our rates have increased since the last update and we believe this has occurred because we are now counting brief physical holds in our restraint numbers. These were not counted in previous results. Our numbers and rates have also been affected as the length of stay has decreased and the numbers of patients on Emergency Detention (and not committed) has increased. Patients on Emergency Detention are patients we are managing without any medication or only emergency medication administration until the time of commitment which may be 5 to 8 days following admission.

RECOMMENDATION 15:

Develop specific emergency response hierarchy and delineation of responsibility for each shift on each unit.

Response

Action to be taken: Implementation

December, 2007 update

The hospital has a very well detailed Hospital Emergency, Fire, and Disaster Plan. Drills are conducted by the Safety Officer on a monthly basis. The orientation program includes emergency response and the Safety and Security Training class includes the roles, responsibility, and accountability of the staff.

Contact Person: Connie Worl, Director of Quality Improvement

September, 2008 update

We continue to provide staff training in this area and to review incidents after they occur.

May, 2010 update- The September 2008 update reflects current status.

RECOMMENDATION 16:

- a) Proactively address ways to appropriately communicate with families when patients do not sign release forms for communication with families.
- b) If a patient refuses to sign a release allowing communication with family members on admission, follow-up every few days after admission to revisit the consent decision. Educate patients so that they understand that the consent can be limited in any way they feel comfortable with, and can be changed to be broader or narrower at any time.
- c) Study and identify the issues that can be shared that don't require written permission; contact Ron Honberg at NAMI National (ronh@nami.org) or the American Psychiatric Association for more information.

Response

Action to be taken: Implementation

December, 2007 update

If an individual refuses to authorize release of information to family members or other appropriate individuals, social workers and other professional staff will continue to follow up every few days after admission. In addition, staff will educate individuals pertaining to choices they have in regard to limitations of consent. Also, individuals will be educated upon HIPAA Privacy Rule, 45 CFR 164.51(b).

The HIPAA Privacy Rule, at 45 CFR 164.510(b), permits covered entities to notify, or assist in the notification of family members, personal representatives, or other persons responsible for the care of the patient, of the patient's location, general condition, or death. Even when the patient is not present or it is impracticable because of emergency or incapacity to ask the patient about notifying someone, a covered entity can still notify family and these other persons when, in exercising professional judgment, it determines that doing so would be in the best interest of the patient.

Also, an e-mail has been sent to Mr. Ron Honberg seeking information about this issue. To date a reply has not been received. Also, the American Psychiatric Association referred Montana State Hospital to the United States Department of Health and Human Services for advice on this issue.

Unfortunately, due to the high patient census, the Family and Volunteer Coordinator position has been reclassified to a Unit Social Worker Position due to the workload of admissions and discharges and retirement of several long-time employees. It is hoped that this position can be filled once again in the future if an opportunity can be found.

Contact Person: Sherri Bell, Program Manager

September, 2008 update

We continue efforts to effectively engage family members in patient treatment and to provide them with timely and accurate information.

May, 2010 update - We continue efforts to effectively engage family members in patient treatment and to provide them with timely and accurate information.

RECOMMENDATION 17:

- a) Identify and contract with people with knowledge of and expertise in the cultural, ethnic, social, historical, and spiritual issues relevant to American Indian people with mental illnesses.
- b) Work with these experts to develop staff training in these areas.
- c) Regularly consult with these experts in all planning, development, and implementation of Montana State Hospital services.
- d) Develop policies, procedures, and supervisory training addressing cultural / ethnic~~d~~ religious~~d~~ racial prejudice and misunderstanding of American Indian people.

Response

Action to be taken: Implementation

December, 2007 update

The hospital has been actively working with James Mason, of the Montana Dept. of Corrections to provide training on American Indian Culture & Customs. The following identifies the dates and hours of training he has provided. We will continue to work with him on providing annual training.

Date of Program	Hours	Number of Attendees
12/19/2006	4	15
2/26/2007	4	9
3/20/2007	2	29
3/22/2007	2	22
4/16/2007	.5	1
4/16/2007	3.5	6
5/8/2007	2	14
5/8/2007	2	8

Two staff attended a Cultural Competency Training in Polson, MT. Upon their return they have put together and provided training for staff and patients. This training included cultural communication, Native American Traditional practices, the trauma of boarding schools, and the practice and purpose of Talking Circles. This ended in all willing participants being active in the Circle Dance and Drumming. This will continue to be an ongoing training.

Date of Program	Hours	Number of Attendees
11/27/2007	1.5	16
11/28/2007	1.5	7

Montana State Hospital obtained, 10 CD's of Native American Cedar Flute Meditations to be utilized by patients. Each unit has 2 CD's and some are utilized as part of the coping skills being utilized on the units.

Montana State Hospital received as a donation, 6 native flutes with the instructions for learning how to play them. These are currently being utilized by the Rehab Department in their classes and individual sessions with patients.

Montana State Hospital is beginning to implement groups specific to Native American healing practices. The Red Road to Wellbriety has started and is available to any patient on campus. In January 2008 we are planning on beginning a Talking Circle, and it will be open to any patient on campus.

Rehab Therapist helped patients develop a mural of Tribes and Flags as a project to help increase Cultural awareness.

The Rehab Department has available and helps patients make dream catchers and includes Art Therapy/painting as part of the healing process offered to all patients. During the Art show in May, many of the displays included Native American crafts and artwork which were completed by people served at Montana State Hospital.

Montana State Hospital has distributed several publications on cultural implications of treatment for minority populations and treatment of Native Americans.

Montana State Hospital has provided interpreters for individuals from Russia, in which there is a language barrier.

Contact Person: Evonne Hawe, Program Manager

September, 2008 update

Montana State Hospital had a consultation on August 18th and 19th from Stan Fleming, LCPC. Mr. Fleming was a member of the Board of Visitors Site Review Team during the December, 2006 survey. He summed up the August visit as follows:

I would like to extend my appreciation to the staff and patients of Montana State Hospital for my warm reception and sincere communication with all individuals.

I was impressed with the staff's understanding and knowledge of Native American Culture. The staff through their questions and responses indicated considerable awareness of the unique status Native People have in the state of Montana. My presentations and subsequent discussions with staff and patients in the State Hospital showed marked improvement in the awareness of Native American issues and concerns when contrasted with my previous visit to the Hospital when I was a member of the Board of Visitors. Specific issues that have developed with Native American patients seemed to be appropriately resolved within specific units and with involvement of Native American staff. I encouraged staff to maintain regular communication with post-hospitalization Native American resources to address the fluidity of

personnel in "Indian Country." It must be stated that one staff member, James Dempsey of the Spratt Unit, has offered to manage a "Sweat Lodge" that will be utilized quarterly with ample instruction prior to participation.

We continue our efforts to be responsive to the needs of our Native American population.

May, 2010 update – In the last year, four program directors and treatment leaders have attended conferences on cultural sensitivity and the provision of health care and mental health care to Native Americans. We have formed a strong partnership with the Indian Alliance in Butte to advise us and they offer monthly gatherings for tribal people. We routinely take patients to these gatherings.

RECOMMENDATION 18:

The Mental Health Services Bureau (MHSB) should develop policies/procedures/rules that require Montana State Hospital and community providers to work together to proactively reach out to family members to consistently facilitate their timely and active participation in discharge planning.

Response

Action to be taken: Implementation

December, 2007 update

The hospital is providing training to various professional staff related to the process of discharge planning. Social workers will be educated to continually try to engage involvement of family in the discharge process. In cases where the family chooses not to be involved in the discharge process, discharge planning will need to proceed without involvement from the family. In addition, NAMI has been contacted by Montana State Hospital to provide educational programs pertaining to family and provider in order to increase knowledge to families and individuals regarding successful recovery and community reintegration.

Furthermore, Montana State Hospital will be promoting a program called, "Walking Hand in Hand." This program will be dedicated to those in recovery. The program is for families and the community. NAMI, along with other community providers will offer educational seminars to increase awareness and reduce stigma associated with mental illness and Montana State Hospital.

Also, various Program Managers will participate with ADART. Hopefully, this will enable both entities to work together for the common goal of successful reintegration into community for individuals. Also, with engagement of consistent meetings with Program Managers and ADART, various challenges can be addressed.

Contact Person: Sherri Bell, Program Manager

September, 2008 update

We continue efforts to work closely with family members and community mental health agencies.

May, 2010 update - Discharge planning begins at the time of admission and we continue efforts to work closely with family members and community mental health agencies.

RECOMMENDATION 19:

The Mental Health Services Bureau should develop policies/procedures/rules that require Montana State Hospital and community provider psychiatrists to proactively communicate to ensure continuity and integration of care as patients move between the community and Montana State Hospital.

Response

Action to be taken: Implementation

December, 2007 update

MSH agrees that communication across the continuum of care between inpatient and outpatient providers is important. MSH has worked to encourage and facilitate this communication. MSH does not believe that policies or rules are appropriate, as MSH does not have full control over the exchange of information. In addition, there are a number of situations where community psychiatrists are not involved in the care of our patients.

MSH supported and participated in Statewide Met Net conferences designed to increase communications between professionals in the hospital and in the community. On 03/26/07 and 05/21/07, these Met Net conferences were facilitated by Drs. Ken Minkoff and Chris Cline. Some outpatient providers were unhappy with the facilitation by Drs.

Minkoff and Cline. Subsequent statewide conference calls were facilitated by Gene Durand and Deb Sanchez. These conference calls occurred on 06/19/07, 07/25/07, 08/22/07, 09/26/07, and 10/24/07. Overtime community participation diminished. On 09/26/07 and 10/24/07, community participation consisted of several nurse practitioners.

The plan is to have a psychiatric communication conference call on 12/19/07 to review our progress and future plans.

Contact Person: Thomas Gray, M.D., MSH Medical Director

September, 2008 update

The MSH Medical Staff and the Addictive and Mental Disorders Division continue efforts to communicate and collaborate with community psychiatrists and other licensed prescribers on patient care and mental health system issues.

May, 2010 update - The MSH Medical Staff and the Addictive and Mental Disorders Division continue efforts to communicate and collaborate with community psychiatrists and other licensed prescribers on patient care and mental health system issues. The results thus far have been less than desired. MSH providers will continue to make efforts to contact local providers when they are known to us and it is possible to reach them. We strongly support the need for continuity of care for patients.

Please contact either me if you have any questions about the information in this report or services provided by our Hospital.

Sincerely,

John W. Glueckert
Hospital Administrator

2010 RECOMMENDATIONS and MSH RESPONSE

1. Develop a Cultural Effectiveness Plan - with the assistance of recognized experts that includes defined steps for integration at every level of organizational planning.

The Associate Hospital Administrator will research Cultural Effectiveness Plans through communication with other State Hospitals and recognized experts to determine the following: how a Cultural Effectiveness Plan applies to MSH, the incremental steps of a plan, and the resources necessary of such a plan. This information will be attained by April 29, 2011 and shared with pertinent decision makers to determine implementation feasibility and action plan.

2. Define expectations for staff knowledge about cultural, ethnic, social, historical, and spiritual issues relevant to the mental health treatment of MSH patients, with a specific emphasis on American Indian people.

The Directors of Human Resources and Quality Improvement/Staff Development will evaluate the current training and orientation program at Montana State Hospital to determine the expectations of staff knowledge about cultural, ethnic, historical, and spiritual issues by April 29, 2011 and review these findings with the Associate Hospital Administrator. Experts will be identified to determine implementation strategies necessary for improvements and develop competencies for all staff at MSH by July 2011.

All staff at MSH will participate in Diversity Training provided by DPHHS in January 2011.

3. Develop and provide 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, with a specific emphasis on American Indian patients.

Associate Hospital Administrator will contact MT University System to identify experts that can provide training on cultural sensitivity.

Associate Hospital Administrator will contact State Tribal Relations recommended by Anna Whiting Sorrell to schedule training on Tribal Relations for the professional by July 2011.

Associate Hospital Administrator and Director of Nursing will educate staff on information given at the 2010 State Tribal Relations Training.

4. Formalize a section in the treatment plan that captures relevant information concerning cultural issues such whether a patient is bi-lingual, the degree of assimilation into mainstream culture, tribal enrollment/affiliation, etc.

Associate Hospital Administrator will evaluate assessment templates for professional staff to ensure that patient assessments contain the above information as part of the patient interview.

Associate Hospital Administrator and Director of Quality Improvement will implement a Quality Assurance Plan to determine if Treatment Plans address culturally pertinent information

5. Develop a working relationship with one or more clinicians who are qualified to assist in ensuring that treatment plans – in particular plans for American Indian patients – are culturally relevant.

Associate Hospital Administrator will continue to develop the Quality Assurance Treatment Plan and Active Treatment Team to include evaluation and development of clinical competency in culturally relevant mental health interventions. This will include their role in assessing and implementing culturally relevant features of mental health care into the Treatment Milieu particularly in the development of the Recovery Mall at the MSH.

6. Assess the degree to which services on each unit are inconsistent with the AMDD expectation of co-occurring capability; develop a plan with defined time frames to meet this expectation.

Currently, the Spratt Unit has the most developed co-occurring treatment curriculum. However, it is the expectation of the Associate Hospital Administrator that all staff are trained in co-occurring philosophy and treatment. The Associate Hospital Administrator will evaluate our current training and orientation program for appropriate education material and evaluation of competency.

7. Develop an appropriately private/confidential process for administering medications to patients across all treatment units.

During times of medication administration patients will be requested to maintain an appropriate distance from the medication room door to help ensure privacy of communication between each patient and the nurse administering medications. There will be a visual prompt placed on the floor outside each Medication Room on A, D, E and Spratt to indicate appropriate spacing between people. Staff assistance will also be available outside the Medication Rooms at routine medication administration times to remind and prompt people to maintain appropriate distancing. In addition, the current remodeling project on Spratt will include structural changes that will aid in providing improved privacy/confidentiality at the Med Room. The majority of routine medications on B Wing are taken directly to each individual patient for administration.

Licensed Nurses will receive training regarding the need to provide for privacy/confidentiality during medication administration.

Director Nursing Services is responsible.

8. The Addictive and Mental Disorders Division and Montana State Hospital should work with community providers to establish a clearly-defined written protocol for communication and coordination between community providers and MSH providers relative to admission and discharge of MSH patients.

Associate Hospital Administrator will continue to chair Admission and Discharge Review Team and implement communication tools that increase the coordination of the Admission and Discharge processes.

END NOTES

¹ <http://www.mandtsystem.com/>

² <http://www2.ed.gov/about/offices/list/ope/trio/index.html>

³ <http://www.mtwytlc.com/>

⁴ <http://msh.mt.gov/volumei/administration/descriptionofservices.pdf>

⁵ http://www.cgaimh.org/pdf/tool_aims.pdf

⁶ <http://www.smarxtdisposal.net/>

⁷ <http://msh.mt.gov/volumeii/psychiatricservices/involuntarymedications.pdf>

⁸ <http://data.opi.mt.gov/bills/mca/53/21/53-21-127.htm> (see part 6)

⁹ According to the MSH Admission Coordinator and supported by admission data over many years, between 50% and 60% of patients admitted to MSH are not engaged in mental health services in the community prior to admission to MSH.