

OFFICE OF THE GOVERNOR
MENTAL DISABILITIES BOARD OF VISITORS
STATE OF MONTANA



Steve Bullock
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August 12, 2014

The Honorable Steve Bullock
Governor of Montana
State Capitol
Helena Montana

Dear Governor Bullock:

The Mental Disabilities Board of Visitors (Board) is pleased to submit this report of the status of services provided at mental health facilities and treatment programs the Board has inspected the past year. This report includes findings from site inspections conducted, services and programs inspected, and advocacy the Board provided to individuals and families who received services from those programs.

The Montana Legislature established the Board as an independent body so it could have the ability to inspect state facilities, private and public non-profit public mental health providers, hospital inpatient and outpatient programs and residential treatment facilities for children and adolescents without bias. Site inspection reports are published and provided to the Office of the Governor, the Montana Legislature and the public.

During this reporting period the Board completed site inspections of mental health treatment and services facilities, the Montana State Hospital (MSH) and the Montana Developmental Center (MDC). Reports of those inspections are attached; site inspection reports are also posted on the Board's web page at: <http://boardofvisitors.mt.gov>.

Recommendations offered in site inspection reports are based on the Standards for Site Inspections adopted by the Board as established by universally accepted treatment and support best practices. The Board reviews and updates the Standards as needed to reflect current best practice principles, state and federal statutes and administrative rules. Site inspection teams include Board members, clinical professionals and consumer consultants who have knowledge and experience with mental health services and treatment services at MDC for individuals who have developmental/ intellectual disabilities.

Included in this report are Observations based on the information received during site inspections and recommendations from the Board to the Governor.

Respectfully submitted,

Alicia Pichette
Executive Director

ANNUAL REPORT

July

2014

A Report to the Governor Regarding the Status of Mental Health Facilities and Treatment Programs Inspected by the Board from January 2013 through July 2014.

Mental Disabilities Board
of Visitors

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SITE INSPECTIONS 2013-2014

Date of Inspection	Facility	Team Members
March 2013	Shodair Children's Hospital Helena http://boardofvisitors.mt.gov/content/Docs/Shodair_2013_pdf	Patricia Harant, Board Member Nancy Morton, Board Member Dr. Jack Hornby, MD Pat Frawley, MSW, LCSW BOV Staff
April 2013	South Central Regional Mental Health Center Billings http://boardofvisitors.mt.gov/content/Docs/SCMRMHC2013.pdf	Connie Frank, Board Member Adele Furby, LCPC Joan Daly, LCPC Mary Chronister, Ph.D. BOV Staff
May 2013	Montana Mental Health Nursing Care Center Lewistown http://boardofvisitors.mt.gov/content/Docs/2013_MMHNCC	Tracy Perez, Board Member Scott Malloy LCSW Rosemary Miller, RN BOV Staff
June 2013	Montana Developmental Center Boulder Annual Inspection http://boardofvisitors.mt.gov/content/MDC_Inspection_2013.pdf	Lin Olson, Board Member BOV Staff
September 2013	Youth Dynamics Group Homes Boulder/Helena http://boardofvisitors.mt.gov/content/Docs/20013ydireport.pdf	Tracy Perez, LCSW Adele Furby, LCPC BOV Staff
November 2013	Western Montana Mental Health Center Missoula (Group Homes/Outpatient Services) http://boardofvisitors.mt.gov/content/Docs/wmmhcmissoula2014.pdf	Nancy Morton, Board Member Mary Chronister, PhD BOV Staff
January 2014	Montana State Hospital Warm Springs http://boardofvisitors.mt.gov/content/Docs/2014mshreport.pdf	Graydon Moll, Board Chair Miriam Hertz, Board Member Dr. Jack Hornby, MD Dr. Jennifer Elison, Ed.D., APRN, LCPC Pat Frawley, LCSW, MSW Sarah Hanson, PharmD BOV Staff
April 2014	AWARE, Inc. Anaconda Pennsylvania Homes http://boardofvisitors.mt.gov/content/Docs/2014awareincreport.pdf	Tracy Perez, Board Member Adele Furby, LCPC BOV Staff
May 2014	Billings Clinic Psychiatric Services Department Billings http://boardofvisitors.mt.gov/content/Docs/2014billingsclinicpsd.pdf	Connie Frank, Board Member Irene Walters, APRN Brooks Baer, LCPC BOV Staff
June 2014	Montana Developmental Center Boulder Annual Inspection http://boardofvisitors.mt.gov/content/Docs/2014mdcreport.pdf	Brodie Moll, Board Chair BOV Staff

Site Inspections Tentatively Scheduled for 2015		
September 2014	Riverfront Counseling & Support - Hamilton	
November 2014	Kalispell Regional Health Center – Pathways- Kalispell	
January 2015	Winds of Change – Missoula	
March 2015	Western Montana Mental Health Center - Bozeman	
April 2015	Eastern Montana Mental Health Center – Miles City	
June 2015	MDC Site Inspection – Boulder (to include an inspection of the facility and treatment services)	

Types of Inspections:

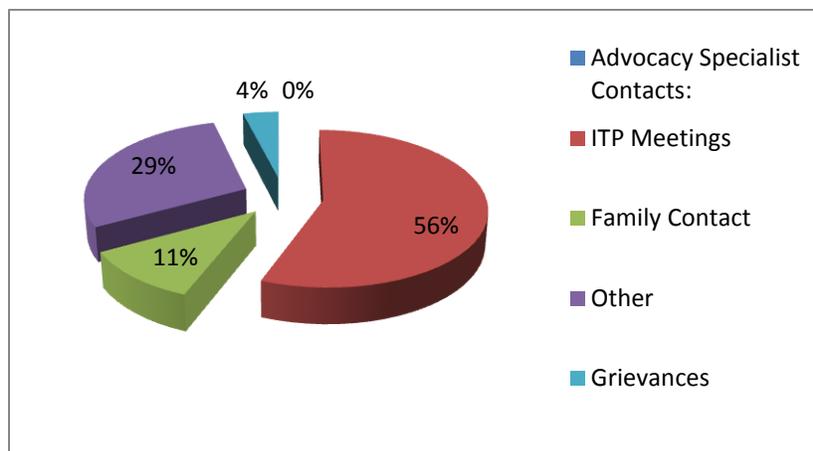
The Board may conduct site inspections at any time, but inspections are primarily:

- (1) routine, scheduled inspections, or
- (2) special inspections prompted by specific issues that come to the Board’s attention.

Other Functions and Duties of the Board

- (1) review and approve all plans for experimental research or hazardous treatment procedures involving people admitted to Montana Development Center or any mental health facility
- (2) annually complete an inspection of the Montana Developmental Center
- (3) review, and if necessary, conduct investigations of allegations of abuse or neglect of people admitted to Montana Development Center or any mental health facility
- (4) review and ensure the existence and implementation of treatment plans
- (5) inquire concerning all use of restraints, isolation, or other behavioral controls
- (6) assist persons admitted to Montana Development Center or any mental health facility to resolve grievances, and
- (7) report to the director of the Department of Public Health and Human Services if the Montana Development Center or any mental health facility is failing to comply with the provisions of state law.

MONTANA DEVELOPMENTAL CENTER ADVOCACY



I. The Graph: The large slice reflects 140 Individual Treatment Plan (ITP) meetings which the Advocacy Specialist at the Mental Disabilities Board of Visitors (BOV) attended, July 1, 2013, through June 30, 2014 (FY14). The primary responsibility of the BOV at Montana Developmental Center (MDC) is to attend ITP meetings and advocate on behalf of clients served at those meetings. The smaller slices represent the number of contacts received by the BOV from MDC clients, families/guardians of clients, and persons receiving mental health services in the community. Individuals contact the BOV primarily to seek assistance during the grievance process, to receive help sorting through confusing or difficult situations, to request information about the mental health service system, and to register complaints about services/service providers.

II. Restraints & Seclusions: One individual served was placed in an emergency seclusion during FY14. Seclusion is used in the secure unit known as the Assessment and Stabilization Unit (ASU) pursuant to MDC policy and procedure. Seclusion is used only when clinically indicated and for the express therapeutic purpose of protection from harm when less restrictive interventions have been ineffective. Seclusion is never used for coercion, punishment, or threat. (*Section 53-20-146(3) MCA, and ARM 37.106.2140 & 2144*)

A total of 117 incidents of restraint using the Mechanical Restraint Chair were reported during FY14; 105 physical holds were used with individuals for safety reasons. One individual has a physician's order for a seatbelt on a wheelchair to assure safety in the event of a seizure. (*MDC Policy/Procedure ATD 204.8, 8a and 8b; and CMS Interpretive Guidelines for SCFMR, Tags 297-300*)

III. Abuse/Neglect: During FY14, investigations were conducted on 43 allegations of abuse/neglect reported by individuals served and/or staff. Abuse/neglect or mistreatment was substantiated through the investigations in 12 of the allegations. Thirty-one investigations found the allegations to be unsubstantiated. Beginning in April 2014 investigations into allegations of abuse/neglect have been conducted by an investigator at the Department of Justice under legislation passed by the 2013 Legislature.

IV. Census/Referrals/Transfers: The census as of July 1, 2014 was 51 (12 individuals are located in the Intermediate Care Facility for the Developmentally Disabled (ICFDD) and 39 clients are located in the Intermediate Care Facility for Individual Intellectual Disability (ICFIID). ICFIID was formerly called "Intermediate Care Facility for the Mentally Retarded (ICFMR). Included in these numbers are 7 individuals under criminal commitments and 5 individuals are not civilly committed. Twenty-two individuals remain on the referral list for placement in community-based services. Two individuals remain at Montana State Hospital awaiting placement in community-based services. During FY14, 9 individuals transferred into community-based services, 8 individuals were admitted into MDC. Since July 1, 2014, two individuals have transferred into community-based services.

BOV / MONTANA STATE HOSPITAL STATISTICS

July 2014

Fiscal Year (July 1 – June 30)	2014*	2013	2012	2011	2010	2009	2008	2007
Admissions to MSH	286	625	604	739	762	739	723	683
Discharges from MSH	288	606	594	714	775	736	736	680
LEGAL REPRESENTATION								
Petitions for recommitment (<i>total</i>)	81	161	167	162	179	194	186	202
Court hearings	14	27	25	23	39	60		60
Recommitment	13	24	23	21	33	53		
Transfer to MMHNCC	0	1	1	0	1	4		
Guardianship	1	1	1	2	5	3		
CI-90	0	0						
Involuntary Medication Review Board (IMRB)	86	170	186	214	200	132	82	194
Initial	40	75	84	99	88	59		81
14-Day Review	38	71	72	79	85	54		77
90-Day Review	8	24	30	36	27	19		36
Forensic Review Board Hearings	11	116	15	21	24	27	35	17
GRIEVANCES								
Grievances (total number)	505	981	749	380*	591	390	519	390
Solved by program manager	335	689	+50%	268	280	265	276	
Addressed by Committee	170	292		73	311	125	243	
2 patient grievances not included in total				336				
Abuse/Neglect investigations	9	23	32	33	13	26	43	30
Treatment Plan Reviews	195	415	370	424	358	327	295	
Seclusion/Restraint reports (<i>total</i>)	330	615	842	740	843	482	379	142
Seclusion	154	307	536	376	450	195	201	86
Restraint	176	308	306	364	393	287	178	56
Hours of seclusion *Pre Intensive treatment unit	905.01	2665.76	29,929*	814	1867	1431		302
Hours of restraint **one patient in walking restraints	105.3	345.91	574	3,518**	756	700		151

*January 1, 2014 – June 30, 2014

OBSERVATIONS

The Mental Disabilities Board of Visitors (BOV) conducts site inspections for state facilities that provide treatment and habilitation, licensed public mental health centers, psychiatric residential treatment facilities for children and adolescents, therapeutic group homes for youth and adults and hospitals. The BOV does not inspect mental health programs in the prisons. The observations of team members who participated in those inspections and the resulting recommendations are reflected in this document.

The state provides an array of services to our citizens who have mental illness and intellectual/developmental disabilities. An examination of those service systems reveals areas where the services compete with each other and areas where the services are inadequate. Like most of the rest of the country Montana is recognizing that mental illness, chemical dependency, and intellectual/developmental disabilities do not occur discretely, are not mutually exclusive, and treatment to address this complexity of need must be co-occurring.

Children who are identified at an early age as having an intellectual/developmental disability can also be identified and diagnosed with a mental illness that will result in lifelong disability. The complicating factors for addressing treatment of this select group of individuals exists and is further confounded when, as they age, these young men and women develop a co-occurring chemical dependency and/or commit a crime. This evolving treatment need is capturing the attention of programs and services that provide treatment and of policy makers at the Department of Public Health and Human Services (DPHHS), the Department of Corrections (DOC) and the Montana Legislature. Advocacy groups across the state highlight the challenges of providing treatment to these men, women, and children to policy makers at every opportunity.

Services across the state that address the treatment needs of individuals who are disabled by mental illness/intellectual and developmental delay/acute chemical dependency are fragmented and not integrated or coordinated. Leadership/policy staff at DPHHS often turns to the not-for-profit mental health services providers and those providers who serve individuals who have intellectual/developmental disabilities and urges them to better integrate services to serve our citizens who have disabilities. Yet the organizational structure at the state is fragmented.

DPHHS has two divisions responsible to serve some individuals while others are under the jurisdiction of DOC; both agencies are responsible to address mental illness, intellectual/developmental disability, chemical dependency and criminal behavior. Coordination of reimbursement and technical support from state agencies to service providers is also fragmented. Legislation in recent years has provided some relief to providers by reimbursing for specialized services (crisis interventions and 189 transition monies); again this is a scattered, shotgun approach to funding services.

Montana State Hospital (MSH), Montana Developmental Center (MDC) and the Montana Mental Health Nursing Care Center (MMHNCC) serve individuals who have mental illness complicated by other disabling conditions, including dementia. Until recently the mental health services provided to individuals incarcerated at Montana State Prison (MSP) and Montana Women's Prison (MWP) were limited and transfers between MSH, MDC, MWP and MSP based on the treatment needs of the individual has left people 'stuck' in a facility that is not the most therapeutically appropriate place for them.

One piece of evidence that the existing services system is not adequate is identified by reviewing admission data at MSH. Half – fifty percent -- of the admissions each year for the past 10 years have been individuals who had not previously been identified/diagnosed with a mental illness; people who never accessed or received mental health treatment. Discharge information from MSH indicates that at times individuals cannot access community-based services – some of whom remain in state facilities after it is appropriate for them to receive services in that environment.

Community-based services have been financially starved over the past 10 years and often do not have the basic infrastructure flexibility to address the needs of individuals who have complex treatment requirements. Service providers periodically report that they “cannot meet the needs” of some individuals who are served in a state

facility – the most restrictive treatment environment. When that happens, the individual must remain at the facility. Individuals seeking services who have complex treatment needs have, in some communities, exhausted the services available. Service providers can choose not to serve any individual seeking services. Community-based mental health services range in quality from very good to ‘ok’ –DPHHS does not have a method to incentivize providers that deliver excellent, innovative services.

Across the state, community-based services do not have enough transition options for all individuals leaving state facilities (MSP, MSH, MDC, MMHNCC) to go into community-based services. The bottleneck effect of individuals who cannot leave a state facility when a community provider cannot provide services is felt when state-owned facilities are full and don’t have open beds to provide acute stabilization services to acutely ill individuals.

Access to mental health treatment at MSP is limited for hundreds of inmates, a shortage of mental health professional staff at the prison results in scarcity of treatment options for inmates. Inmates at MWP access limited mental health services through a contract with a licensed mental health center in Billings. Individuals on forensic placements at MSH and MDC can complete treatment and be in recovery long before being able to discharge to the community and leave the facility. Sentencing language keeps people at MSH and MDC after they are psychiatrically stable and could move to the community on conditional release if the community had pre-release programs designed to serve them.

Overcrowding in the forensic unit at MSH stretches hospital resources; group homes on campus, including a new 8-bed group home, are at capacity with individuals on forensic commitment; patients who are psychiatrically stable, not diagnosed with a severe disabling mental illness (SDMI) continue to receive services at MSH long-term which contributes to the overcrowding.

Some individuals who have intellectual/developmental disabilities and/or mental illness and have been incarcerated do not have access to services when discharged from a state facility to their home community because the mental health center will not accept them back into services.

Department study groups, task force teams, Advisory Councils, and Legislative committees have met, discussed these issues, made recommendations, and created a patchwork of remedies that do not fully address the systemic improvements that are currently needed. Solutions to the identified gaps in service may prove difficult because barriers are inherent in the system and lack of funding is not completely to blame. Without a long-range plan for system improvement that starts with a strategic plan to identify and address change the system will continue to evolve piecemeal.

What is missing is a strategic planning process that identifies specific areas of need and agrees on a long-term planning strategy to develop services that address the actual need – state-wide, community by community. This process should include service providers, decision makers from the executive branch, department policy staff, and legislators who can craft effective legislation to address system redesign. Until a long range strategic plan is implemented, the patchwork approach to addressing unmet need in the state will continue and this jumble of services that are proving inadequate to address need will continue.

RECOMMENDATIONS

- Engage in a strategic planning process that will result in system improvement. This process will include:
 - appointing a group of individuals who are the ‘decision-makers’ – service providers, legislators, representatives from advocacy groups, executive branch policy staff (including cabinet and Governor policy staff)
 - drafting legislation for long-range funding to develop identified service structure changes
 - assuring that the strategic plan once developed is implemented
- Recognize the need for thoughtful approach to the services and begin a long-range strategic planning process that will:
 - accurately count the number of children and adults who have an identified lifelong disability from intellectual/developmental delay and/or mental illness
 - accurately calculate the percentage of individuals who need services and which level of services they need, from intensive services to follow-along
 - survey service providers to determine the costs of serving individuals who have lifelong disabilities
 - inventory existing transitional services, group homes, independent and semi-independent living, PACT programs, adult foster care, and pre-release centers to determine what infrastructure must be created to facilitate discharges from state facilities.
- Expand forensic infrastructure at state facilities to address the growing population of individuals with serious mental illness who are sentenced there.
- Fund and disburse funding to create pre-release centers with programs to serve people with serious mental illness who need mental health treatment on parole/probation from MSH, MDC, MWP, or MSP.
- Seek amendments to Title 53 to add authority to the Mental Disabilities Board of Visitors to inspect mental health programs at MSP and MWP.
- Approach funding for services and programs differently, the first step should be to determine the need then create the funding structure to fund the services, rather than seeking funding then requiring services to adapt to the funding to provide services.