ANNUAL REPORT

FY2017

A Report to the Governor Regarding the Status of Mental Health Facilities and Treatment Programs Inspected by the Board from July 2016 through June 2017.

Mental Disabilities Board of Visitors

Contents

MENTAL DISABILITIES BOARD OF VISITORS
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SITE INSPECTIONS FY 2016

Date of Inspection	Facility	Team Members
November 21, 2016	Partnership for Children Missoula, MT 59807 Informal Review	Dan Laughlin, Board Chair Tracy Perez, Board Member Craig Fitch, BOV Legal Counsel Daniel Ladd ED, BOV
December 2016	WMMHC Butte Campus 106 West Broadway, Butte, MT 59701 Full Review	Dan Laughlin, Board Chair Irene Walters, APRN Craig Fitch, BOV Legal Counsel LuWaana Johnson, BOV staff Daniel Ladd ED, BOV
January 2017	Acadia Treatment Center 55 Basin Creek Road Butte, MT 59701 Informal review	Dan Laughlin, Board Chair Dennis Nyland, MH Ombudsman LuWaana Johnson, BOV staff Daniel Ladd ED, BOV
February 2017	Montana Community Services 993 South 24th Street West, Ste B Billings, MT 59102 Full Review	Jim Hajny, Board Member Michelle Blair, APRN Amy Tipton, Board Member Melissa Ancell, Board Member Daniel Ladd ED, BOV
March 2017	Center for Mental Health- Helena Campus 900 Jackson street Helena, MT 59601 Full Review	Michelle Blair, APRN Craig Fitch, BOV Legal Counsel Lisa Swanson, BOV staff Daniel Ladd ED, BOV
April 2017	Montana Developmental Center 310 4th Ave Boulder, MT 59632 Full Review	Lisa Swanson, BOV staff LuWaana Johnson, BOV staff Daniel Ladd ED, BOV
May 2017	New Day treatment Center 1111 Coburn Rd Billings, MT 59101 Full Review	Dan Laughlin, Board Chair Amy Tipton, Board Member Melissa Ancell, Board Member Dennis Nyland, MH Ombudsman Erin Butts, Education Specialist Daniel Ladd ED, BOV
Site Inspections Tentatively Scheduled for FY 2017		
Jan. 2018	Yellowstone Boys and Girls Ranch Billings, MT	
March. 2018	Sunburst MHC Kalispell, MT	
April 2018	MDC Site Inspection – Boulder (to include an inspection of the facility and treatment services)	

Types of Inspections:

The BOV 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 BOV'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.

BOV Helena office / Advocate's Annual Report
2017 FY

The BOV's Helena office staff assisted approximately 263 constituents, their families, and members of the public via phone calls, emails and/or face-to-face meetings during the past fiscal year. Reasons for contacting the BOV are numerous and varied, to include, but not limited to, people requesting assistance, submitting grievances, arranging home visits for clients committed to state institutions, discussing options for family members and concerns about getting family member into a community-based setting, discussing commitment issues with a facility such as the Montana Developmental Center (MDC) in Boulder, the Montana State Hospital (MSH) in Warm Springs or the Montana Mental Health Nursing Care Center (MMHNCC) in Lewistown, Montana. Oftentimes, family members just need someone who can walk them through the system and help explain the process to them.

Montana Developmental Center (MDC)

The census at the Montana Developmental Center is currently 21 residents. House Bill 387 was passed in the 2017 legislative session, allowing for the admission of new clients to the ASU facility and effectively keeping MDC open until June 30, 2019. The long-term plan continues to be unclear but residents remaining at MDC are receiving quality care, overall residents are demonstrating improved behaviors. Of the 21 remaining residents, 5 reside in Unit 1, 5 reside in Unit 5, and 11 residents remain in the Assessment and Stabilization Unit (ASU) the "locked-down" unit. Units 2,3,4, and 6 have closed and windows are boarded up.

The BOV participated in approximately 47 Individual Treatment Plan (ITP) meetings, 2 Forensic Review Board meeting, and 3 parole hearings during the past year. BOV Advocate assists clients with grievances, attends ITP and other meetings to advocate on their behalf, helps clients stay on track with their goals and objectives, advocates when necessary on clients' behalf, provides independent oversight and review; and ensures clients receive humane and decent treatment.

The BOV conducted a site inspection of MDC on April 20, 2017. (*See report, Mental Disabilites Board of Visitors Annual Inspeciton of the Montana Developmental Center, April 20, 2017.*) The site inspection covered Units 1 and 5 (Unit 3 was still open at the time), the treatment mall, ASU, recreation and vocational buildings, and reviewed treatment plans and medical records.

MDC Allegations of Abuse and/or Neglect from June 30, 2016-July 1, 2017:

ICF-IID Staff to Client Allegations:
Substantiated Staff-Client: 4
Unsubstantiated Staff-Client: 7
Information Only Staff-Client: 2
Investigations in progress: 0
Total ICF-IID Staff-Client: 13

ICF-IID Client-Client Allegations:
Substantiated Client-Client: 3
Unsubstantiated Client-Client: 17
Information Only Staff-Client: 74
Investigations in process: 0
TOTAL IID Client-Client: 107

ICF-DD Staff-Client Allegations:
Substantiated Staff-Client: 10
Unsubstantiated Staff-Client: 18
Information Only Staff-Client: 1
Investigation in progress: 0
TOTAL DD Staff-Client: 29

ICF-DD Client-Client Allegations:
Substantiated Client-Client: 8
Unsubstantiated Client-Client: 7
Information only Client-Client: 205
Investigations in progress: 0
TOTAL DD Client-Client: 220

Groups Homes Utilized for MDC Clients:
-AWARE, Butte, MT
-AWARE, Great Falls
-MT/QLC, Great Falls
-MMHNCC, Lewistown
-Benchmark, Helena,
-Benchmark, Clancy- Not yet open.
-Benchmark, Indiana
-Flathead Industries, Kalispell

Clients Discharged in last year to other State Institutions:

- 1 Client discharged to MMHNCC, Lewistown
- 7 Clients discharged to Benchmark
- 3 Clients discharged to Flathead Industries
- 1 Client to AWARE
-0 Clients to MSH
-0 Client discharged to MT State Prison, Deer Lodge
-1 Client discharged out of state

Restraints used in past fiscal year:

55 Clients placed in physical restraints
12 Clients placed in mechanical restraints

(The above Restraints are rated High or Medium and Restraints Related to Behavior, Restraint-other, Restraint-other/PRN, Restraint-other/Injury. No Physician Orders required for mechanical restraints)

BOV / MONTANA STATE HOSPITAL STATISTICS
FY 2016

Under 53-21-104(6) MCA, the Board of Visitors (BOV) shall employ and is responsible for full-time legal counsel at the state hospital, whose responsibility is to act on behalf of all patients at Montana State Hospital (MSH). The BOV 's attorney represents patients at MSH during recommitment, guardianship, and transfer to MMHNCC hearings, and during administrative hearings (Involuntary Medication Review Board and Forensic Review Board). BOV staff also talk to patients and attend the grievance committee meetings when a grievance is filed. During the fiscal year, MSH admitted 790 individuals for treatment and coordinated discharge from the facility for 818 patients. Average daily census at the MSH campus for the past fiscal year was approximately 232. This average census includes the Forensic Unit at Galen, which houses approximately 50 patients. Most of these individuals are at Galen for forensic evaluations and so they retain the services of their community defense attorney through the course of the evaluation process. BOV still reviews grievances, and complaints of abuse and/or neglect from within this facility, and regularly schedules reviews of the treatment plans and other documentation for these individuals. BOV meets regularly with the administrator of the hospital to present concerns and discuss issues related to advocacy of the patients served at the facility.

Fiscal Year (July 1 – June 30)	2017	2016	2015	2014	2013	2012	2011	2010
Admissions to MSH	**790**	691	691	625	604	735	715	739
Discharges from MSH	**818**	658	657	606	594	705	775	738
LEGAL REPRESENTATION								
Petitions for recommitment *(total)*	**219**	242	219	161	167	162	179	194
Court hearings	**23**	30	24	27	25	23	39	60
Recommitment	**22**	20	20	24	23	21	33	53
Transfer to MMHNCC	**1**	1	0	1	1	0	1	4
Guardianship	**5**	2	3	1	1	2	5	3
CI-90	**6**	7	2	1				
Involuntary Medication Review Board (IMRB)	**161**	302	220	170	186	214	200	132
Initial	**72**	169	106	75	84	99	88	59
14-Day Review	**62**	96	85	71	72	79	85	54
90-Day Review	**27**	37	29	24	30	36	27	19
Forensic Review Board Hearings	**23**	20	23	16	15	21	24	27
GRIEVANCES								
Grievances (total number)	**959**	1213	1005	981	749	380*	591	390
Solved by program manager	**633**	839	702	689	380	268	280	265
Addressed by Committee	**326**	374	303	292	396	73	311	125
*2 patient grievances not included in total						336*		
Abuse/Neglect investigations	**41**	30	31	23	32	33	13	26
Treatment Plan Reviews	**363**	272	395	415	370	424	358	327
Seclusion/Restraint reports *(total)*	**1652**	1199	879**	615**	842	740	843	482
Seclusion	**836**	645	427	307	536	376	450	195
95 Restraint	**816**	554	452	308	306	364	393	287
Hours of seclusion *one patient **seclusion hours do not include intensive treatment unit numbers.	**5226**	6513	2762	2665.7	29,929*	814	1867	1431
Hours of restraint *one patient in walking restraints	**620**	500	721	245.91	574	3518*	756	700

OBSERVATIONS

The community providers and state facilities offer an array of services to our citizens who have mental illness and intellectual/developmental disabilities. 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 the complexity of needs must be co-occurring. An examination of our service systems reveals that most often the services are inadequate to effectively meet these complex community needs.

Services across Montana that address the treatment needs of these individuals are often fragmented and not well integrated. Over the years department study groups, task force teams, advisory councils, and legislative committees have met, discussed these issues, and made recommendations. They have created a patchwork of remedies that do not fully address the systemic changes that are currently needed. Without a long-range plan for system improvement that starts with strategic policy planning to identify and address change, the system will continue to evolve piecemeal. The cost of this system will continue to increase more rapidly than the national average and outcomes will continue to decline across the spectrum. Currently, with the admission freeze at Montana Developmental Center, the State is having to admit developmental disabled adults to Montana State Mental Hospital which is not an appropriate place to treat individuals with developmental disabilities. This policy is both inefficient and cost prohibitive.

During the 2017 legislative session, a trigger bill was implemented to cut funding for these community programs if revenue did not meet expectations. Projected revenues were far below actual and budget cuts are ensuing that will dramatically cut community services for this vulnerable population. The reality is that these individuals who were getting served in the community are not simply going away, they will be served in higher, more expensive levels of care, i.e., Montana State Hospital, Montana State Prison, emergency rooms, group homes and detention facilities across the state. Law enforcement will be required to pick up much of the slack. The proposed budget reductions will simply move funds from more effective community-based services to less effective and more expensive levels of care.

What decades of research has shown is that evidenced-based, community-based care is less-costly and more-effective than all other treatment modalities. Montana needs to move toward this payment model as rapidly as possible. Many states have already been moving that direction and are showing very good outcomes. There is no perfect system for funding these services, but Montana has been locked into the most ineffective and inefficient model possible. As a state, we need to move forward together, no single entity can do this alone. The outcome of utilizing this type of methodology would be improved therapeutic outcomes and stabilized costs for these systems, i.e. reducing costs at Montana State Hospital, Montana State Prison, emergency rooms and local law enforcement.

To be clear, a policy that shifts the funding priority to increase spending at the community level, without addressing the current fee-for-services funding structure is insufficient. The State of Montana needs to transform our archaic, fee-for-service system into a more modern value-based system where community providers are paid for quality of services and not merely quantity. Currently providers are paid based on their billing, not having any correlation to their quality of services or value added to their community. A value-based system financially incentivizes community-based providers for demonstrating effectiveness in their services. If they demonstrate more effective services they make more money.

This model would reward providers for quality care and encourage best practice models to develop in communities across the state. Fee-for-service models incentivize volume over quality of care, the more patients a provider sees, the more they make, quality of service becomes less and less relevant. Montana mental health and developmental disability providers will provide the type of services that DPHHS reimburses for, they cannot afford to do otherwise.

RECOMMENDATIONS

- Recognize the need for a thoughtful approach to funding effective, research-based services and begin a long-range planning process that will:
    - Accurately calculate the percentage of individuals who need services and at which level they need them, from intensive services to follow-up.
    - Survey service providers and national averages to determine the costs of serving individuals who have lifelong disabilities with research-based services.
    - Inventory existing transitional services, group homes, independent and semi-independent living, Mobile Community Treatment (MCT) teams, adult foster care, and pre-release centers to help determine what infrastructure must be created to facilitate discharges from state facilities.
    - Maintain an active/evidence-based crisis response system to divert individuals from entering the highest levels of care, when what they actually need is short-term stabilization.
    - Utilize an evidence-based outcome measure for these populations to better determine quality of services provided.

- Disburse funding to increase evidence-based options for pre-release centers as well as transitional housing options with programs to serve these populations who need treatment and are on parole/probation from MSH, MDC, MWP, or MSP. These programs must be dovetailed with long-term housing options or the incarceration cycle is likely to perpetuate.

- Approach funding for services and programs differently, Accountable Care Organizations model (ACO) or value-based payment.