Montana State Hospital

Warm Springs, Montana

August 29 & 30,

2023

Site Inspection Conducted by the Mental Disabilities Board of Visitors

Jeremy Hoscheid

Jeremy Hoscheid, Executive Director

INTRODUCTION

Mental Health Facility reviewed:

Montana State Hospital (Warm Springs)

David Culberson, Interim Administrator

Authority for review:

Montana Code Annotated, 53-21-104

Purpose of review:

1. To learn about services provided by Montana State Hospital at both the main campus (MSH) and the Forensic Mental Health Facility at Galen.
2. To assess the degree to which the services provided by MSH are humane, consistent with professional standards, and incorporate Mental Disabilities Board of Visitors standards for services.
3. To recognize excellent services.
4. To make recommendations to MSH for improvement of services.
5. To report to the Governor regarding the status of services provided by MSH.

Site Review Team:

Board:

Melissa Ancell, Board Member

BOV Staff:

Jeremy Hoscheid, Executive Director

Dennis Nyland, MHO

Consultants:

Teslynn Anderson, LCPC

Jeff Folsom, LCSW, JD

Review process:

- Interviews with MSH staff and clients
- Review of treatment activities, tour of MSH facilities
- Review client treatment plans
- Review policy and procedures, organizational structure

Overview

Per M.C.A. 53-21-104 the Mental Disabilities Board of Visitors (Board) conducted a site review of Montana State Hospital (MSH) on August 29 and 30, 2023. The Board reviewed the main hospital campus and the Forensic Mental Health Facility at Galen.

MSH provides inpatient psychiatric treatment for adults with serious mental illness. Patients are committed to MSH through either a civil or criminal commitment process. MSH is the state's only public psychiatric hospital and operates as the safety net for the entire adult mental health population in Montana, serving individuals admitted from communities across the state.

Services provided by MSH: evaluation and assessment, medication management, individual and group therapy, psycho-educational programs, rehabilitation and vocational services, chemical dependency treatment, and peer support.

MSH has fallen under a lot of scrutiny the past few years after losing CMS certification on April 12, 2022. De-certification of MSH was the result of failing to maintain compliance with CMS basic health and safety requirements. MSH Leadership mentioned they are actively working on the whole system at the facility due to the decertification from CMS and the highest priority is rebuilding the organization to be recertified with CMS. This includes the Administrator talking to everyone, from the bottom up. It was mentioned that the Administrator has had numerous meetings throughout the ranks of the organization, from leadership meetings to having town hall meetings with staff, to better understand where people are in the organization.

During the entrance interview, there was a lot of talk about staff shortages at MSH. MSH leadership did state that they have been able to get some staffing back up to manageable levels, but some of the more specialty staffing positions are still short staffed. This includes mental health professionals (therapists), Physical Therapists, Speech Therapists, Dental, and Chaplains. Staff spoke of the need to increase recruitment and retention efforts within the hospital.

The overall morale at MSH appeared upbeat and many staff stated they believe MSH is going in the right direction. They stated that the MSH leadership walk around and talk with staff more often and actively participate in meetings with staff. While there is still a long road ahead for MSH to regain CMS certification, it appears clear to the Board that regaining CMS certification is the top priority currently.

Organizational Planning and Quality Improvement

MSH does not currently have a strategic plan outside of preparing the hospital for CMS certification. This strategic plan is part of the overall work being completed by MSH leadership, DPHHS leadership, as well as the consultants that have been hired to assist MSH and the other state operated facilities. Leadership at MSH spoke of including individual patient surveys and feedback, along with community stakeholders' feedback into the development of the strategic plan.

MSH has gone through staffing changes within the QA/QI department. The current QA/QI staff are working toward developing a "true" QA/QI process. The QA/QI department has been an area of struggle in the past at MSH and it seems that the hospital recognizes and understands the important role that department plays in the overall success of patient care and treatment.

Talking with staff regarding the process of QA/QI, they stated they want to change the process from looking at QA/QI to focus on specific time frames rather than just doing an annual year over year comparison. Staff also discussed wanting to look at the data that is collected and drilling down to specifics, for example, looking at patient falls instead of just generalized data. Staff also shared the desire to create an encouraging environment for incident reporting and sharing that information with respective departments.

Rights, Responsibilities, and Safety

MSH clearly defines to the patients the individual rights and responsibilities both verbally and in writing to patients upon admission. Patients receive this information in their intake packet as well as in the patient handbook.

MSH provides and promotes to patients the independent advocacy services available to patients. This includes the Mental Disability Board of Visitors and Disability Rights Montana. The Board did not notice any information regarding the Mental Health Ombudsman Office, which is another advocacy service available to patients.

MSH does have an established grievance procedure. In discussions with staff, there currently is work being completed to revamp how MSH handles patient grievances and the grievance process. Staff stated that they want to focus on the process of creating criteria to determine if the grievance is substantiated or unsubstantiated. Staff stated that even if the grievance was unsubstantiated or it was determined that there was no grievance, that MSH is still focused on working through the issue and attempting to resolve it for the patient. The Board questions the grievance committee substantiating or unsubstantiating a patient grievance as this violates the current policy which states that any sort of complaint or grievance should be treated as such. Staff mentioned numerous times that when a patient does bring a complaint or concern to the staff's attention that they try to resolve the issue before it rises to the grievance level.

MSH does have abuse and neglect policy and procedures which fully implement the requirements of Section 53-21-107 MCA, for detecting, reporting, and investigating, determining the validity of, and resolving allegations of abuse and neglect of individual patients. Staff assigned to handle the investigations is new to this role and at the time of the Boards review has not had any abuse and neglect allegations to investigate.

Staff received training on MANDT de-escalation upon hire and then annually thereafter. Staff did state that they believe that staff could benefit from additional training throughout the year rather than just the minimum required training.

Policy regarding the use of medical restraints was reported inconsistently ranging from clear communication that the hospital "never" uses medical restraint to specific examples of how medical restraint has been used with a specific client. State policy around Sell Hearings and the use of involuntary medications should be addressed, consistently applied, and considered in the context of the best interests of the clients served.

Individual, Family Member, Guardian Participation

MSH encourages individual and family member/guardian participation within the treatment process. Unfortunately given the nature of MSH and admissions to the hospital, family involvement is minimal and often described as happening after treatment planning is completed.

Staff shared with the Board that family members of patients are often burnt out and not particularly helpful resources and that at times patients decide that they do not want to communicate with family members during their treatment stay.

Efforts to help residents find, develop and or re-develop community connections should be embraced. Building meaningful networks of support could help increase more timely and successful discharge and reduce recidivism.

MSH does have peer support available on campus, but it appeared to the Board that the staff are unclear about the exact role of peer support and how to integrate these positions into individual patients' treatment.

Cultural Effectiveness

Currently MSH does not have cultural effectiveness training or a cultural effectiveness plan in place. Staff described to the Board that prior to the COVID-19 pandemic, that MSH had a robust cultural effectiveness program but that this program was halted during the pandemic and due to

the loss of pastoral and other staff those cultural effectiveness programs have not yet been able to be re-established.

MSH could greatly benefit the patients by establishing a cultural effectiveness training and culture program within the hospital. This could include Native American, religious programs for patients to participate in, as well as an emphasis towards understanding military service members.

Staff Competence, Training, Supervision, and Relationships with Residents

MSH does define optimum knowledge and competence expectations within each of the staffing positions providing services.

While MSH does have a written training curriculum for new hires, staff expressed to the Board several times about the need for more training for the mental health technician positions, specifically regarding mental illness and understanding the different aspects of mental illness. These comments were specific to traveling Certified Nursing Assistants (CNA's) who have experience in nursing home or medical/surgical hospital setting, but not necessarily experience in psychiatric/behavioral health care. Staff stated that while the training being provided was good, there could be additional focus on mental health education and that new staff could use additional time to train/job shadow prior to beginning to work on the units. Often this is not done because of staffing shortages on the units.

Staff interviewed stated MSH is continually working on computer and refresher-type training. They also stated that there have been more trainers that have been coming directly to the units to provide the training for staff.

Staff stated there are opportunities within MSH for training and education. Staff also shared that MSH leadership encourages staff to attend "outside" trainings and educational opportunities, but due to staff shortages, it is almost impossible to go to those trainings or conferences. Staff also shared with the Board that previously certain providers were afforded an educational allowance to attend training or conferences, but that several years ago this funding was removed. Staff hoped to see the educational allowance for providers re-established by the hospital administration.

During the Boards tour of the Spratt unit, staff observed actively engaged with patients, showing positive demeanor and patience towards the patients. A Board member who had previously participated in the 2019 site review shared that the Spratt unit appeared much more active, engaging, and cleaner than it did during 2019. The Board was also able to see the new sensory garden that had been developed outside the Spratt unit. This sensory garden was a highlight as it is a great addition to the unit and adds another activity for patients to participate in during their treatment.

Treatment and Support

A written treatment plan is created and implemented for each patient admitted to MSH. Multiple team members emphasized the importance of the treatment plans as a key initiative that is underway, but the purpose and emphasis of that effort was inconsistently reported. Staff reported an awareness of the initiative but could not describe any details of what the initiative entailed. Of the patients interviewed, not one could recall their own unique treatment plan and treatment goals that they are currently working on or had worked on in the past. While this was a relatively small sample size of patients, the Board recommends that staff increase discussion with patients related to their individual treatment goals and work towards achieving those goals on a regular basis.

The "team' approach of the treatment planning appears to involve a single point person reflecting the reports of others, rather than engagement in a true team discussion/planning process. Shift change "Huddles" on the units are described as "fast and loose" basing treatment on a day to day, shift to shift perspective, with inconsistent short-term goals.

In relation to clinical treatment and overview, the clinical therapists report not having any autonomy in what therapy modalities they utilize. There are two therapeutic approaches that could potentially aid patients in their healing process, decrease symptoms, and make an overall positive difference in their mental wellbeing. Firstly, Eye Movement Desensitization and Reprocessing (EMDR) therapy is the most effective trauma treatment available to date that benefits those with PTSD and even those who have depression and anxiety which is found in most patients at MSH. Individuals experience traumas whether they are cognitively acknowledged or not, and being a patient in a facility brings its own traumas and stressors that can be reprocessed appropriately on a neurological level with EMDR therapy. Secondly, Polyvagal Therapy is a precise scientific understanding of how the autonomic nervous system impacts body regulation, social behavior, and connection. With this type of therapy, interventions are focused on helping patients learn about their parasympathetic and sympathetic nervous system to catch dysregulation earlier and effectively regulate once the system is activated. Polyvagal theory offers interventions addressing autonomic activation and building resiliency and regulation. Patients are more capable of connecting and having healthy social relationships with others when their nervous system feels safe. This theory puts an emphasis on how patients have survived, adapted, and learned through difficult times in their life which is very trauma informed. Polyvagal theory does not put an emphasis on "overcoming" mental illness, but rather it is a scientific approach that integrates "bottom-up" physiological therapies with "top-down" cognitive therapies. Polyvagal Informed therapy is trauma-informed because staff must use interventions focused on helping the patient feel safe and secure in their environment. Trauma survivors report that polyvagal informed therapy is validating and affirming because it doesn't use the unhelpful cognitive narrative that "it's all in your mind/thoughts" which is "bottom-up" therapy. Aiding clinicians to become trained or proficient in these different therapeutic approaches and allowing them to practice them daily would single handedly make a significant difference in the patients' progress towards treatment goals.

The Board recognized that staff need to be more accountable in following through on the scheduled calendar of events on the units. There were several "group therapy" sessions written

on the calendar, but during the two day period the Board did not witness a single group therapy session being led. Despite what appeared to be a full complement from direct care staff, the level of activities is still below what is identified as the goal. The culture and expectations of specialized staff (e.g., rec therapists or others) as being the only staff able to lead activities, walks, etc. diminishes the opportunity for clients to be more engaged and active. Across the board, it seems that the majority of MSH patients would like to receive additional mental health/trauma psychotherapy than they currently receive. Several patients reported that they've told MSH staff that they'd like to receive therapy services but never get to. Patients at Galen would also benefit from psychotherapy, psychoeducation, and trauma reprocessing. A patient at the FMHF stated that "Every day I just want someone to talk to about my PTSD. It would be helpful to talk to somebody about the daily [emotional] triggers we experience from our trauma that negatively impacts the way we interact with others here."

Patients report wanting to learn more about their diagnoses and ways to manage difficult symptoms. Such lessons can be taught through individual and group activities like games, gardening, art, and exercise/movement. A major shortcoming of MSH is that it's not utilizing the clinical therapists to the best of their ability- resulting in patients having minimal involvement with clinical services. There are many patients in MSH who are not receiving any type of mental health treatment. Both long- and short-term clients can benefit from therapy. There is a lack of clinical documentation across the board since the therapists are not doing therapy frequently or consistently, and the psych techs are not documenting clinical necessities (symptoms observed, measurable goal progress, what interventions were being used to work on goal). It seems, based on information gathered during the site review, the clinicians are not given any trust or authority in the overall treatment of their patients. Clinical therapists report that they are not allowed to do or be a part of the initial biopsychosocial assessment even though they are trained to do so.

Additionally, clinical therapists don't have a say in what clinical goals patients are working on. Clinical therapists at MSH report that the psychiatrists tell them what patients they can and cannot provide therapy. In one wing of MSH, the psychiatrist is only recommending two patients for therapy even though the therapist communicated that she sees a need to work with several other patients. There are patients who have requested counseling services themselves and the therapist agrees they would benefit from therapy; however, the psychiatrists instruct the clinicians not to work with those patients. When a therapist does get to work with a patient, they are told which therapy modalities to use by the psychiatrist. Therapists have the competency to decide which modalities to use with patients based on their clinical assessment. The therapist should then create a measurable goal with the patient and proceed to keep documentation focusing on objective and subjective clinical findings from the therapy sessions. For a true wrap-around service, the psych techs would then need to be documented similarly to get a collective picture of how the patient is doing with their goal(s).

A consensus from MSH staff is that it would be beneficial to organize facility patients by diagnosis, specifically sort patients between psychotic diagnoses and mood disorders. This will allow for more specialized care/interventions to help the patient individually and among group settings. Psych techs would like more training/education on psychiatric diagnoses and physical de-escalation techniques so they can better support patients while keeping themself safe. One MSH staff member recommended creating an opportunity for psych techs to get trained with

more clinical skills so they can be licensed to a) make more money (which helps retain employment and increases familiarity/trust with patients) and b) utilize clinical skills to help patients actively work on a clinical treatment goal. Psych techs could then provide additional encouragement for patients to actively work on their clinical goals, such as hanging a poster in a patient's room reminding them what their clinical goals are. Unfortunately, it was reported that psych techs are often doing miscellaneous tasks because MSH is often short staffed. Psych techs currently use a binder that tracks daily information about patients with no direct connection between their services and the patients' goals. When shifts change there is no guaranteed clinical communication about patients.

MSH does have an on-site medical clinic which provides patients with physical and medical exams upon admission, annually thereafter, or as requested by their respective provider. Staff reported that they wished they had increased communication with the medical clinic. The new EHR program that MSH predicts it will use will hopefully improve staff's ability to communicate pertinent information about patients' specific goals between the medical and therapeutic domain; For example, if a nurse can see what mental health goal(s) the patient is working on then they are better able to help patients actively work on their treatment goal(s) hourly and daily. Each interaction that staff has with patients can be medically and clinically necessary. Interventions could look like a variety of things depending on the patient's diagnosis, charge, and presenting problem such as: de-escalation/polyvagal somatic techniques, prompts, redirections, praise, reflecting emotion, modeling behavior/communication skills…etc.

Access and Entry

Admission to MSH is completed through either the criminal or civil courts commitment proceedings. Given the unique role MSH plays within the states mental health system, MSH is unable to deny admission to any patients committed to the hospital. This has caused unique set of patient population problems at MSH as there is a certain number of patients admitted to MSH who typically could be served by community-based providers, but due to closure of group homes, nursing facilities, and ongoing staffing shortages across the state, these patients are being committed to MSH.

The commitment process was noted by staff at FMHF to cause a bottle neck where there is a significant waitlist of individuals in a correctional setting who are awaiting admission to the FMHF. Resources was a term used frequently in discussion, including the need for additional community-based evaluators who can conduct assessments of these individuals in the community rather than individuals coming to the FMHF for the evaluation. Additional community evaluators would help smooth out this bottle neck and ease delays.

Continuity of Services through Transitions

MSH staff identified that opportunities for discharge are clearly declining as several community group home beds and other community-based resources/program have closed or greatly reduced capacity in recent years. Staff stated that many patients have "nowhere to go". The Board strongly recommends that MSH address discharge planning in a deliberate, systematic fashion. For example, re-instituting the Admissions Discharge Review Team (ADRT) on a regular (weekly, monthly basis) would improve coordination and communication with community providers and stakeholders, create more appropriate discharges specifically designed to meet client needs. This should include on-site visits with community providers. It was mentioned that there could also be some additional beneficial factors to help with reducing repeat admissions and increase the discharges from MSH. Staff shared that previously MSH had a Discharge Coordinator position that has been vacant for some time. This position worked directly as a point of contact for Montana communities and could be very beneficial in addressing the discharge planning issues that the hospital currently faces.

As part of recently passed legislation during the 2023 Legislative session, now is the time for DPHHS and stakeholders around the state to identify and address the difficult challenges and unique opportunities within Montana's behavioral health system. The challenges of discharging residents from the Spratt unit are noted and the efforts of the Spratt Discharge Task Force are supported.

Recommendations

The Board recommends: the need for increased staffing of clinically trained practitioners and specialty staff (Physical Therapists, Occupational Therapy, Speech Therapists, Dental, and Chaplains). This will also lead to increased active treatment and engagement across the hospital campus.

The Board recommends: that MSH increase communication between all staff and patients regarding their mental health diagnoses, needs, individual treatment plan goals and objectives.

The Board recommends: Additional Trauma Informed Care and de-escalation training opportunities provided to staff.

The Board recommends: MSH and DPHHS leadership develop and implement a recruitment and retention program for MSH. Program leadership clearly identified the need and value of hiring permanent staff including more consistent implementation of treatment goals and overall quality of care from developing a team.

The Board recommends: that MSH review the grievance committee policy and procedure to ensure that patients have the right for their grievance to be heard and reviewed by the grievance committee and the right to exhaust all options for appeal afforded to them within the grievance policy.

The Board recommends: that MSH and DPHHS re-establish a regularly occurring on-site discharge planning meeting with community providers/stakeholders.

The Board recommends: that MSH establish a Cultural Effectiveness Plan and Cultural Effectiveness Training hospital wide. This program can be developed to recognize and respect Native American cultures and practices, variety of different religious practices, and Military education and recognition.

The Board recommends: that MSH include the contact information for the Mental Health Ombudsman office as part of the independent advocacy services available to patients.