

Mental Disabilities Board of Visitors

SITE REVIEW REPORT

Center for Mental Health
Chinook, Montana

December 8-9, 2008

Gene Haire

Gene Haire, Executive Director

TABLE OF CONTENTS

Overview	3
Purpose and Background for this Review	4
Qualities Observed in Center for Mental Health - Chinook Services	5
General Observations.....	5
General Recommendations.....	6
Mental Disabilities Board of Visitors Standards for Cultural Competence	6
Recommendation Summary.....	13
Center for Mental Health - Chinook Response.....	14

**Mental Disabilities Board of Visitors
Site Review Report
Center for Mental Health - Chinook, Montana
November 12-13, 2008**

Overview

Mental Health Facility reviewed :

Center for Mental Health - Chinook
Chinook, Montana
LeeAnne Lewis, LCPC - Blaine County Director
Joe Uhl, LCSW - Regional Rural Services Director

Facility Type: Mental Health Center

Authority for review :

Montana Code Annotated, 53-21-104

BOV review team :

Staff:

Gene Haire, Executive Director

Board:

Joan Nell Macfadden, Chair
Suzanne Hopkins, Vice-Chair

Consultants:

Bill Snell, Cultural Consultant

Review process :

- Group interview with CMH-C staff
- Group interview with Fort Belknap Indian Health Services staff
- Inspection of physical plant
- Review of written service descriptions

Purpose and Background for this Review

The Mental Disabilities Board of Visitors (BOV) has established standards for its site reviews of mental health facilities, including standards for “cultural competence”¹. While BOV recognizes that cultural competence is important and relevant to the way in which mental health programs work with people from all cultural backgrounds, BOV’s primary focus is on cultural competence in working with American Indians. American Indians make up about 6.2% of the population of Montana, making them the largest ‘minority’ in Montana². In a number of mental health programs in Montana, especially programs that serve children and programs that are on or near Indian reservations, the proportion of American Indians served as a percentage of all people served is much higher – as high as 40% for some programs. Particular aspects of the experience of American Indians and Indian families such as intergenerational trauma and historical grief; high exposure to loss and violence and resulting post traumatic stress³; and high rates of suicide⁴ and chemical dependency⁵ make it critically important for mental health providers to develop a high level of sensitivity to and competence in working with American Indian people.

This is the first of a series of reviews BOV intends to conduct of mental health programs that are located close to or on Montana Indian reservations, that have in their catchment areas a significant population of American Indian people, or whose clientele include significant overrepresentation of American Indians. The objectives of this and subsequent reviews of these programs are:

- (1) to develop an understanding of the working relationship between the mental health provider and reservation health and other human services,
- (2) to assess the degree of cultural competence demonstrated by the mental health programs, and
- (3) to make suggestions and recommendations for improvement.

With regard to this review, a specific set of circumstances caused BOV to believe that it would be helpful to look at cultural competence in this center. Both the staff of the Chinook office of the Center for Mental Health (CMH-C), and the staff of the Fort Belknap Behavioral Health Program (FBBH) had experienced frustration in working through issues related to referrals and coordination of services to Indian children served by FBBH. Prior to January 1, 2009, all requests by mental health providers to place children in out-of-home services had to go through the local agency designated by the Children’s Mental Health Bureau (CMHB) to provide children’s case management. In the Chinook area, this agency was CMH-C⁶. This arrangement put the CMH-C children’s case manager in the position of “signing off” on such requests made by the mental health professionals at FBBH. This situation created controversy, frustration, and tension between FBBH professionals and CMH-C staff. FBBH staff reported to BOV that in some of these situations, individuals’ mental status deteriorated and children ended up in the juvenile justice system. The outcomes were that the FBBH staff became angry and frustrated with both the state mental health “system”, and angry with and mistrustful of the case manager; and that CMH-C staff pulled back from active coordination with FBBH and suggested that FBBH become a provider of their own children’s case management services.

BOV hopes that this review and the following suggestions and recommendations will contribute to improvement in this working relationship.

¹ BOV uses the term “cultural” in a broad, pluralistic context, i.e., to include not only the traditional sense relating to knowledge, experience, beliefs, values, attitudes, meanings, etc. held by a group of people over the course of generations; but also relating to areas such as sexual preference religion/spirituality, and race/ethnicity.

² 2000 census: Montana minority statistics: American Indian – 6.2%; Latino – 2%; Asian - .5%; African American - .3%. http://ceic.mt.gov/PL2000_mt.asp

³ It is estimated that the incidence of post traumatic stress disorder among American Indians is approximately 22%, compared to 8% for the general population. <http://www.gifffromwithin.org/html/amindian.html>

⁴ Among American Indians ages 15 to 34, suicide is the second leading cause of death.

⁵ The rate of admission of American Indians to chemical dependency programs in Montana (19.8%) is more than three times the percentage of American Indians in the general population (6.2%).

<http://www.dasis.samhsa.gov/webt/quicklink/MT07.htm>

⁶ As of Jan 1, 2009, case managers were no longer in this role as the result of an Administrative Rule change.

Qualities Observed in Center for Mental Health - Chinook Services

- The CMH-C office is a warm, home-like, and welcoming place.
- CMH-C services are client-driven; staff report that clients are always part of the treatment planning.
- It appears that the Chinook Mental Health Center makes every effort to involve families in the services provided to clients.
- CMH-C makes it a priority to ensure good coordination with primary healthcare providers in the community, and to ensure that clients are referred to primary healthcare providers. Conversely, it appears that primary healthcare providers work to make it convenient for clients to receive services at the mental health center.
- Clients are seen quickly – it appears that there is timely access to service and assessments.
- The CMH-C staff are very dedicated and have been in their current positions for significant periods of time.
- CMH-C staff are very aware of the community mental health needs in Chinook.
- CMH-C is interested and active in systemic mental health committees and working groups including the Local Advisory Council, the Central Service Area Authority, and the Havre Kids Management Authority (KMA).

General Observations

Some factors to consider that may have an effect on mental health service delivery by CMH-C for American Indians:

- CMH-C staff estimate that the percentage of its total caseload who are American Indian is as high as 30%.
- While there is a strategic plan developed by the CMH central office for the regional organization, this plan does not address cultural issues and needs directly related to the Chinook-Fort Belknap area - and in particular, does not address issues related to serving the Chinook-Fort Belknap area's significant number of American Indian clients.
- CMH-C and FBBH have inadvertently developed an "arms length" relationship - partially as a result of the difficult and awkward process that had been in place for referring youth to out-of-home placement.
- The needs in the Chinook-Fort Belknap area for services within the state mental health system continuum - particularly intermediate level services for youth such as group homes - appear to be unarticulated and unaddressed.
- FBBH has become frustrated with state and federal rules that they believe do not serve their clients well.
- Coordinating provision of mental health services between CMH and tribes in the catchment area presents significant logistic challenges.
- There are inadequate "step-down" services provided on or near the Fort Belknap reservation - for either youth or adults who are returning to their home communities from higher levels of services (residential treatment facilities for youth; Montana State Hospital for adults).
- Coordination between behavioral health services and tribal juvenile probation services is challenging.
- Tribal Court orders sometimes do not take into account the mental health needs of clients served.
- Contact between FBBH staff and the Kid's Management Authority (KMA) team in Havre has been ineffectual; it is unclear to FBBH staff what role the KMA could play in serving Indian youth on or near the Fort Belknap reservation; the KMA may be unaware of the needs and concerns of the FBBH staff and/or clients served by FBBH.
- Funding for ongoing cultural training is a challenge for CMH-C.
- Some services provided by the tribes "come and go" as a result of time-limited grants.
- Identifying trainers, consultants, and other resources with expertise in assisting CMH-C to increase its cultural competence in working with American Indians is difficult.
- The CMH central office and its satellite offices may not have a mutual understanding of the local service needs and priorities for each satellite office - especially with regard to coordination with tribal behavioral health services and providing culturally competent services to American Indian clients.

General Recommendations

1. Organize a meeting to include representatives from the CMHB, First Health Services, CMH-Chinook, and FBBH staff to thoroughly review the new out-of-home referral process, identify potential barriers, and develop contingency plans for future problems and disagreements relative to service requests / recommendations by FBBH staff.
2. Develop an active, ongoing, collegial working relationship between CMH-C and FBBH.
3. Establish a consistent communication/coordination protocol when clients (adults or youth) are discharged from a higher level of services to the Chinook-Fort Belknap area, when a client is being served or could be served by both FBBH and CMH-C.
4. DPHHS/CMHB, First Health Services, CMH, the KMA, and FBBH should begin to meet to plan for improving and expanding mental health services in the Chinook-Fort Belknap area. These meetings should provide an ongoing forum to discuss, identify, and address the needs in this area for services within the state mental health system continuum - with particular emphasis on intermediate level services for youth such as Therapeutic Youth Group Homes.

Mental Disabilities Board of Visitors Standards for Cultural Competence

<p>Does CMH have a Cultural Competence Plan developed with the assistance of recognized experts that includes defined steps for its integration at every level of organizational planning?</p>	<p>No</p> <p><u>Strengths:</u></p> <ul style="list-style-type: none"> ▪ The CMH-C staff would like to encourage the CMH central office in Great Falls to develop a Cultural Competence Plan for their organization. ▪ CMH-C staff utilize their own personal experience and knowledge in providing culturally competent services where possible. <p><u>Recommendation 5:</u> Develop a CMH regional Cultural Competence Plan - with an emphasis on issues relevant to providing mental health services to American Indian clients.</p> <p><u>Suggestions for development of a Cultural Competence Plan:</u></p> <ul style="list-style-type: none"> ▪ Develop a clear understanding of the number of American Indians currently served, and the demographics of the American Indians who are unserved, but in need of services. ▪ The CMH central office should establish the goal of recruiting a member of the American Indian community to serve on its Board of Directors. ▪ Consider developing a Cultural Competence Plan specific to the needs of the Chinook-Fort Belknap area. ▪ Conduct an internal staff survey regarding the development of a Cultural Competence Plan - what it should contain, and what steps would need to be taken to integrate the plan at every level of the CMH organization. ▪ Identify recognized experts who could assist CMH-C in developing a Cultural Competence Plan. ▪ Conduct research to gather information about existing models for cultural competence (ex: U.S. Departments of Education and Justice, SAMHSA, and other federal and state agencies).
--	---

<p>Does CMH-C define expectations for staff knowledge about social, historical, and spiritual issues relevant to the mental health treatment of American Indian people?</p>	<p>No</p> <p><u>Strengths:</u></p> <ul style="list-style-type: none"> ▪ Although no formal expectations for CMH-C staff knowledge exists, the staff demonstrate a high level of ethical and cultural awareness when working with all clients, including American Indians. ▪ CMH-C staff have developed knowledge and awareness of some cultural issues as a result of working within close proximity of the Fort Belknap Reservation. <p><u>Concern:</u></p> <ul style="list-style-type: none"> ▪ Consistency of knowledge across all staff - as well as the insight and ability to apply this knowledge - do not appear to be in place. <p><u>Recommendation 6:</u> Define expectations for staff knowledge about cultural, ethnic, social, historical, and spiritual issues relevant to the mental health treatment of American Indian people.</p> <p><u>Suggestions for developing expectations for staff knowledge about cultural issues:</u></p> <ul style="list-style-type: none"> ▪ Continue learning and expanding staff cultural knowledge - including awareness of what knowledge is needed specific to the Chinook-Fort Belknap area; seek out information from the Fort Belknap community. ▪ Develop relationships with recognized cultural experts; ask for help in developing expectations for staff knowledge needed to provide culturally competent mental health treatment. ▪ Continue to apply high ethical standards regarding <i>all</i> people, with an emphasis on <i>individualized</i> treatment.
<p>Does CMH-C 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 American Indian people?</p>	<p><u>Strengths:</u></p> <ul style="list-style-type: none"> ▪ CMH-C staff have attended training in the past related to American Indian cultural issues. ▪ CMH-C staff express the desire to have additional cultural training. ▪ CMH-C staff rely on each other's experience and knowledge for support and awareness of cultural needs and expectations in meeting client needs. <p><u>Concerns:</u></p> <ul style="list-style-type: none"> ▪ There is no ongoing training for staff related to cultural issues relevant to the provision of mental health treatment to American Indian people. ▪ No experts have been identified to assist in the training of staff in meeting expectations for knowledge about cultural issues relevant to the provision of mental health treatment to American Indian people. <p><u>Recommendation 7:</u> Establish ongoing training 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 American Indian people.</p>

	<p><u>Suggestions for developing training opportunities:</u></p> <ul style="list-style-type: none"> ▪ Identify cultural training available locally, regionally, and nationally and have designated staff attend. The staff who attend could then conduct in-service training for other CMH staff. ▪ Identify local individuals who could conduct in-house training on cultural diversity, American Indian traditions, values, and beliefs. ▪ Develop a library of resource material on cultural issues which would be mandatory for all staff to read. ▪ Attend local cultural events to gain personal insight into the American Indian culture first hand. ▪ Consider attending annual National Indian Child Welfare Conference⁷. ▪ Consider attending the annual Native American Child and Family Conference⁸. ▪ Attend cultural training offered by the Montana State University-Northern, Fort Belknap Community College, and Stone Child Community College. ▪ Include ongoing training with an emphasis on American Indian issues in the CMH-C annual training plans. ▪ Establish cross-training agreements with the Fort Belknap and Rocky Boy's reservations. This would enhance everyone's knowledge through on-site involvement, observation, and hand-on experience.
<p>Do CMH-C treatment plans include therapeutic modalities that address specific cultural issues?</p>	<p>No</p> <p><u>Strengths:</u></p> <ul style="list-style-type: none"> ▪ Annual licensing reviews of CMH-C records are conducted by the Department of Public Health and Human Services; CMH-C staff indicated that treatment plans meet all standards and licensing requirements of Medicaid and the State of Montana. <p><u>Concern:</u></p> <ul style="list-style-type: none"> ▪ Without therapeutic modalities specific to cultural issues and the implementation of services based on specific cultural values, it is "left to chance" whether services will be culturally appropriate. ▪ Some American Indian parents and grandparents taking care of grandchildren, may want some things done the traditional way and may feel that CMH-C is not aware or open to this. ▪ Collection of information at the time of assessment pertaining to cultural issues relevant to the mental health needs of American Indian clients is limited; such information as whether an individual is bilingual; what the individual's tribal affiliation is; whether an individual is enrolled in a tribe and/or is a descendant of a tribe; whether an individual has a traditional orientation; the individual's degree of assimilation, spiritual interests, family relations; and other important information relating to cultural orientation is not gathered by CMH-C.

⁷ <http://www.nicwa.org/>

⁸ <http://www.southwestconsortium.org/>

	<p>Recommendation 8: Begin to collect assessment data pertaining to cultural issues relevant to the mental health needs of American Indian clients.⁹</p> <p>Recommendation 9: Begin to include therapeutic modalities in treatment plans that address specific cultural issues relevant to the mental health needs of American Indian clients</p> <p>Suggestion for using therapeutic modalities that address specific cultural issues:</p> <ul style="list-style-type: none"> ▪ Explore ways to increase awareness of traditional approaches to parenting, with particular emphasis on matters that are relevant to emotional disturbance. ▪ Begin to use the System of Care (SOC) cultural matrix developed by In-Care Network. It includes the primary diagnosis used for youth, comparing “Western” interventions and American Indian interventions¹⁰.
<p>Do CMH-C treatment plans include the use of relevant community cultural resources?</p>	<p>No</p> <p>Strengths:</p> <ul style="list-style-type: none"> ▪ CMH-C staff have a strong desire to incorporate relevant community cultural services and resources in their services. <p>Concern:</p> <ul style="list-style-type: none"> ▪ The use of cultural resources for mental health services have not been incorporated into treatment plans. <p>Recommendation 10: Begin to identify cultural resources in the community that can be used to enrich treatment plans and service delivery.</p> <p>Suggestions for bringing cultural services and resources into treatment planning and service delivery:</p> <ul style="list-style-type: none"> ▪ Create in-house groups for youth and adults using cultural diversity information as a means to teach about differences between individuals; open these groups to all clients - American Indian clients and others - as a way of opening communication and awareness, and teaching values important to all people. ▪ Identify culturally-oriented groups in the community that adults or youth could attend, such as school Indian clubs, and culturally-oriented faith-based services and activities. ▪ Contact the Montana State University-Northern (Havre), Fort Belknap Community College, and Stone Child Community College to explore opportunities for cultural diversity training, interns with knowledge and expertise in various cultures, cultural events, etc., as a resource to assist CMH-C in creating

⁹ assessment tool for adults:

http://www.ihs.gov/Cio/BH/documents/Biopsychosocial_Templates/Adult_Traditional_%20Biopsychosocial_%20Assessment.pdf

assessment tool for youth:

http://www.ihs.gov/Cio/BH/documents/Biopsychosocial_Templates/Child_Adol_Wellness_Biopsychosocial_Assessment.pdf

¹⁰ System of Care Cultural Service Matrix developed by Tina Cline (designed for youth, could be adapted for adults): <http://healingnativenations.org/culturalservices/index.shtml>

	<p>community-based culturally relevant services.</p> <ul style="list-style-type: none"> ▪ Team-up with the tribes to conduct and support after-school services for youth and adult support groups. Open these groups to all clients - American Indian clients and others. ▪ Use family group conferencing to encourage American Indian clients and their families to self-identify resources that would be culturally relevant and applicable specifically to each individual and family.
<p>Are CMH-C treatment plans for American Indian clients developed by a clinician who is an expert in relevant cultural issues or in consultation with such a clinician?</p>	<p><u>STRENGTHS:</u></p> <ul style="list-style-type: none"> ▪ The CMH-C clinician incorporates strong values and respect regarding the diversity of all individuals - including cultural diversity - into treatment planning and individual therapies. ▪ The CMH-C staff described a positive relationship with clinicians at the Fort Belknap Behavioral Health Program. Communication was described as good. <p><u>CONCERN:</u></p> <ul style="list-style-type: none"> ▪ CMH-C has not identified a clinician who has acknowledged cultural expertise with whom they could consult to ensure that relevant cultural issues are addressed in development of treatment plans. <p><u>Recommendation 11:</u> Add to the present clinical expertise of CMH-C by identifying clinicians who are recognized as experts in cultural issues relevant to providing mental health treatment to American Indians. Engage these people in reviewing, teaching, consulting, and otherwise assisting in designing mental health treatment plans that are culturally appropriate.</p> <p><u>Suggestions for identifying and working with a clinician who is recognized as an expert in cultural issues:</u></p> <ul style="list-style-type: none"> ▪ Approach the Human Services Departments at Montana State University-Northern, Fort Belknap Community College, and Stone Child Community College to review generic issues regarding cultural aspects of mental health services that can be addressed in treatment plans. ▪ Consider having treatment plans reviewed no less than annually by clinician who is recognized as an expert in cultural issues.
<p>Has CMH-C developed links with organizations that have relevant experience and expertise in the provision of mental health treatment and support to American Indian people?</p>	<p><u>STRENGTHS:</u></p> <ul style="list-style-type: none"> ▪ Most of the CMH-C staff has been providing mental health services in the Chinook area for many years. ▪ CMH-C works closely with other local providers as needed, and uses local resources as much as possible. <p><u>CONCERNS:</u></p> <ul style="list-style-type: none"> ▪ Isolation and logistics are significant challenges in the delivery of mental health services to this geographic area of Montana. This is primarily an agricultural community with distances between towns/communities ranging from 20 to 70 miles or more.

	<ul style="list-style-type: none"> ▪ There appears to be a disconnect between the KMA and FBBH. ▪ Time spent driving to deliver services is not “billable”. Providers can drive for hours to deliver critical services. ▪ While CMH-C has had contact with tribal social services and FBBH staff, there does not appear to be an ongoing, collegial working relationship in the provision of mental health treatment and support. ▪ Approximately 30% of the individuals served by CMH-C are American Indian; however, the director has not visited the Fort Belknap Reservation, which is part of the CMH region. Reciprocally, Fort Belknap Behavioral Health Program clinicians have not visited the CMH-C center. There may be a feeling that since the reservation has four experienced clinical professionals that CMH-C staff shouldn’t intrude on their territory, and vice-versa - when in fact - they likely all share similar problems and frustrations, and could very well provide much-needed mutual support. <p><u>Recommendation 12:</u> Develop links with organizations that have relevant experience and expertise in the provision of mental health treatment and support to American Indian people.</p> <p><u>Suggestions for developing links with other service providers / organizations that have relevant experience and expertise in the provision of mental health treatment and support to American Indian people:</u></p> <ul style="list-style-type: none"> ▪ Develop a local Cultural Advisory Committee for the purpose of obtaining advice and feedback on services provided to American Indians. ▪ Consider ways to further explore or to initiate collaboration with organizations such as In-care Network¹¹, Pretty Shield Foundation¹², Fort Belknap Community Council / The Family Support Resource Centers¹³, and Hopa Mountain¹⁴. ▪ Identify and develop relationships with American Indian service providers. ▪ Form a more formal link with the Fort Belknap Behavioral Health Program staff¹⁵, and Rocky Boys Behavioral Health Program staff¹⁶. ▪ Contract with individuals you trust in assisting your organization to develop competent and relevant cultural services particularly with American Indians in your service area. ▪ Assist the Fort Belknap Behavioral Health Program staff to become involved with the KMA; and to work with the KMA to increase its relevance to FBBH.
--	---

¹¹ <http://www.incarenetwork.com/>

¹² [Pretty Shield Foundation](#). 2906 2nd Ave N Ste 316, Billings, MT 59101-2026. (406) 259-4040.

¹³ <http://www.ftbelknap-nsn.gov/directory.htm>

¹⁴ <http://www.hopamountain.org/>

¹⁵ <http://www.ihs.gov/FacilitiesServices/AreaOffices/billings/fortbelknap/fbsu-services.asp>

¹⁶ <http://www.rockyboy.org/Resource%20Dir/Resource%20Directory/CCT%20%20Nah-tos.htm#Behavioral Health Program>

<p>Does the mental health service 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?</p>	<p><u>Strengths:</u></p> <ul style="list-style-type: none"> ▪ The CMH have an American Indian staff person who has been with the agency for more than 10 years. <p><u>Concern:</u></p> <ul style="list-style-type: none"> ▪ The CMH in Chinook doesn't appear to have a formalized plan to recruit American Indian individuals. <p><u>Suggestions:</u></p> <ul style="list-style-type: none"> ▪ When advertising for vacant staff positions at CMH-C, include the phrase "qualified American Indians are encouraged to apply".
<p>With regard to its own staff, does the mental health service 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?</p>	<p>Yes</p> <p><u>Strengths:</u></p> <ul style="list-style-type: none"> ▪ CMH-C staff appear to maintain high ethical standards in the services they provide. ▪ CMH-C staff appear to treat all individuals with respect and dignity. ▪ There appears to be no prejudice toward any minority group by the CMH-C staff.

Recommendation Summary

1. Organize a meeting to include representatives from the CMHB, First Health Services, CMH-Chinook, and FBBH staff to thoroughly review the new out-of-home referral process, identify potential barriers, and develop contingency plans for future problems and disagreements relative to service requests / recommendations by FBBH staff.
2. Develop an active, ongoing, collegial working relationship between CMH-C and FBBH.
3. Establish a consistent communication/coordination protocol when clients (adults or youth) are discharged from a higher level of services to the Chinook-Fort Belknap area, when a client is being served or could be served by both FBBH and CMH-C.
4. DPHHS/CMHB, First Health Services, CMH, the KMA, and FBBH should begin to meet to plan for improving and expanding mental health services in the Chinook-Fort Belknap area. These meetings should provide an ongoing forum to discuss, identify, and address the needs in this area for services within the state mental health system continuum - with particular emphasis on intermediate level services for youth such as Therapeutic Youth Group Homes.
5. Develop a CMH regional Cultural Competence Plan - with an emphasis on issues relevant to providing mental health services to American Indian clients.
6. Define expectations for staff knowledge about cultural, ethnic, social, historical, and spiritual issues relevant to the mental health treatment of American Indian people.
7. Establish ongoing training 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 American Indian people.
8. Begin to collect assessment data pertaining to cultural issues relevant to the mental health needs of American Indian clients.
9. Begin to include therapeutic modalities in treatment plans that address specific cultural issues relevant to the mental health needs of American Indian clients.
10. Begin to identify cultural resources in the community that can be used to enrich treatment plans and service delivery for American Indian clients.
11. Add to the present clinical expertise of CMH-C by identifying clinicians who are recognized as experts in cultural issues relevant to providing mental health treatment to American Indian clients. Engage these people in reviewing, teaching, consulting, and otherwise assisting in designing mental health treatment plans that are culturally appropriate.
12. Develop links with organizations that have relevant experience and expertise in the provision of mental health treatment and support to American Indian people.

Center for Mental Health - Chinook Response

1. Organize a meeting to include representatives from the CMHB, First Health Services, CMH-Chinook, and FBBH staff to thoroughly review the new out of home referral process, identify potential barriers, and develop contingency plans for the future problems and disagreements relative to service requests/recommendations by FBBH staff.

On 5-29-09 Joe Uhl, Ken Kleven and LeaAnne Lewis met with Ft Belknap Tribal President, Julia Doney, CSAA representatives from Ft Belknap, Lenore Stiffarm, Blaine County Commissioner, Dolores Plumage, and FBBH clinicians Ralph Russell, Cynthia Chapman and Paula Bronson. No problems particular to the Center for Mental Health (CMH) were defined. General issues regarding access and barriers to service at all locations including FBBH were identified. Ralph Russell requested some assistance with Ft. Belknap patients who are detained in the Hill County Detention Center. Presently he is seeing those patients at no charge to the county on one evening per week. Similar issues exist in Chinook at the Juvenile Detention Center there. It is understood that that facility will soon be closing. All parties shared frustration with the lack of resources for children who need out of home placements. The primary outcome of this meeting was an agreement to form a group of stakeholders, including all those who attended this meeting, who could continue to meet on a quarterly basis at Ft. Belknap. I suggest that this body consider becoming an LAC for Blaine County and the Ft. Belknap reservation. I am not sure if that is the intention presently but I will continue to advocate for that.

2. Develop an active, ongoing collegial relationship between CMHC and FBBH. I believe we have a collegial relationship with FBBH. However we have not had a vehicle to maintain it. With the agreement to meet at least quarterly we now have that.

3. Establish a consistent communication/coordination protocol when clients (adults or youth) are discharged from a higher level of services to the Chinook Ft. Belknap area, when a client is being served or could be served by both FBBH and CMHC-C.

We will put this on the agenda for discussion at our first quarterly meeting.

4. DPHHS/CMHB, First Health Services, CMH, the KMA, and FBBH should begin to meet to plan for improving and expanding mental health services in the Chinook- Ft Belknap area. The meetings should provide an ongoing forum to discuss, identify, and address for needs in this area for services within the state mental health continuum – with particular emphasis on intermediate level services for youth such as Therapeutic Youth Group Homes.

We will invite the above named entities to attend the quarterly meetings to explore the options for expanding these services.

5. Develop CMH regional Cultural Competency plan- with an emphasis on issues relevant to providing mental health services to American Indian clients.
The regional plan for the CMH cultural competency training is to use Netsmart University which includes on-line training in cultural competency and is available to our employees in their offices. The center will set requirements for each employee to complete specified courses of study and pass exams to demonstrate competency. The center will consider purchasing live training to be conducted at mass staff meetings e.g. our annual all staff in-service.
6. Define expectations for staff knowledge about cultural, ethnic, social, historical, and spiritual issues relevant to the mental health treatment of American Indian people.
It would seem that this would have to be accomplished prior to developing the regional plan called for in item number 5. Center management would have to review the content of Netsmart University and decide which trainings in Cultural Competence would be included in a required course of study. For both item 5 and 6 we will enlist advice of staff from FBBH and Ft. Belknap Tribal representatives who we will be meeting with quarterly. They should be able to help us target specific learning objectives and provide resources in addition to those available on Netsmart University. We have the capability of designing our own training materials for Netsmart University. This will allow us to create very specific educational materials for our staff with input from Tribal representatives.
7. Establish ongoing training 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 American Indian people.
Net smart University is ongoing and customizable. Staff can work at a set of trainings over a specified period of time and test out when they are ready. Records of each staff person's training will be available in our Human Resources office.
8. Begin to collect assessment data pertaining to cultural issues relevant to the mental health needs of American Indian clients.
I presume the data being referred to is related to an individual who is being assessed by a clinician, not the entire culture. Our assessments are part of our electronic medical record that dictates exactly what information is to be gathered from a client. While the clinician has flexibility to write narrative descriptions, there are no specific prompts requiring the clinician to include relevant cultural data. We can review our assessment and make recommendation to change it, but making the actual changes is a time consuming and expensive process.

9. Begin to include therapeutic modalities in treatment plans that address specific cultural issues relevant to the mental health needs of American Indian people.
In order to include these therapeutic modalities in treatment planning the modalities would first have to be identified and taught to our clinicians. Hopefully, the content in Netsmart University will be adequate for us to make a start. We will also explore therapeutic modalities of merit with the tribal leaders and FBBH staff in our quarterly meetings at Ft. Belknap.
10. Begin to identify cultural resources in the community that can be used to enrich treatment plans and service delivery for American Indian clients.
Quarterly meetings with Tribal representatives and FBBH staff will serve as a vehicle for identifying such resources. I have already identified a colleague at the hospital who is Native American and was raised on the Ft. Belknap Reservation. He is an MSW with extensive experience and he is willing to meet with and assist my staff in learning cultural competence.
11. Add to the present clinical expertise of CMH-C by identifying clinicians who are recognized as experts in cultural issues relevant to providing mental health treatment to American Indian clients. Engage these people in reviewing, teaching, consulting, and otherwise assisting in designing mental health treatment plans that are culturally appropriate.
We currently have a co-occurring disorders change agent group that is working on policies, procedures, and clinical skills including treatment planning for Co-occurring clients. Co-occurring competence includes cultural competence. By identifying and adding “experts” to that group we will begin to revise our current treatment planning technology. It must be understood that we use an electronic medical record including an electronic treatment plan. This software is not flexible. To design a new treatment plan and make it work with in our current system is a daunting task. We are training our own IS staff to program changes in our clinical record but the learning curve is steep and long. In other words, any revised treatment plan that we write may not show up in our records for many months. There is enough flexibility to write treatment plans that include cultural issues and staff can be trained to do so. Our experts could train on how to identify and state specific cultural issues in the plan but due to the extra effort in writing the plan from scratch we may not get the best compliance.
12. Develop links with other organizations that have relevant experience and expertise in the provision of mental health treatment and support to American Indian people.
We’ve made a good start by setting up regular meetings with tribal and FBBH staff. Tribal staff have already identified some local resources that we may access and I presume there will be more focused searches for those resources in subsequent meetings.