Mental Disabilities Board of Visitors

SITE REVIEW REPORT

Western Montana Mental Health Center

Butte, Montana

May 14-15, 2009

Gene Haire

Gene Haire, Executive Director

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OVERVIEW

Mental Health Facility reviewed :

Western Montana Mental Health Center - Butte (WMMHC-B)
Butte, Montana
Natalie McGillen – Clinical Director
Kathy Dunks, Operations Director
Jodi Daly – Southwest Regional Director

Mental Health Center

Authority for review :

Montana Code Annotated, 53-21-104

Purpose of review :

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

BOV review team :

Staff:	**Board:**	**Consultants**:
Gene Haire, Executive Director	Sandy Mihelish	Bill Snell, Cultural Consultant
Craig Fitch, Legal Counsel	Brodie Moll	Carol Waller, Client Consultant
LuWaana Johnson, Paralegal		Rhonda Champagne, LCSW, Clinical Consultant
		Bill Docktor, PharmD, BCPP

Review process :

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

MENTAL DISABILITIES BOARD of VISITORS STANDARDS

Organizational Planning and Quality Improvement

Planning:

Does WMMHC-B produce and regularly review a strategic plan developed and reviewed through a process of consultation with staff, clients, family members/carers, other appropriate service providers, and community stakeholders?	WMMHC-B has a written strategic plan that identifies seven areas of new services, four areas of expanded current services, and four areas of new physical plant/administrative support projects. Strengths: ▪ WMMHC-B leaders embrace and proactively pursue service innovation and expansion of evidence-based practices. ▪ The WMMHC-B strategic plan includes significant initiatives in co-occurring/residential detoxification services and establishment of emergency detention services - both at Hays Morris House. ▪ During daily morning staff meetings, all new projects, ideas, and Requests for Proposals are shared and discussed; this process feeds into the strategic plan. ▪ In 2008, WMMHC-B used focus groups to get staff input into changing the structure of case management, assistance with development of a resource manual, marketing ideas on how to better serve the consumers in a welcoming environment, and ways to improve organizational communication. ▪ WMMHC-B recently held staff meetings to explore development of a 'team' culture and ways to increase donations to help the consumers with essential needs. ▪ While the Workers Now program (see **Employment**, page 24) is not included in the current strategic plan, it represents noteworthy originality in assisting people with serious mental illnesses to find and keep jobs, and has been implemented in the context of WMMHC-B's proactive approach to planning and implementing innovative services. ▪ WMMHC-B managers meet every week to review the status of planning initiatives. ▪ Planning includes proactively-sought input from the Local Advisory Council and consumer surveys, and community meetings. Observations: ▪ The strategic plan document does not break down goals into objectives/implementation activities and does not specify timelines or personnel responsibilities. Suggestions: ▪ Consider ways to involve line staff more in the development of the strategic plan. ▪ Consider breaking down goals into objectives/implementation activities and specifying timelines and personnel responsibilities. ▪ Consider incorporating the WMMHC-B strategic plan into an overarching WMMHC master strategic plan.

Quality Improvement:	
Does WMMHC-B have and use a plan of continuous quality improvement to evaluate and improve all of its activities related to services to clients and families?	WMMHC-B uses an informal process of identifying organizational improvement needs, but not a formal process of continuous quality improvement. Strengths: ▪ WMMHC-B staff descriptions of their work were consistent with a *philosophy* of quality improvement. ▪ WMMHC conducts 'quality assurance' reviews of client files in all of its offices. These reviews look at completion of documentation required by its mental health center license under the Department of Public Health and Human Services. This appears to be an excellent process for monitoring the agency's performance relative to documentation. Observations: ▪ The WMMHC Clinical Policies and Procedures Manual contains a section called "Annual Quality Improvement Reports" which lists several areas of information to be included that show changes made in programming based on licensing visits, BOV visits, internal Quality Improvement visits, and client satisfaction surveys. WMMHC-B does not have a current document meeting this description. ▪ There are no defined service quality/outcome standards and no formal process of evaluation based on such standards. Suggestion: ▪ Consider developing a formal continuous quality improvement process to evaluate and improve all activities related to services to clients and families and the *results* of services[1].
Are designated staff of WMMHC-B accountable and responsible for the continuous quality improvement process?	Yes The Directors are responsible for evaluation of services. Strengths: ▪ WMMHC-B leadership is intensely motivated and engaged in the day-to-day operations of the center and in ensuring that services are of high quality. (see Suggestion above)
Is WMMHC-B able to demonstrate a process of continuous quality improvement that directly affects health and functional outcomes for individual clients?	Strengths: ▪ WMMHC-B participates in the statewide 'Recovery Marker' project which has begun to measure the status of clients receiving services in the areas of employment, housing, and level of symptom interference. This is a good step in the right direction - the intention of which is to correlate these measures with services provided.

[1] http://psychservices.psychiatryonline.org/cgi/content/abstract/45/8/789

Rights, Responsibilities, and Safety

Rights, Responsibilities:

Does WMMHC-B define the rights and responsibilities of and provide verbal and written information about rights and responsibilities to clients and family members/carers?	Yes Strengths: ▪ Each new client is given a packet that contains written information about client rights and responsibilities; case managers verbally inform each client about his/her rights and responsibilities; families receive this information on request.
Does WMMHC-B actively promote client access to independent advocacy services by: ▪ providing verbal and written information? ▪ prominently displaying in all of its facilities posters and brochures that promote independent advocacy services including the Mental Disabilities Board of Visitors, the Mental Health Ombudsman, and the Montana Advocacy Program?	Yes Strengths: ▪ The staff of WMMHC-B are knowledgeable and well-trained regarding client rights and responsibilities. As a client goes through the orientation to the services, the staff makes sure that he/she is aware of their rights and responsibilities. ▪ Information describing advocacy services is posted in all areas. Observations: ▪ Staff and clients interviewed by BOV did not seem familiar with efforts to actively promote client access to independent advocacy services.
Does WMMHC-B provide to clients and their family members/carers at the time of entering services written and verbal information about assistance available from the Mental Disabilities Board of Visitors in filing and resolving grievances?	Yes
Does WMMHC-B have an easily accessed, responsive, and fair complaint / grievance procedure for clients and their family members/carers to follow?	Yes Strengths: ▪ The WMMHC-B administration takes grievances very seriously; BOV staff have been invited to attend and support a client during two grievance hearings at WMMHC-B. ▪ Clients interviewed by BOV said that all problems are addressed as soon as they arise, usually by the case manager or supervisor; and if the problem is not able to be resolved at that level, it is referred to the Operations Director and resolved on that level. Observations: ▪ Staff and clients interviewed by BOV did not seem familiar with the grievance process as described in the WMMHC-B policy. Suggestions: ▪ Consider providing more training for line staff and information to clients on the grievance policy. ***WMMHC-B Comment: The grievance policy as well as the abuse and neglect policy will become part of the mandatory yearly training.***

Safety:	
Does WMMHC-B protect clients from abuse, neglect, and exploitation by its staff or agents?	Yes Strengths: ▪ The WMMHC-B administration takes abuse, neglect, and exploitation of clients very seriously. Observation: ▪ Some staff interviewed by BOV were and others were not familiar with the abuse/neglect policy and procedure; though all stated they feel comfortable reporting a possible abuse or neglect situation directly to their supervisor or to a Director. ▪ Not all staff interviewed by BOV seemed clear about the definitions of abuse and neglect. Suggestion: ▪ Consider providing more training for staff on definitions of abuse and neglect[2] and the abuse and neglect policy.
Has WMMHC-B fully implemented the requirements of 53-21-107, Montana Code Annotated (2007) with regard to reporting on and investigating allegations of abuse and neglect?	Yes
In investigations of allegations of abuse, neglect, or exploitation of clients by its staff or agents, does WMMHC-B thoroughly analyze the events and actions that preceded the alleged event – including actions and/or non-actions of its staff or agents?	No allegations have been reported to BOV since the last site review in 2003.
After an allegation of abuse, neglect, or exploitation of a client by its staff or agents is determined to be substantiated, does WMMHC-B debrief all related circumstances – including all staff and supervisory actions or non-actions that could have contributed to the abuse, neglect, or exploitation – in order to decrease the potential for future recurrence?	No allegations have been reported to BOV since the last site review in 2003.
Are staff of WMMHC-B trained to understand and to skillfully and safely respond to aggressive and other difficult client behaviors?	Yes Strengths: ▪ All staff who have direct interaction with clients receive Mandt®[3] training and de-escalation training when first employed, and take a refresher course annually thereafter.
Does WMMHC-B use special treatment procedures that involve behavior control, mechanical restraints, locked and unlocked seclusion or isolation, time out, etc. in a manner that is : ▪ clinically justified? ▪ properly monitored? ▪ implemented only when other less restrictive measures have failed? ▪ implemented only to the least extent necessary to protect the safety and health of the affected individual or others in the immediate environment?	To BOV's knowledge, the Hays Morris House - which is developing services (emergency detention) which have the potential for using special treatment procedures - has not used these procedures yet. The nurse at Hays Morris House described the planned process for involving nurses, medical doctor, and Mental Health Professionals (MHP) during evaluations and imposition of controls.

[2] http://data.opi.state.mt.us/bills/mca/53/21/53-21-102.htm
[3] http://www.mandtsystem.com/

Does WMMHC-B debrief events involving special treatment procedures, emergency medications, aggression by clients against other clients or staff, and client self-harm; retrospectively analyze how such events could have been prevented; and support staff and clients during and after such events?	See comment above.

Client / Family Member Participation	
Does WMMHC-B identify interested family members/carers at the time of the client's entry into services?	Yes Strengths: ▪ At the initial assessment, clients are asked if they have family members who want to be involved with their treatment; If the client agrees to a family member's or other support person's involvement, they are included from that time forward, per the client's permission and instructions. ▪ The intake packet at Hays Morris House includes the parameters for family/carer involvement. ▪ Peer Support Specialists reported to BOV that they have a formal process for attempting to involve friends/family/carers in the provision of treatment and the development of treatment plans.
Do WMMHC-B assessments, treatment planning sessions, and treatment reviews proactively include the participation of clients and – with consent - family members/carers?	Strengths: ▪ Clients are always included in formulation of treatment plans; with client permission, family members/carers are also included.
When a diagnosis is made, does WMMHC-B provide the client and – with consent - family members/carers with information on the diagnosis, options for treatment and possible prognoses?	Yes See comments above.
Does WMMHC-B proactively provide clients, and – with consent - family members/carers a copy of the treatment plan?	Strengths: ▪ WMMHC-B staff reported that they provide the client a copy of the treatment plan if he/she asks, and that families would also get one if they ask and if permission has been given. Suggestion: Consider adopting a more proactive approach to providing copies treatment plans to clients and family members/carers.
Does WMMHC-B work with clients and – with consent - family members/carers in developing plans for discharge/exit from services.?	Yes Strengths: ▪ WMMHC-B is very strong in working with clients through transitions – including transitions out of services.

Does WMMHC-B promote, encourage, and provide opportunities for client and family member/carer participation in the operation of the following components of the mental health service: ▪ participation in developing the strategic plan and plan for continuous quality improvement? ▪ advisory groups? ▪ participation in public meetings? ▪ interviews and selection of prospective staff? ▪ peer and staff education and training? ▪ family and client peer support? Does the service have written descriptions of these activities?	Yes <u>Strengths:</u> ▪ A Peer Support Specialist from WMMHC-B is now on the Governing Board for WMMHC. ▪ Strategic planning ideas are presented first to clients in the day treatment area for a discussion and input; then to the local advisory council for collaboration and support. <u>Observations:</u> ▪ There is not a written description of opportunities for client and family member/carer participation in the operation of WMMHC-B programs. <u>Suggestions:</u> ▪ Consider developing a written description of opportunities for client and family member/carer participation in the operation of WMMHC-B programs.
Does WMMHC-B promote, encourage, and provide opportunities for client and family member/carer participation in the evaluation of the following components of the mental health service: ▪ 'customer service' ▪ effectiveness of communication with clients and family members/carers ▪ measurement of health and functional outcomes of clients Does the service have written descriptions of these activities?	<u>Observations:</u> ▪ The primary mode of obtaining client input into service evaluation is the consumer survey. ▪ There does not appear to be a formal way to solicit input from family members/carers. ▪ The survey approach – while helpful – is a way for clients and family members/carers to "react" to services by giving feedback. ▪ There is no written description of opportunities for client/family member participation in the evaluation of WMMHC-B services. <u>Suggestions:</u> ▪ There may be opportunities to expand and enrich the roles of clients and family members/carers into an ongoing "evaluation" role – congruent with a dynamic quality improvement process focused on results of services. ▪ Consider developing a handout that describes all opportunities for client/family member participation in the evaluation of WMMHC-B services.

Cultural Competence

Note*:* The Mental Disabilities Board of Visitors (BOV) has established standards for its site reviews of mental health facilities, including standards for "cultural competence"[4]. While BOV recognizes that cultural competence is important and relevant to the way in which mental health programs work with people from *all* ethnic, racial, and 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 Montana[5]. In a number of mental health programs in Montana, especially programs that serve children and programs that are on or near Indian reservations, the number of American Indians served as a percentage of all people served is much higher – as high as 40% for some programs. The low percentage of American Indians on client caseloads in other mental health programs indicate that they may be under-identified and under-served. Particular aspects of the experience of American Indians and Indian families such as intergenerational trauma and historical grief; high exposure to loss and violence resulting in post traumatic stress[6]; and high rates of suicide[7] and chemical dependency[8] make it critically important for mental health providers to develop a high level of sensitivity to and competence in working with American Indian clients.

All comments and recommendations below can and should be applied to the diversity of individuals served in Montana's mental health system.

Does WMMHC-B 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?	No Strengths: ▪ WMMHC-B leaders and staff expressed interest and motivation in developing a Cultural Competence Plan with the assistance of American Indian experts. Observation: ▪ When a decision is made to develop a formalized Cultural Competence Plan, it will be critical to have a clear understanding of the number of American Indians and other minorities currently served - as well as those in need of but not receiving services - in the WMMHC-B catchment area. (see p. 17) Recommendation 1: Develop a Cultural Competence Plan - with the assistance of recognized experts - specific to the needs of the WMMHC-B service area that includes defined steps for integration at every level of organizational planning. Suggestions for implementation of Recommendation 1: ▪ Develop relationships with recognized cultural experts; ask for help in developing a Cultural Competence Plan. ▪ Recruit a member of the American Indian community to serve on the WMMHC Board of Directors. ▪ Develop a local Cultural Advisory Committee for the purpose

[4] 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.

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

[6] 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.giftfromwithin.org/html/amindian.html

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

[8] 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://wwwdasis.samhsa.gov/webt/quicklink/MT07.htm

	of obtaining advice and feedback on services provided to American Indians and other cultural/ethnic minorities. ▪ Conduct an internal staff survey regarding the development of a Cultural Competence Plan; ask for staff input on what such a plan should contain, and what steps would need to be taken to integrate the plan at every level of the WMMHC-B organization.
Does WMMHC-B define expectations for staff knowledge about cultural, ethnic, social, historical, and spiritual issues relevant to the mental health treatment of all WMMHC-B clients, with a specific emphasis on American Indian people?	No <u>Strengths:</u> ▪ Philosophically, WMMHC-B leadership and staff appear to acknowledge and nurture the innate understanding that each client's uniqueness includes his/her cultural, ethnic, social, historical, and spiritual background. ▪ Butte has a rich and diverse community of cultures; leaders and staff appear to work out of a comfort level related to the significant historical cultural diversity of the Butte community. ▪ Each staff person BOV interviewed expressed strong personal expectations for his/her sensitivity to cultural issues based on individual awareness of cultural issues. ▪ As a team, WMMHC-B staff demonstrate a range of interests and commitments to sharing their cultural experiences with each other and to improving. <u>Observations:</u> ▪ Position descriptions do not have statements related to having knowledge and/or experience working with people from diverse ethnic and cultural backgrounds including American Indians.
	<u>Suggestions:</u> ▪ Consider defining expectations for staff knowledge about cultural, ethnic, social, historical, and spiritual issues relevant to the mental health treatment of all WMMHC-B clients, with a specific emphasis on American Indian people. ▪ Develop relationships with recognized cultural experts; ask for help in developing expectations for staff knowledge that is needed to provide culturally competent mental health treatment. ▪ Incorporate cultural expectations into WMMHC-B position descriptions. ▪ Develop specific standards/policies that support attainment of defined expectations regarding cultural, ethnic, social, historical, and spiritual issues relevant to mental health treatment.

Does WMMHC-B 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 all WMMHC-B clients, with a specific emphasis on American Indian clients?	No Strengths: ▪ Some informal training occurs through general discussions during staff meetings, and contact with other professionals with culturally-relevant experience. ▪ Some WMMHC-B staff received cultural competence training in Kalispell a few years ago. ▪ WMMHC-B leaders and staff acknowledge the need and express the desire for more training designed to increase cultural competence. ▪ WMMHC-B staff expressed awareness that among various American Indian Tribes there are differences; staff don't generalize that "all Indians are the same". Observation: ▪ WMMHC-B staff appear to have the "heart" to learn ways in which to apply culturally-relevant services, but need access to information or individuals that can help accomplish this. Recommendation 2: Develop and provide training conducted by recognized experts that enables staff to meet expectations for knowledge about cultural, ethnic, social, historical, and spiritual issues relevant to the provision of mental health treatment to all WMMHC-B clients, with a specific emphasis on American Indian clients. Suggestions for Implementation of Recommendation 2: ▪ Develop relationships with recognized cultural experts; ask for help in developing and providing cultural competence training that incorporates cultural diversity in mental health treatment generally; and American Indian traditions, values, and beliefs in particular. ▪ Identify local, regionally, and nationally cultural training opportunities that can be attended by a WMMHC-B staff and in return that individual can "share and debrief" with others what was presented and learned. ▪ Identify and utilize insights and specialized skills of current staff who have knowledge and expertise related to cultural competence in ongoing in-house training. ▪ Develop a library of resource material on cultural issues, which could be incorporated into staff training. ▪ Attend local cultural events to gain personal insight into the American Indian culture first hand. ▪ Consider attending annual National Indian Child Welfare Conference[9]. ▪ Consider attending the annual Native American Child and Family Conference held in Montana each year, usually held in October[10]. ▪ Attend cultural training offered by the Montana Tech - University of Montana. ▪ Include on-going training with an emphasis on American Indian issues in the WMMHC-B annual training plans. ▪ Establish cross-training agreements with the North American Indian Alliance in Butte.

[9] http://www.nicwa.org/
[10] http://www.southwestconsortium.org/

	▪ Utilize trainers who are "positive thinkers" and tend not to dwell on the "negative past and wrongs" that have occurred. History and past issues between the western culture and American Indian culture are important but it can be addressed and taught in a positive and healing manner. Historical factors must be kept in proper perspective when developing an understanding of how best to provide mental health services to American Indians.
Do WMMHC-B's treatment plans take into account individually-identified cultural issues, and are they developed by a culturally competent clinician or in consultation with such a clinician?	No <u>Strengths:</u> ▪ Consistent with the previous observation that WMMHC-B acknowledges and nurtures awareness of and respect for its clients' cultural backgrounds, these values appear to be incorporated into treatment plans. ▪ Individual clinicians bring their own level of cultural awareness into treatment plan development; some have significant cultural knowledge. ▪ The narratives in treatment plans address cultural differences where appropriate. <u>Observations:</u> ▪ The treatment plan format does not prompt for specific information related to individually-identified cultural issues that could be relevant to mental health treatment. ▪ When cultural issues relevant to individual clients' treatment arise, the general approach is to refer to a local source outside of WMMHC-B. ▪ Since expectations for staff knowledge about cultural, ethnic, social, historical, and spiritual issues relevant to the mental health treatment of all WMMHC-B clients have not been defined, the degree of cultural insight reflected in treatment plans appears inconsistent. ▪ 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. <u>Suggestions:</u> ▪ Consider ways to include therapeutic modalities in treatment plans that address specific cultural issues relevant to the mental health needs of American Indian clients**.** ▪ Identify and develop relationships with American Indian/culturally-competent mental health service providers in the State of Montana. ▪ Develop relationships with American Indian/culturally competent clinicians; ask for help in developing treatment plans that take into account individually-identified cultural issues. ▪ Consider using the System of Care Cultural Services Matrix developed by In-Care Network[11]. This tool includes the primary diagnoses used for youth, comparing "Western" interventions and American Indian interventions - and can be adapted for adults.

[11] Cultural Services Matrix - http://healingnativenations.org/

	▪ Consider having treatment plans reviewed no less than annually by a clinician who is recognized as expert in cultural issues. ▪ Revise intake format to include prompts and information fields that include information such as whether the client is bilingual, client's tribal affiliation, as whether the client is enrolled in a tribe and/or is a descendant of a tribe, the degree of the client's assimilation into "main stream society", client's individual spiritual interests, the client's interest in and preference for ceremonial practices, the client's role in his/her family, and the specific make-up of the extended family members. ▪ Explore ways to increase awareness of American Indian approaches to parenting that would be relevant to working with American Indian children with emotional disturbance.
Has WMMHC-B developed links with other service providers / organizations that have relevant experience and expertise in the provision of mental health treatment and support to WMMHC-B clients from all cultural / ethnic / religious / racial groups in the community, with a specific emphasis on American Indian people?	Yes <u>Strengths:</u> ▪ The staff of WMMHC-B maintains an awareness of cultural concerns and issues, which they work to address by drawing on the limited local resources that are available. ▪ WMMHC-B is open to engaging with organizations that have relevant experience and expertise in the provision of mental health treatment and support to a culturally diverse clientele; WMMHC-B staff express particular interest regarding how these links can assist in serving American Indian clients. ▪ WMMHC-B appears to be vigilant in exploring new culturally-relevant resources for their organization. ▪ Most of the WMMHC-B staff have been providing mental health services in the Butte area for many years, and are well-aware of and comfortable with the diversity of cultures in the community. ▪ WMMHC-B leaders and the North American Indian Alliance (NAIA) staff expressed mutual interest in forming a constructive, mutually respectful/beneficial working relationship.
	<u>Observations:</u> ▪ NAIA expressed a need for their staff to receive training in working with people with mental illnesses, and seems open to working with WMMHC-B to this end. <u>Suggestions:</u> ▪ Consider designating one WMMHC-B staff person as "cultural specialist/liaison" who would be responsible for coordinating internal cultural competence activities and working relationships with cultural experts and organizations. ▪ Identify cultural resources - organizations and individuals - in the greater Butte/Montana community that can be drawn on to enrich treatment plans and service delivery; develop relationships with these organizations and individuals. These could include the Pretty Shield Foundation[12], Hopa Mountain[13], various Tribal Social/Behavioral Health Services, State of Montana Office of Public Instruction[14], Helena Indian Alliance[15], and White Bison Inc.[16]. ▪ Identify supportive American Indian mental health professionals in the community who would be willing to help in identifying others cultural resources.

[12] Pretty Shield Foundation - 2906 2nd Ave N; Billings, MT 59101-2026; 406-259-4040
[13] http://www.hopamountain.org/

Does WMMHC-B have a plan for recruitment, retention, and promotion of staff from cultural/racial/ethnic backgrounds representative of the community served with a specific emphasis on American Indian people?	No Strengths: ▪ WMMHC-B has several American Indian staff who have been with the agency for several years and with whom it can consult or obtain advise regarding enhancement of the cultural aspects of treatment. ▪ There is a desire by WMMHC-B staff to recruit qualified people from diverse ethnic and cultural backgrounds, with a particular interest in hiring and retaining American Indians where possible. Observations: ▪ The WMMHC-B doesn't appear to have a formalized plan to recruit American Indian or other qualified people from diverse ethnic and cultural backgrounds. ▪ There are no formal incentives or promotion opportunities for staff who have expertise in working with people from diverse ethnic and cultural backgrounds including American Indians. Suggestion: ▪ When advertising for vacant staff positions at WMMHC-B, consider including the phrase "qualified American Indians are encouraged to apply". ▪ Consider setting up booths during "career days" or "career recruitment" at colleges/universities in Butte, Helena, and Missoula in an effort to recruit minorities.
	▪ Consider enhanced compensation for specialized staff skills such as being bilingual or multi-lingual, or having expertise in cultural issues relevant to mental health treatment. ▪ Contact the Indian Health Services Area Office[17] for potential graduates who are looking for employment with a mental health provider.
With regard to its own staff, does WMMHC-B monitor and address issues associated with cultural / ethnic / religious / racial prejudice and misunderstanding, with a specific emphasis on prejudice toward and misunderstanding of American Indian people?	Yes Strengths: ▪ WMMHC-B appears to apply high ethical standards regarding *all* people, with an emphasis on *individualized* treatment. ▪ WMMHC-B staff appears to treat all individuals with respect and dignity. ▪ There appears to be no prejudice toward any minority group by the WMMHC-B staff. ▪ There is an obvious "positive energy" among WMMHC-B leaders to acknowledge and resolve any misunderstanding or bias toward minority groups/individuals that may arise. Observations: ▪ There are no formal questions in the staff performance evaluations to assess cultural / ethnic / religious / racial prejudice and misunderstanding. ▪ There is no formal orientation for new employees that address issues regarding cultural/ethnic/religious/racial prejudice and misunderstanding, with a specific emphasis on prejudice toward and misunderstanding of American Indian people.

[14] Montana Indian Education - http://www.opi.mt.gov/indianed2/ ; Essential Understandings Regarding Montana Indians - http://www.opi.mt.gov/PDF/IndianEd/Resources/EssentialUnderstandings.pdf
[15] Helena Indian Alliance - http://www.helenaindianalliance.com/
[16] http://www.whitebison.org/
[17] Billings Area Indian Health Service - http://www.ihs.gov/FacilitiesServices/areaOffices/billings/

	Suggestions: ▪ Consider developing a section in employee performance evaluations that assesses cultural / ethnic / religious / racial prejudice and misunderstanding. ▪ Provide formalized cultural training several times a year for on-going and new staff orientation to address potential for cultural / ethnic / religious / racial prejudice and misunderstanding.
Does WMMHC-B assess the demographics of its catchment area and identify underserved cultural groups, with a specific emphasis on American Indian people?	No Strengths: ▪ WMMHC-B leaders appear motivated to identify underserved populations and to work toward providing services to the undeserved in their catchment area. Observations: ▪ American Indian people appear to be underrepresented in WMMHC-B's client population. Suggestions: ▪ Develop a method of measuring the number of American Indians and other minorities currently served - as well as those in need of but not receiving services - in the WMMHC-B catchment area.

Staff Competence, Training, Supervision, and Relationships with Clients

Competence and Training:

General Comments:

- Outpatient staff appear to have good foundational knowledge; and appear to be supportive, respectful, and dignifying in working with clients.
- Strong emphasis on comprehensive, timely communication among the outpatient staff.
- All staff who participate in medication management and delivery (nurses, secretaries, case managers, therapists, and support staff) appear to operate at a high level of efficiency that significantly offsets the challenges resulting from high prescriber caseloads.
- Case Management staff are energetic and appear to work well together as a cohesive team.
- All of the clients that BOV spoke with were very positive - even effusive - about their case managers.
- Peer Support Specialists add an important dimension to both case management and day treatment services.
- BOV was impressed with the quality and proactive nature of the ongoing communication and problem-solving that flows freely within and among all service components.

Does WMMHC-B define optimum knowledge and competence expectations directly related to mental illnesses and working with people with mental illnesses for each staff position providing services to clients?	No Strengths: ▪ Even though expectations for knowledge and competence directly related to mental illnesses are not specifically defined, WMMHC-B has established a culture of high expectations for its staff. ▪ Many WMMHC-B staff interviewed have 10+ years of direct service experience. ▪ A bachelor level education and two years relevant experience is required for adult case management staff. Observations: ▪ Beyond generic requirements in direct care position descriptions, optimum knowledge and competence expectations for each staff position are not defined; knowledge and competence expectations in management/clinical position descriptions are more thoroughly described. ▪ The Community Support Nurse position description contains no knowledge expectations. Recommendation 3: Define optimum knowledge and competence expectations directly related to mental illnesses and working with people with mental illnesses; include knowledge and competencies related to specific illnesses and evidence-based practices.
Does WMMHC-B have a written training curriculum for new staff focused on achieving optimum knowledge and competence directly related to mental illnesses and working with people with mental illnesses?	No Initial orientation for new staff is structured through general outlines with topic headings focusing largely on organizational policies; this is followed up with shadowing and on-the-job training with experienced staff. Strengths: ▪ Program Director, supervisors, and line staff all appear very clear about their process for increasing competence levels through personal and professional growth and development. ▪ Peer Support Specialists receive good training in the peer-staff model.

	Suggestion: ▪ Consider arranging for all staff to participate in NAMI's Provider Education. ▪ Consider developing a staff training specialist position. ***NOTE***: *Since this review, WMMHC-B has shifted 50% of one clinician's duties to staff training. There is a plan to begin twice per quarter "Mental Health 101" training for direct care staff.* Recommendation 4: Based on optimum knowledge and competency expectations, develop a written training curriculum and provide training for new staff focused on achieving optimum knowledge and competency levels. This curriculum should focus on major mental illnesses and evidence-based practices.
Does WMMHC-B proactively provide staff opportunities for ongoing training including NAMI-MT Provider Training, NAMI-MT Mental Illness Conference, Mental Health Association trainings, Department of Public Health and Human Services trainings, and professional conferences?	Yes Strengths: ▪ WMMHC-B has sent two groups of leaders and staff (a total of 20 people from the SW Region of WMMHC) to Long Beach, CA to participate in immersion training at the Village[18] program - a nationally-recognized, recovery-oriented program. This was followed-up with a visit with WMMHC-B in Montana by Mark Ragins, M.D., psychiatrist and founding staff member of the Village and a primary developer of the recovery concept. WMMHC-B leaders are to be commended for investing in this invaluable experience and for committing to emulating this model. ▪ Each staff person has funding set aside each year marked specifically for training purposes. Most staff BOV interviewed has attended the annual NAMI conference. ▪ Staff are encouraged to attend training that they desire and need.
Does WMMHC-B periodically assess current staff and identify and address knowledge and competence deficiencies?	Yes
Supervision:	
Does WMMHC-B provide active formal and informal supervision to staff?	Yes Strengths: ▪ WMMHC-B supervisors are actively involved in all levels of service provision including active side-by-side supervision. ▪ The close proximity of WMMHC-B program locations facilitate supervisor/manager availability to staff.
Does WMMHC-B train supervisors and hold them accountable for appropriately monitoring and overseeing the way clients are treated by line staff?	Yes
Does WMMHC-B train supervisors and hold them accountable for appropriately monitoring, overseeing, and ensuring that treatment and support is provided effectively to clients by line staff according to their responsibilities as defined in treatment	Yes Observations: ▪ Accountability is clearly a priority, however, there does not

[18] http://www.mhavillage.org/

plans?	appear to be formal training for supervisors. Suggestion: ▪ Consider developing a written training curriculum for supervisors.
Relationships with Clients:	
Do mental health service staff demonstrate respect for clients by incorporating the following qualities into the relationship with clients: ▪ active engagement? ▪ positive demeanor? ▪ empathy? ▪ calmness? ▪ validation of the desires of clients?	Yes Strengths: ▪ Clients appear very pleased with their working relationships with staff and service they were getting. ▪ Many WMMHC-B staff have been working for the center for years and have developed close, supportive relationships with the clients.
Active Engagement with Clients:	
Do WMMHC-B direct care staff demonstrate proactive, assertive, supportive, engagement with clients?	Yes Strengths: ▪ Clients in Silver House stated to BOV that the services they receive from WMMHC-B are among the best they have experienced.
Are WMMHC-B professional staff consistently present in all treatment environments interacting with direct care staff and clients teaching, modeling, and reinforcing healthy, constructive, respectful interactions?	Yes Strengths: ▪ Daily staff meetings appear to facilitate excellent communication among all professional and line staff. ▪ BOV observed professional staff in the various treatment settings.

Treatment and Support

General Comments:

- A number of the WMMHC-B staff have been working in this program for 10+ years and as a result, the depth of experience is significant.
- WMMHC-B staff are dedicated and responsive to one another, the clients, and the community.
- Services are friendly and welcoming.

Is a written treatment plan in place and being implemented for every client receiving services from the mental health service?	Yes
Is a written discharge plan in place for every client receiving services from the mental health service?	Yes
For all new or returning clients, does WMMHC-B perform a thorough physical / medical examination or ensure that a thorough physical / medical examination has been performed within one year of the client entering / re-entering the service?	Comprehensive medical information is gathered for each new or returning client. Based on this process, a medical decision is made regarding the need for a complete physical / medical examination and/or specialized medical testing.
Does WMMHC-B link all clients to primary health services and ensure that clients have access to needed health care?	Yes

Does WMMHC-B proactively rule out medical conditions that may be responsible for presenting psychiatric symptoms?	Yes
Does WMMHC-B ensure that clients have access to needed dental care?	Yes – within the limits of dental care resources.
Evidence-Based Practices:	
Does WMMHC-B provide treatment and support to adults that incorporates the following SAMHSA-identified evidence-based practices: Illness Management and Recovery, Assertive Community Treatment, Family Psychoeducation, Supported Employment, Integrated Treatment for Co-occurring psychiatric and substance use disorders[19]?	Strengths: ▪ WMMHC-B provides Assertive Community Treatment, and is very involved in providing and further developing an innovative employment program that appears to incorporate the critical, constructive aspects of Supported Employment (see p. 23) ▪ WMMHC-B is participating in the project led by the Addictive and Mental Disorders Division to implement Illness Management and Recovery and Integrated Treatment for Co-occurring Psychiatric and Substance Use Disorders - and will be subject to new Administrative Rules in these areas. ***WMMHC-B Comment****: WMMHC-B has sent three employees to Illness Management and Recovery training; these staff are now conducting groups using the materials. NAMI-MT will be conducting Provider training in early spring 2010 for all staff. Peer Support Specialists employed in the Adult Day Treatment Program have received NAMI Family training in the past, and we will consider a refresher course when offered by NAMI. WMMHC-B will continue to encourage family members to start support groups in the community and we will request support from the Local Advisory Council to facilitate these groups.*
	Comments specific to ACT: Strengths: ▪ The PACT team seems to know their clients very well and works to provide the best service to each of them. ▪ The PACT team has done a good job of preventing unnecessary hospitalizations and incarcerations of their clients. ▪ The Peer Support Specialist on this PACT team is exceptional. He appears to have daily contact with the clients, is a good mentor, and understands the needs of the clients from personal experience. ▪ A PACT team member is on call 24/7 to step in if the person answering the crisis line feels it is necessary. Observations: ▪ Because the treatment team members work 4 days on and 3 days off, not all members of the PACT team are present for daily team meetings. This appears to be a workable trade-off between staffing schedules that are attractive and diminish burn-out and the benefits of having the entire team present for all team meetings. ▪ The WMMHC-B psychiatrist / medical director is the PACT APRN supervisor; he consults with the APRN on PACT cases. ▪ Several positions on the PACT team split their responsibilities between PACT and other non-PACT duties. ▪ The PACT team does not have a dedicated telephone line for PACT clients to access PACT staff directly.

[19] http://mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/

	Suggestions: ▪ Consider developing a telephone line that would allow PACT clients to be able to access the PACT team directly without going through the Crisis Line. The treatment team has established a relationship with the clients and the clients might be more comfortable being able to talk to someone they know. True – but the overall purpose is to provide integration not enablement. This would also create two different crisis systems – which would be confusing and inefficient. I would hate to 'label' those on PACT versus traditional case management as well. ▪ Consider using the SAMHSA information to develop Psychosocial Education for Families.
Housing:	
Does WMMHC-B ensure that clients have access to safe, affordable, quality housing in locations that are convenient to community services and amenities?	Yes Strengths: ▪ WMMHC-B has developed a rich continuum of residential options including staff-supported independent living, center-operated apartments (Spurlock Apartments) and group home (Our House). ▪ WMMHC-B staff helps all clients who need housing access Section 8 low-income housing. ▪ Clients BOV talked with appear genuinely happy with all aspects of residential support they receive.
Does WMMHC-B provide support and advocacy to clients in communicating and problem-solving with landlords?	Yes
Does WMMHC-B work closely with landlords to ensure that clients do not lose their housing during periods of hospitalization or other temporary out-of-community treatment, or other illness-related circumstances?	Yes
Does WMMHC-B provide access to and assistance with options for client home ownership.	Yes Strengths: ▪ WMMHC-B has worked with the Montana Home Choice Coalition[20].
Education:	
Does WMMHC-B facilitate access to opportunities for continuing education?	Yes Strengths: ▪ Education is addressed in treatment plans. ▪ WMMHC-B has used a "supported education" approach with some clients in which a staff person attends classes with a client. ▪ The PACT team offers help with clients obtaining their GED certificates through a "GED Group".

[20] Montana Home Choice Coalition - http://www3.aware-inc.org/awareinc/montanahomechoice/main.asp

Employment:	
Does WMMHC-B assist clients to find and keep competitive employment through a Supported Employment model?	Yes Strengths: ▪ WMMHC-B has developed an innovative approach to assisting clients to find and keep jobs called Workers Now. Workers Now provides a wide variety of employment options including in-house employment, program-operated employment in the community, day-to-day odd jobs, and fully-integrated long-term jobs in the community. The staff supervisor and Peer Support Specialists who operate this service provide an active, supported structure with flexibility in training and supervision based on client and employer need. There is an emphasis on creating some separation from the WMMHC-B mental health program identity in an attempt to address potential barriers that may arise from stigma. At the time of this review, Workers Now had 100 clients at some level of employment. ▪ WMMHC-B deserves much credit for the initiative represented by the Workers Now project. The tremendous effort and energy that has been put into this project is paying huge dividends for the people served and the entire agency. The continued effort to find work and discussion about work has permeated all program settings and is creating a transformative consciousness within WMMHC-B about what is possible for people with mental illness. ▪ One client BOV spoke with who last worked in 1993 has now worked with Workers Now for 2-1/2 hours/day (M-F) for over a year.
Co-Occurring Psychiatric and Substance Use Disorders:	
Has WMMHC-B fully implemented the protocols established by AMDD for treatment of people who have co-occurring psychiatric and substance use disorders?	WMMHC-B is participating in the project led by the Addictive and Mental Disorders Division to implement Integrated Treatment for Co-occurring Psychiatric and Substance Use Disorders - and will be subject to new Administrative Rules in this area. Strengths: ▪ WMMHC-B staff and leaders are very aware of the dynamics of co-occurring psychiatric and substance use disorders, and are taking steps toward better integration of mental health and substance us disorder treatment. ▪ The Hays Morris House has three detoxification beds designated for clients who have co-occurring psychiatric and substance use disorders. ▪ The PACT team has a Licensed Addiction Counselor who works with clients who have co-occurring psychiatric and substance use disorders. ▪ Butte Alcohol and Drug (BAD) and WMMHC-B have a memorandum of understanding under which both agencies participate in a collaborative group at Silver House that works with clients who have co-occurring psychiatric and substance use disorders. ▪ BAD comes to WMMHC-B to conduct intakes and assists us with treatment dispositions. add Deb's list

	Observations: ▪ Systemic requirements including separate "funding streams" continue to create barriers for truly integrated treatment for people who have co-occurring psychiatric and substance use disorders. ▪ When a client is identified as having a co-occurring substance use disorder, he/she is referred to the local substance abuse service. Suggestions: ▪ Look for ways to continue moving toward full implementation of the Comprehensive Continuous Integrated System of Care model[21].
Crisis Response and Intervention Services: ***Comments specific to the relatively new crisis stabilization house, Hays Morris House:*** Strengths: ▪ Hays Morris House is a new facility designed from the ground up as a mental health crisis facility with all the latest "tools". It is very impressive. It is an excellent example of proactive innovation in development of a crisis stabilization facility that has the capacity (and licensure) for serving clients who are ordered by the court into "emergency detention" status (normally, people in this status are sent to Montana State Hospital). This is a great asset to mental health services provided in the Butte area. ▪ Each client who is admitted to Hays Morris House is assigned a Case Manager and given an admission package with comprehensive information; this information package could be a model for information to be provided to new clients in any program.	
Does WMMHC-B operate a 24 hour / day, 7 day / week crisis telephone line?	Yes Strengths: ▪ The WMMHC-B crisis response system is well-integrated among Hays Morris house, PACT, and the Mental Health Professional responders. ▪ WMMHC has a well-thought-out and comprehensive crisis response procedure. Crisis response staff have strong connections within the communities in which crisis services are delivered. ▪ BOV called the Crisis Line after working hours and the worker who answered the phone was kind, did her best to make sure the BOV caller was safe, and answered all questions appropriately. ▪ BOV also called the Crisis Line during working hours and discussed with the worker how the Crisis Line works. The worker was knowledgeable, her explanations were clear, and she answered all BOV's questions appropriately. Observations: ▪ Crisis response Mental Health Professionals (MHP) are very, very busy with six counties to cover and one MHP on duty at any given time.

[21] http://www.kenminkoff.com/ccisc.html ;
Minkoff, MD, Kenneth. What Is Integration?. Journal of Dual Diagnosis, Vol. 2(4) 2006. http://www.kenminkoff.com/articles/dualdx2006-4-whatisintegration.pdf :
"...integration is distinct from "parallel" services or functions in which mental health and substance components or services are "co-located" within the organization, or provide care in tandem to the client, but without the interwoven fabric between them and the provision of integrated interface within each component."

Does WMMHC-B list and advertise its crisis telephone number in a manner designed to achieve maximum visibility and ease of location to people in crisis and their families?	Yes Strengths: ▪ The number is listed in the telephone directory, in newspapers, and on the radio. ▪ Business cards with the crisis line number are given to all clients. ▪ Crisis line information is posted in all WMMHC-B program areas by telephones. ▪ Each treatment plan has a crisis plan with the crisis line number included. ▪ WMMHC-B has close working relationships with the local police and hospital emergency rooms. ▪ The Regional Director analyzes crisis call logs to determine trends.
Does WMMHC-B respond directly to its own clients, clients of other service providers, and to "unattached" individuals who call its crisis telephone line?	Yes
For crisis line callers who are engaged with another service provider, does WMMHC-B- after responding appropriately to each caller's immediate need, and after addressing life safety concerns - carefully refer those clients to that provider?	Yes ▪ If the MHP determines a caller is high-risk, he will make the service connection for the caller and fax information to the provider. ▪ If the MHP determines a caller is lower-risk, he will provide immediately-needed assistance, and recommend that the caller see his/her provider.
Is the WMMHC-B crisis telephone line able to route multiple calls to appropriate responders?	Yes
Does WMMHC-B follow-up on crisis line callers whom it refers out to ensure that the outside provider received the referral?	Yes
Medication:	
Is the medication prescription protocol evidence-based and reflect internationally accepted medical standards?	Yes Medication used is consistent with diagnosis or symptoms presented.
Is medication prescribed, stored, transported, administered, and reviewed by authorized persons in a manner consistent with laws, regulations, and professional guidelines?	The way that medication is repackaged by nurses would be considered illegal by the State Board of Pharmacy, but legal by the State Board of Nursing. Strengths: ▪ Morning and evening community-based home delivery of and reminders to take medication is a valuable service, and carried out with discretion and respect. ▪ The nursing staff provides medications to the clients in calendars (medication boxes) when needed. ▪ The contents of each medication box is reviewed with the client when it is picked up; the client signs a form indicating that the medication box is filled correctly. Observations: ▪ The way that medication is repackaged by nurses would be considered illegal by the State Board of Pharmacy, but legal by the State Board of Nursing. Suggestions: ▪ Review the medication repackaging protocol to ensure that it is in compliance with appropriate guidelines and laws.

Are clients and – with consent - family members/carers provided with understandable written and verbal information about the potential benefits, adverse effects, and costs related to the use of medication?	Yes Nurses give the information sent by the pharmacy to the client as well as a copy of the medication administration sheet. Nurses also talk with patients about their medication whenever they see them to pick up their medication boxes or talk to them over the phone. The nurses main source of drug information is the Nurses Drug Handbook. <u>Suggestions:</u> ▪ The patient medication information sheets are not ideal sources of usable information. As a supplement to the Nurses Drug Handbook, BOV suggests using the medication information located on the NAMI website[22].
Is "medication when required" (PRN) only used as a part of a documented continuum of strategies for safely alleviating the resident's distress and/or risk?	<u>Observations:</u> ▪ There is not a formal policy or guidelines for a continuum of strategies for the use of PRN medications. The clients at home, of course, decide when the PRN is needed. In the group home/ crisis house the approach is to always try behavioral de-escalation and redirection before PRN medication, step back, and redirection before using a PRN medication. <u>Suggestions:</u> ▪ Develop written guidelines for the use of PRN medications in program facilities.
Does WMMHC-B ensure access for clients to the safest, most effective, and most appropriate medication and/or other technology?	Yes <u>Strengths:</u> ▪ The nurses make extensive use of samples and assistance program to be sure each client has access to medication. <u>Observations:</u> ▪ There are cases in which samples or assistance programs are not available or when pre-authorization is not given which results in prescribed medications needing to be switched.
Does WMMHC-B acknowledge and facilitate clients' right to seek opinions and/or treatments from other qualified prescribers and promote continuity of care by working effectively with other prescribers?	Yes <u>Strengths:</u> ▪ If a client wants another WMMHC-B prescriber (choice is the psychiatrist of the Advance Practice Registered Nurse [APRN]), he/she can see the other one or an outside prescriber. There is a requirement that the client have an "exit" discussion with the current prescriber to see if any problems can be worked out.
Where appropriate, does WMMHC-B actively promote adherence to medication through negotiation and education?	Yes
Wherever possible, does WMMHC-B not withdraw support or deny access to other treatment and support programs on the basis of clients' decisions not to take medication?	Yes

[22] NAMI medication information - http://www.nami.org/Content/NavigationMenu/Inform_Yourself/About_Mental_Illness/About_Treatments_and_Supports/About_Medications/Default798.htm

For new clients, is there timely access to a psychiatrist or mid-level practitioner for initial psychiatric assessment and medication prescription within a time period that does not, by its delay, exacerbate illness or prolong absence of necessary medication treatment?	Yes - in emergent or crisis situations. Otherwise, it may take 4-8 weeks to get an appointment with a WMMHC-B prescriber. Observations: ▪ WMMHC-B is actively recruiting another provider. ▪ The WMMHC-B psychiatrist sees 15-20 clients per day which he says is only possible due to the efficiency of the staff. He has 1000-1200 on his caseload. ▪ The APRN sees about 10 clients per day in the PACT program (Mondays and Fridays) and 18-24 in outpatient on other days for about 90 per week total.
For current clients, does WMMHC-B provide regularly scheduled appointments with a psychiatrist or mid-level practitioner to assess the effectiveness of prescribed medications, to adjust prescriptions, and to address clients' questions / concerns?	Yes Strengths: ▪ Prescribers see open clients on a frequent basis depending on their stability.
When legitimate concerns or problems arise with prescriptions, do clients have immediate access to a psychiatrist or mid-level practitioner?	Yes
Are medication allergies, side effects, adverse medication reactions, and abnormal movement disorders well documented, monitored, and promptly treated?	Yes Strengths: ▪ The APRN state that she does Abnormal Involuntary Movement Scale (AIMS) tests on clients every six months. ▪ Prescribers and nurses observe clients at each appointment for side effects. Side effects are documented in the medication notes and often lead to changes in medications. Observations: ▪ BOV did not see any AIMS tests documented in any of the ten records reviewed.
Are medication errors documented?	Yes Strengths: ▪ Medications errors are reported as incident reports and the people who need to know right away are informed. Observations: ▪ BOV observed extensive use of error-prone abbreviations in reviewed charts. Suggestions: ▪ Eliminate the use of error-prone abbreviations in all settings. See The Institute for Safe Medication Practices website for a current list[23]. ▪ Form a committee to review medications errors. This committee should include those involved in the medication prescription and dispensing functions. Reviewing groups of errors is useful in identifying systems errors that allow errors to occur.
Is there a quality improvement process in place for assessing ways to decrease medication errors?	Medication error reports are reviewed by supervisory staff at the time incident reports are generated, filed, and sent periodically to the regional headquarters in Missoula. There is an informal quality improvement process locally that follows from this.

[23] The Institute for Safe Medication Practices - http://www.ismp.org/Tools/errorproneabbreviations.pdf

	Suggestions: ▪ Consider formalizing the quality improvement process for medication errors.
Is the rationale for prescribing and changing prescriptions for medications documented in the clinical record?	Yes Observations: ▪ Medication-related documentation is cryptic; sometimes one must be able to connect data from several places in the documentation to decipher prescribing rationale. ▪ There is excessive use of abbreviations at times which make the notes difficult to understand. ▪ Diagnoses in the medications notes sometimes differ from those on the intake or initial psychiatric evaluations. ▪ In two records reviewed a medication change was documented in the orders and medication note, but did not appear on the medication administration sheet. Suggestions: ▪ See above suggestion on the use of error prone abbreviations. ▪ Update diagnoses in all records when changed, so that all staff have access to the most current information.
Are unused portions of medications and expired medications disposed of appropriately after expiration dates using – when resources are available - the protocols described in SMAR$_X$T DISPOSAL™ [24] ?	WMMHC-B follows a procedure similar to the SMAR$_X$T system.
Is there a clear procedure for using and documenting emergency medication use, including documentation of rationale, efficacy, and side effects?	Emergency medications are not used.
Is there a clear procedure for using and documenting 'involuntary' medication use, including documentation of rationale, efficacy, and side effects?	Involuntary medications are not used.
Are there procedures in place for obtaining medications for uninsured or underinsured clients?	Yes Strengths: ▪ The nurses make extensive use of samples and assistance programs to be sure each client has access to medication. ▪ The nurses also complete pre-authorizations for medications when needed. ▪ WMMHC-B has access to donated funds that are used to help clients with medication co-pays when needed.
When a client who is transitioning to another service provider is taking psychotropic medications, does WMMHC-B proactively facilitate the seamless continuation of access to those medications by ensuring that: (1) the client has an appointment with the physician who will be taking over psychotropic medication management, (2) the client has enough medications in hand to carry him/her through to the next doctor appointment, and (3) the client's medication funding is established prior to the transition?	Yes

24 http://www.smarxtdisposal.net/

Access and Entry

Are mental health services convenient to the community and linked to primary medical care providers?	Yes
Does WMMHC-B inform the community of its availability, range of services, and process for establishing contact?	Yes
For new clients, is there timely access to psychiatric assessment and service plan development and implementation within a time period that does not, by its delay, exacerbate illness or prolong distress?	Yes
Is an appropriately qualified and experienced staff person available at all times - including after regular business hours - to assist clients to enter into mental health care?	Yes
Does WMMHC-B ensure that clients and their family members/carers are able to, from the time of their first contact with the mental health service, identify and contact a single mental health professional responsible for coordinating their care?	Yes
Does WMMHC-B have a system for prioritizing referrals according to risk, urgency, distress, dysfunction, and disability, and for commencing initial assessments and services accordingly?	Yes

Continuity of Services Through Transitions

General Comment:
Proactively managing client transitions of all kinds is a major strength of WMMHC-B.

Does WMMHC-B ensure smooth transitions of children into adult services if necessary and appropriate?	Yes
Does WMMHC-B review the outcomes of treatment and support as well as ongoing follow-up arrangements with each client and - with consent - family members/carers prior to their exit from the service?	Yes
Does WMMHC-B provide clients and their family members/carers with information on the range of relevant services and supports available in the community when they exit from the service?	Yes
When a client is transitioning to another service provider, does WMMHC-B proactively facilitate involvement by that service provider in transition planning?	Yes
Does WMMHC-B ensure that clients referred to other service providers have established contact following exit from the mental health service?	Yes

If a client ***was*** receiving services from WMMHC-B prior to an inpatient or residential treatment admission, does WMMHC-B assume primary responsibility for continuity of care between inpatient or residential treatment and community-based treatment?	Yes <u>Strengths:</u> ▪ The Operations Director is very active in staying in touch with clients in inpatient settings, Montana State Hospital (MSH) in particular. Hayes Morris staff/MHPs coordinate well with local inpatient settings and providers. All MSH packets are reviewed by a clinician for treatment planning initial goals and linkage.
Leading up to and at the time of discharge, does WMMHC-B communicate and coordinate in such a way as to ensure continuity of care when a client is discharged from inpatient / residential treatment including - with consent - involvement of family members / carers?	Yes <u>Observations:</u> ▪ There appears to be a recurring problem with incomplete discharge information being provided to WMMHC-B staff by MSH when a patient is being discharged to Butte. WMMHC-B staff are in communication with MSH staff about how to address this issue.

STATUS of IMPLEMENTATION of 2003 RECOMMENDATIONS

1) Survey charts and assure that allergy information posted on the outside of all charts is consistent with allergy information contained in all clinical documentation inside the charts.
2009 Status: Done
2) **ALL PROGRAMS**: Prepare to align WMMHC services for consumers with a co-occurring mental illness and chemical use disorder with guidelines being developed by AMDD.
2009 Status: see comments on p. 24
3) Require Adult Foster Care residents to be involved during weekdays in a constructive activity commensurate with their treatment goals.
2009 Status: WMMHC-B no longer provides Adult Foster Care services.
4) Establish treatment teams for each Adult Foster Care resident. Teams should include: Adult Foster Care Specialist, Adult Foster Care Provider, Case Manager, Day Treatment staff (if resident is involved in Day Treatment), Therapist, and Payee.
2009 Status: WMMHC-B no longer provides Adult Foster Care services.
5) Conduct treatment team meetings once per month per Adult Foster Care resident.
2009 Status: WMMHC-B no longer provides Adult Foster Care services.
6) Begin to establish separate treatment plans or a component of the master treatment plan to address Day Treatment services in the Butte program.
2009 Status: BOV has discontinued this level of treatment plan review
7) In all treatment plans, improve the distinction between "objective" statements and "intervention" statements, focusing on "objective" statements that describe outcomes that treatment is intended to bring about.
2009 Status: BOV has discontinued this level of treatment plan review
8) In Silver House monthly summaries, describe interventions and consumers' responses to treatment in terms of progress or lack of progress relative to the treatment plan goals.
2009 Status: BOV has discontinued this level of treatment plan review
9) In Dillon Outpatient treatment plans, describe "psychotherapy" interventions more specifically so that the relationship between the objective and the intervention is more clear.
2009 Status: BOV did not review the Dillon office as part of the 2009 review.

2009 RECOMMENDATIONS

1. Develop a Cultural Competence Plan - with the assistance of recognized experts - specific to the needs of the WMMHC-B service area that includes defined steps for integration at every level of organizational planning.
2. Develop and provide training conducted by recognized experts that enables staff to meet expectations for knowledge about cultural, ethnic, social, historical, and spiritual issues relevant to the provision of mental health treatment to all WMMHC-B clients, with a specific emphasis on American Indian clients.
3. Define optimum knowledge and competence expectations directly related to mental illnesses and working with people with mental illnesses; include knowledge and competencies related to specific illnesses and evidence-based practices.
4. Based on optimum knowledge and competency expectations, develop a written training curriculum and provide training for new staff focused on achieving optimum knowledge and competency levels. This curriculum should focus on major mental illnesses and evidence-based practices.

WMMHC-B RESPONSE

To: Gene Haire, Executive Director
Mental Disabilities Board of Directors

Fr: Natalie McGillen, Clinical Director
Western Montana Mental Health – Butte

Re: 2009 Site Review Recommendations/Response

1. Develop a cultural competence plan with the assistance of recognized experts specific to WMMHC-B service area that includes defines steps for integration of every level of organizational planning.

   Response: WMMHC-Butte will consult with other WMMHC agencies working towards this goal. We will review policies and options and work towards developing a cultural competency plan for WMMHC as a whole.

2. Develop and provide training conducted by recognized experts that enables staff to meet expectations for knowledge about cultural, ethnic, social. Historical, and spiritual issues relevant to the provision of mental health treatment to all WMMHC-B clients with a specific emphasis on American Indian clients.

   Response: Quarterly as part of WMMHC-B training of all staff we shall have the Native American Indian Alliance provide training on the unique needs of the Native American Population and how WMMHC can best meet these needs. All staff would be required to attend one training per year in conjunction with the Native American Indian Alliance. WMMHC-B will be using a client satisfaction survey this year and add whether client's identified themselves as having a cultural affiliation and the degree to which their treatment was culturally sensitive. This will assist in providing additional information to develop training based on need.

3. Define optimum knowledge and competence expectations directly related to mental illnesses and working with people with mental illnesses; include knowledge and competencies related to specific illnesses and evidence based practices.

   Response: WMMHC-B developed a new position for a part time trainer to develop and implement training to all staff. All staff are required to now attend two trainings per quarter. A total of eight trainings a year on mental illness and evidence based treatment. Also one 4 hour training is required per year on DBT. The trainings are facilitated by clinicians or the medical director.

4. Based on optimum knowledge and competency expectations, develop a written training curriculum and provide training for new staff focused on achieving optimum knowledge and competency levels. This curriculum should focus on major mental illnesses and evidence-based practices.

   Response: We initiated a new orientation checklist that includes many of the specific job requirements/duties for new staff. This includes: De-escalation; CPR/First Aid, documentation, billing, suicidality assessment training, DBT skills, HIPAA and confidentiality and co-occurring philosophy. Additionally, we have formalized a training program for staff on specific illness and evidenced based treatment. See above Recommendation 3.