Mental Disabilities Board of Visitors

SITE REVIEW REPORT

Winds of Change Mental Health Center

Missoula, Montana

November 20, 2008

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Gene Haire, Executive Director

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OVERVIEW

Mental Health Facility reviewed :

Winds of Change Mental Health Center (WOC)
Missoula, Montana
Kay Jennings, RN, MHSA - Director

Mental Health Center

Authority for review :

Montana Code Annotated, 53-21-104

Purpose of review :

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

BOV review team :

Staff:
Gene Haire, Executive Director

Board:
Joan-Nell Macfadden, Chair
Teresa Lewis, LCSW

Consultants:
Carol Waller - Client Consultant
Eve Franklin, MSN, RN, CS - Mental Health Ombudsman
Bill Docktor, PharmD - Pharmacology Consultant

Review process :

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

NOTE: This was the first review of the Winds of Change Mental Health Center conducted by the Mental Disabilities Board of Visitors. The Board team was impressed with the services provided, the commitment of the leadership, and the enthusiasm of the staff.

MENTAL DISABILITIES BOARD of VISITORS STANDARDS

Organizational Planning and Quality Improvement	
Planning:	
Does WOC produce and regularly review a strategic plan? Does the plan include: ▪ client and community needs analysis? ▪ strategy for increasing the use of evidence-based practices? ▪ strategy for the measurement of health and functional outcomes for individual clients? ▪ strategy for maximizing client and family member / carer participation in the mental health service? ▪ strategy for improving the skills of staff? ▪ time frames and responsibilities for implementation of objectives?	STRENGTHS: ▪ The leadership of WOC has a comprehensive vision of what it wants to accomplish, and a number of specific goals. WOC provided BOV with a document titled "Summary of Winds of Change Strategic Accomplishments and Initiatives During 2008" which is a good general overview. ▪ In 2007, WOC conducted an 8 hour strategic planning session in which all staff participated. The follow-up to that session appears to consist of Friday program reviews and plans to conduct yearly client surveys. ▪ A number of the areas described under the "Plan" headings in this document represent 'strategic objectives' - at least in retrospect - and have provided a meaningful roadmap for the good progress WOC has made since becoming licensed as a Mental Health Center in October 2006. Several of these plan statements represent goals going forward into 2009. ▪ Both the Program Director and Case Manager Director are strong, capable people who are passionate about their work and their organization and who appear to be very aware of and committed to the needs of the staff and clients. ▪ WOC appears committed to and focused on developing programs and services that are evidence-based and that emphasize recovery. SUGGESTION: ▪ Consider ways to establish a strategic planning process - in consultation with staff at all levels, clients, family members/carers, and community partners - that leads to a strategic plan document with defined action steps and responsibilities for implementation.
Quality Improvement:	
Does WOC have and use a plan of continuous quality improvement to evaluate and improve all of its activities related to services to clients and families?	STRENGTHS: ▪ WOC provided BOV with a section from its policy and procedure manual titled "Quality Improvement". In a general way, this policy addresses a quality improvement process for medication errors, "Incident and Accident Reports", and "Employee Injury Reports". ▪ WOC has purchased the Sigmund Software™ [1] package for electronic record-keeping. This appears to be a good application that includes "a comprehensive set of performance improvement, quality assurance and outcome management utilities".
Are designated staff of WOC accountable and responsible for the continuous quality improvement process?	The Program Director has the responsibility for implementing a continuous quality improvement process. The initiation of the use of the Sigmund Software is the focus of these efforts.
Is WOC able to demonstrate a process of continuous quality improvement that directly affects health and functional outcomes for individual clients?	Implementation of Sigmund Software-driven activities appears to have the potential for accomplishing this.

[1] http://sigmundsoftware.com/index.aspx

Rights, Responsibilities, and Safety

Rights, Responsibilities:

Does WOC define the rights and responsibilities of and provide verbal and written information about rights and responsibilities to clients and family members/carers?	YES
Does WOC 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 Disability Rights Montana?	STRENGTHS: ▪ Each client is provided a client handbook at time of entry into service. ▪ WOC staff are enthusiastic about obtaining advocacy information to give to clients. SUGGESTION: Consider additional proactive ways to: a) Ensure that verbal and written information about independent advocacy services provided by the Mental Disabilities Board of Visitors, the Mental Health Ombudsman, and Disability Rights Montana is provided to each client and family member upon entering service and thereafter as needed. b) Establish bulletin boards in locations where clients gather that display information about independent advocacy services including the Mental Disabilities Board of Visitors, the Mental Health Ombudsman, and Disability Rights Montana.
Does WOC have an easily accessed, responsive, and fair complaint / grievance procedure for clients and their family members/carers to follow?	STRENGTHS: ▪ Information about the complaint / grievance process is provided in client handbook. CONCERN: ▪ Interviews with staff and informal conversations with clients indicated inconsistent awareness of the client complaint/grievance process. SUGGESTION: Consider ways to more proactively ensure that all WOC staff, clients, and family members are knowledgeable about the complaint / grievance procedure.
Does WOC 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?	No RECOMMENDATION 1: Ensure that all WOC staff, clients, and family members are knowledgeable about assistance available from the Mental Disabilities Board of Visitors in filing and resolving grievances.

Safety:	
Does WOC protect clients from abuse, neglect, and exploitation by its staff or agents?	YES STRENGTHS: ▪ Expectations for staff in protecting clients from abuse, neglect, and exploitation are included in job description for case managers. ▪ WOC appears to be vigilant regarding issues of abuse and/or neglect within the organization; staff watches for events that might precipitate dangerous situations. OBSERVATION: ▪ WOC definitions of abuse and neglect in policies and procedures are different from state and federal statutes.
Has WOC fully implemented the requirements of 53-21-107, Montana Code Annotated (2007) with regard to reporting on and investigating allegations of abuse and neglect?	Several requirements in the law are not addressed in the WOC policy and procedure. RECOMMENDATION 2: a) Revise definitions of abuse and neglect in policies and procedures so that they are congruent with definitions in state and federal statute. b) Revise the abuse/neglect policy and procedure so that it is fully compliant with the requirements of 53-21-107, Montana Code Annotated (2007). c) Ensure that all staff are knowledgeable about the policy and procedure for responding to allegations of abuse and/or neglect.
In investigations of allegations of abuse, neglect, or exploitation of clients by its staff or agents, does WOC thoroughly analyze the events and actions that preceded the alleged event – including actions and/or non-actions of its staff or agents?	WOC has not reported any allegations to BOV and has not yet been in a situation requiring such analysis. SUGGESTION: ▪ In the WOC abuse / neglect investigation procedure, include analysis of events and actions that preceded the alleged event – including actions and/or non-actions of staff.
After an allegation of abuse, neglect, or exploitation of a client by its staff or agents is determined to be substantiated, does WOC 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?	WOC has not reported any allegations to BOV and has not yet been in a situation requiring such debriefing. SUGGESTION: ▪ In the WOC abuse / neglect investigation procedure, include debriefing all circumstances related to substantiated abuse/neglect allegations into the revised policy and procedure.
Are staff of WOC trained to understand and to skillfully and safely respond to aggressive and other difficult client behaviors?	YES STRENGTHS: ▪ WOC uses the Crisis Prevention Institute model [2].
Are clients of WOC given access to staff of their own gender?	YES

[2] http://www.crisisprevention.com/

Does WOC 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?	These procedures are not used by WOC.
Does WOC 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?	These procedures are not used by WOC.

Client / Family Member Participation	
Does WOC identify in the service record clients' family members/carers and describe the parameters for communication with them regarding clients' treatment and for their involvement in treatment and support?	YES STRENGTHS: ▪ Staff and clients report that interested family members are identified during the initial interview with the client; clients are then approached periodically to see if they want other people involved their services. ▪ Staff report that they make an effort whenever family members want to be involved, or when clients say they want family members involved. SUGGESTION: Consider ways to develop a more consistent, proactive procedure for identifying interested family members and formally reaching out to and including them as active partners in clients' services.
Do WOC assessments, treatment planning sessions, and treatment reviews proactively include the participation of clients and – with consent - family members/carers?	See comments above.
When a diagnosis is made, does WOC provide the client and – with consent - family members/carers with information on the diagnosis, options for treatment and possible prognoses?	clients - YES family members - see above
Does WOC proactively provide clients, and – with consent - family members/carers - a copy of the treatment plan?	clients - YES family members - see above
Does WOC review exit plans in collaboration with clients and – with consent - family members/carers as part of each review of the individual service plan?	clients - YES family members - see above
Does WOC 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?	STRENGTHS: ▪ Some WOC clients are active in Western Service Area Authority and the Local Advisory Councils. ▪ WOC is working to form an in-house client advisory council. ▪ Clients participate in community meetings. ▪ WOC provides training for peer support specialists. SUGGESTION: ▪ Consider developing roles for clients and family members in developing the strategic plan and plan for continuous quality improvement, in interviewing and selecting prospective staff, and in peer and staff education and training.

Does WOC 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 has written descriptions of these activities?	<u>STRENGTHS:</u> ▪ Client surveys are conducted once a year and appear to be highly valued by the program in making program improvements. <u>OBSERVATION:</u> ▪ WOC does not survey family members. <u>SUGGESTION:</u> ▪ Consider developing a process to survey family members' opinions and suggestions.

Cultural Competence	
Does WOC 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?	WOC does not have a written Cultural Competence Plan. STRENGTHS: ▪ BOV is impressed with WOC commitment to providing culturally-competent services to the American Indian population in the St. Ignatius area. RECOMMENDATION 3: Develop a Cultural Competence Plan – with the assistance of recognized experts - that includes defined steps for its integration at every level of organizational planning.
Does WOC define expectations for staff knowledge about cultural, ethnic, social, historical, and spiritual issues relevant to the mental health treatment of all people in the community, with a specific emphasis on American Indian people?	WOC does not define expectations for staff knowledge about cultural, ethnic, social, historical, and spiritual issues relevant to the mental health treatment of all people in the community, with a specific emphasis on American Indian people. STRENGTHS: ▪ One WOC case manager lives in a Flathead Reservation community and is an American Indian descendent. In addition to using his background and expertise by incorporating tribal values into his own work, other staff and the program look to him for consultation and expertise in working with American Indian clients and families. See RECOMMENDATION 3
Does WOC 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 people in the community, with a specific emphasis on American Indian people?	See RECOMMENDATION 3
Do WOC treatment plans include therapeutic modalities that address specific cultural issues that are implemented with specific cultural values?	STRENGTHS: ▪ Plans developed by the case manager mentioned above address specific cultural issues. SUGGESTION: Explore this area with clinicians who are experts in this area.
Do WOC treatment plans include the use relevant community cultural services and resources?	YES It appears to BOV that some staff do an excellent job of facilitating access by clients to relevant community cultural services and resources depending on the initiative and insight of the employee directing service. STRENGTHS: ▪ Clients are regularly referred to the Missoula Indian Center. SUGGESTION: ▪ Given the expansion of service to the Flathead Reservation, consider including phone numbers and other information about Tribal Social Services in the client handbook.

Based on relevant, individually-identified cultural issues, are WOC treatment plans developed with a culturally competent clinician or in consultation with such a clinician?	WOC does not employ clinicians with specific expertise in cultural issues relevant to mental health treatment. However, it appears that when these needs are identified for individual clients, WOC staff do their best to incorporate them into services. STRENGTHS: ▪ WOC is recruiting an American Indian therapist.
Has WOC developed links with other service providers / organizations that have relevant experience and expertise in the provision of mental health treatment and support to people from all cultural / ethnic / religious / racial groups in the community, with a specific emphasis on American Indian people?	There appears to be a good association with the Missoula Indian Center and specific staff, but no formal link was described.
Does WOC 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 SUGGESTIONS: ▪ Consider creating a dedicated staff position or positions to be filled by American Indian people. ▪ Consider developing one staff position that is a cultural specialist to enhance cultural competence of WOC services.
With regard to its own staff, does WOC 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?	Based on the quality of WOC leadership, it appears clear that if a problem arose in this area, it would be addressed appropriately by leadership.

Staff Competence, Training, Supervision, and Relationships with Clients

Competence and Training:

Does WOC define optimum knowledge and competence expectations for each staff position providing services to clients?	General employment expectations are described in position descriptions relative to Administrative Rules of Montana and guidelines in the WOC handbook. WOC has not developed specific definitions of optimum knowledge and competence expectations for staff. STRENGTHS: ▪ Case Management staff (the primary direct service staff position) are expected to have a B.A. in a "helping profession" and at least one year experience working with adults with serious mental illness. ▪ WOC recruits people who are motivated to work on recovery and who have the desire to work with people with serious mental illnesses. Clearly, the motivation and intent is to build a staff who have the experience and expertise to work effectively with adults with serious mental illness. ▪ WOC has a relatively young staff, who are both enthusiastic and proud of what they are doing and the accomplishments of their program and clients.
Does WOC have a written training curriculum for new staff focused on achieving optimum knowledge and competence levels defined for each position providing services to clients?	There is no written training curriculum for new staff focused on achieving optimum knowledge and competence levels. STRENGTHS: ▪ New staff are provided with basic job-specific training and complete three days of "shadowing" with experienced staff. ▪ WOC leadership is committed to ongoing staff training, has provided a number of one-time training sessions on relevant topics, and is researching relevant training curricula. ▪ The "Mandatory Orientation" checklist includes "promotion of group home resident rights", "abuse prevention and reporting, emergency situations and crisis line", "confidentiality", "medications", "resident treatment plan". RECOMMENDATION 4: a) Define optimum knowledge and competency expectations for each staff position providing services to clients. b) Based on optimum knowledge and competency expectations, develop written training curricula for new staff focused on achieving these knowledge and competency levels. This training should include basic information about all major mental illnesses. c) Develop and implement a training protocol for new staff in job-specific knowledge and competence that follows a written curriculum based on defined optimum knowledge and competence expectations.

Does WOC 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: ▪ Staff attended "Partners In Excellence for Psychiatry" training in Seattle in 2007. ▪ WOC has sent staff to several workshops and conferences to enhance their skills. SUGGESTION: ▪ Consider attending immersion training in the Recovery Model at The Village program [3]. ▪ Consider arranging for staff to complete the NAMI Provider training.
Does WOC periodically assess current staff and identify and address knowledge and competence deficiencies?	YES
Supervision:	
Does WOC provide active formal and informal supervision to staff?	YES STRENGTHS: ▪ WOC develops and nurtures quality in its staff through active mentoring and supervision. ▪ Both the Program Director and Case Manager Director are strong, capable people who are passionate about their work and their organization, and who appear to be very aware of the needs of the staff and clients. CONCERN: ▪ While the contractual arrangement with a Licensed Clinical Professional Counselor (LCPC) (see p. 14) is understandable from a practical/management/financial perspective, it makes it very difficult for this person to have an active presence in the treatment environment, or to have an ongoing supervisory relationship with line staff. SUGGESTION: ▪ Improve clinical supervision for line staff.
Does WOC train supervisors and hold them accountable for appropriately monitoring and overseeing the way clients are treated by line staff?	STRENGTHS: ▪ It appears that supervisors do appropriately monitor the way clients are treated by line staff. SUGGESTION: ▪ Develop written expectations for supervisors and training for future supervisors who succeed the current ones.
Does WOC 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 plans?	See comments above.

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

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: ▪ Staff actively engage in promoting the growth of clients and linking them with other resources they may need. There is great effort in training on Illness Management and Recovery.
Active Engagement with Clients:	
Do WOC direct care staff (case managers, group home staff, day treatment staff, psychiatric technicians, etc.) demonstrate proactive, assertive, supportive, engagement with clients in every applicable environment (including facility-based community programs, case management in the community, residential programs, group homes, hospital inpatient programs, etc.)?	YES STRENGTHS: ▪ Staff actively and enthusiastically engage with and support clients.
Are WOC 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: ▪ The Program Director is present and engaged with direct care staff in a significant way. ▪ The Case Management Director, while not a licensed mental health professional (she is pursuing this), appears to be the driving force who is present in the treatment environment teaching and modeling for direct care staff and clients. ▪ The contract psychiatrist appears to be interested in and is involved in a limited way in teaching staff. OBSERVATION: ▪ WOC contracts with a LCPC for outpatient therapy. While this arrangement is understandable from a practical / management / financial perspective, it makes it very difficult for this person to have an active presence in the treatment environment.
Do WOC supervisors ensure that direct care staff spend their time with clients engaged in consistently positive, recovery-oriented incidental interactions?	YES STRENGTHS: ▪ A hands-on approach with an emphasis on recovery is a strong value of WOC, and the supervisors appear to be passionate about ensuring that direct care staff are involved with clients.

Treatment and Support	
General:	
Is a written treatment plan in place and being implemented for every client receiving services from the mental health service?	*There are no licensed clinical professionals on WOC staff. WOC contracts with a part-time LCPC for outpatient therapy and clinical supervision.* *The Program Director had made arrangements for the contract LCPC to be available for a telephone interview with BOV at a designated time, but he was unavailable for this interview and it did not occur.* *All charts available at J's Place were reviewed. A sample of clinical records in the outpatient office were also reviewed.* <u>CONCERNS:</u> ▪ It is difficult to discern the chronological and therapeutic framework of treatment plans. ▪ Plans do not include adequate information on which to form a sound rationale for interventions. ▪ Plans do not clearly articulate how they are to be used as a framework for the delivery of services. ▪ It is not clear who has been involved in developing treatment plans; a number are unsigned or have signatures and roles that are illegible. ▪ A number of plans have insufficient diagnostic information and/or inadequate descriptions of behaviors and clinical needs. ▪ Clinical assessments are not readily available at the group home site. This makes it difficult for line staff to understand the way in which treatment plans develop out of the clinical assessment. ▪ The weakness of treatment plans appears to be linked to the limitations of the initial assessments; in a number of the charts reviewed, "presenting problems" do not appear to reflect the client's stated presenting health complaints or behaviors, but instead appear to defer to previous diagnoses, i.e. "appears to be bipolar and schizophrenic". While It is clinically appropriate to include previous history and assessments – these should be used as objective supporting data in the history gathering, not as a substitute for independent assessment, as appears to be the case in the charts reviewed. A note in one chart that clinical information "is limited" caused BOV to question whether the restricted availability of the contract LCPC compromises thorough in-person assessment, follow up on acquisition of records, or telephone contacts related to previous treatment experiences. ▪ There is little indication in the charts of consistent tracking of clinical changes, documentation of ongoing progress or lack of progress, or revisions in treatment plans in response to client's evolving needs.

	RECOMMENDATION 5: Reevaluate the clinical needs of the program. a) Establish a sound protocol for development of treatment plans. b) Ensure that individuals responsible for implementing plans are involved in plan development and understand the plans. c) Ensure that case managers and group home staff have ready access to clinical information necessary for their understanding of illness etiology and history of the clients they are working with. d) Ensure timely and ongoing evaluations of clients' clinical changes, and resulting revisions in treatment plans.
For all new or returning clients, does WOC 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?	BOV did not see evidence of this in the charts. see Recommendation 6
Does WOC link all clients to primary health services and ensure that clients have access to needed health care?	YES STRENGTHS: ▪ If a client does not have a primary care provider prior to beginning WOC services, WOC connects the client to county health services. ▪ WOC clients who live on the Flathead Reservation are referred to Indian Health Service for primary health care.
Does WOC proactively rule out medical conditions that may be responsible for presenting psychiatric symptoms?	BOV did not see evidence of this in the charts. RECOMMENDATION 6: Ensure that a thorough physical / medical examination has been performed within one year of the client entering / re-entering the service; and that this process proactively rules out medical conditions that may be responsible for presenting psychiatric symptoms.
Does WOC ensure that clients have access to needed dental care?	YES STRENGTHS: ▪ If a client does not have a dental care provider prior to beginning WOC services, WOC works to connect clients county dental services. ▪ WOC clients who live on the Flathead Reservation are referred to Indian Health Service for dental care.

Evidence-Based Services:	
Does WOC 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 [4]?	STRENGTHS: ▪ WOC leaders appear invested in establishing evidence-based services. ▪ WOC is embracing the Illness Management and Recovery implementation initiative that the Addictive and Mental Disorders Division (AMDD) is coordinating. ▪ WOC has developed an approach to providing a service similar to Assertive Community Treatment (PACT) in rural areas through what it calls the Montana Intensive Treatment Teams (MITT). WOC MITT teams consist of a Case Manager, two Community-Based Rehabilitation and Support staff, and a part-time Peer Support Specialist to work with 20-25 clients. At the time of this review, WOC had implemented six MITT teams – including one specializing in jail diversion, one specializing in working with group home clients, and one working in coordination with clients who are Salish-Kootenai tribal members that has contracted with Indian Health Services. BOV believes that this is an excellent initiative that should be supported and monitored for outcomes. SUGGESTIONS: ▪ Study the SAMHSA information on evidence-based practices [5].
Housing:	
Does WOC ensure that clients have access to safe, affordable, quality housing in locations that are convenient to community services and amenities?	YES Within the limits of low income housing available in Missoula.
Does WOC provide support and advocacy to clients in communicating and problem-solving with landlords?	YES
Does WOC 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
Education:	
Does WOC facilitate access to opportunities for continuing education?	YES

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

Employment:	
Does WOC assist clients to find and keep competitive employment through a supported employment model?	STRENGTHS: ▪ WOC is working to become a Supported Employment vendor with Vocational Rehabilitation. ▪ Currently, WOC appears to work actively with individual clients to assist them to find and keep integrated employment in the community. SUGGESTION: ▪ Study the information about employment available on the Fountain House website[5].
Co-Occurring Psychiatric and Substance Use Disorders:	
Has WOC fully implemented the protocols established by AMDD for treatment of people who have co-occurring psychiatric and substance use disorders?	WOC has not fully implemented the protocols established by AMDD for treatment of people who have co-occurring psychiatric and substance use disorders. WOC reports that 50-90% of its clients have co-occurring psychiatric and substance use diagnoses. STRENGTHS: ▪ All clients are screened on admission for substance use disorders. ▪ WOC is planning to hire a person who is dually licensed (Licensed Addiction Counselor / Licensed Clinical Social Worker-Professional Counselor) in spring 2009. CONCERNS: ▪ WOC refers its clients who have a substance use diagnosis to another agency. RECOMMENDATION 7: a) Begin actively coordinating mental health treatment with substance abuse treatment provided by outside agencies. b) As soon as possible, begin providing both mental health and substance use treatment within the WOC organization.
Crisis Response and Intervention Services:	
Does WOC operate a 24 hour / day, 7 day / week crisis telephone line?	YES The WOC crisis telephone service operates as follows: ➢ J's Place staff are the "first responders" to crisis telephone calls. These staff decide what to do next, ex: call 911, call Case Manager, call mental health professional. ➢ The Case Manager on call talks to the crisis caller, completes a "risk assessment" and decides intervention necessary. ➢ The contract LCPC is called as determined by the J's Place staff or Case Manager. ➢ The contract LCPC supervises crisis call responders. STRENGTHS: ▪ WOC develops Crisis Intervention Plans for all its clients that

[5] http://www.fountainhouse.org/moxie/who/who_jobs/index.shtml

	are used when clients call the WOC crisis line. ▪ Case Managers appear very conscientious about working with crisis callers and appear diligent in getting them the help they need. ▪ The Case Manager Supervisor works hard to train and supervise crisis line responders. <u>CONCERNS:</u> ▪ J's Place staff are high school degreed or GED level staff with no or minimal experience working with people with mental illness, and minimal (1 – 2 hours) WOC training in responding to people with mental illness in crisis. BOV does not believe that they are qualified to make decisions about when to involve case managers or clinical professionals. ▪ It does not appear that Case Mangers are qualified to make the kind of "risk assessment" that is described in WOC policy and training materials. ▪ While a Case Manager may know people on her/his caseload well enough to determine how to "de-escalate" a person she/he knows, Case Managers rotate through a call schedule and respond to clients they don't know. ▪ The supervision of crisis call responders and involvement by the contract LCPC appears minimal. ▪ The process of moving calls from initial contact with J's House to Case Managers and the LCPC appears potentially cumbersome and untimely. ▪ It appears that the heavy reliance on Case Mangers in the crisis telephone service is a function of the minimal presence of licensed mental professionals in the WOC organization. ▪ The WOC crisis telephone service reliance on the Western Montana Mental Health Center's (WMMHC) Mental Health Professionals (MHP) appears too heavy, and appears not to be the result of a clear understanding worked out between WOC and WMMHC. <u>Recommendation 8:</u> a) Redesign the crisis telephone service so that J's Place staff or some other initial responder functions only to facilitate direct contact with a Case Manager or a licensed mental health professional. b) Redesign the crisis telephone service so that it is more clear where the line is between basic risk assessment by Case Managers and the clinical assessment of risk conducted by a licensed mental health professional. c) Redesign the crisis telephone service so that the nature of the supervision provided to crisis call responders by the licensed mental health professional is more well-defined. d) Initiate a conversation with WMMHC to ensure that whatever involvement the WMMHC MHPs have in working with WOC clients who call the WOC crisis line is clear and agreed on by both organizations.
Does WOC 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

Does WOC respond directly to its own clients, clients of other service providers, and to "unattached" individuals who call its crisis telephone line – making referrals as appropriate?	YES
Medication:	
Is the medication prescription protocol evidence-based and reflect internationally accepted medical standards?	YES STRENGTHS: ▪ The contract psychiatrist's use of medications appears consistent with the standard of practice. Many of the medication regimens are inherited from outside providers. The changes the contract psychiatrist makes appear appropriate based on the information in progress notes.
Is medication prescribed, stored, transported, administered, and reviewed by authorized persons in a manner consistent with laws, regulations, and professional guidelines?	YES The WOC medication system is set up reasonably well. For J's Place clients, the contract psychiatrist writes medication orders and the case manager, who is usually present at the appointment, faxes them to the pharmacy. The pharmacy delivers the medication in bubble packs. The Medication Administration Record (MAR) is printed by the pharmacy and sent to J's Place monthly. Medications are stored in a locked office in a cabinet. Controlled substances are in this office in a locked cabinet. Clients come to the office to get their medications. Technically, medication are not administered by the staff; clients take medications themselves – with staff assistance. For other clients, case managers assist in filling prescriptions and setting up med boxes. CONCERN: ▪ The WOC medication system lacks input and monitoring by a licensed medical professional with an understanding of medications. This creates opportunities for errors to occur and to go unnoticed. ▪ It is unclear what training and supervision are provided to unlicensed staff who "assist" clients in taking their medications. ▪ For J's Place clients, the MAR is printed by the pharmacy and sent to J's place monthly, but if medication changes are made during a given month, they are hand-written on the printed MAR by unlicensed staff; these new entries on the MAR are not checked by licensed medical personnel. Recommendation 9: When medication changes are made, send the doctor's order to the pharmacy and ensure that an amended MAR is sent to J's Place. Recommendation 10: Ensure that unlicensed staff who "assist" clients in taking their medications receive appropriate training and supervision.

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?	STRENGTHS: ▪ Families are given medication information if the client signs a release of information and if the family member asks. OBSERVATION: ▪ The only WOC staff person who is able to provide medication education is the contract psychiatrist. He does discuss the medication with the client during infrequent appointments with clients, but this information needs to be reinforced more often. SUGGESTION: Ask the pharmacy to provide written medication information for each client's medications.
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?	In this outpatient setting, PRN medication is taken at the discretion of the client. Without medical personnel at the site, this is appropriate. CONCERN: ▪ At the group home, unlicensed staff must provide access to PRN medications when clients request them. It is unclear whether these staff have training and supervision adequate to perform this function. see Recommendation 10
Does WOC ensure access for clients to the safest, most effective, and most appropriate medication and/or other technology?	YES
Does WOC 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
Where appropriate, does WOC actively promote adherence to medication through negotiation and education?	YES
Wherever possible, does WOC not withdraw support or deny access to other treatment and support programs on the basis of clients' decisions not to take medication?	The contract psychiatrist reports that services have been discontinued on rare occasions for clients who refuse to take medications and/or and continue to abuse substances. Extensive attempts at educating these clients and addressing side effects are attempted before services are discontinued to these clients. OBSERVATION: ▪ This practice may not be consistent with best practice standards for prescribing psychotropic medications to people with co-occurring psychiatric and substance use disorders [6].

[6] *"Treatment for known diagnosed mental illness must be initiated and maintained, including maintaining non-addictive medication, even for individuals who may be continuing to use substances. In addition, the best available psychiatric medication regime for each disorder may promote better outcomes for both disorders."* Minkoff, M.D., Kenneth. Behavioral Health Recovery Management - Service Planning Guidelines - Co-Occurring Psychiatric and Substance Disorders. Behavioral Health Recovery Management project. University of Chicago Center for Psychiatric Rehabilitation. http://www.bhrm.org/guidelines/Minkoff.pdf April 2001.

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 The contract psychiatrist sees all new patients during his regular appointments with WOC clients - every two weeks.
For current clients, does WOC 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
When legitimate concerns or problems arise with prescriptions, do clients have immediate access to a psychiatrist or mid-level practitioner?	YES <u>STRENGTHS:</u> ▪ Case managers have telephone access to the contract psychiatrist; the Saint Patrick Hospital emergency department is available for legitimate emergencies. ▪ WOC staff consult the Nurse First Line, the physician at Blue Mountain Clinic, or the clients' primary care providers with questions about medication.
Are medication allergies, side effects, adverse medication reactions, and abnormal movement disorders well documented, monitored, and promptly treated?	<u>STRENGTHS:</u> ▪ Allergies are listed on the case management face sheet. Side effects are documented in the contract psychiatrist's notes. Side effects noted have been managed appropriately. ▪ Metabolic monitoring (lipid profile, fasting blood sugar, weight) is ordered by Dr. Smith routinely. <u>CONCERN:</u> ▪ No formal process for detecting abnormal movement disorders was noted. <u>RECOMMENDATION 11:</u> Implement a formal process for detecting and addressing abnormal movement disorders.
Are medication errors documented?	There is no system in place to identify or document medication errors.
Is there a quality improvement process in place for assessing ways to decrease medication errors?	There is no quality improvement process in place for assessing ways to decrease medication errors. <u>RECOMMENDATION 12:</u> a) Consult licensed medical personnel to implement a medication error detecting, reporting, and review system. b) Implement a quality improvement process for assessing ways to decrease medication errors.
Is the rationale for prescribing and changing prescriptions for medications documented in the clinical record?	YES
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™ [7] ?	YES <u>STRENGTHS:</u> ▪ Use of the SMAR$_x$T DISPOSAL™ system is part of the WOC written policies and procedures.

[7] http://www.smarxtdisposal.net/

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 <u>STRENGTHS:</u> ▪ WOC attains access to samples and vouchers. ▪ Partnership Health Care helps WOC with access to medications. ▪ The SavMor pharmacy is very accommodating when payment is not immediately available.

RECOMMENDATIONS AND WOC RESPONSE

1. Ensure that all WOC staff, clients, and family members are knowledgeable about assistance available from the Mental Disabilities Board of Visitors in filing and resolving grievances.

   WOC Response: Since October 2008, Winds of Change has posted the Board of Visitors information on all client/visitor bulletin boards and we have included the information in our admission information packet. The information sheet also lists Disability Rights Montana and the Mental Health Ombudsman contact information. Staff members are educated about the different avenues of grievance resolution at orientation.

2. a) Revise definitions of abuse and neglect in policies and procedures so that they are congruent with definitions in state and federal statute.
   b) Revise the abuse/neglect policy and procedure so that it is fully compliant with the requirements of 53-21-107, Montana Code Annotated (2007).
   c) Ensure that all staff are knowledgeable about the policy and procedure for responding to allegations of abuse and/or neglect.

   WOC Response: Abuse and Neglect Policy and Procedure and definitions have been changed to be congruent with the state and federal definitions. We will also in-service all staff on the changes at our next regularly scheduled in-service.

3. Develop a Cultural Competence Plan – with the assistance of recognized experts - that includes defined steps for its integration at every level of organizational planning.

   WOC Response: We will initiate a Cultural Sensitivity questionnaire to be completed by the Case Manger upon admission to our programs. We will customize our treatment plan and care depending on the responses by the consumer on this questionnaire. We will utilize our in-house staff of Native American descent to direct us in competencies and cultural sensitivity for the Native American clients. We will also continue our annual training program, which includes multicultural competencies.

4. a) Define optimum knowledge and competency expectations for each staff position providing services to clients.
   b) Based on optimum knowledge and competency expectations, develop written training curricula for new staff focused on achieving these knowledge and competency levels. This training should include basic information about all major mental illnesses.
   c) Develop and implement a training protocol for new staff in job-specific knowledge and competence that follows a written curriculum based on defined optimum knowledge and competence expectations.

   WOC Response:
   (a) We are currently in the process of defining competencies for each staff position. We have started a literature search and have bought several text books to help us define these competencies. We have asked staff for their input. We have asked consumers/families to help us define competencies via an advisory committee meeting on February 24, 2009.
   (b) We have started developing the case manager competency training and completed the first one, Treatment Planning, on February 19, 2009. Over the next 12 months we would hope to have the basic competencies and related training's completed for all staff members.
   (c) New staff will have the benefit of having a handbook of their competencies and the references used at their disposal. We have begun this process.

5. Reevaluate the clinical needs of the program.
   a) Establish a meaningful protocol for development of treatment plans.
   b) Ensure that individuals responsible for carrying out plans are involved in plan development and understand the plans.
   c) Ensure that case managers and group home staff have ready access to clinical information that will be part of their understanding of illness etiology and history of the clients they are working with.
   d) Ensure timely and ongoing evaluations of clients' clinical changes, and resulting revisions in treatment plans.

   WOC Response:
   (a) We have developed a meaningful protocol for the development of treatment plans. We have trained the CM's and are in the process of starting Treatment Planning Team Meetings.
   (b) The staff responsible for carrying out the treatment plans will be involved. This is currently happening at the group home with our weekly treatment team meetings. The team leader is to involve the CBPR&S staff and this process will be more formalized over the next few months. The licensed RN on staff and CM Director will start to meet with the teams as they develop treatment plans.
   (c) The group home staff is now required to sign copies of the treatment plans. The treatment plans are printed from Sigmund, our electronic health record, and placed in the resident binders under tab (2). The resident binders are kept in the Medication Room at J's Place where staff has 24-hour access to them . The staff at Winds of Change Mental Health Center will have access to the treatment plans by 1 June 2009 when all CBPR&S staff have the proper training and access to Sigmund. In the interim, the CM will print a paper copy of the treatment plan and obtain the staff signatures. This treatment plan will be filed in the client clinical chart.
   (d) Sigmund, our electronic health record, has a feature in the progress note to pull down the appropriate objectives for each note. This feature will cue CM's of the need to update the treatment plan if revisions are needed more frequently than every 90 days..

6. Ensure that a thorough physical / medical examination has been performed within one year of the client entering / re-entering the service; and that this process proactively rules out medical conditions that may be responsible for presenting psychiatric symptoms.

   WOC Response: It is our policy that a thorough physical/medical examination is done upon admission and yearly thereafter to rule out medical conditions that may present as psychiatric conditions. Our CM's were instructed in this policy February 19, 2009. A standard medical form will be developed by the Psychiatrist and RN to help direct the medical providers by June 1, 2009.

7. a) Begin actively coordinating mental health treatment with substance abuse treatment provided by outside agencies.
   b) As soon as possible, begin providing both mental health and substance use treatment within the WOC organization.

   WOC Response: Winds of Change is in the process of hiring a program director for substance abuse treatment program. We have hired a LAC as a case manager for a co-occurring group of consumers. Funding for treating co-occurring disorders is an issue in Montana and we are currently investigating the process and will make a decision soon. Once funding is determined, we will be modeling our program on the Comprehensive Continuous Integrated System of Care (CCISC) developed by Kenneth Minkoff, MD.

8. a) Redesign the crisis telephone service so that J's Place staff or some other initial responder functions only to facilitate direct contact with a Case Manager or a licensed mental health professional.
   b) Redesign the crisis telephone service so that it is more clear where the line is between basic risk assessment by Case Managers and the clinical assessment of risk conducted by a licensed mental health professional.
   c) Redesign the crisis telephone service so that the nature of the supervision provided to crisis call responders by the licensed mental health professional is more well-defined.
   d) Initiate a conversation with WMMHC to ensure that whatever involvement the WMMHC MHPs have in working with WOC clients who call the WOC crisis line is clear and agreed on by both organizations.

WOC Response:
a) The staff at J's House have been trained in how to answer the crisis screening line. This line functions solely to assure our Mental Health Center that an awake person will always respond immediately and to protect the on call staff from non-crisis calls.
b) In the event of a crisis, the Case Manager taking call will help the client get relief and call into action all the people and other resources required to do so. This process will consist of an assessment of psychosocial and lethality status, identification of the major problem or crisis precipitants, planning of therapeutic interventions, the intervention is implemented and then evaluation of the crisis resolution and anticipatory planning. If at any time during this process the client is rendered incompetent or unable to assume personal responsibility, is acutely suicidal, has overdosed, is reacting to a hallucinogenic, is acutely psychotic, experiencing uncontrolled anger or has alcohol intoxication emergency responders (911) will need to be called for assist.
c) The Case Manager, on call, will be responsible for the initial phases of the crisis. If previous problem-solving techniques do not work and all possible resources have been exhausted the Case Manager should call the licensed mental health professional or RN on staff for advice. If the decision is made that the client needs psychiatric intervention, then the Case Manager or licensed mental health professional will contact the Western Montana Mental Health Professional on call to inform them of the crisis and plan. The Case Manager or licensed mental health professional on call will also notify the Emergency Room to inform them of the crisis and the plan and the estimated time of arrival (ETA). The Case Manager will accompany or meet the client in the ER and remain with them until the crisis is resolved and/or the client is admitted.
d) Crisis Intervention Competency training is in the process of being developed by the program director/RN and all staff will be instructed and tested upon hire and annually.

9. When medication changes are made, send the doctor's order to the pharmacy and ensure that an amended MAR is sent to J's Place.

WOC Response: The pharmacy receives a doctor's order for any medication change. Normally the medications change during treatment team meetings at J's Place. The new order is delivered to the pharmacy the same day as the medication change. The Program Director, Kay Jennings, RN, reviews the MAR's on a weekly basis. The RN, during treatment team meetings, completes medication changes as they take place. If changes are made by another physician, in the community, SavMor Pharmacy will fill it and then send the labels for the MAR.

10. Ensure that unlicensed staff who "assist" clients in taking their medications receive appropriate training and supervision.

WOC Response: J's Place were trained in proper assistance with medications on Dec. 31, 2008. The staff are observed for competency by the Group Home Manger, and must pass the Medication Skill and the Medication Pass Competency checklist prior to doing medications, and every 6-months thereafter.

11. Implement a formal process for detecting and addressing abnormal movement disorders.

WOC Response: The Abnormal Movement Disorder policy and procedure has been implemented using the AIMS which is to be completed by the prescriber or the RN on staff who has been trained in the technique. The forms will be kept in the paper file and re-evaluated every 6 months. This form will be used on appropriate clients prior to prescribing an antipsychotic or upon admission to our program if they are on an antipsychotic.

12. a) Consult licensed medical personnel to iimplement a medication error detecting, reporting, and review system.
b) Implement a quality improvement process for assessing ways to decrease medication errors.

<u>WOC Response</u>: We have had a medication error detecting, reporting and review system in place for many years. Quarterly, all MAR's for the previous months are reviewed and a summary composed. The summary is shared with Group Home Staff and appropriate education implemented if there seems to be a problem. Additionally, the RN checks each clients MAR's at all treatment team meetings for errors.