Mental Disabilities Board of Visitors

SITE REVIEW REPORT

MONTANA DEVELOPMENTAL CENTER
Assessment & Stabilization Unit

January 27-28 / February 10, 2009

TABLE OF CONTENTS

<u>Overview</u>

● **Facility Reviewed**

Assessment and Stabilization Unit
Montana Developmental Center
Boulder, Montana

Kathy Zeeck, Superintendent

● **Authority for Review**

Montana Codes Annotated, 53-20-104

● **Purpose of Review**

To analyze the operation of the Assessment and Stabilization Unit and make recommendations for improvement.

● **Review Team**

Staff: Gene Haire, Executive Director
Consultant: Gail Baker, L.C.S.W.

● **Review Process**

1.   Interviews with Montana Developmental Center Staff
2.   Interviews with clients
3.   Review of treatment records
4.   Review of written descriptions of treatment programs
5.   Observation of treatment activities
6.   Inspection of physical plant

History

Secure Unit Creation and Development

As part of the plan of correction following a 2002 survey by the Centers for Medicare and Medicaid Services, the Developmental Disabilities Program (DDP) of the Department of Public Health and Human Services (DPHHS) planned to create a "secure unit" on the campus of the Montana Developmental Center (MDC) in order to provide treatment in a safe, secure environment to MDC clients whose behavior posed a danger to other clients in the general living units. Opened in the Spring of 2002, the original site of this secure unit ("104-R") was an older building on the MDC campus that was retrofitted to provide a higher level of control and supervision. The 104-R unit served males only. Soon after, a unit to serve females was added – 104-W – for a total licensed capacity of 16. The main campus of MDC is licensed as in Intermediate Care Facility for the Mentally Retarded (ICFMR)[1]. DDP decided to license the 104 unit as an Intermediate Care Facility for the Developmentally Disabled (ICFDD)[2]. MDC's ICFDD license differs from its ICFMR license in that - among other things - it does not require that people served in an ICFDD be provided with "active treatment"[3]. It is also not eligible to receive Medicaid funding.

While the 104 unit addressed the immediate need to keep clients safe in the main campus residences by placing clients who posed a risk to themselves or others in a separate area, the retrofitted physical space in a circa 1950s building was inadequate in many ways and did not fully facilitate either security or services.

The 2005 Montana Legislature appropriated $2 million to design and build a new "compound" on the MDC campus to replace the 104 unit. The new compound – named the Assessment and Stabilization Unit (ASU) - opened in December, 2007. It consists of three separate buildings: one four-bed female residential building, two four-bed male residential buildings, and one administrative / treatment building. ASU is separated somewhat from the rest of the MDC residential units and is fenced.

Changing Clientele

During the past decade, the profile of the client population at MDC has changed dramatically. For various reasons beyond the scope of this report, MDC no longer admits people who in the past have been thought of by the general public as the typical "mentally retarded". Presently there are only about eight individuals who could be considered to be in this category. These individuals have lived at MDC for most of their lives, and now range in age from 50s to 70.

People who are admitted to MDC today present with some of the most multifaceted and complex diagnostic and behavioral profiles of all people served by DPHHS programs. MDC clients typically have primary diagnoses of one or more major mental disorders including developmental and learning disorders (Axis I of the DSM-IV)[4] in addition to mild mental retardation (Axis II of the DSM-IV). It is not unusual for MDC clients to also have diagnosed personality disorders (Axis II of the DSM-IV), medical and/or neurological disorders that may be relevant to primary psychiatric problems (Axis III of the DSM-IV), as well as significant psychosocial and/or environmental stressors (Axis IV of the DSM-IV). Of the clients who were served in ASU for significant periods of time during calendar year 2008, **87% had a major mental disorder**; 20% had pervasive developmental disorders; 20% had disorders and/or histories related to sexual offense - as perpetrators or victims or both; 20% had impulse control disorders; and 13% had substance use disorders. **67% had displayed severe aggression** toward other people - involving assaults and/or physical injuries requiring medical intervention - on residential units at MDC and/or in community settings prior to admission to MDC (one community program staff person lost an eye after a current ASU client pushed a lit cigarette into her eye). Two were admitted to MDC as a result of having committed murder in the community. One of these individuals is serving a 30 year criminal sentence for a double homicide.

Prior to 2002, there had never been an admission to MDC via criminal commitment. At the time of the opening of 104-R in 2002, there was one person who was criminally committed to MDC (this person did not reside on 104-R). ***At the time of this review, 18% of the MDC clientele were criminally committed***.

Board of Visitors Involvement

Beginning with the creation of the 104 unit and following the opening of ASU, the Mental Disabilities Board of Visitors (BOV) has closely monitored the operation and functioning of this service according to its responsibilities under §53-20-104, Montana Code Annotated 2007[5]. BOV's Developmental Disabilities Specialist is on-site regularly and has frequent contact with ASU clients, staff, and supervisors - as well as all MDC leaders and treatment professionals. BOV and MDC have a good working relationship and have communicated regularly about both the successes and challenges of the unit as it has evolved. BOV's Executive Director, Developmental Disabilities Specialist, and a BOV consultant[6] have been involved in observing, critiquing, and making recommendations from this unit's inception.

BOV conducted a thorough analysis of the 104 unit during its formal site reviews in 2002 and 2006[7], and considers 10 of the 26 recommendations made in 2002 and reiterated in 2006 to be currently valid in the present ASU setting. (see **Addendum 1**).

Rationale and Plan for the 2009 BOV Review

During 2008, both BOV and MDC became increasingly concerned about how ASU was functioning. On December 30, 2008, the BOV Executive Director and Developmental Disabilities Specialist met with the DDP Director and the MDC Superintendent to discuss the concerns and the possibility of a BOV site review focused on ASU. It was agreed that BOV would conduct this review in January and February 2009. It was emphasized in this discussion that BOV and MDC/DDP would work closely together as partners in the process of reviewing and implementing necessary change. The following areas needing to be assessed were identified during this discussion:

1) staff dynamics
2) staff training
3) ASU staff selection
4) leadership
5) policies and procedures
6) client refusal of treatment
7) behavioral and physical security

These areas of inquiry were further refined during the review process and are reflected in the seven headings below under **Observations and Recommendations**.

ASU Successes Described by MDC Leaders

- decrease in challenging behaviors
- elimination of "unwritten rules"
- clarification of misinterpreted policies
- prioritization of Behavior Treatment Programs
- some progress in the motivation of ASU unit staff[8] to learn about the reasons for clients' challenging behaviors
- good staff : client ratio
- good coordination between QMRP and treatment support areas (Psychology, Recreation, Vocational, Communication, Occupational/Physical Therapy, Social Work, Education, Health Services)

Qualities Observed by BOV

- MDC leadership and unit staff have worked hard to make ASU function effectively. They know intuitively what most of the answers are.
- MDC leaders have very strong personal ethics, and take their responsibilities very seriously.
- Staff at all levels are passionate about and sincerely committed to working with the clients and have a heartfelt desire to help clients.
- The frustration described by all staff is focused on disappointment about feeling unable to effectively help ASU clients.
- MDC has an excellent array of professional treatment services.
- excellent technical expertise
- The addition of the College Of Direct Support[9] as an educational resource for staff has been a significant success and has added to both the quality and consistency of the baseline of staff knowledge and competence.
- The psychiatric clinics facilitated by the contract psychiatrist provide a good forum for discussion and plan formulation for ASU clients (and others).
- The "sections" meetings (meetings involving section leaders - Psychology, Recreation, Vocational, Communication, Occupational/Physical Therapy, Education, Health Services, as well as Client Services Directors [CSD]) are a great start in developing cohesion within the "Professional Services"[10] component of MDC - and have been experienced and described by MDC leaders and meeting participants as a positive move toward reducing fragmentation.
- ASU staff receive enhanced Mandt training (how to gain release from choke holds, how to avoid being injured by weapons, etc.)
- Some ASU staff have received training in Collaborative Problem Solving[SM]. This is an excellent model of therapeutic communication based on the concept that:

  > *"...challenging behavior – whether it's screaming, swearing, biting, spitting, hitting, kicking, destroying property, or worse – is set in motion by lagging cognitive skills, especially in the domains of flexibility, frustration tolerance, and problem solving. We now know that* [this kind of] *challenging behavior ,,,, is best understood as a form of developmental delay."* [11]

- ASU gets immediate support from leadership in addressing immediate crises.
- MDC leadership has made a sincere effort to help ASU staff develop needed level of knowledge and skill needed to work with ASU clients.
- Professional Services leaders are committed to providing support to ASU.
- The staff development and occupational therapy components of MDC have improved significantly since BOV's last site review.
- "What Works" meetings are held in units 3 & 5 and 1 & 4 with members of the treatment team meet with staff once or twice a week to talk about issues/concerns staff have about the clients and/or team/staff observations about "what works" with a particular client.
- MDC has been working with a facilitator to develop vision, mission, values, and strategic plan.

Observations and Recommendations

(NOTE: Recommendations that appear in bold are intended to be the highest priority recommendations in a category. Other recommendations appear roughly in order of priority.)

There is universal agreement at all levels of MDC and DDP that ASU is functioning ineffectively and that action is needed to identify and correct the problems. The results of this ineffectiveness are an atmosphere of reactivity, compromises in client and staff safety, and unsuccessful treatment.

As stated above, MDC leaders and staff have worked hard to address problems on ASU. Much of this effort appears to have been directed at symptoms of problems rather than root causes. In general, these efforts appear to have been counter-measures taken in reaction to daily challenges based on changing definitions of what isn't working that are too narrow. A number of interventions have been attempted that - while valid and sometimes helpful in the short term - have been concerned mostly with only one or another of the problems' facets without overarching integration.

That said, it cannot be overemphasized how open and candid MDC leaders and ASU staff have been in discussions with BOV. This willingness to be vulnerable, to enthusiastically invite close scrutiny, to acknowledge difficulties, and to ask for help is a rare quality. BOV particularly commends the Superintendent for her openness and non-defensiveness, and for her deep feeling of personal responsibility for ensuring the best for MDC clients and staff. The passion and sincere commitment to working with the clients and the heartfelt desire to help clients that radiates from these good people is truly impressive. In that spirit, this critique is offered by imperfect people who are also committed to finding ways for the clients of MDC to have better lives. In whatever way it may help, we offer our ideas and our assistance. We are well aware that it is much, much easier to make recommendations than to implement them.

Finally, this analysis of ASU must be interpreted within the larger organizational context in which ASU functions - MDC, DDP, and the Montana developmental disabilities / mental health / corrections systems.

With that in mind, BOV believes the challenges facing ASU can be organized into the following categories:

1) Vision / Purpose
2) Milieu
3) Organizational Culture
4) Leadership / Supervision / Teams
5) Clinical Issues
6) Physical Plant
7) Systemic Issues

1)   Vision / Purpose

There is a significant level of ambiguity about the purpose of ASU. This ambiguity grows out of the dilemma about how to address both the security or correctional aspects, and the psychiatric aspects of the ASU clients' needs.

18% of the MDC clients are criminally committed, are potential ASU clients, and therefore ASU has a responsibility to address very real physical security issues.

100% of the people served on ASU have diagnosed mental disorders, and therefore ASU has a responsibility to treat psychiatric illnesses.

Almost 70% of the people served on ASU have demonstrated serious aggression, and therefore ASU has a responsibility to address the personal safety of both clients and staff and behavioral management.

ASU can't be a "multi-purpose" unit without having the confusion that is seen there today. When a person does go to ASU, she/he needs to be served according to an individualized plan within a milieu that has been established around the purpose of ASU. The milieu needs to be the constant; if the milieu is changed for each individual situation, or because of the crisis of the day - the result is no longer a therapeutic milieu - it is disarray. (see **MILIEU,** p. 11).

MDC needs to clearly define the purpose of ASU, and then create an overarching vision that describes the change it wants to create within ASU before anything else can be accomplished.

Observations

- The primary behavioral presentation of clients on ASU reflects acute symptomology related to serious mental illnesses. Though some clients are also in a long-term correctional status, mental illness is the crucial driver.

- Though staff at all levels describe a similar *understanding* of the *theoretical* purpose of ASU (protect MDC residents from harm, assessment, stabilization, security, structure, intensive short term treatment), no one could say definitively what its *actual* purpose is.

- Staff in the various roles involved in leadership, supervision, and provision of direct services to ASU clients articulated in a number of differing ways (some of which were contradictory) : assessment *of what?*, stabilization *of what?*, intensive treatment *of what?*, *what kind* of structure?

- MDC, DDP, and DPHHS are unclear about how to integrate ASU's treatment and security responsibilities.

- The full implications of the complexity of the diagnostic and behavioral presentations of people being served on ASU - in terms of the sheer difficulty of the task; the knowledge, skill, and education requirements for unit staff; the level of mental health expertise and experience needed by clinical staff; and organizational leadership needed - while intuitively understood by MDC leaders and staff working on ASU - have not been fully acknowledged and addressed.

- The emergent[12] status of clients admitted to ASU drives the purpose and role of ASU, and causes the purpose to defer to the current crisis, instead of the purpose of ASU informing the admission decision-making.

- The ASU admission/discharge criteria are unclear and/or undefined.

- MDC and DDP have struggled since the inception of 104/ASU about whether to pursue ICFMR status for that component of the MDC campus. The perception among MDC staff and leaders has

been that - eventually - ICFMR status would be sought since this would allow for Medicaid funding. At the same time, it has been clear - at least in its current configuration and mode of operation, and perhaps by definition - that ASU would not qualify for ICFMR status. This situation has created an atmosphere of indecision since at least 2007 about what direction to take on ASU from both clinical and management perspectives. This has placed MDC leaders in limbo, and has led to a level of related decision-making paralysis.

Recommendations

- **Clearly conceptualize the purpose of ASU - then develop a cogent, written statement of the purpose of ASU.[13] The goal of this process is to bring absolute clarity and focus to the reason for the existence of ASU that will drive the development of the approach to treatment and provide the underpinning for decision-making. Ensure that unit staff are involved in this process.**

- **Develop a written vision of what ASU will look like when it is fulfilling its purpose. Ensure that unit staff are involved in this process.**

- Use the statement of purpose as a foundation for decision-making; if the Interdisciplinary Team[14] or Management Team is considering doing something that is not consistent with the ASU purpose, it is probably the wrong thing to do. Make every effort to look for alternatives that do not lead down the slippery slope of compromising the purpose of ASU.

- Develop admission and discharge criteria that are congruent with the statement of purpose. Ensure that unit staff are involved in this process.

- Bring new admissions directly into ASU only if they clearly meet the ASU admission criteria.

- When a decision to admit or discharge a person that does conflict with the purpose of ASU is absolutely unavoidable, process the decision with all team members - including unit staff - and do everything possible to mitigate the inconsistencies.

- Develop a more proactive approach to intervening with escalating behavior problems in units 1-6; transfer clients to ASU only when absolutely necessary and only in adherence to the ASU admission criteria. Develop the capacity to assign increased resources to the cottages to preserve the coherence of the ASU milieu (and the home residence milieu).

- Proactively protect ASU's ability to make coherent decisions about who comes into the unit under what circumstances and when clients leave the unit - based on treatment needs.[15]

- Establish the clear programmatic norm that states: "These are the circumstances that are appropriate for admission to ASU; when clients are admitted to ASU, this is why they're here, this is what they're going to do while they're here, this is what has to happen in order to be discharged from ASU."

- Develop an alternate "new admission assessment" venue within MDC to function as a separate "intake" unit for new clients coming into MDC with unknown presentations that require a period of observation and assessment prior to being integrated into a residential unit, or into the ASU milieu.

- Develop values statements that will provide the foundation for the milieu and for making day-to-day decisions on ASU. Everyday experiences of staff and clients must become congruent with values statements. Ensure that unit staff are involved in this process.

- BOV strongly recommends that MDC/DDP make the decision not to pursue ICFMR licensing. While there may be some advantages to ASU becoming an ICFMR, BOV believes that retaining ICFDD licensing status will allow maximum flexibility for ASU to develop along the lines recommended in this report. The issue of "active treatment" will, in BOV's opinion, become moot since the development of a dynamic therapeutic treatment milieu will be a very active - and effective - framework for treatment. At any rate, it is critical for MDC/DDP to be decisive about the licensing status of ASU so that a clear transformation process can commence.

2)   Milieu

The therapeutic milieu is an approach that has been shown to be highly effective in helping people who are experiencing acute exacerbation of psychiatric and behavioral disorders to regain personal control and to begin to improve.

A therapeutic milieu supports:

- development of internal controls
- reduction of psychiatric symptoms
- development of adaptive coping skills
- engagement in group activities that promote positive feelings of self worth
- development of independent living skills

Characteristics of a therapeutic milieu:

- A stabilizing environment that is characterized by structure, routine, predictability, and respect for all people in the milieu – clients and staff.
- Individualized behavior management plans that are based on a combination of firm limits and nurturance.
- Clients who have a history of challenging behaviors and a lack of impulse control experience a sense of safety and trust because the environment around them provides positive, nurturing care and consistent, dependable containment of threatening and disruptive behaviors.
- Dangerous, potentially violent behaviors are responded to in a manner that attempts to de-escalate the situation and provide the client with the opportunity to take responsibility and control.
- The belief that every interaction between a client and a staff member has therapeutic potential for learning new ways of interacting and negotiating with others in a healthy way.
- Competent, caring, ethical, educated, well-supervised staff who respond to clients' behavior by attempting to understand the meaning and the function of the behavior.
- The belief that clients' difficulties arise out of, and are expressed within, their relationships with other people.
- The opportunity to closely observe and develop an understanding of how clients' interpersonal relationships deteriorate and become problematic and how certain situations trigger dysfunctional responses.
- An emphasis on the importance of social relationships on the individual's ability to make improvements.
- An entire staff that is part of the milieu team and works closely together to generate an understanding of each individual client and the client community.
- A comprehensive approach to working with each client and providing structure for the client community.
- Frequent milieu team meetings, and continual incidental and individual supervision of all staff.
- Staff who are fully engaged in serving as role models and sources of support and encouragement, and who are compassionate - but firm - authority figures.

Key elements of a therapeutic milieu are:

- maintenance of a safe and containing environment
- a significant level of structure
- physical and emotional support
- collective involvement of the client and staff in the unit regimen
- continuous evaluation of all therapeutic interventions

Observations

- There is no real "model" for working with clients on ASU.

- There appears to be no defined programmatic or environmental structure; activity schedules for clients either do not exist or are inconsistently followed; some clients spend significant portions of the day watching TV or playing video games in their rooms; some clients stay up all night playing cards with night staff, then sleep until late the next day.

- There appears to have been a loss of proper perspective that has resulted in acceptance of clients on ASU "refusing treatment" under the well-intentioned, but misguided belief that acquiescing to clients who "refuse treatment" by allowing them to do whatever they want to do – day or night - is acceptable in this treatment setting, and that it is the only option for responding to an excessively narrow interpretation of "rights" and/or perceived and/or actual advocacy pressure.

- Unit staff do not feel safe and describe the environment on ASU as "scary".

- Clients do not feel safe.

- Unit staff perception is that clients do not believe staff have any 'rights'; clients seem to have a low opinion of and demonstrate disrespect for staff; respect for unit staff is not acknowledged as a critical component of the milieu.

- Unit staff perceive client rights as trumping common sense.

- Staff at all levels describe the environment on ASU as "chaos".

- Unit staff perceive that the psychology staff engages in interactions with clients about "rights" that set the stage for clients' refusing to participate in treatment activities.

- Unit staff perceive some psychology activities with clients as being in conflict with or as undermining the operation of the unit.

- Frequent, significant property destruction by clients without meaningful response by staff appears to have become a norm in the ASU environment. Unit staff believe that they are precluded from responding rationally to property destruction because of an excessively narrow interpretation of "rights", perceived and/or actual advocacy pressure, or by reasons they don't understand given by the psychology department.

- Some unit staff appear to interact with ASU clients in ways that trigger challenging behaviors, possibly involving power struggles between clients and staff. To the extent that this happens, it is probably the result of insufficient education, lack of incidental teaching, lack of active supervision, or some combination of these things.

- There is too much movement of clients in and out of ASU (via transfers from and to cottages and new admissions) to establish a coherent milieu.

- No one is perceived to be in control of or responsible for the coherence of the ASU milieu; de facto control of the milieu appears to be in the hands of clients.

- The chaos of the ASU environment has pulled staff into polarized 'camps'.

- Client allegations against staff trigger disruption that sometimes could be averted by proactive intervention and decision-making earlier in the process.

- "Collaborative Problem Solving" - potentially a very good approach with the ASU population - has not been consistently applied; there does not appear to be agreement among all staff about how or when to implement this approach.

- Unit staff perceive that psychology staff "gives in" to "choices" by clients not to participate in treatment, and lets clients "get away with" behaviors that unit staff believe should be met with some kind of response.

- Psychology staff believe that unit staff do not fully appreciate the clinical/cognitive/developmental conditions that underlie challenging behaviors, and that unit staff mistakenly believe that "consequences" which amount to punishment are necessary.

- Unit staff believe that psychology staff mistakenly interpret unit staff's belief that there needs be some kind of reasonable response to challenging behavior as a desire for "punishment" of clients.

- Unit staff believe that ASU clients sometimes manipulate psychology staff so that the clients can get out of treatment activities and go to the psychology offices.

Recommendations

- **Comprehensively transform the model of working with clients on ASU. Following from a newly-developed purpose of ASU, clearly conceptualize, define, and put into operation a therapeutic milieu based on the characteristics and key elements described above. Ensure that unit staff are involved in this process.**

- Establish absolute clarity about roles and responsibilities of each "on-site" ASU staff person (Unit Manager[16], Shift Managers, Psychiatric Aides), including who the final decision-maker about day-to-day functioning of the unit is. (see **Leadership/Supervision/Teams**, p. 18)

- Establish clear expectations for unit staff, supervisors, and Professional Services staff regarding ongoing, active engagement with ASU clients in the milieu.

- Establish an atmosphere of continual incidental mentoring and education on ASU in which supervisors and Professional Services staff - especially psychology staff - work as active, on-site partners with unit staff modeling healthy and constructive interactions with clients.

- Comprehensively analyze the current approach to "treatment refusal"; redesign a different, clinically appropriate approach to the concept of engaging clients in treatment activities in the context of the defined treatment milieu. Work to establish positive, therapeutic alliances with clients that actively encourage clients to engage in treatment. Training in engaging the involuntary client would include motivational enhancement techniques such as Dialectical Behavior Therapy commitment strategies, "seeking safety" programs, or motivational interviewing techniques. Some kind of token economy to enhance motivation could be considered. Ensure that unit staff are involved in this process.

- Establish dynamic on-site presence of Professional Services staff - especially psychology staff - as integral participants in the milieu. The primary base of services should be on the unit (including auxiliary rooms in the ASU treatment building). Off-site services should be incorporated into individual clients' regimens as they move through the milieu ASU treatment protocol.

- Ensure that the Unit Manager and Shift Managers actively work with unit staff so that they are functioning in a way that actively contributes to the mission of ASU and to the treatment goals of individual clients; immediately address job performance issues through incidental teaching and additional training. Address continuing performance issues in formal, written performance evaluations.

3)   Organizational Culture

Ideally, an organizational culture supports positive, productive experiences for the people in that environment. No MDC/ASU staff person BOV spoke with during the course of this review described ASU in these terms.

MDC's and ASU's culture is made up of the values, beliefs, underlying assumptions, expectations, attitudes, and actions of the people who work and live in it. Everyone's behavior on ASU - staff and clients - is the result of a set of "rules" (some of them unspoken and unwritten - which MDC leaders have recognized and, to some extent, addressed) for working and interacting together. Among other things, the ASU culture plays out in staff's and clients' language, decision making, shared experiences, choices, and daily activities.

ASU staff behaviors establish and maintain the operational and relational norms in the ASU environment - for better or worse. A norm of openness and inclusiveness will help improve ASU's interpersonal and 'professional' communication. A norm of accountability will help ASU reach its goals. A norm of optimism and collaboration will help bring about positive client outcomes. Norms of toleration of poor or inconsistent staff performance, indecisiveness, or a lack of discipline in establishing and maintaining constructive processes will impede ASU's success. New staff learn the ASU cultural norms by interacting with more experienced staff.

A norm of toleration of clients opting out of treatment and disrespecting staff will perpetuate frustration and cynicism among unit staff.

A small group of decision-makers cannot create or change the ASU culture. Positive culture change will come about through meaningful participation and input by all members of the ASU team with the guidance of its leaders. All members of the ASU team must be involved in strategic planning, milieu development, and ongoing decision-making. Otherwise, excluded staff will not feel they have a stake in these efforts.

ASU staff and MDC leaders recognize that the current ASU culture needs to be transformed in order to support positive changes in clients' lives, and in order for staff to feel gratified by their work. Again, ASU staff and MDC leaders are to be commended for this attitude of openness and desire to change.

Observations

Organizational Structure:

- The roles of the two Client Services Directors (CSD) - and the placement of each over a sub-group of residential units and a sub-group of Professional Services departments - contribute to organizational fragmentation, and limits availability of the insights, skills, and attention of these two key leaders to the big picture in strengthening the interdisciplinary approach. (see **Addendum 2** - Suggested Organizational Chart Revisions)

- The current placement of the Psychology Department in the MDC organizational structure has unintentionally compromised the integration of this department into an interdisciplinary approach, creates a tendency toward isolation of psychology staff, and creates ambiguity in the administrative and clinical chain of command. These problems are intensified for ASU. (see **Addendum 2** - Suggested Organizational Chart Revisions)

- Having both a QMRP and a Unit Coordinator for ASU appears redundant, contributes to a lack of leadership focus and confusion about the chain of command, and is a factor in polarization of staff.

- The lack of a dedicated Social Worker position assigned to ASU, and the division of social work coverage for ASU among three Social Workers contributes to organizational fragmentation.

- Social Workers are underused on ASU. (see **Clinical Issues**, p. 21)

- ASU has no dedicated Psychology Training Program Specialist (P-TPS); the P-TPS does not appear to spend any significant periods of time in the ASU milieu. (see **Clinical Issues**, p. 21)

Planning / Decision-Making / Quality Improvement:

- There does not appear to be an ongoing planning process for ASU. (The MDC strategic planning project currently underway does not specifically address ASU.)

- Much of the day-to-day decision-making on ASU appears to be ad hoc and reactive.

- The "crisis of the moment" and a sense of "chaos" appears to drive the decision-making on ASU.

- Staff perceive that their input into planning and decision-making is requested and then ignored.

- Data are not used effectively for decision-making.

- There does not appear to be a Continuous Quality Improvement process at MDC.

Staff Competence and Education:

- MDC does not define optimum knowledge, skill, and competence expectations - relative to mental illnesses / therapeutic milieu / crisis intervention - for staff who work on ASU.

- There is no specialized education for ASU unit staff commensurate to the complex array of clients' disorders and behaviors.

- Staff training is primarily designed to be generic "pre-service training" for incoming unit staff (Psychiatric Aides) who have little or no prior experience; and ongoing, annual "in-service" educational requirements - some of which is through the College of Direct Support (a good resource).

- Inexperienced staff - sometimes very young, immature individuals - with no demonstrated knowledge or competence in working with adults with multiple disabilities (including serious mental illnesses) are assigned to ASU right out of orientation class.

Staff Dynamics:

- Staff have become polarized around two "camps" - the psychology camp and the unit staff camp. A somewhat oversimplified description of this polarization is that the unit staff camp believes that the psychology camp is responsible for the deterioration of the milieu by allowing clients to be unaccountable for their behavior. The psychology camp believes that the unit staff camp thinks that "consequences" (which amounts to punishment) are necessary for clients and that unit staff do not understand the complexities of the clients' problems or the underlying sources of their challenging behavior.

- In its frustration with attempts to achieve understanding and buy-in by ASU unit staff to work in more clinically-informed ways with clients with serious mental illnesses, psychology staff appear to have pulled back from the unit and are perceived by unit staff to be isolated in their offices; unit staff perceive that communication with ASU by psychology staff has been reduced to directives and email notification of new programs.

- In its sincere effort to address the many daily challenges at MDC – including the tremendous burden of paperwork and data collection – MDC administration appears to have found it more and more difficult to see the big picture and to focus on ASU programmatic objectives – resulting in the understandable and justified tendency to become dejected and to feel a little resentful at times toward staff in all areas.

Communication:

- The polarization of staff has resulted in communication styles that do not appear to be helping the situation; the people in each "camp" tend to talk among themselves and not with people in the other "camp". "Opinions" about how to work with clients have coalesced solidly around these poles, resulting in an impasse to creative problem-solving and healthy communication.

- There appears to be a lot of indirect communication and venting that makes team fragmentation worse.

- A contract psychologist facilitated communication sessions between psychology/management and unit staff for a while. This was reported to BOV as a good process by unit staff - but they reported that it was not continued past three or four sessions - and that they wish it would resume.

Recommendations

- **Consolidate the ASU QMRP and Unit Coordinator positions into one Unit Manager position; BOV recommends that this position be a licensed mental health professional (LCPC, LCSW, or psychiatric RN - preference for LCSW or RN) and be filled by a person with significant adult psychiatric inpatient and/or adult community psychiatric milieu experience with excellent communication, team-building, and supervisory skills.**

- Move the psychology department on the organizational chart so that it is integrated into a "Professional Services" component of MDC. (see **Addendum 2** - Suggested Organizational Chart Revisions)

- Develop decision-making processes that support adherence to the statement of purpose and admission / discharge criteria of ASU. Ensure that unit staff are involved in this process.

- Rethink the roles of the CSDs; consider reorganizing so that there is one Residential Services Director[17] and one Professional Services Director[18]; integrate these roles across the MDC service continuum via an "Interdisciplinary Team". (see **Addendum 2** - Suggested Organizational Chart Revisions)

- Develop simple, concrete, measurable, achievable strategic objectives for ASU with specific "who will do what by when" actions and responsibilities. Integrate these objectives into the MDC strategic plan. Ensure that unit staff are involved in this process.

- Define minimum and optimum knowledge and competency expectations for all staff in ASU - emphasize mental illness, therapeutic milieu, and crisis intervention.

- Develop a comprehensive ASU staff education matrix based on the mission of MDC, the specific purpose of ASU, and the defined knowledge and competency expectations.

- Develop ASU-specific performance / quality improvement standards and a system for tracking adherence to standards and for establishing improvement activities. Ensure that unit staff are involved in this process.

- Consider having administrative staff fill in for ASU unit staff as a way to maximize the meaningful participation by unit staff in planning (PCP and programmatic), decision-making, and quality improvement activities.

- Implement evaluation of leaders and supervisors by ASU unit staff.

- Establish an ASU team self-critique process.

- Put into place data systems that support decision-making. (MDC is slated to implement a web-based system for documentation and communication - Therap®[19]. At the time of the writing of this report, there was some question whether contractual issues that would allow scheduled training and implementation would be able to proceed.)

4)   Leadership / Supervision / Teams

What do ASU staff need from its leadership?

- a visionary core of <u>unified</u> leaders that functions as a guiding coalition driving the transformation of ASU

What do ASU staff need from the Superintendent?

- having and articulating to all MDC staff a clear vision for the big picture - lead staff at all levels in setting the vision, goals and objectives - then sees to it that the goals are achieved

What do ASU staff need from the Residential Service Director and Professional Services Director?

- to be the point people for ***proactive thinking*** - stay ahead of the curve - anticipate - practice contingent planning - mentor all units and disciplines
- take Interdisciplinary Team recommendations to the Superintendent - thoroughly vetted - including costs, treatment relevance, alignment with ASU goals and strategic plan
- back the Superintendent up by reinforcing the vision and strategic objectives

What do ASU staff need from the clinical professionals?

- solid clinical skills - knowledge of psychiatric disorders and their interplay with developmental disorders, and best practice interventions
- active presence in the milieu
- incidental teaching in the milieu - 'in the moment' modeling
- focus on a holistic, relevant approach to clinical interventions
- leadership in achieving buy-in from staff at all levels for clinically appropriate interventions

What do ASU staff need from other professionals?

- proactive contribution to integration of Professional Services into the treatment continuum
- continual communication and coordination with ASU staff

Observations

Leadership:

- No ASU or other staff person BOV spoke with could definitely say who **the** leader of ASU is.

- Because of the lack of clarity about who the leader of ASU is, the QMRP appears to spend a lot of time and effort 'negotiating' with staff.

- There appears to be a negative connotation of the concept of "professional" on ASU.

- A significant level of cynicism has resulted from the disconnect between everyone's intuitive awareness of pieces of the solutions needed to address the challenges on ASU, and the difficulty leadership has encountered in implementing solutions.

- To some extent, leadership decisions at both the MDC and DDP level appear to be overly-influenced by concern about the reaction/criticism of outside entities.

<u>Supervision:</u>

- Related to the lack of clarity about who the leader of ASU is, the chain of command is ambiguous, i.e., do the Psychiatric Aides report to the Shift Manager/Unit Coordinator or the QMRP? Does the Unit Coordinator report to the Client Services Director or the QMRP? What level of authority does the Psychology Specialist have on the unit?

- There is a vicious cycle of ASU staff calling off shift due to the chaos and stress of working on ASU --->unprepared staff being pulled from other units to cover ASU ---> other units ending up being understaffed due to pulls to ASU. This cycle contributes to the downward spiral of morale, and the upward spiral of chaos - both on ASU and to some extent on the other units when they are understaffed.

- Expectations for unit staff are unclear and potentially conflicting.

<u>Teams:</u>

- There are too many teams with overlapping, incohesive functions.

- No ASU or other staff person BOV spoke with could definitely describe the ASU team.

- Unit staff are not consistently empowered to participate in planning, decision-making, and problem-solving.

- The ASU staff do not have regular meetings.

- The Psychology Department does not participate consistently in the sections meetings.

Recommendations

- **Following from recommendations under ORGANIZATIONAL CULTURE above, designate and empower the Unit Manager as <u>the</u> leader of ASU. The Unit Manager should function as the leader and final decision-maker for day-to-day operations of the unit, and the leader/facilitator of the ASU Interdisciplinary Team. Supervisors of other Professional Services staff should supervise their staff with regard to their professional work, but the ASU Unit Manager <u>should be the leader of the ASU team</u> - of which the Professional Services staff are members.**

- *Relative to treatment and unit operation*, reorganize into <u>one</u> ASU team:

  - ➢ <u>Interdisciplinary Team</u> = CSDs, Unit Manager, Professional Services staff assigned to ASU, unit staff.
  - ➢ This team should function as the unit team for ASU and as the treatment planning team for each individual ASU client. Ensure that unit staff are involved in this process.
  - ➢ As soon as possible, begin weekly ASU unit team meetings. Ensure that unit staff are involved in this process.

- The Superintendent, Residential Services Director, Professional Services Director, and Professional Services supervisors should go to ASU <u>on a regular basis</u> and "visit" - spend time - talk with and listen to clients and staff - learn the environment - become a part of the milieu - listen to the frustrations - ask for everyone's ideas.

- When ASU strategic objectives are established, the Superintendent, CSDs, and Professional Services supervisors should lead actively every day to bring the objectives to reality - celebrating

achievements, acknowledging and processing mistakes, and always being consistently 'on message'.

- Institute a formal performance improvement project - through 'performance contracts' or some other relational approach to bringing staff into the process - to create increased buy-in and ownership of performance improvement, and a collaborative approach to performance expectations and appraisal. Create explicit written expectations for all ASU staff that are directly related to the healthy functioning of the milieu and the purpose of ASU. Ensure that unit staff are involved in this process.

5)   Clinical Issues

As described earlier in this report the primary treatment needs that clients served on ASU have are related to serious mental illnesses; complicated by developmental, personality, and impulse disorders and severe aggression. Since the 2006 BOV site review, MDC has moved decisively toward acknowledging the primacy of the clinical presentation of the clients on ASU, and has appropriately placed the Psychology Department in a more central role in developing treatment strategies for ASU clients and with increased authority to direct the implementation of these strategies. BOV believes the next steps in this process of developing ASU as an intensive psychiatric treatment unit should involve:

1)   consolidating the clinical strategies by enhancing the depth of credentialed staff resources available to ASU,

2)   increasing all staff's understanding of the clinical components of clients' problems and competence in working with clients with multiple mental and behavioral disorders,

3)   addressing and assertively moving away from the "clinical <--> non-clinical" schism that has developed among staff, and

4)   designing and implementing the therapeutic milieu as the treatment model for ASU.

All of these should be put into practice under the guidance of professional mental health expertise, and at the same time, well-integrated within the ASU organizational structure - with the input and full participation of all staff.

Observations

- The placement of the psychology department in the organizational structure has created some unforeseen and unintended challenges. (see **Organizational Structure**, p. 14)

- The MDC psychiatrist is a wonderful resource and a reliable foundation of knowledge. MDC/ASU may benefit by having the psychiatrist on campus more than one day per week.

- While a number of nurses have years of valuable experience working with clients with multiple disabilities at MDC, none have experience working in a primary mental health treatment setting or certification such as the Psychiatric & Mental Health Nurse certification available through The American Nurses Credentialing Center[20].

- Except for the contract psychiatrist, MDC has only one licensed mental health professional (Licensed Clinical Social Worker).

- The role of the Social Worker has not kept pace with the treatment needs of the clients served on ASU.

- The role of the P-TPS, while it may meet traditional needs/requirements for client training, has not kept pace with the complex treatment needs of the clients served on ASU. The position description for the TPS position does include good language that describes a potentially meaningful role in working with ASU clients[21]. It is unclear to BOV whether the expectations of this position are being fully implemented.

- ASU staff appear to be confused about various treatment approaches that have been / are being used with ASU clients - Dialectical Behavioral Therapy?, Collaborative Problem Solving?; therapy for Post Traumatic Stress Disorder?.

- The phenomenon of clients "splitting"[22] and manipulating staff - significant dynamics in the ASU environment - do not appear to be adequately acknowledged or addressed.

- The contract psychiatrist is the only clinician who is diagnosing MDC clients. (It is unclear whether the relatively new Licensed Clinical Social Worker is doing this, or if it is planned for him to do this.) While the psychiatrist certainly has the expertise to diagnose ASU clients, it may helpful to have additional expertise that would enable more comprehensive, ongoing differential diagnosis of these complicated clinical presentations.

- While MDC clients are occasionally transferred to the Montana State Hospital (MSH) for brief periods of treatment, often focusing on medication adjustment, MSH is not a realistic source for consultation given significant challenges in meeting the needs of its own patients. MDC could possibly benefit from an ongoing consultative relationship with other mental health professionals.

Recommendations

- **Fill the vacant social worker position and assign this position full-time to ASU. This should be at minimum a bachelor level position and be filled by a person with adult psychiatric inpatient and/or adult community psychiatric milieu experience. A licensed clinical social worker in this position would be a great benefit, by further solidifying the professional clinical foundation needed on ASU. Develop the ASU social worker position into a comprehensive role that is integral to and present in the milieu.**

- Dedicate one P-TPS to ASU. This position should be a bachelor level position and be filled by a person with adult psychiatric inpatient and/or adult community psychiatric milieu experience. Develop the ASU P-TPS position into a role that is integral to and present in the milieu.

- Consider expanding the contract with the psychiatrist or recruiting a psychiatric nurse practitioner or advance practice RN with prescriptive authority.

- Consider either recruiting a nurse with a strong psychiatric background for ASU, or support the current nurse in pursuing Psychiatric & Mental Health Nurse certification.

- Consider establishing a contractual relationship with an organization that can provide ongoing psychiatric consultation. The Center for Mental Health[23] has a satellite office in Boulder, and may be interested in such an arrangement.

6)   Physical Plant

Observations

- Some aspects of the physical environment in the ASU residential buildings contribute to challenging behaviors by intensifying the tension and the tendency toward chaos on the unit:
    - ➢ the high ceilings and absence of soft surfaces create poor acoustics and generates echoes
    - ➢ there is only one big space onto which all bedrooms open - creating only two options for where to be - in a bedroom or in the big, open common space

- The fence around the ASU compound is attached to buildings, creating an opportunity (one that is frequently used by a current client) to scale the fence and leave the MDC campus.

- The treatment building in the ASU compound was built with treatment rooms to be used for school, boundaries and communication classes, recreation and other treatment activities so that the clients could participate in treatment and remain in ASU. These rooms have never been used for the intended purpose, and are rarely used at all except as an office, and a television room and as client stress reduction areas (this is a good use of this separate, quiet space).

Recommendations

- With the entire ASU team - and clients - do a walk-through of the ASU buildings and identify all environmental features / characteristics that contribute to milieu degradation. Develop a plan with specific actions, time frames, and responsibilities to correct each identified feature / characteristic.

- Analyze the use of the rooms originally intended for treatment activities in the treatment building, and strongly consider using these rooms for their original purposes; this simple action could be a great step forward to clarifying the purpose of ASU, developing a coherent milieu, and re-setting treatment expectations.

- Make correction of the problem with the security fence a high priority. The cost of fixing this problem will pale in comparison to any number of events that could result from clients going over the fence.

7)   Systemic Issues

Observations

- There is a great need to continue working on a collaborative relationship with Disability Rights Montana (DRM), so that MDC is proactive in communicating with DRM and so that DRM staff do not unintentionally respond to clients who call them in ways that are counter-therapeutic.

- It appears that a working relationship between MDC and the Department of Corrections appears not to have kept pace with the increasing number of individuals placed at MDC who have been criminally committed.

- There appear to be aspects of union contracts that make it difficult to select staff for ASU who have the necessary knowledge, experience, and skills.

Recommendations

- **Engage DRM in a dialogue about a newly-designed therapeutic milieu model for ASU. Work together to establish guidelines for working together in a way that supports legitimate advocacy activities <u>and</u> supports MDC's responsibility to provide quality, professional, clinically-based treatment services. Provide comprehensive information to DRM about the clinical and organizational underpinnings of the treatment of clients on ASU. Seek buy-in and support from DRM, including agreement to do the following when an ASU client calls DRM with a concern or complaint about some aspect of their experience in ASU:**

  1)   redirect the client to the ASU Unit Manager,
  2)   consult with the ASU Unit Manager about the client's treatment plan and its clinical rationale before coming to any conclusion or making any commitment of action to a client, or before having a conversation with the client about the strengths or weaknesses of the client's concern/complaint,
  3)   give the ASU team the benefit of the doubt when a client describes any experience he/she is having on ASU.

- Schedule regular monthly meetings between the Unit Manager of ASU (and/or the Residential Services Director and Professional Services Director) and a representative of DRM to proactively address issues before they become problems.

- Schedule a meeting with the Superintendent, and representatives from the DPHHS and the Department of Corrections (DOC) to establish a baseline for an ongoing working relationship, and for addressing the needs of MDC clients whose placement at MDC have both treatment and correctional implications. Identify individual contact people at DPHHS and DOC that MDC staff can contact about these issues when needed.

- DDP/DPHHS should clarify the role of MDC relative to criminal commitments; consider the future needs for "housing" people who are criminally committed to MDC and who require a correctional level of security independent of treatment needs. Proactively plan and develop the capacity for these clients to be housed outside of the ASU treatment milieu (unless an individual meets the ASU admission criteria).

- Begin discussions with the unions about how MDC leaders can select - with union support - staff for ASU who have the necessary knowledge, experience, and skills.

Addendum 1 - Key Recommendations from 2002/2006

(NOTE: These are recommendations originally recommended in 2002, and reiterated in 2006.)

2002 RECOMMENDATION 1:
A representative from the administrative level should conduct a weekly walk-through of the units.

This "management by walking around" method will reassure staff and residents with a sense of "buy in" by allowing their concerns to be heard. It will increase communication between the units to have issues clarified and rumors eliminated on a regular basis, and can be used as an opportunity to reinforce to staff the importance of following policies in Unit 104-R.

2002 RECOMMENDATION 3:
Make all off-grounds trips and other activities a part of each 104-R resident's INDIVIDUAL TREATMENT PLAN. Ensure that the approach to these activities and their relationship with residents' behavior is individualized and consistently enforced by the treatment team.

Implementation of this recommendation should ensure at a minimum that the resident is being given an earned privilege as a part of an incentive-based behavioral management program that is commensurate with cause-and-effect time frames that make sense for each resident, and that there have been no behaviors within the immediate time frame that should reasonably preclude the activity or that indicate an immediate danger to the community. If the resident refuses to participate in an activity or has not been allowed to go on an activity due to recent unacceptable behaviors, then the opportunity should be lost and should not be "made up" at an unscheduled time or upon demand.

2002 RECOMMENDATION 4-A:
Send staff working in Unit 104-R to a one-day training session in the concepts of "Cognitive Principles and Restructuring" (CP & R), to include antisocial personality traits and associated behaviors.

2002 RECOMMENDATION 4-B:
Implement resident involvement in CP & R training as a part of each 104-R resident's individual treatment plan (ITP).

It is possible to identify the cycle of aggression/assault for each resident, enabling staff to understand how behaviors escalate, and giving them a tool to de-escalate destructive behaviors. The Department of Corrections utilizes a program called "Cognitive Principles and Restructuring" (CP & R). Staff can be taught this program so they may recognize each resident's cyclical/escalating behaviors.
The psycho-educational program is behavioral based and can be provided to residents by a trained staff member. Staff can reinforce the concepts in interactions with residents, correcting dysfunctional thoughts before they escalate to actions.

2002 RECOMMENDATION 5-A:
Ensure that <u>at least one</u> staff member assigned to Unit 104-R on each shift is trained in the following:
- Searches
- Antisocial personality traits
- Non-Violent Crisis Intervention ("CPI")
- Report Writing
- Interpersonal Communication
- Restraints (if the decision is made to utilize restraints, see Recommendation Eleven)
- Emergency Response Procedures
- Crime Scene/ Evidence Preservation
- Security Inspections

2002 RECOMMENDATION 5-B:
Ensure that all staff assigned to Unit 104-R receive formalized orientation and on-site training, <u>prior</u> to working in the unit, to include:
• Antisocial Personality Disorder traits
• Suicidal Behaviors and Mental Health Issues
• Self Defense Tactics (as prescribed in MANDT or another appropriate program)
• Emergency response, key control, tool control, safety issues
• Stress Management/Wellness/Healthy Boundaries
• A review of each resident's ITP
• Policies specific to the unit
• Post orders developed for the unit, as recommended in Observation Number Nine.

2002 RECOMMENDATION 6-A:
Establish a protocol for determining whether each individual placed on 104-R is being placed there temporarily with a planned return to his/her "home" residence, or whether he/she will remain on 104-R as the appropriate ongoing treatment and residential environment.

2002 RECOMMENDATION 6-B:
For individuals who are placed on 104-R temporarily, add a specific treatment completion component to discharge criteria from Unit 104-R, such as completion of the CP & R program, or another specific cognitive-behavioral based performance measure for treatment.

2002 RECOMMENDATION 6-C:
For individuals who are placed on 104-R temporarily, establish incentive-based measures, such as a set time without destructive behaviors toward self, property or others as part of the discharge criteria.

2002 RECOMMENDATION 6-D:
Establish behaviorally specific goals for each resident to reach; eliminate the generic term "as decided" or "as determined by the Interdisciplinary Team" - these are too difficult to measure and are open to individual staff subjectivity.

2002 RECOMMENDATION 6-E:
Incorporate the following clinical components into a more specific admission criteria:
1. An Axis II diagnosis of Antisocial Personality Disorder or Borderline Personality Disorder; OR
2. Any Axis I diagnostic code that includes a behavioral disturbance; Conduct Disorder, Oppositional Defiant Disorder, Disruptive Behavior Disorder Not Otherwise Specified, Explosive Disorder, Impulse Control Disorders or sexual paraphilias (severe), as listed in DSM IV-TR™, as the focus of clinical attention; OR
3. Any Axis IV diagnostic code that includes physical abuse or sexual abuse with the focus of clinical attention on the perpetrator. (When these problems become the principal focus of clinical attention, they are listed on Axis I). These V-codes from DSM IV-TR™ would include: V61.21; V61.12; V62.83; V71.01; OR
4. An additional condition that could warrant admission to Unit 104-R would also include non-compliance with treatment, V15.81, when the problem is sufficiently severe to warrant independent clinical attention for maladaptive personality traits or coping styles. This category can be used when the focus of clinical attention is noncompliance with an IMPORTANT aspect of treatment for a mental or general medical condition, such as:
   • Refusal to comply with a special diet for a medical condition, resulting in stealing or running away to obtain the food, when the behavior represents a significant danger to self as a result; or with Obsessive Compulsive Disorder (poor insight) when compulsive behaviors are a danger to self, warranting more intensive supervision, or with a psychotic/manic episode if the resident becomes a danger to self or others.

By making admission criteria clinically based as well as behavioral based, the Unit is more clearly identified as an <u>intensive treatment unit</u>, with behavior based specific measures/incentives for discharge

(for those who are placed there temporarily), while at the same time separating these residents from potential victims in the vulnerable population. The intensive treatment component is additionally addressed in the recommended training for 104-R staff. Making every interaction with a resident a "teachable moment" will happen when staff begins to feel more confident/safe with learned behavioral management techniques.

It should be noted that these entrance criteria could be incorporated with the currently utilized Psychological or Mental Status Report, an assessment instrument utilized in the admission process already.

2002 RECOMMENDATION 7:
Based on the individual clinical needs and cognitive limitations of each resident, incorporate reimbursement for property destruction into the ITPs for 104-R residents who intentionally destroy property on a regular basis.

It would be a good behavioral management tool to extinguish his destructive behaviors by making reimbursement a part of his ITP. This is not suggested as a punishment, but as a method of treatment to assist residents in regaining control of their behaviors through accountability for their actions. It reinforces anti-social personality traits to NOT hold them accountable. It is also escalating their destructiveness. Some 104-R residents have a great sense of accomplishment and enjoys bragging about their behaviors, telling "war stories" about the things they have destroyed/damaged. It is a disservice to residents not to aid them in improving these behaviors. It is also extremely dangerous to continue to let these behaviors escalate.

2002 RECOMMENDATION 9:
Implement "post orders" (detailed description of what is done when) that entail the following:
- Overall resident schedules for activities that staff can follow in detailed 1/2-hour increments to determine what should be offered or completed at each time of the day.
- An individual post order for each resident so the staff member assigned to that resident can follow it.
- Guidelines for enforcement of each resident's schedule and for planned/controlled movement of residents through the campus or into town.
- Documentation of the scheduled activities and opportunities for activities that may be refused (see **Recommendation 2-A**).

Post orders will give residents a sense of stability and staff a sense of routine/predictability more specific then a general policy. Previously recommended was a set schedule for each resident, enforcing that if they refuse an activity, the opportunity for the activity will not be offered again until scheduled. The Department of Corrections can provide technical assistance in developing post orders.

2002 RECOMMENDATION 15:
Add chain link or wire mesh as a ceiling to the outdoor recreation fence to make it more secure.

Best practice would be to have concrete footing at the base of the fence so it cannot be dug out for a planned escape. With one-on-one supervision, it can reasonably be expected that a resident would not have time to dig out the base of the fence without being observed. Staff should be aware that this is a common means of escape from locked units, and security inspections should include the fencing and base of the fencing to ensure this is not happening over a period of time.

2002 RECOMMENDATION 16:
(NOTE: in 2009, cell phones are used by staff to request assistance.)

Correct deficiencies in the alarm system 104-R staff use to request assistance in an emergency.

Address the following:
- Increase the volume of the distress alarm receiver.

- Implement procedures that absolutely ensure that when staff on 104-R activate the alarm, help is on the way immediately.
- Establish procedures for responding staff to follow.
- Implement specialized training to prevent injuries.
- Provide and store protective equipment in the closet outside of the unit, readily available if needed for an immediate response.
- Develop procedure for maintenance, inventory and sanitation after use of protective equipment.
- Implement a procedure for the exchange of walkie-talkies during shift exchange, or if this communication method is not to be implemented, this should be removed from policy.
- If walkie-talkies are to be used, implement a procedure for testing, inventory, and maintenance of this system.

2002 RECOMMENDATION 18:
Develop a formal, consistent means to orient residents to 104-R. This process should include a written checklist and possibly a handbook for staff to use in order to ensure consistent orientation.

An orientation handbook can include policies that pertain to residents, or can be a written overview of expectations. It is best practice to separate staff procedures from policies related to resident rules/regulations and then incorporate policies related to residents within this handbook. At admission to the unit, a formal orientation session should be held with the resident to verbally go over the rules and to provide an opportunity to answer resident questions. This will alleviate resident anxiety and clarify behavioral expectations. The orientation process can additionally include the ITP and discharge criteria for the resident, if he/she is on the unit temporarily.

Addendum 2 - Suggested Organizational Charts

Endnotes

[1] http://www.icfmr.com/home.htm

[2] http://www.dphhs.mt.gov/qad/2100icfddrules.pdf

[3] 42 CFR Ch. IV § 483.440 Condition of participation: Active treatment services.
(a) *Standard: Active treatment.* (1) Each client must receive a continuous active treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services described in this subpart, that is directed toward—
(i) The acquisition of the behaviors necessary for the client to function with as much self determination and independence as possible; and (ii) The prevention or deceleration of regression or loss of current optimal functional status. (2) Active treatment does not include services to maintain generally independent clients who are able to function with little supervision or in the absence of a continuous active treatment program.

[4] American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders DSM-IV-TR . Fourth Edition. Arlington, VA: American Psychiatric Publishing, Inc., 2000. http://www.appi.org/book.cfm?id=2024

[5] http://data.opi.state.mt.us/bills/mca/53/20/53-20-104.htm

[6] This consultant is a licensed clinical social worker who specializes in secure treatment settings.

[7] See 2006 report here >> http://boardofvisitors.mt.gov/docs/MDC_Site_Review_Report_092806.pdf

[8] The term "Unit Staff" is used in this report to refer to the Psychiatric Aides, Shift Managers, and Unit Coordinator.

[9] http://info.collegeofdirectsupport.com/

[10] The term "Professional Services" is used in this report to describe the treatment services provided by Psychology, Recreation, Vocational, Communication, Occupational/Physical Therapy, Social Work, Education, Health Services, and Psychiatry.

[11] http://www.explosivechild.com/

[12] Emergent: occurring unexpectedly and requiring urgent action.

[13] In order to reconcile the reality of the mix of clientele and the need for a coherent purpose, BOV recommends that the purpose be framed to address the most intense security **and** psychiatric scenario a client could present.

[14] The term "Interdisciplinary Team" is used in this report to describe the team that would function as the unit team for ASU and as the treatment planning team for each individual ASU client (see

[15] This will necessarily involve working with community providers to ensure that they have the resources and expertise to proactively respond to escalating behaviors in their programs in order to avoid unnecessary MDC admissions.

[16] The term "Unit Manager" is used in this report to describe a recommended position to be the leader of ASU – a consolidation of the QMRP and Unit Coordinator positions.

[17] The term "Residential Services Director" is used in this report to describe a recommended position that would be a reworking of one of the current Client Services Directors and whose new duties would be to direct all of the residential services, including ASU.

[18] The term "Professional Services Director" is used in this report to describe a recommended position that would be a reworking of one of the current Client Services Directors and whose new duties would be to direct all of the Professional Services.

[19] http://www.therapservices.net/about.php

[20] http://www.nursecredentialing.org/NurseSpecialties/PsychiatricMentalHealth.aspx

[21] The MDC position description for Treatment and Programming Specialist (TPS) included the following duties: "*Develops behavioral interventions derived from an understanding of the multiple biomedical, neurological, psychiatric and psycho-social conditions that contribute to challenging behavior and that are designed to assist the client in accomplishing their personal goals in a self-enhancing manner*"; "*Designs interventions to address adaptive skills related to emotional, cognitive and behavioral domains that can be used by the individual to cope with specific problematic situations*"; and "*Designs crisis prevention protocols...*".

[22] Gabbard, Glen O.. Splitting in Hospital Treatment. American Psychiatric Association. American Journal of Psychiatry. 1989. : "In splitting, the patient tends to divide people about whom he or she has ambivalent feelings into glorified saviors and devalued or hated malefactors. Staff members unconsciously identify with projected aspects of the patient and behave accordingly, thus justifying or reinforcing the ... behavior."

[23] http://www.center4mh.org/locations.php