Mental Disabilities Board of Visitors

SITE REVIEW REPORT

GOLDEN TRIANGLE COMMUNITY MENTAL HEALTH CENTER

Helena, Montana

MAY 20, 21, 2004

Gene Haire

Gene Haire, Executive Director

_____

Date

TABLE OF CONTENTS

Mental Disabilities Board of Visitors
Site Review Report
Golden Triangle Community Mental Health Center (Helena)
May 20 - 21, 2004

INTRODUCTION

- **Mental Health Facility reviewed** :

  Golden Triangle Community Mental Health Center - Helena (GTCMHC - Helena)

  Mike McLaughlin, Ph.D. - Executive Director
  Darren Nealis, LCSW – Program Director

- **Reviewed by** :

  Mental Disabilities Board of Visitors (BOV)

- **Date of review**:

  5 / 20 – 21 / 04

- **Authority for review**:

  53-21-104, Montana Code Annotated, 2003

- **Purpose of review** :

  1) To assess the degree to which the services provided by GTCMHC - Helena are humane, are consistent with established clinical and other professional standards, and meet the requirements in state law.
  2) To recognize excellent services.
  3) To make recommendations to GTCMHC - Helena for improvement of services.
  4) To report to the Governor regarding the status of services provided by GTCMHC - Helena.

- **BOV review team** :

  Board members: Kathleen Driscoll
  Cindy Dolan

  Consultant: Carla Cobb, Pharm.D., B.C.P.S. (pharmacology consultant)

  Staff: Gene Haire, Executive Director
  Craig Fitch, Attorney

OVERVIEW

- **Service type** :

  Regional Community Mental Health Center

- **Catchment area** :

  Counties : Glacier, Toole, Liberty, Hill, Blaine, Pondera, Teton, Chouteau, Lewis and Clark❋, Cascade, Jefferson, Broadwater.
  ❋Covered in this Review

- **Review process** :

  1) interviews with GTCMHC - Helena staff
  2) interviews with consumers and representatives of community agencies
  3) review of treatment records and written descriptions of treatment services
  4) tour of facilities

- **Services reviewed** :

  I. <u>Services for Children and Families</u>:

  - Family, Individual, and Group Therapy
  - Therapeutic Family Care

  II. <u>Services for Adults</u>:

  - Case Management
  - Outpatient Therapy
  - Day Treatment
  - Emergency Services
  - Adult Foster Care
  - Group Home (Hannaford House)
  - Program for Assertive Community Treatment (PACT)
  - Psychiatric Evaluation, Medication Management / Monitoring

  III. <u>Other Services</u>:

  - Staff Training and Supervision
  - Integration of Treatment for Co-Occurring Mental Illness and Substance Use Disorders

ASSESSMENT OF SERVICES

I. SERVICES FOR CHILDREN AND FAMILIES

Family, Individual, and Group Therapy

- **Brief overview of services (from GTCMHC - Helena literature)** :

  - Outpatient, in-home, and in-school services.
  - Family systems treatment approach.
  - Focus on conflict resolution, problem solving, parenting, and communication skills.
  - Specialize in services for coping with depression, anxiety, anger management, trauma, ADHD, behavior management, attachment issues, and family conflict.

Therapeutic Family Care

- **Brief overview of services (from GTCMHC - Helena literature)** :

  - Multiple therapeutic services provided within the homes of families who are dealing with serious family relationship and mental health issues.
  - Family systems approach.
  - Promote family reunification and preservation.

- **Strengths :**

  - Quality care for consumers provided by a competent team with high morale, good training and consistent support from the Team Leader.

- **Areas of concern :**

  - There appears to be a challenging working relationship between the GTCMHC Child & Family Team and A.W.A.R.E., Inc. (which has the contract for children's case management in the Helena area). It appears that in some cases it is difficult for GTCMHC consumers to access case management from A.W.A.R.E., Inc.

- **Questions :**

  - Does the current 'single vendor' approach to children's case management serve children and families well? It appears that in Helena and in other communities, having case management provided by one agency and other services to children and families provided by another agency leads to fragmentation at best and poor service coordination and sub-par service quality at worst.

- **Suggestions :**

  - None

- **Recommendations :**

  1. GTCMHC Child & Family Team and A.W.A.R.E., Inc. should meet with a third party facilitator (Children and Adult Health Resources Division?) to discuss the barriers that GTCMHC perceives and resolve them so that there is no negative impact on children and

families who receive services from both organizations. GTCMHC Child & Family Team and A.W.A.R.E., Inc. should develop a protocol for communication and coordination, and agree on an ongoing process for problem identification and resolution.

- **Update on Previous Site Review Recommendations :**

  - No recommendations in 2001.

II. SERVICES FOR ADULTS

Case Management

- **Brief overview of services (from GTCMHC - Helena literature)** :

  - Assist consumers with development and coordination of a comprehensive treatment plan.
  - Needs assessment, advocacy, case planning, monitoring, service coordination, crisis assistance/intervention, service linkage.

- **Strengths :**

  - Attempts to control case management loads to a reasonable number.
  - Case Management and clinical supervisors are readily available to answer questions, provide support, allow for schedule flexibility, monitor boundaries, and work to avoid burn out.
  - Improvement since BOV's last visit in connection between the Case Managers, Case Management Supervisor, and the Clinical Coordinator via a weekly team meeting.
  - Pilot program to provide case management to veterans.

- **Areas of concern :**

  - Inadequate space in case management work areas compromises ability to communicate privately with consumers and to have private telephone conversations.
  - The lack of a local inpatient psychiatric unit creates significant problems when consumers need hospitalization. Consumers in psychiatric crisis being admitted to Benefis Hospital in Great Falls have to travel 1-½ hours by car with a case manager or family member or by commercial bus.
  - Caseload sizes appear to be too large (in the mid 30s per case manager).

- **Questions :**

  - None

- **Suggestions :**

  - None

- **Recommendations :**

  - None

- **Update on Previous Site Review Recommendations :**

  2001 Recommendation: *Analyze the current payee system and implement system adjustments that assure that payee funds cannot be mishandled.*

  2004 Update: Payee system was appropriately revamped in January 2002 to address problems that existed. As of May 2004, GTCMHC was planning to divest itself of the payee function to work with Social Security to transfer payee accounts to a private contractor.

Outpatient Therapy

- **Brief overview of services (from GTCMHC - Helena literature)** :

  - Individual, family, and group therapy.
  - Groups: parenting skills, domestic violence treatment using the Duluth model, dialectical behavioral therapy, emotion management, suicide prevention, coping with severe mental illness, social skills development.

- **Strengths :**

  - One therapist is both a Licensed Addiction Counselor and a Licensed Clinical Professional Counselor.
  - If an emergency exists, or if a person is transitioning from Montana State Hospital or other inpatient unit, a consumer does not have to wait for an intake (see Concern below).

- **Areas of concern :**

  - Currently a 20 - 30 person waiting list with a 4 - 8 week wait between applying for services and intake appointment.
  - There is no mechanism in place to monitor people on the waiting list to ensure immediate access if a person's situation changes and his/her need for service increases.
  - In the five charts that BOV thoroughly reviewed, assessments, treatment objectives, interventions, treatment reviews, and documentation all clearly indicated a lack of awareness of the concept of identifying co-occurring mental illness and substance use disorders and an absence of any level of treatment integration. See **Integration of Treatment for Co-Occurring Mental Illness and Substance Use Disorders** for further comments.

- **Questions :**

  - None

- **Suggestions :**

  - Consider incorporating Adult Foster Care and Group Home staff into the weekly team meeting that currently involves the Outpatient Therapy Coordinator and Case Managers.

- **Recommendations :**

  - See **Integration of Treatment for Co-Occurring Mental Illness and Substance Use Disorders**.

- **Update on Previous Site Review Recommendations :**

  2001 Recommendation: *Assure that therapists who supervise treatment planning review and sign off on plans only for consumers whose cases and plans they are familiar with.*

  2004 Update: This has been appropriately addressed.

  2001 Recommendation: *Make environmental adjustments to therapists' offices that assure that confidential sessions cannot be heard in adjoining offices.*

  2004 Update: This has been appropriately addressed.

  2001 Recommendation: *Establish a goal to have enough therapists certified as chemical dependency counselors so that each consumer with a co-occurring mental illness and chemical dependency can be treated by one therapist who can simultaneously treat both disorders.*

  2004 Update: GTCMHC – Helena still has one "dually licensed" therapist. As noted above, the way in which the center approaches co-occurring mental illness and substance use disorders needs to be improved. See **Integration of Treatment for Co-Occurring Mental Illness and Substance Use Disorders**.

Day Treatment (Montana House)

- **Brief overview of services (from GTCMHC - Helena literature)** :

  - Psychosocial day treatment model of psychiatric rehabilitation.
  - Skill building, employment, socialization.
  - Groups designed to promote development of personal goals, interpersonal relationships, and self-esteem.
  - Transitional and supported employment.
  - Adult education.

- **Strengths :**

  - GTCMHC - Helena has made great progress since BOV's last review in developing Montana House. There is now a focus for activities, a viable vocational program with two Employment Specialists, and a full-time on-site experienced leader.
  - Program Coordinator is knowledgeable, actively involved in the milieu, and provides a solid sense of leadership.
  - Teacher 4.5 hours per week through an Adult Learning Center grant.
  - Member-run Addictions Support Group.
  - Serious efforts are under way to share Montana House decision-making and responsibility with consumers. Program Coordinator and staff are working to empower consumers.

- **Areas of concern :**

  - Even though the number of staff in Montana House has been increased, Rehabilitation Specialists expressed concern about safety given the current consumer/staff ratio; and while they receive and like Mandt training, they still are uneasy about the level of anger/disorganized/aggressive behavior of some clients.

- **Questions :**

  - None

- **Suggestions :**

  - Consider updating outdated computer software for program computers.
  - Consider installing disability-friendly software which makes computer based work more accessible for persons with a variety of learning and other disabilities.

- **Recommendations :**

  2. Analyze the Rehabilitation Specialists' concerns about safety in the milieu; identify and address legitimate issues.

- **Update on Previous Site Review Recommendations :**

  2001 Recommendations:
  > *Research, analyze, and implement an overall conceptual/philosophical model/structure in Montana House.....*
  > *Analyze the dynamics related to consumer: staff ratio and establish meaningful scenarios that fully equip the program to actively engage members in work that achieves measurable rehabilitation outcomes.*
  > *Analyze the dynamics related to required attendance of adult foster consumers and group home residents and implement program adjustments to fully accommodate acuity levels and other aspects of the regular attendance by these consumers.*
  > *Provide assertive leadership that sets clear expectations for staff roles in the program milieu, and that establishes standards for and enforces acceptable consumer behavior that is respectful of all who attend.*
  > *Make adjustments in the utilization of the Montana House supervisor FTE so that the program has the benefit of a full-time manager.*

  2004 Update: GTCMHC – Helena has done some research into rehabilitation models, improved the staffing numbers, and placed a full time coordinator in the program. Employment is clearly now an important component of services. Overall structure, expectations for staff and consumers, and engagement of consumers by staff has improved. While BOV continues to have some concern about the required attendance of Adult Foster Care and group home consumers, the improved quality of the milieu generally has somewhat mitigated this concern. Montana House (and most other mental health programs in Montana) still needs to work on establishing specific recovery-oriented outcome objectives for consumers and to measure the outcomes.

  2001 Recommendation: > Assess *the knowledge and competency of staff relative to serious mental illness and how to work with adults with serious mental illness, and implement training.*

  2004 Update: The addition of a full time, experienced coordinator has improved the situation regarding staff competency in the milieu to the extent that the coordinator interacts with and guides staff. Staff training is still a rather loose on-the-job affair. See **Staff Training**.

  2001 Recommendation: *Take immediate action to identify consumers who are dealing drugs...*

2004 Update: GTCMHC – Helena is addressing this issue appropriately.

Emergency Services

- **Brief overview of services (from GTCMHC - Helena literature)** :

  - A 24-hour mental health emergency phone line is available to residents of the Helena and surrounding areas. Face-to-face professional emergency assessments are available when required. Emergency evaluations are also provided in the county jails.

  Darren – I still don't have a very good handle on the big picture with regard to emergency response. Some areas I have questions about are:
  > difference between how GTCMHC clients, non clients (attached to other professionals), and unattached individuals are responded to?
  > efforts to engage unattached individuals with GTCMHC services, including hook up with CM?
  > face-to-face eval of GTCMHC clients who are told to go the ER? Non-clients? unattached?
  > follow-up on people sent to ER?

  I would like to talk more with you in person about this before we finalize the report.

- **Strengths :**

  -

- **Areas of concern :**

  - GTCMHC's ability to stabilize consumers in psychiatric crises locally has been significantly diminished since the closure of the crisis stabilization facility (New Visions). This limitation is exacerbated by the lack of local psychiatric inpatient services since St. Peter's Hospital closed the Support Center.

- **Recommendations :**

- **Update on Previous Site Review Recommendations :**

  - No recommendations in 2001.

Adult Foster Care (AFC)

- **Brief overview of services (from GTCMHC - Helena literature)** :

  - Placement of individual consumers with state-licensed foster home providers who are specially trained to work with adults with mental illness
  - Coordination with other necessary services to meet individual consumer needs

- **Strengths :**

  - Excellent service that allows consumers with significant challenges and difficulty living at more independent levels to live in the community with needed support.
  - AFC Manager has developed good communication with referral sources, AFC providers,

law enforcement, and all other pertinent community entities.
- The GTCMHC - Helena has set the standard for comprehensive AFC service that includes provider training and support and a system for respite.

- **Areas of concern :**

  - None

- **Questions :**

  - Is there a way to overcome the challenge of having unfilled AFC beds when the MSH census is over capacity?

- **Suggestions :**

  - None

- **Recommendations :**

  - None

- **Update on Previous Site Review Recommendations :**

  2001 Recommendation: *Analyze reports of concern about foster care providers and take assertive action to correct any situations in which consumers are not treated with utmost dignity and respect.*

  2004 Update: Addressed appropriately.

  2001 Recommendation: Provide additional case management support for the two Adult Foster Care Specialists.

  2004 Update: In 2002, one half time AFC Specialist was added, for a total of 2.5 FTE. As of May 2004, there were 2.0 FTE AFC Specialists.

  Darren – status??

Group Home (Hannaford House)

Darren – I want to talk with you in person more about HH.

- **Brief overview of services (from GTCMHC - Helena literature)** :

  - Long-term transitional care for eight individuals in a structured setting
  - Participation in day treatment, outpatient therapy, case management, psychiatric services

- **Strengths :**

  - Hannaford House is clean, in good condition, and well integrated in the community.
  - Excellent option in the array of services available in Helena.
  - Good initiatives in the following areas: (1) creation of a program description including

admission and discharge criteria; (2) development of a Residential Services Team with increased multidisciplinary decision-making process for group home admission and discharge decisions; (3) increase in group home staff meetings; (4) increase in in-service training for group home staff.

- **Areas of concern :**

  - BOV team overheard a HH staff person speaking on the phone with a consumer calling from Montana House. In this conversation, the staff person used an inappropriately confrontational style phone conversation with the consumer. This appeared to be an indication that training is lacking in sensitivity, empathy, understanding of what it means to be mentally ill, communication skills, etc. and possibly an indication of the need for more on-site and/or more comprehensive supervision of line staff.
  - As reported to BOV, it appears that staff who may not be qualified are training new staff.

- **Questions :**

  - None

- **Suggestions :**

  - None

- **Recommendations : (see also Staff Training)**

  3. Continue to develop the Hannaford Group Home Program Manual so that it is more professional, more recovery-oriented, more positive regarding consumer strengths, abilities, and aspirations, and more detailed and positive in describing new consumer orientation.
  4. Refine admission and discharge criteria to address (a) clarification of criteria in the Residential Assessment of Client form, (b) the question "does the consumer need what the program offers?", (c) attainment of *individualized* treatment goals relative to discharge criteria, and (d) assistance provided by Hannaford House when a consumer is discharged for refusing treatment.

- **Update on Previous Site Review Recommendations :**

  2001 Recommendation: *Develop clear written entry and exit criteria for Hannaford House.*

  2004 Update: Hannaford House now has written admission and discharge criteria described in the Hannaford Group Home Program Manual. BOV has several observations: (1) the admission criteria list includes the statement "meet criteria as outlined in the Residential Assessment of Client form". This form consists of 11 questions, but does not indicate the types of answers that would constitute meeting the criteria in this document. (2) Nothing in the admission criteria frames the question "does the consumer need what the program offers?", which would seem to be the central criterion. (3) The discharge criteria list does not mention anything about attainment of *individualized* treatment goals, only "goals as related to the Level System". (4) The discharge criteria list describes conditions under which a consumer may be discharged for refusing treatment, but does not describe what Hannaford House or other GTCMHC staff will do to assist a consumer in this kind of transition from Hannaford House to wherever he/she goes next.

2001 Recommendation: *Develop a more collaborative decision-making process for determining*

who will be admitted to the group home and when a consumer is ready for discharge that includes everyone on the group home treatment team and that references the entry/exit criteria.

2004 Update: GTCMHC – Helena now involves several of its disciplines/program staff in decision-making about Hannaford House and AFC admission/discharge through its Residential Services Team.

2001 Recommendation: *Research existing group home treatment models and develop a clear conceptual framework for the treatment approach in the group home along with a clear written description of the treatment approach (program description) and the structure within which consumers are expected to function and progress. The Case Manager who works with all group home consumers has submitted a proposal for a four-tier level system that seems to warrant serious consideration.*

2004 Update: GTCMHC – Helena has developed a program description that describes the basic approach to treatment and a level system.

2001 Recommendation: *Analyze the skill levels and training needs of the group home staff and provide necessary training. Consider offering the NAMI provider training.*

2004 Update: GTCMHC – Helena describes giving increased attention to assessment of staff knowledge and skills and training. BOV team members observed problematic communication between a staff person and a consumer that appeared to indicate inadequate knowledge, skill, and perhaps aptitude of this staff person for working with people with mental illness. It also appears that staff who may not be qualified are training new staff. See **Staff Training**.

2001 Recommendation: *Clearly establish what is expected of staff relative to treatment of consumers, incorporate into treatment standards, and assertively consequate staff behavior that is counter-therapeutic and/or abusive.*

2004 Update: It appears that GTCMHC – Helena has increased the level of structure and expectation for Hannaford House staff. See **Staff Training**.

2001 Recommendation: *Assure that consumers have full access to the grievance process and that there are no barriers to this access.*

2004 Update: The GTCMHC grievance procedure is listed in the Hannaford Group Home Program Manual as one piece of "paperwork all consumers must complete".

Program for Assertive Community Treatment (PACT)

- **Brief overview of services (from GTCMHC - Helena literature)** :
  - Comprehensive mental health care for adults with severe and persistent mental illness
  - Multidisciplinary approach to provision of medical care coordination, symptom management, crisis response, medication monitoring, supportive therapy, on-site support
- **Strengths :**

- Excellent leadership and commitment from the PACT Team Leader.
- Because the model is so well defined and the team so cohesive, new staff training and ongoing supervision are good and focused on the defined parameters of the service.
- Impressive commitment of staff team to providing innovative, flexible services to very ill consumers.
- Excellent team dynamics; staff report high job satisfaction.
- Very good integration of vocational and substance abuse services with other PACT components.
- 33% of consumers employed through PACT support (model goal is 60%).

● **Areas of concern :**

- It appears that many more GTCMHC - Helena adult consumers need and would greatly benefit from PACT services.

● **Questions :**

- None

● **Suggestions :**

- Consider conducting a needs assessment for PACT services for all GTCMHC-Helena adult consumers and working with the Mental Health Services Bureau (MHSB) to expand the PACT program in Helena accordingly.

● **Recommendations :**

- None

● **Update on Previous Site Review Recommendations :**

2001 Recommendation: *Analyze true need for PACT funding as driven by consumer need, quantify this need, and actively advocate for this level of funding.*

2004 Update: GTCMHC works closely and proactively with the MHSB advocating for continual improvements in PACT services.

Psychiatric Evaluation, Medication Management / Monitoring

● **Brief overview of services (from GTCMHC - Helena literature)** :

- Evaluation, prescription, consultation, education, and medication management provided by center psychiatrists for children and adults
- Medication monitoring provided by psychiatric nurses for adults

● **Strengths :**

- Strong physician support with LPN who does problem solving and crisis management.
- Good resource management for medication access – samples, county medical for co-pays, indigent program medication.
- Patient education for enhanced medication adherence.

- No involuntary medication use.
- Improved psychiatrist access with new psychiatrist.
- Appropriate use of new medications.
- Proactive approach to medication related weight gain – patients are weighed regularly, educated, referred to dietician as appropriate, increased activity at Montana House.
- Glucometer available for blood glucose screening for patients on atypical antipsychotic medication with symptoms of diabetes.
- Medication room is well organized.
- Samples well-organized, expired medications removed and disposed of appropriately, documented in patient's medical record.
- Medications are clearly labeled.
- Good, well organized documentation of medication administration, prescriptions, and refills.

● **Areas of concern :**

- Caseload of 500 – 600 patients per psychiatrist is clearly too high and necessarily compromises treatment quality despite the efforts of the medical team.
- 30 – 45 day wait for initial psychiatrist appointments.
- Significant delay for dictations to be placed in the patient's medical record.
- Use of three concomitant second generation antipsychotics in 1 patient (#2500453) – increased cost and risk for adverse effects and drug interactions.
- Rationale for above combination not documented in the medical record (possibly due to dictation delay).
- Patient #2500453 had a clozapine level of 1086 on 6/20/03. There is a risk of a further increase in the drug level due to the drug interaction with increasing doses of Risperdal, which could increase the risk of seizures with clozapine. Recent therapy notes indicate that the patient is also very sedated.
- Lack of consistent documentation of patients' other medications, not prescribed by the GTCMHC psychiatrists. All medications must be considered in evaluating for disease-state and medication-related psychiatric symptoms, and the risk of drug interactions with psychiatric medications.

● **Questions :**

- None.

● **Suggestions :**

- Avoid using more than one second generation antipsychotic in a patient, to minimize the risk of adverse effects, drug interactions, and drug cost.[1]
- Consider developing routine monitoring for the metabolic complications of the second-generation antipsychotics. [2]

● **Recommendations :**

---

[1] Texas Implementation of Medication Algorithms Antipsychotic Algorithm
http://www.mhmr.state.tx.us/centraloffice/medicaldirector/TIMA.html

[2] American Diabetes Association; American Psychiatric Association; American Association of Clinical Endocrinologists; North American Association for the Study of Obesity. Consensus development conference on antipsychotic drugs and obesity and diabetes. J Clin Psychiatry. 2004 Feb;65(2):267-72

6. Document all medications in the medical record including those prescribed by other providers.

- **Update on Previous Site Review Recommendations :**

  - No recommendations in 2001.

III. OTHER AREAS

Staff Training and Supervision

- **Observations:**

  - While BOV did not review staff training specifically, the BOV team did discuss staff training with a number of interviewees. It appears that in some areas, staff training is good. The question of whether staff training is adequate in some other areas was a recurring theme during the site review. BOV team members observed several 'red flags' related to training and supervision.

- **Strengths :**

  - Staff training and support in the Child and Family Team, Adult Foster Care program, and PACT appear to be and are reported by staff to be very good.
  - Case Management is developing a training manual.

- **Areas of concern :**

  - Except for PACT, which is a well-developed model with written standards and training guidelines, new staff at GTCMHC – Helena are trained via brief orientation sessions that focus mainly on company policies and on-the-job training. It is unclear whether in all cases the trainers are qualified to train.
  - As noted in **Group Home (Hannaford House)**, BOV team members observed unacceptable telephone communication with a consumer by a staff person and noted that a staff person who seemed unqualified had trained a new staff person.

- **Questions :**

  - Do staff in all areas demonstrate defined competencies and/or receive adequate training in competency areas?

- **Suggestions :**

  - None

- **Recommendations :**

7. Define minimum knowledge and competency expectations for each staff position providing services to consumers.
8. Develop written training material for new staff focused on acheiving minimum knowledge and competency levels.
9. Train new staff in job-specific knowledge and skills OR require new staff to demonstrate

defined minimum knowledge and competency prior to working with consumers.

10. Assess current staff so that knowledge and competence deficiencies can be identified and addressed.

- **Update on Previous Site Review Recommendations :**

  2001 Recommendation: BOV made four recommendations related to staff training in its 2001 Site Review Report:

  - *Establish a goal to have enough therapists certified as chemical dependency counselors so that each consumer with a co-occurring mental illness and chemical dependency can be treated by one therapist who can simultaneously treat both disorders.*
  - *Send selected staff to the NAMI provider education class.*
  - *Assess the knowledge and competency of staff relative to serious mental illness and how to work with adults with serious mental illness, and implement training.*
  - *Analyze the skill levels and training needs of the group home staff and provide necessary training. Consider offering the NAMI provider training.*

  2004 Update: GTCMHC works closely and proactively with the MHSB advocating for continual improvements in PACT services.

Treatment for Co-Occurring Mental Illness and Substance Use Disorders

- **Observations** :

  - The importance of addressing the phenomenon of co-occurring mental illness and substance use disorders has been described thoroughly in mental health literature, and identified nationally and in Montana as a critical area needing development.
  - Providers report that approximately 60% of adults with serious mental illness also have a co-occurring substance use disorders.
  - Montana State Hospital has identified untreated substance use disorders in people with co-occurring mental illness and substance use disorders as a primary cause of rehospitalization.
  - "Integrated Dual Disorders Treatment" has been established as a core evidence-based mental health practice by the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Mental Health Services (CMHS). [3]

- **Strengths :**

  - GTCMHC – Helena is very aware of the need to and appears committed to identifying and treating in an integrated manner individuals who have co-occurring mental illness and substance use disorders.
  - GTCMHC – Helena has one 'dually licensed' (LCPC and LAC) therapist.
  - Other therapists speak to the importance of integrating treatment of co-occurring

[3] United States Department of Health and Human Services. Evidence-Based Practices: Shaping Mental Health Services Toward Recovery. Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, http://www.mentalhealthpractices.org/index.html , 2004.

disorders and state that they do so.
- The PACT team has an addiction counselor and integrates his services into the service package for PACT consumers.

- **Areas of concern :**

  - For each individual whose chart BOV reviewed, there are clear indications from treatment history, consumer report, GTCMHC intake assessment, and concurrent evaluations by other mental health professionals that a co-occurring mental illness and substance use disorder exists, yet charts showed examples of inconsistent diagnosis, absence of substance use disorder diagnosis when pertinent information appeared to indicate its presence, absence of application of information from relevant treatment history, absence of communication with previous treating professionals, absence of communication with concurrent addiction counselors to whom GTCMHC therapists referred, absence of substance use-related treatment goals and interventions when GTCMHC did diagnosis a substance use disorder, and absence of or inadequate documentation of therapeutic interactions about substance use issues between therapist and consumer.

- **Questions :**

  - None

- **Suggestions :**

  - None

- **Recommendations :**

  11. To the greatest degree possible pending implementation of a fully integrated "co-occurring disorders" continuum of care per guidelines being developed by AMDD:

      (a) proactively identify in initial assessments each consumer who has a co-occurring mental illness and substance use disorder;
      (b) develop treatment plans for these consumers that thoroughly integrate treatment for the co-occurring disorders;
      (c) conduct all counseling and treatment activities within the structure of an integrated treatment plan;
      (d) when referrals are made for substance use disorder counseling outside of GTCMHC, ensure that GTCMHC initiates and maintains ongoing communication and treatment coordination with that counselor.

- **Update on Previous Site Review Recommendations :**

  2001 Recommendation: *Establish a goal to have enough therapists certified as chemical dependency counselors so that each consumer with a co-occurring mental illness and chemical dependency can be treated by one therapist who can simultaneously treat both disorders.*

  2004 Update: See above.

FACILITY RESPONSE TO THIS REPORT