MENTAL HEALTH ISSUES AND OPTIONS
A Decision Making Tool

Prepared for the Children, Families, Health, and Human Services Interim Committee
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1. ISSUE: HB 395 Study and 53-21- 132, MCA.

The 2005 Legislature passed HB 395 (Ch. 480) (see Attachment 1). As introduced, one of its proposals was for the state to assume the precommitment costs of a person if the person was eventually committed to the Montana State Hospital. Currently, that is a county responsibility. In the fiscal note, it was estimated that there would be over a $1.1 million impact to the state fund balance for each fiscal year, and the counties would save over an estimated $700,000 each year if this bill were to pass. As the bill made its way through the legislative process it was amended several times and the provision to transfer costs was deleted. The bill that was finally enacted included a cost study that stated that:

> The department of public health and human services shall work with county attorneys and county commissioners to ascertain the actual precommitment costs of involuntary commitments and present that information and any findings and recommendations to the 2007 legislature through an appropriate interim committee.

The AMDD has included a placeholder in the EPP process for potential changes to 53-21-132, MCA. The background indicates that the counties are not paying precommitment costs incurred at the Montana State Hospital because of a departmental interpretation of the law. The amendments to HB 395 appear to have created an ambiguity that may need clarifying.

OPTION: The Committee could request a bill to amend 53-21-132, MCA, back to its original language to make precommitment costs clearly a county responsibility, subject to a county's ability to bill third party payers (the amendments that were actually intended in HB 395). The Committee needs more information from the counties and from the Department in order to know if either entity wishes to proceed in a different manner. Bill Kennedy representing Montana Association of Counties will provide information on June 8.

2. ISSUE: Montana State Hospital (MSH) Study.

The Committee has received testimony that AMDD had started a study of the commitments to MSH to ascertain more information about where the commitments are coming from, why, and why so many seem to have no prior contact with the public mental health system, etc. A letter was sent to AMDD inquiring about the status of the study. In the meantime, the Legislative Audit Committee had placed an audit of the mental health managed care system on their list of priorities. The Audit Division has explored the possibility of doing the study of the admission trends at Montana State Hospital records to ascertain the kinds of information that the Committee and AMDD had been seeking as a contribution to understanding the public mental

health care system and the continual overcrowding crisis at the MSH and subsequent supplemental.

OPTIONS:

It is recommended that the Committee:

(1) to send a letter of support to the Legislative Audit Committee in conducting a study of the Montana State Hospital records of admissions to determine where people are coming from and why and why do they stay at the hospital; and

(2) to send a letter to encourage AMDD to participate in the study and to assist in the development of questions to gain information necessary to strengthen the public mental health system and to relieve the overcrowding at MSH.

3. ISSUE: Statutory authority for DPHHS to license secure nonhospital crisis stabilization facilities.

Currently, the DPHHS authority to adopt rules for licensing health care facilities is very broad: "The department shall adopt rules and minimum standards for implementation of parts 1 and 2." (General provisions and licensing for hospitals and related facilities, 50-5-103, MCA.) Part 1 includes definitions for "health care facilities" which include "mental health centers", also a defined term, 50-5-101, MCA.

DPHHS used the authority in 50-5-103, MCA, to adopt rules for inpatient crisis stabilization programs and outpatient crisis response facilities under the definition of mental health centers. There is authority in statute for behavioral health inpatient facilities (BHIFs), but no BHIFs have been licensed.

Because of the breadth of the rulemaking authority, the department may be able to proceed with adoption of rules for secure crisis stabilization facilities, but without specific parameters or guidelines, the DPHHS may: (1) be reluctant to adopt rules because of the nature of a secure facility; or (2) go in a direction that was not necessarily contemplated by the Legislature or the Committee which would leave the Legislature second-guessing and trying to change or stop implementation after the fact.

OPTIONS:

(1) Recommend a bill draft to specifically authorize DPHHS to adopt rules for a secure crisis stabilization facilities and to provide parameters for the licensure.

(2) Amend Behavioral Health Inpatient Facility (BHIF) statutes to be used as secure crisis facilities. Additional information may be needed to determine why BHIFs are not being developed.

4. ISSUE: Certification of Mental Health Professionals

At the March 2006, meeting, a representative of the Montana Psychological Association raised the issue of certification of mental health professionals. Certification of mental health professionals is authorized in statute, 53-21-106, MCA. Defined terms include "mental health professional" and "professional person". Mental health professionals include certified professional persons, physicians, professional counselors, psychologists, social workers, and an advanced practice registered nurses licensed by the appropriate board in the Department of Labor and Industry.

A professional person is defined as a medical doctor or an advance practice registered nurse with a clinical specialty in psychiatric mental health nursing. This means that persons who fit either of those categories are professional persons by default and not required to be certified. The DPHHS has added a qualification for the advanced practice registered nurse in rule requiring one year of clinical experience, but has no additional qualifications for medical doctors.

This was one of the issues raised by the psychologists. All medical doctors do not have mental health education or experience as psychologists do, yet they are default professional persons. Very few physicians exercise this authority, however. AMDD staff said that in times of emergency when a mental health professional cannot be found, there is usually a physician that can be found to assist with an emergency detention and act as a safety net. APRNs with psychiatric training were added in 2001.

The DPHHS is required to certify professional persons for the purposes of treatment of the seriously mentally ill. The DPHHS has rulemaking authority and the rules must address education, experience, continuing education, training, instruction and work experience, examination, and procedures for certification.

A certified professional person qualifies to:

(a) examine and evaluate a person with mental illness;

(b) make recommendations regarding voluntary admissions or involuntary commitments or recommitments to a mental health facility (danger to self or others, etc.);

(c) testify to that evaluation and recommendation in mental health proceeding in court;

(d) concur in emergency detentions;

(e) supervise treatment plans;

(f) authorize restriction of rights, restraint, isolation;

(g) order discharge; and

(h) request court-ordered release or conditional release.

Currently there are 5 licensed clinical psychiatric APRNs in this state and all 5 have prescriptive authority. There are 3,659 medical doctors, of which 155 are active psychiatrists. There are approximately 196 psychologists licensed in-state. The other mental health professionals that may be certified are professional counselors, 907, and clinical social workers, 483. Of the potential pool of mental health professionals, currently, there are just over 100 certified mental health professionals in the state. It is clear that not all who are eligible seek certification. Most work for community mental health centers and are already participating in the public mental

health system. Some with facility certification work for the Montana State Hospital.

Including psychologists would certainly widen the safety net, and as a result of the training in psychology, they have expertise in mental illness. However, there is no guarantee that more psychologists would actively participate in the public mental health system, just as there is none for physicians or advanced registered practice nurses.

Other options mentioned are a better handbook or flowchart of the system for professionals to better understand the system, or incorporating the certification process into the licensure process. An example of a Maine Handbook was provided. The handbook in Maine was created by the Disability Rights Center, which is Maine's counterpart to our Montana Advocacy Program.

Currently, the examination for licensure as a psychologist includes a couple of general questions on mental health law. The certification process involves a more detailed, open book, written examination in addition to the educational and experience requirements. The written examination covers Title 53, chapter 21, MCA, on treatment of the seriously mentally ill, which contains the statutes for voluntary admission, involuntary commitment requirements, procedures, and dispositions, emergency detention and evaluation, patients rights, discharge, conditional release, and recommitment laws. The examination also covers the resources available for persons with serious mental illness.

As multiple mental health professionals are involved in the certification process, it would be inefficient to move the certification into the licensure process for all of the various boards. Also given the few numbers of the various professions that seek certification, it would be an additional requirement for all licensee applicants with a net result of few who are involved in the activities of a certified professional person. Although technically more mental health professionals may be available for that type of work, there has not been an indication that there is great interest in that kind of work or that the certification process has been a barrier to certification. The more efficient option may be to allow psychologists to be default professional persons. This would be of benefit to the psychologists as they would all be professional persons, but it is unclear if there would be any benefit to the public mental health system overall.

In summary, the certification process appears to work and provide that persons who are recommending that the court commit individuals to mental health facilities know the Montana law and the resources available. Individual psychologists would like to see a change but the Montana Psychological Association has not made a statement to date on this issue. The current certification rules are being updated to reflect past statutory changes, but no major policy change is being sought by the department.

OPTIONS:

(1) In conversations with two individual psychologists, an interest in the following options was indicated:

(a) a **handbook or guide to the commitment law & process**, which would be more user

friendly and accessible than are the current methods of getting that information.

(b) some would like to have the statute 53-21-102(16) amended to **define licensed psychologists as "professional persons,"** as APRNs and MDs are.

(c) move **professional person certification of psychologists to the licensing board** for inclusion in the oral exam.

(2) Since the AMDD administers the certification process, there may be potential to **use the certification and training process in a more proactive fashion**. One of the elements tested for certification is the resources available in the public mental health system. Because of overcrowding at the Montana State Hospital and the evolving and potential development of new crisis services in various communities across the state, the department could more proactively train, manage, or encourage the certified mental health professionals to find alternative placements and programs in the community. This suggestion would be compatible with option (1)(a) above requiring the department to more actively provide information about the process and mental health resources and use the certification requirements, such as enhanced training or outreach, to accomplish greater management of public mental health resources. This recommendation is also relevant to the use of community commitments (see Issue # 5).

5. ISSUE: Parity in Insurance Coverage for Mental Illness

Some of the options that had been proposed for additional research from the March 2006 report included:

1. the adequacy of the definition of mental illness or severe mental illness in the insurance code. How does it compare with the definition of "severe disabling mental illness" or "serious emotional disturbance" used by the public mental health system?
2. the adequacy of the definition of outpatient benefits, should it include other services, such as in-home services or other providers.
3. the adequacy of limits for mental illness, alcoholism, and drug addiction for additional coverage. Is a change warranted at this time?
4. the adequacy of current coverage for mental illness in government-funded health care, such as CHIP, Medicaid, State Employee Health Plan, Montana Comprehensive Health Association Plan.

The definition of "severe mental illness" in 33-22-706(6), MCA, is as follows:

> As used in this section, "severe mental illness" means the following disorders as defined by the American psychiatric association:
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> (a) schizophrenia;
> (b) schizoaffective disorder;
> (c) bipolar disorder;
> (d) major depression;
> (e) panic disorder;
> (f) obsessive-compulsive disorder; and
> (g) autism.

The AMDD definition of serious and disabling mental illness includes the following in addition

to other requirements:

a DSM-IV diagnosis of

(i) schizophrenic disorder (295);

(ii) other psychotic disorder (295.40, 295.70, 297.1, 297.3, 298.9, 293.81, 293.82);

(iii) mood disorder (296.2x, 296.3x, 296.40, 296.4x, 296.5x, 296.6x, 296.7, 296.80, 296.89, 293.83);

(iv) amnestic disorder (294.0, 294.8);

(v) disorder due to a general medical condition (310.1); or

(vi) pervasive developmental disorder not otherwise specified (299.80) when not accompanied by mental retardation;

(vii) anxiety disorder (300.01, 300.21, 300.3) or

(c) has a DSM-IV diagnosis of personality disorder (301.00, 301.20, 301.22, 301.4, 301.50, 301.6, 301.81, 301.82, 301.83, or 301.90) which causes the person to be unable to work competitively on a full-time basis or to be unable to maintain a residence without assistance and support by family or a public agency for a period of at least 6 months (or for an obviously predictable period over 6 months);

The MHA COMPdata April and May 2005 indicated that two-thirds of the primary diagnoses of mental illness were psychoses and 10% were depressive neuroses. Additional information provides greater detail. COMPdata is reported by Diagnosis Related Groups (DRG) or by the International Classification of Diseases (ICD) Diagnosis.

Note: The American Psychiatric Association is the publisher of the DSM-IV or the Diagnostic and Statistical Manual of Mental Disorders, Fourth Ed. The International Classification of Diseases (ICD) Diagnosis has been adopted by the World Health Organization and has become the international standard diagnostic classification for all general epidemiological and many health management purposes. Diagnosis Related Groups (DRG) are derived from a system of payment for the operating costs of acute care hospital inpatient stays under Medicare Part A (Hospital Insurance) based on prospectively set rates. This payment system is referred to as the inpatient prospective payment system (IPPS). Under the IPPS, each case is categorized into a diagnosis-related group (DRG). Each DRG has a payment weight assigned to it, based on the average resources used to treat Medicare patients in that DRG.

OPTIONS:

(1) **Adopt full parity for mental health and substance abuse coverage or change the definition of severe mental illness.** Rhode Island changed from the list of diagnoses that qualified as severe to a definition of mental disorders or substance abuse disorders that is listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM) or the International Classification of Disease Manual (ICD), with exceptions for tobacco, caffeine, mental retardation, learning disorders, motor skills disorders communications disorders and mental disorders classified under "V" codes. Arkansas allows illnesses and disorders in the ICD and DSM. Some states have lists of different mental illnesses. As psychology and psychiatry are

evolving in their understanding of mental illnesses, the Committee needs more information on the classification of mental illnesses and what should be included or excluded. By using a broader definition, you place the interpretation in the hands of licensed professionals as a delegation of authority.

Massachusetts provides greater elaboration of the benefits for children and adolescents under the age of 19 and to a range of inpatient, intermediate, and outpatient services that are medically necessary and in the least restrictive clinically appropriate setting.

(2) **Change inpatient or outpatient benefits or change the limits for coverage for mental illness and substance abuse.** Some states provide number of hours or visit limits rather than a dollar limit. Massachusetts provides a minimum of 60 days of inpatient treatment and a minimum of 24 outpatient visits. Rhode Island limits outpatient services for up to 30 visits a calendar year. Although treatment protocols will change over time, they are more stable than dollar amounts subject to the high rate of medical inflation. The Committee may need more information to know what an adequate amount of time per year is necessary for effective treatment.

6. ISSUE: Inventory of public mental health system resources and gap analysis. See "Elements of a Mental Health System Inventory." Staff prepared a draft listing of the elements that could be included in an inventory of the mental health resources around the state. The list is not all inclusive or exhaustive, simply a start to identifying relevant elements. At the end of the document, there is included some Measures of Various Groups. The list includes AMDD's Service Model, the Montana Mental Health Association's recommended Continuum of Care, and
the components of a high-quality system as identified by NAMI's Grading the States Report. These provide different examples of how various entities within mental health view the critical elements of the system.

Also included are the recommendations from the 2001 TAC Report. This report was the result of a directive by the 1999 Legislature. In Spring of 2000, AMDD selected The Technical Assistance Collaborative, Inc. to evaluate the strengths and the weaknesses of the Medicaid Mental Health Program and the Mental Health Services Plan. The recommendations are included to provide a snapshot of what was recommended in 2001 in order to gauge where the public mental health system has come and perhaps some direction of where it needs to go. Staff highlighted recommendations that identified a similar need for the identification of a core service array, an analysis of state infrastructure and staff, clarification of roles and responsibilities in the system, defining levels of care and eligible populations, and a system wide needs assessment/gap

analysis. AMDD is currently reviewing the needs for the capacity of the public mental health system.

OPTION: Recommend that AMDD complete a System-Wide Needs Assessment and Gap Analysis based on the TAC Report and the changes that have occurred to the public mental

health system over the past 5 years. Ask that AMDD provide the Committee with information regarding the possibility of this analysis and the resources necessary to complete this work.

7. ISSUE: Community Commitments.

The term "community commitment" refers to a disposition that may be used for a person who is found to be suffering from a mental disorder and requires commitment. A person may be committed to "a community facility or program or to any appropriate course of treatment." 53-21-127, MCA. The Committee had expressed an interest in learning more about whether community commitments were being used, by whom, and how often. That information would be available only from the district courts and because it is the county attorneys who prosecute and prepare documents for commitment proceedings, it would be necessary to survey county attorneys and district court judges regarding this information.

Information was received from Joan Daly of Yellowstone County. Community commitments are used often as a first disposition and to commit a person to the Billings Clinic. In 2005, Yellowstone County made the following commitments:

- 44 community commitments
- 5 transients committed to Montana State Hospital (MSH)
- 36 residents to MSH
- 8 revoked community commitments to MSH
- 8 to Lewistown (Montana Mental Health Nursing Care Center)
- 1 to VA Sheridan

Other counties:

- 8 commitments to MSH
- 1 revoked
- 5 community commitments

One conclusion that may be derived is that if there is an alternative in a community or the near vicinity, community commitments are used. In Yellowstone' County's case, approximately one-half of the commitments are a community commitment. The statutes appear to allow this possibility if there are resources in the communities, which is consistent with the anecdotal information that the Committee has received. Assuring that resources exist in the communities may be the more pressing issue.

In inquiring about surveying district court judges and county attorneys, it was brought to my attention that district court judges respond to the petitions that county attorneys place before them. County attorneys work from information gathered through evaluation by the certified professional persons. If the certified professional persons do not have or do not know about community resources, the community commitments may not be an option that is presented to the county attorneys for consideration by district court judges. Again this is a resource issue, but it may also be a training issue as well.

OPTIONS:

(1) Recommend that the district court judges, county attorneys, or community mental health centers be surveyed to determine the actual use of community commitments. The Committee would need to determine the appropriate party responsible for the survey.

(2) Recommend that information regarding the use of community commitments be integrated into the certification of mental health professionals (Issue #4) and in training on mental health resources for district court judges, county attorneys, and public defenders.

(3) Concentrate on the resources for the public mental health system (Issue # 6) with the knowledge that the community commitment statutes are in place and provide authority for district courts to commit a person within a community. This is especially relevant to the secure crisis stabilization issues (see Issue #3).

8. ISSUE: Telephone listings for mental health crisis or suicide.

A requirement to provide toll-free emergency telephone services throughout each respective assigned area is included in the AMDD contracts with four licensed (community) mental health centers. Testimony has been received regarding the difficulty of finding emergency telephone numbers or listings for crisis or suicide lines. A content analysis was performed on 12 telephone books for communities across Montana and the analysis determined that little uniformity exists.

General Observations:

1) Emergency Services telephone numbers are generally on Page 1. Only 1 directory listed a Mental Health Center Crisis Line -- Greater Flathead Valley CenturyTel.
2) On the Emergency Services page, there is a listing for the statewide toll-free Child Abuse Hotline that is administered through DPHHS for centralized intake.
3) In most directories, there is a Community Services Numbers section in the front, XX included a reference to mental health, only 1 had a mention of a Suicide line, in Great Falls Community Service Numbers under Emergency. Substance Abuse numbers are listed under every community services numbers page.
4) In the major 7 cities, there are various listings under both the white pages and the yellow pages. Yellow Pages are by category and uniformly called Mental Health Services. If you have to use the White Pages, however, you must know the correct name of the mental health center and crisis numbers are mentioned in only 6 out of 12 directories. Crisis or emergency numbers are included in 11 of 12 of the directories. Under the Community Services listings, there are two local number listings and one toll-free number; under the White Pages, there are 3 toll-free numbers and 3 local numbers listed; and under the Yellow Pages, there are 4 local listings and 6 toll-free numbers.
5) Dex Community Service Numbers provides that if the you want changes, deletions, or additions in Community Service Numbers, you must call 303-896-6147.

OPTIONS:

1) Statewide toll-free crisis hotline with a listing similar to the child abuse hotline. This would require resources to AMDD or another entity, or could be a statewide contract

related to the 2-1-1 legislation from 2005. There was only 1 mention of suicide in any directory. Given our high suicide rate, that may be the most compelling argument for a statewide toll-free line and listing under emergency services. This may also provide for a more centralized data collection for analysis.

2) Requirement in state contracts that each mental health center with a contract that requires a crisis line is required to secure a mental health crisis line listings for all communities in its service are under emergency services as a condition of the contract.

Telephone Book Search Content Analysis Results

Helena Dex-

- Pg. 43 under Community Service Numbers - Mental Health - Golden Triangle - Crisis Line (24 hours) local number.
- White Pages listing for Golden Triangle Community Mental Health - large type, bold, includes emergency crisis line local number and emergencies toll free number
- Yellow Pages - listing under Mental Health Services - Boulder, Helena, Lincoln, Townsend. Large ad with Emergency Crisis local and toll free numbers.

Missoula Dex

- Nothing under Community Service Numbers in front listings.
- White Pages listing for Western Montana Mental Health (no bold)
- Yellow Pages - listing under Mental Health Services - Alberton, Missoula, Superior, Thompson Falls. Large ad on previous page that includes emergency (24 Hour Availability) includes local number and toll-free number.

Bozeman Dex

- Pg. 31 under Community Pages Community Service Numbers - Mental Health Center listing for Bozeman, MSU, and Livingston - local numbers only (no emergency or toll free numbers).
- White Pages listing for Gallatin Mental Health Center (bold) local number (no emergency number).
- Yellow Pages listing for Gallatin Mental Health Center, local number. Large ad on same page lists emergency services and includes local number.

Butte Dex

- Pg. 41 under Community Service Numbers - Mental Health Services (Outpatient) local numbers for Anaconda, Butte, Deer Lodge County, Dillon - local numbers only (no emergency or toll free numbers).
- White Pages listing for Western Montana Mental Health Center (Large, Bold) local number (no emergency number).
- Yellow Pages listing for Western Montana Mental Health Center, local number. Large ad on next page includes local number and 24-Hour Crisis Line Toll Free Number

Billings Dex

- Pg. 49 under Community Service Numbers - Mental Health - for Carbon County, Red Lodge, Musselshell County, Stillwater County, Yellowstone County - Mental Health Center and Emergency - 24-hour local numbers.
- Under White Pages for Business - Large, colored ad with 24-Hour Emergency Services toll-free number.
- Yellow Pages listed under Mental Health Services for Big Timber, Billings, Columbus, Hardin, Harlowton, Red Lodge, Roundup, includes local numbers and toll free numbers. Large Ad on previous page with local and toll free, 24 Hour Emergency services numbers.

Great Falls Dex
- Pg. 35 under Emergency Numbers, Suicide Intervention local number.
- Pg. 36 under Mental Health, Golden Triangle Mental Health Center local number.
- White Pages - Golden Triangle Community Mental Health regular type, local number.
- Yellow Pages - Under Mental Health Services, Golden Triangle Mental Health Services (bold) local number. Large ad on same page. For Emergencies Only toll free number.

Greater Flathead Valley CenturyTel
- Pg. 1 under Emergency Numbers, Mental Health Crisis Line local number.
- White pages - no listing for Western Montana Mental Health Center (listing of toll free number for Pathways Treatment Center.)
- Yellow Pages under Mental Health Services Mental Health Center, 24-hr. Crisis Services local number.

Libby Frontier Pages
- Pg. 8 Community Services - Western Montana Mental Health Center local number.
- White pages - Western Montana Mental Health Center local number.
- Yellow Pages under Mental Health Services, Mental Health Center Crisis Line Toll Free.

Mid-Rivers Communications Montana/Dakota Regional Telephone Directory (Eastern Montana
- Green Pages - no mental health listings.
- White pages (red tab) - listing for Mental Health Center for Glendive (local crisis line), Miles City (local crisis line), Roundup (toll free), Sidney (local number), none for Wibaux, Terry, Baker, Fairview.
- Under Billings Business (purple tab) - listing for Mental Health Center including local number and 24-Hour Emergency Services toll free number.
- Yellow Pages under Mental Health Services, listing for Miles City Emergency Call local number under Eastern Montana Community Mental Health Center. Also listing for Deaconess Billings Clinic Psychiatric Services - Billings Toll Free.

3 Rivers Communications Directory North (Northcentral Montana)
- White pages listing for Golden Triangle Mental Health Services - Browning, Chouteau, For Emergencies Toll Free number. Conrad, Cut Bank local number. (No listing for Shelby except Yellow Pages)

- Yellow Pages listing under Mental Health Services for Golden Triangle Community Mental Health Center Toll Free number (no mention of emergency, crisis, or 24-hour).

Lewistown Dex
- White Pages local number under Mental Health Center
- Yellow Pages listing under Mental Health Services for Mental Health Center - local and toll free number (no mention of crisis, emergency, 24-hour)

Blackfoot Directory (Western Montana)
- Pg. 57 Community Service Numbers under Mental Health Center Emergency Services local number.
- White Pages Mental Health Center listing for Thompson Falls, Plains, Superior, Ronan, Hamilton, Missoula local numbers. Only Emergency Services number is a local number for Missoula.
- Yellow Pages under Mental Health Services local number for Ronan, no mention of emergency or crisis.