

1-10-07

GARY MINGOS

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EXHIBIT 6
DATE 1-10-07
HB 2

Western Service Area Authority

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Joyce DeCunzo, Administrator
Addictive and Mental Disorders Division
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Re: Adult Mental Health System Crisis Management Initiatives

At our January 18th WSAA Board of Directors meeting we spent a considerable amount of time evaluating, discussing and ranking the options for Crisis Management Initiatives in order of priority in our opinion. We have added or changed some wording from the way they were listed in your chart to clarify our recommendations.

- Presumptive eligibility for 72 hours at local hospitals and Mental Health Centers.
- Statewide 24/7 emergency assistance to local hospitals. Psychiatric consultations by MSH staff (or mental health centers/private providers) and video conferencing for consultations.
- Emergency room professional assistance and training program.
- Individuals at imminent risk, automatic enrollment in mental health system.
- Discharge medications for patients leaving MSH - enough to get consumer through till a local psychiatrist can prescribe.
- Increase MHSP poverty level to 200% of P.L. from 150% - Matching the poverty level for co-occurring disorders coverage.
- Train law enforcement staff for crisis intervention to work with individuals in a mental health crisis humanely. (New item – see reasoning below)
- Peer support services. Drop in centers, i.e. The Hub in Billings, NAMI's Peer to Peer program and Montana Mental Health Association's WRAP training.
- Enhanced services for all MSH (and community hospital) discharges for 90 days.
- Recruit and retain professional staff with higher reimbursement rates for services provided.

NATION/WORLD

Officials: Increase in inmate suicides connected to solitary confinement

USA Today

The number of suicides in the nation's largest state prison systems is ticking upward, and authorities in California and Texas are linking the increase to the rising number of inmates kept in solitary confinement.

In California, which has the largest state prison system with about 170,000 inmates, there have been 41 suicides this year, the most in at least six years and a 17 percent increase from 2005.

Although an estimated 5 percent of California's inmates are housed in solitary confinement — also known as "administrative segregation" — 69 percent of last year's suicides occurred in units

where inmates are isolated for 23 hours a day, and about half the suicides this year were committed in such units, according to state Department of Corrections records.

In Texas' prison system, which has 169,000 inmates, there have been 24 suicides this year, up from 22 in 2005. Most of the inmates who killed themselves were in some form of solitary confinement, said John Moriarty, inspector general for the prison system.

Texas prisons also are reporting a big increase in attempted suicides: 652 so far this year, compared with 559 in 2005. The number of attempted suicides this year is the most in nearly a

decade, according to state prison records. Statistics on attempted suicides in California prisons were not immediately available.

The figures from California and Texas are fueling a debate over whether solitary confinement is the best way to control or punish violent or dangerous inmates, particularly those who are mentally ill.

More than 70,000 of the 1.5 million inmates in state and federal prisons are kept in isolation, a reflection of prisons' get-tough policies that are designed to separate rival gang members and those who have gotten into fights while behind bars.

Isolated inmates typically have significant restrictions on visitors

and receive little help in dealing with the psychological problems that can be caused by isolation. They usually are allowed out of their cells for no more than an hour a day to exercise alone. Their exposure to TV and reading material also is limited.

"Are we housing the mentally ill in prison facilities?" Moriarty asked. "I think the answer is yes. But I don't know if that's the best place for them to be."

Moriarty said stress from isolation and increasing numbers of inmates with long sentences have contributed to the rise in suicides. "Length of sentence is a big factor," he said. "There is this despair about not getting out."

The increase in inmate suicides

in California has triggered recent changes in segregation units. In October, guards began checking inmates housed in solitary confinement every 30 minutes, rather than every hour, says Shama Chaiken, the state prison system's chief psychologist for mental health policy.

Some segregation cells also will be modified to remove shelving, vent openings and other features that offenders could use in hangings, the most common form of suicide in California prisons, Chaiken said.

This month, California Gov. Arnold Schwarzenegger announced plans to spend \$1 billion for 10,000 beds in prison medical and mental health units.

Montana

Grade: F

Category Grades

Infrastructure	F
Information Access	D-
Services	F
Recovery Supports	F

Spending, Income, & Rankings

PC Spending/Rank	\$123.41	11
PC Income	\$24,610	45
Total MH Spending/Rank	\$113 <i>(in millions)</i>	39
Suicide Rank		3

Recent Innovations

- Regional service area plan for Medicaid
- Multi-level approach to curb alcohol abuse that connects to core mental health problems, including the nation's third-highest suicide rate

Urgent Needs

- More beds in hospital and crisis units—not jails
- Crisis Intervention Teams (CIT) and jail diversion programs
- American Indian inclusion
- Better pay for providers



Montana is a profoundly beautiful state with a strong culture of self-reliance. It also is a vast and relatively poor state, a combination that leads to chronic shortages of healthcare providers, low pay, and a constant challenge to provide quality services. The state also has a significant Native American population, posing its own set of unique challenges to the mental healthcare system.

Montana is the only state in the country that has as many Assertive Community Treatment (ACT) teams as employees of the state mental health agency (5). It also can be credited for taking steps to address structural problems within the oftentimes complicated mental health system. It has a competent data collection system. Services have recently been aligned with Medicaid spending through three regional nonprofit agencies, taking into account local decision making. On the latter initiative, the jury is still out on how well it will work.

What is appalling is the lack of adequate psychiatric hospital beds in Helena, especially when one considers the lack of day treatment programs. Consumers report long hauls in shackles in the back of police cars taking them to the distant state hospital. The practice is not only an assault on individual dignity, but a burden on sheriffs, who are themselves victims of the system's inadequacies. Statewide, there is a need for more inpatient beds—the supply of which is shrinking.

Criminalization of mental illness is tied to capacity issues. If there are not beds in hospitals, it is easier to put people where there are beds—in jails and prisons. Jail diversion programs are needed in Montana. The absence of housing options, providers, and Crisis Intervention Teams (CITs) help fill homeless shelters as well. PACT teams in Missoula, Bozeman, Billings, Great Falls, and Helena reflect a sensible deployment and a significant achievement. From the perspective of an overall system of care, however, without beds, the PACT are like an airplane trying to fly on only a wing and a prayer. Big Sky horizons need to be broader.

Alcohol abuse and co-occurring disorders have been a major problem for Montana, causing the state to consult national experts and develop a plan to address the problem. At a larger level, the Montana legislature has made efforts toward reducing its many highway deaths by outlawing open alcohol containers in vehicles. With alcohol and depression oftentimes underlying suicide,

Montana has realized that it has to try to curb the high numbers of suicides in the state. NAMI applauds this first attempt to do just that.

Families and consumers help to get things done in the Big Sky State. It is difficult to see how progress is made at all, given the tiny infrastructure in the state. With such a small existing infrastructure, consumer and family involvement is essential to develop appropriate services. NAMI Montana's advocacy in helping support the development of ACT teams statewide, the first Crisis Intervention Training (CIT) for law enforcement officers in Helena, and consumer and provider education programs has been instrumental in creating services that really work for the people they are intended to help.

Montana's mental healthcare system has the feel of a rural "barn raising" philosophy—people working together with their limited raw materials. Yet if you are a Native American Indian consumer, you may not be connected. There has been little success in bringing this population sector to the table. While this is a challenge with a difficult history, Montana could be a leader here, given its relative success in being consumer- and family-driven.



National Alliance on Mental Illness

SPENDING MONEY IN ALL THE RIGHT PLACES: OUTCOMES MEASUREMENT FACT SHEET

Why measure outcomes?

There's an old adage that "you can't manage what you can't measure." Measurement ensures accountability—an important concept in a time of competing demands for limited resources. Standardized outcome measures document the effectiveness of mental health treatment and provide a rationale for additional funding.

Measuring mental health outcomes is useful at both the individual and systems level. Providers and consumers can use outcomes to track progress towards recovery and assist with treatment decisions. Advocates can use outcomes to establish the positive impact of mental health treatment on society at large and the decrease in costs associated with the criminal justice system, hospitalization and homelessness. Outcomes measurement can also highlight services that are not effective and allow systems to redirect resources.

The outcomes to be measured will vary depending on the use of the data.

What can I do to bring outcomes measurement to my state?

Below are profiles of two approaches that NAMI advocates have used in their states.

Minnesota's Mental Health Action Group

To further their vision of change, a group of diverse citizens joined together to create the Minnesota Mental Health Action Group (MMHAG). The MMHAG includes consumer and family advocates, public and private providers and payers, and state policymakers committed to improving Minnesota's mental health system.

MMHAG prioritized the creation of standardized outcomes measurement to assess the system's strengths and weaknesses and provide a starting point for quality improvement. NAMI Minnesota joined an Action Team to focus on outcomes and develop a plan for system-wide implementation. The Action Team designated four domains to measure: *access* to care;

National Outcomes Measures

The National Outcomes Measures (NOM) project, operated by the Substance Abuse and Mental Health Services Administration (SAMHSA), has established a baseline of ten domains across mental health and substance abuse for measurement, including: decreased symptoms of mental illness with improved functioning, social connectedness, involvement in employment and/or education, decreased involvement with the criminal justice system, stability in housing, access to services, retention in services, perception of care, use of evidence-based practices, and cost-effectiveness.

Over 30 states are reporting some data and SAMHSA is projecting participation from all states in the near future. More information on NOMs and preliminary outcomes data is available online at: www.nationaloutcomemeasures.samhsa.gov.

Advocates should find out whether their state is reporting this data and which outcomes are being reported and use this as a foundation for further advocacy.

appropriateness of care in moving people towards recovery; *effectiveness* of the care in improving functioning, and *efficiency* and *equity* of care to ensure that people are treated fairly and funds are used wisely. To measure outcomes, the Action Team identified pre-existing outcomes questionnaires to capture this data at the consumer, family, provider and payer level.

As a result of this work, in 2006, the legislature dedicated \$436,000 to the development of outcomes measurement for the mental health system. At the request of MMHAG and with the support of the state legislature, a full-time position was created within the state's mental health authority to oversee the system-wide implementation. Minnesota has begun piloting the new outcome measures for children in some county-based public mental health systems and one private health insurance plan; pilots for adults will start soon.

Here are some lessons from the experience of the MMHAG:

- Involve a broad group of stakeholders, but ensure a strong consumer/family voice.
- Determine if any data is already collected in the state; stop collecting useless data.
- Reduce the burden for providers in collecting data and ensure a useful reporting format.
- Carefully analyze policies to avoid unintended consequences; do not create disincentives to treat individuals with the most serious mental illnesses.
- Designate a single person to oversee the implementation of the process.

To learn more contact Sue Abderholden, NAMI Minnesota's Executive Director and a member of the MMHAG, at 651-645-2948 or sabderholden@nami.org. You can also visit the MMHAG website at <http://www.citizensleague.net/what/projects/mmhag/>.

Contracting for Outcomes Measurement in Utah

Advocacy groups in Utah repeatedly encountered legislators who viewed the mental health system as a "black hole" needing endless funding with little positive results. To combat this perception, NAMI Utah and other advocacy groups requested increased accountability to show the effectiveness of the state's investment in mental health.

In response, Utah's Division of Substance Abuse and Mental Health (DSAMH) announced that the state will begin to systematically track outcomes within the state's community mental health system. In 2006, the state entered into a five year contract with a private company to utilize a computerized tool that tracks consumer progress and assists clinicians with treatment decisions.¹ At every outpatient visit, and weekly in inpatient settings, a consumer answers a series of questions that can be used by the provider to improve treatment and by the system to aggregate outcomes at the state level. DSAMH has mandated that outcomes be measured at all community mental health centers that receive funds from the state.

As NAMI Utah's Executive Director said, outcomes measurement is a "win for consumers, a win for family members, a win for providers and a win for the state."

To learn more contact Sherri Wittwer, NAMI Utah's Executive Director, at 801-323-9900.

¹ "Utah set to implement outcome tracking measure," *Mental Health Weekly*, Volume 16 Number 18, May 1, 2006.



National Alliance on Mental Illness

SPENDING MONEY IN ALL THE RIGHT PLACES: DISEASE MANAGEMENT FACT SHEET

What is Disease Management?

Disease management is a system of coordinated health care interventions and communications for populations with conditions in which patient self-care efforts are significant. DM:

- Supports the physician or practitioner/patient relationship and plan of care;
- Emphasizes prevention of exacerbations and complications utilizing evidence-based practice guidelines and patient empowerment strategies; and
- Evaluates clinical, humanistic, and economic outcomes on an on-going basis with the goal of improving overall health.

DM components include:

- Population identification processes;
- Evidence-based practice guidelines;
- Collaborative practice models to include physician and support-service providers;
- Patient self-management education;
- Process and outcomes measurement, evaluation, and management;
- Routine reporting/feedback loop

Source: The Disease Management Association of America, www.dmaa.org/definition

Disease management (DM) is becoming the new trend in health care for individuals with long-term or persistent medical conditions for two important reasons: improved quality of care and decreased cost. Quality is improved because treatment is coordinated across the spectrum of care for individuals with these conditions using evidence-based practice guidelines and education on illness self-management. Costs are contained because DM targets the most expensive conditions and develops standardized packages of care that allow for greater efficiency and economies of scale for purchasing of supplies and services by health care systems.¹

How could disease management be used in mental health systems?

The combination of improved quality with lower costs has made DM very attractive for policymakers. The Centers for Medicaid and Medicare Services (CMS) issued a letter to state Medicaid directors encouraging the adoption of DM.² DM is now widely used in states for asthma, diabetes, hypertension and other persistent medical conditions, but the trend towards DM in mental health has been slow even with the large number of Medicaid enrollees with serious mental illnesses.³

Despite the slow start, DM is becoming more common among mental health systems. For advocates, the introduction of DM is an opportunity to promote the inclusion of recovery-oriented and evidence-based programs as part of the DM service package. Advocates can make the case that several services fall under DM, including Assertive Community Treatment, supported employment and housing, and consumer and family education programs. However, advocates should carefully monitor the implementation of DM to be sure that cost savings do not come at the expense of quality, and that savings are reinvested in the mental health system.

The Texas Experience: A Homegrown Disease Management Model

In 2003, the Texas legislature adopted a disease management model to completely redesign the state's mental health system. With the support of advocates, including NAMI Texas, the legislation created a strategic investment of the state's limited resources towards evidence-based treatments for children and adults with the most serious mental illnesses. The goal of Texas's Resiliency and Disease Management (RDM) initiative is to provide the "right service to the right person in the right amount to promote the best outcomes."⁴

Texas's RDM approach contains the key components of disease management recognized by the Disease Management Association of America, including:

- *Population identification* – Uniform assessments are conducted using the Texas Recommended Assessment Guidelines (TRAG) to determine if individuals seeking services meet the state's priority population of adults and children with the most serious mental illnesses. TRAG results are used to identify the most appropriate service package.
- *Evidence-based practice guidelines* – National experts in mental health care developed standardized clinical practice guidelines to ensure that the various service packages include the most effective treatment. Utilization Management (UM) guidelines outline the amount, duration and scope of services in each package.
- *Collaborative practice models* – The service packages include a variety of collaborative treatment approaches, including Assertive Community Treatment, supported housing and employment, medication and case management, skills training, psychosocial rehabilitation, individual and group counseling, and consumer and family education.
- *Consumer and family education* – Programs provide knowledge about illness management to empower consumers and families to be equal partners in treatment and recovery.
- *Process and outcomes measurement, evaluation, and management* – The TRAG is used to measure outcomes for individuals in treatment, and, along with the UM guidelines, allows for a comparison of outcomes at a system level to measure the performance of the local mental health authorities. Already, the state has documented an improvement in a wide variety of outcomes for children and adults, including improved or stabilized functioning, housing, employment, time in crisis and involvement with the criminal justice system.⁵
- *Routine reporting/feedback loop* – Results are communicated to local mental health authorities and the state imposes consequences if clinical or financial standards are not met. The data is also useful to advocates in obtaining an accurate picture of what services are delivered, to whom, and at what cost; that information can be used by advocates to address clinical and system outcomes.

To learn more about Texas's successful experience with disease management, contact Robin Peyson, NAMI Texas's Executive Director, at 512-693-2000.

¹ American Psychiatric Association Alternatives to Managed Care Resource Document, January 2004. Retrieved October 16, 2005 from http://www.psych.org/edu/other_res/lib_archives/archives/200403.pdf.

² Centers for Medicare and Medicaid Services, Dear State Medicaid Director Letter, SMDL #04-002. Retrieved October 16, 2006 from <http://www.cms.hhs.gov/smdl/downloads/smd022504.pdf>

³ Williams, C., "Medicaid Disease Management: Issues and Promises," Kaiser Commission on Medicaid and the Uninsured, September 2004. Retrieved October 16, 2006 from: <http://www.kff.org/medicaid/upload/Medicaid-Disease-Management-Issues-and-Promises-Issue-Paper.pdf>.

⁴ Texas Department of State Health Services (DSHS). Retrieved October 24, 2006 from <http://www.dshs.state.tx.us/mhprograms/RDM.shtm>.

⁵ Presentation by the Texas DSHS to the Senate Health and Human Services Committee, Interim Chart #1, August 23, 2006.