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HELENA COLLEGE
University of Montana

A Proposal for the NAMI-MT Sponsored Montana Institute Reboot Project

Helena College University of Montana

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On behave of myself and my students at Helena College University of Montana we would like to offer this proposal for the NAMI-MT sponsored Montana Institute Reboot contest.

- **Introduction**
  - Helena College University of Montana developed a plan for the Montana Institute Reboot (MIR) contest created the NAMI-Montana. Over a period of approximately two months Helena College students Kate Glenn, Amy Myers, Cassia Goodwin, Andrea Edgar, and Katie Thennis, and psychology instructor Nathan A. Munn, M.D. met both formally and informally to discuss perceived problems and potential solutions to the issues facing the mental health care delivery system for the State of Montana. What follows is the culmination of these efforts.
  - Please note that in this proposal "mental illness" refers to substance use disorders and personality disorders along with other major Axis I disorders.
  - In addition this proposal evaluates the entire mental health system of Montana as it is not feasible to address one level of care, institutions, without acknowledging the interwoven system.

- **Problems**
  - *High patient census at Montana State Hospital (MSH)*

Montana State Hospital was built for a capacity of around 160 patients. It often has a census of over 200. Though the staff at MSH is very dedicated, having high census will by necessity impair effective mental health care.

  - *Unacceptable number of mentally ill in Montana State Prison (MSP)*

Montana State Prison actually has more people with mental illness than does MSH. Though many individuals on psychiatric medications may not need the level of care provided at MSH, having over 700 inmates at MSP on some form of psychiatric medication most likely represents a displacement of people with mental illness from MSH to MSP.

  - *Care not local for many patients given use of MSH*

Best practices in mental health care consistently demonstrate local care as more effective than care in distant facilities. Montana is a very vast state, and having patients go to MSH for care often impedes inclusion of local treatment providers and family members.

  - *Services not coordinated adequately for adults*

Consumers and family members often find it daunting to traverse the complex structure of the mental health system. Though many companies have case management services these are too often characterized by inadequately trained staff and unclear expectations as to what is clinically pertinent data.

- *Lack of coordination of services for children and adolescents*

Though there are many services for children and adolescents including Kids Management Authorities (KMA), facilities such as Shodair Hospital, Intermountain, Yellowstone Boys & Girls Ranch, A.W.A.R.E., outpatient providers, and many others, family members often have difficulty knowing where to start receiving treatments and how to coordinate care. They are often left with feeling lost in a sea of providers not knowing where to steer their boat. This problem becomes worse when considering the number of high-intensity children who are being treated at expensive out-of-state programs.

- *Lack of continuity of care from children and adolescent to adulthood*

Once an individual turns 18 they are considered an adult. This results in them going from the child and adolescent system to the adult system rapidly. Having this abrupt change impairs continuity of care as few organizations treat both children & adolescents and adult populations. Realistically there is no particular date where an individual suddenly becomes an adult but rather it is a developmental process. This thus results in discontinuity of care and subsequent disruption of a person's mental health.

- *Data on treatment outcomes including lack of data on treatment plans not readily available*

Too often patients will undergo various treatment modalities and yet the effectiveness of these treatments is lost to subsequent providers. For example medication trials are reduced to listing what medications were tried and not go into detail on treatment responses, doses, and length of treatment. The same could be said for psychotherapeutic interventions as well. Usually notes on psychotherapy only indicate it was or wasn't provided. Details into what kind of psychotherapy that was provided, the clinical outcomes aimed for, and effectiveness of the trials are not clearly identified.

- *Shortage of Psychiatrists*

The need for psychiatrists is a long-standing issue for Montana. Most psychiatric medications are prescribed by primary care physicians who frequently lack the necessary education required to prescribe them. There are several issues in recruiting psychiatrists to Montana including pay rates, case-load, and professional isolation.

- *Need to coordinate care with primary care physicians and other primary medical providers*

Given the large percentage of psychiatric medications prescribed by primary care physicians the need for coordination of care is vital. However frequently primary care providers are on a tight schedule to see patients and do not review the effectiveness of treatments. In addition, given the limited mental health training of primary care physicians, many are not aware of the different treatment options nor the way psychiatric medications need to be used such as targeting symptoms and therapeutic trials. Many primary care providers do not provide the level of follow-up required as they are very busy with large case-loads. Finally the understanding of mental illness is often inadequate with primary care physicians. They often regard complex psychiatric illnesses as simplistic "serotonin imbalances" and thus do not refer to psychotherapy and other treatment modalities.

- *Insufficiently trained Mental Health Direct Care providers*

Training for Mental Health Direct Care (MHDC) varies widely across Montana. Some facilities require only a High School diploma while others require a Bachelor's degree (though not necessarily one within psychology). Most provider institutions provide some training for the MHDC providers, but again this training varies widely. Many MHDC providers do not understand basic mental health concepts such as diagnosis, the five Axes' used for DSM-IV, neurochemistry, psychological treatments, and social treatments. This is particularly problematic given MHDC providers spend the most time with clients and are in a unique position to monitor care efficacy and to provide detailed accurate reports to other providers such as psychotherapists, psychiatrists, and primary care providers.

- *Under-use of Peer Support Specialists*

Peer Support Specialists (PSS) have been shown to add significant benefit to overall treatment outcomes for people suffering from mental illnesses including decreased hospitalization rates and improved recovery measures. Though many facilities do utilize PSS more should do so to fully maximize this treatment provider specialty. Additionally, specific areas of PSS that need further scientific research should be accounted for.

- *Need to apply current scientific knowledge of the treatment of mental illness to State and facility policies*

Neuroscience knowledge rapidly expanded over the past few decades and especially in the last few years. Data from neuroimaging and cognitive processing studies could enhance psychiatric treatment. There are ongoing difficulties getting the research base to the clinical field nation-wide. In Montana institutional procedures are at times counter to basic neuroscience. For example, there is an agreement with MDC and MSH that when a client from MDC goes to MSH they have ten days for treatment prior to returning to MDC. This number of days is arbitrary and does not reflect the known process of altering psychiatric medications and the time it takes to do so efficiently. New medications take at least 6 to 8 weeks before there are indications as to their treating target symptoms or not, and that assumes the first medication would be effective.

- *Need to advance scientific knowledge of mental illness and mental health care*

Though the scientific knowledge base of mental illness and mental health care has advanced tremendously over the past few decades, much more needs to be done to understand these devastating illnesses. For example, the use of psychiatric medications, though again much improved, still does not fully treat many individuals suffering from mental illness. They do not result in relief of symptoms. Montana offers a unique research base given its relative isolation of population.

- **Solutions**
    - *Better trained direct care providers*

A basic tenet of Helena College's MIR proposal is that MHDC providers play a vital role in the overall mental health care system. However they are often dismissed as "baby sitters" and not included in team meetings. Training for MHDC varies widely and often does not adequately prepare providers for the mental health needs of its clients.

To address the lack of and widely varying training of MHDC providers, Helena College proposes the following:

1. That all MHDC providers receive specific training in caring for mentally ill children, adolescents, and adults.
2. That this training includes specific content comprehensively addressing mental illness and its treatment.
3. That MHDC students be trained in monitoring treatment outcomes in very specific ways thus allowing them to provide needed communication between other treatment providers including but not limited to psychiatrists, primary care physicians, and psychotherapists.
4. That MHDC student be trained in specific treatment modalities pertinent to their profession such as day treatment modalities and others.
5. That a specific degree, an Associates of Applied Science in Mental Health Direct Care, be developed and used for the specific training of MHDC providers. This program could be offered at Montana two-year college institutions, and
6. That MHDC be a licensed profession.
7. That in accordance to licensure MHDC providers' services is reimbursed at a higher rate than non-licensed MHDC providers. These higher reimbursement rates then shall be passed on to the providers thereby increasing stability in MHDC staff.
8. Specific training programs with consistency State-wide may be provided at community colleges and tribal colleges.

By enhancing the level of training for MHDC and providing them with a salary that allows for a decent living the overall success of mental health treatments will increase. Clients will receive treatment sooner and with increased effectiveness as specific indications for treatment will be presented to other treatment providers.

- *Better and more equipped care managers*

Good case management can make a huge difference in the care of individuals with mental illnesses. Similarly to the MHDC providers, however, frequently case managers are ill-trained and not up to the level of skill required for their position. Helena College's proposal for MIR is to have equivalent level of training for case managers as with MHDC providers with additional training in reporting symptoms and on the systems of care in Montana. Case managers would work across other treatment institutions providing outcome data and information on treatment plans. They would also monitor symptoms, medication trials, and psychotherapy trials, other interventions, along with levels of care and service utilization. When indicated other measures of a client's well-being could also be implemented such as measures of Recovery. These measures could then be processed

in a centralized location to continue needed research on the delivery and effectiveness of mental health care.

- *Improved culture at institutes*

In the BOV review of MDC and MHS there was mention of the culture at these institutions. Especially at MDC there was concern about staff burn-out and difficult attitudes toward clients. It is proposed that with increased training of the MHDC staff at these facilities and implementation of an expanding role for them in the overall care of clients the institutional culture will improve. It needs to be emphasized how crucial of a role these providers play in the mental health care of some very ill people. A sense of pride and accomplishment along with an improved feeling of cohesion in a strong treatment team shall change the culture of these institutions to a healthier one.

- *Creation of 5 to 10 16-bed inpatient facilities to decrease patient load at MSH*

By creating smaller long-term inpatient treatment facilities across Montana the high census at MSH can be reduced. In addition this allows acute and sub-acute mental health treatments to be provided on a more local level. This closeness to other service providers and family will enhance treatment coordination and family involvement in care.

Having 16-bed units would allow for billing of Medicaid as well. With the upcoming Affordable Care Act this ability will divert funding away from Montana's general fund to Medicaid.

Potential sites for these units include: Missoula, Helena, Butte, Great Falls, Bozeman, Billings, Miles City, and Havre. In addition, the Indian Health Service hospital on the Fort Belknap reservation could be modified to provide inpatient psychiatric care to Native Americans from reservations along the Highline. This modification would allow for culturally specific treatments to be provided. These 16-bed inpatient facilities would not compete for clients with local hospitals as the level of care for the patients they serve would be equivalent to current patients at MSH. Thus, their target population differs from that of current inpatient programs.

Each of these 16-bed inpatient facilities would be highly integrated into the community system. Case management would take place from the moment of admission and continue to discharge, effectively coordinating various levels of care necessary for the healthy treatment of mentally ill.

- *Convert MSH to mainly incarcerated mentally ill*

With the decreasing census at MSH mentally ill prisoners could have their psychiatric care delivered in a more appropriate setting. Having indicated psychiatric care could potentially reduce relapse and recidivism among mentally ill felons. The use of MSH campus for those with mental illnesses who are involved in the criminal justice system.

- *Recruitment of psychiatrists*

The ongoing shortage of psychiatrists is a deep need for Montana. Helena College's MIR proposes this need be addressed by:

1. Loan repayment for psychiatrists. While we may not be able to match reimbursement rates for psychiatrists, having loan repayment would relatively increase payment rates. Increasingly people graduating from medical school carry a large debt burden. Having loan repayment would attract more psychiatrists.
2. Creating a state-wide collaboration between psychiatrists working at the 16-bed inpatient units. A major factor in psychiatric turn-over in Montana is the sheer intensity of case load. Using Skype and other internet-based technologies psychiatrists from across the state can help cover call at the various smaller long-term inpatient units. Thus any individual psychiatrist at each location would not be overwhelmed by the ongoing case loads.
3. Provide extensive continuing medical education (CME) activities for the psychiatrists in Montana. By providing CME opportunities psychiatrists can save money and thus relatively have higher pay rates.
4. Creating of a psychiatric residency program in Montana. Having psychiatric residents would create a strong level of service provision at reduced cost. Also, along with CME offerings, psychiatrists would feel like they had more of a cohort to collaborate with and rely upon.

- *Expansion of Peer Support Services to meet State needs*

Currently there exists a Peer Support Specialist (PSS) task force that is developing the PSS profession. Helena College supports this process and is developing pedagogy for education. Any MIR proposal must incorporate PSS activity given the increasing amounts of data supporting the role of PSS providers in the overall mental health care system.

Training of PSS must be standardized and consistent across Montana. Once a specific training curriculum is developed that corresponds to licensure this curriculum could be implemented at two-year higher education programs State-wide including the community colleges and tribal colleges.

However there exist specific issues within Peer Support Services. These include acceptance from other providers, boundary issues, training consistency, and scope of practice. These elements of PSS need to be monitored in a systematic way to improve this level of care, not only in Montana, but Nation-wide. These research questions need to be studied.

Peer Support Specialist also need to be incorporated into many different levels of care including outpatient, day treatment programs, drop-in centers, inpatient care, etc. In addition PSS from specific populations need to be trained. These include Native Americans and Veterans.

- *Creation of secondary prevention efforts to detect suicidal individuals early and channel them into care*

Montana continues to have a very high rate of suicide. Public awareness campaigns on suicide prevention have not consistently shown effectiveness. Obviously suicide is related to the mental illness burden in Montana. Many individuals hospitalized psychiatrically are so hospitalized due to suicidal ideation and behaviors.

Working with Montana's suicide prevention coordinator, a State-wide intervention program, perhaps analogous to the anti-methamphetamine campaign, will be implemented. By screening for suicidal individuals and providing them with care early on the rate of hospitalization will theoretically be decreased. Hospitalization in this case refers not only to psychiatric hospitalization but to ER visits and ICU stays due to gunshot wounds, overdoses, and other suicide attempts.

- *Develop relatively unique forms of care delivery to address the needs of Montana*

It is likely that even with full implementation of these MIR proposals there will still be areas of Montana that will lack sufficient mental health care. Given this likelihood, Helena College's proposal includes unique interventions. These interventions do have research support.

1. Train lay-people to recognize mental illness and provide basic cognitive psychotherapy. This technique has been utilized in India and a few African nations where mental health care services are severely lacking. Montana is similar to these areas given the lack of mental health care. One of the authors of this proposal, Nathan Munn, has had email contact with Dr. Vikram Patel on this matter. Dr. Patel, though unable to collaborate given his activity in India, has provided contacts in the US for potential collaboration.
2. Train primary care physicians in systematic depression management. There are data suggesting the training of primary care physicians in detecting and managing depression reduces higher levels of care (though not all studies support these findings). Also, a high percentage of individuals who commit suicide have seen their primary care provider within months of committing suicide. Given the large percentage of psychiatric medication monitoring provided by primary care providers it is rational to provide extra training to those receptive to it. Continuing medical education credits could also be provided for this training, hopefully increasing interest.
3. Increased use of web-delivered self-management for recurrent depression and anxiety disorders. A fair body of research is showing web-based treatments for depression and anxiety have a fairly good outcome record. While possibly not ideal for many people, using web-based care may supplement treatment when face-to-face care is unavailable. This would require, of course, access to the Internet with sufficient hardware and software to allow for web-based care delivery.

- *Creation of independent non-profit company for case management to coordinate care throughout the community and across the lifespan*

This point is the main one for Helena College's MIR proposal. Currently case management providers are embedded in other treatment provider organizations. Though

many do their best to manage cases without bias toward the company they work for, it is human nature to stick within "in-group" organizations. Having an independent company would reduce this problem. An independent group could facilitate patient care across many different treatment organizations objectively. It would also provide case management to children, adolescents, and adults thereby improving the transition between the providers of care for children and adolescents and those for adults. Characteristics of this proposed company including:

1. State-wide presence allowing it to coordinate care in our many communities. It would work with each of the 16-bed inpatient facilities to enhance both involvement of outpatient treatment providers and other levels of care such as foster care for adults and children/adolescents.
2. Monitor treatment effectiveness in multiple modalities such as medications, psychotherapy, occupational therapy, etc.
3. Provision of clear and concise reports on treatment to various treatment providers including psychiatrists, psychotherapists, primary care providers, etc. allowing them to better provide treatment to mentally ill patients.
4. Provision of education on psychiatric illnesses to family members and other concerned citizens.
5. Delivery of data to a centralized research facility for ongoing analysis of outcome measures.
6. Coordination of care among MHDC staff increasing consistency of care between this level of service providers.
7. Administering psychological measurements of recovery, life-meaning, symptom burden, and other testing to further research in mental health care.
8. Coordinating client participation in other needed research activities to improve the knowledge base of mental illness and mental health care.
9. Assist in the transition between child & adolescent systems of care and adult systems.
10. Generating reports of effectiveness to governmental bodies and legislative sessions.
11. Collecting service utilization data for analysis using leading-edge statistical methodologies to monitor for effective treatment modalities.

- *Creation of University affiliated research program to monitor outcomes including service utilization, recovery markers, and primary research*

Using research to follow the above proposals is crucial to their overall success and the advancement of mental health care in Montana. Many if not all of the proposals can be subject to research projects and scientific questions. Frequently in the past when new programs were created insufficient research monitoring resulted in unclear outcomes and benefits.

The research base of Helena College's Montana Institute Reboot project is another linchpin, crucial to any effect broad change in the mental health system in Montana. Affiliations with the National Institute of Mental Health, NAMI, and other organizations for potential grants, expand the research potential of this proposal. Helena College stands

ready to incorporate positions and protocol for such research and is willing to partner for grant writing and funding.

Research in mental health care delivery would not only benefit Montana citizens but would help advance mental health care knowledge world-wide.

Potential research questions include:

1. Does the specific training of MHDC providers improve overall mental health care delivery? For example, does it reduce higher levels of service utilization?
2. Does specific case management training and activity improve overall mental health care as indicated by improved service utilization, recovery measures, and client satisfaction with treatment?
3. Can PSS services be maximized? Are there ways to improve PSS acceptance with other providers and measure readiness? Do PSS services decrease high-level services utilization such as hospitalizations?
4. Does improved psychiatric treatment of mentally ill felons result in improved mental health and decreased recidivism?
5. Will secondary prevention strategies and public awareness campaigns decrease suicide rates in Montana?
6. Can lay health worker interventions reduce the burden of depressive and anxiety disorders?
7. Will the training of primary care providers on systematic depression management reduce hospitalizations and suicide rates?
8. How effective is web-based care delivery in treating depression and anxiety?
9. Does the presentation of clear symptom and other client-centered data to treatment providers such as psychiatrists, primary care physicians, and psychotherapist result in improved mental health recovery?
10. Are there other mental health treatment modalities such as existential interventions that can improve mental health?
11. Can the use of sophisticated statistical analysis of utilization data and other outcome measurements such as recovery markers result in finding effective treatments that can be applied in other settings?
12. Are there neuropsychiatric correspondents to underlying psychopathology such as hopelessness, meaninglessness, and suicidal ideation?

- **Conclusions**
  - The above proposal addresses the needs of the mental health care system in Montana in a comprehensive and unique way. It also implements monitoring systems to assure its effectiveness and allows for appropriate modification of treatment delivery reflecting outcome measurements.
  - This proposal is not limited to Montana Institution only but rather addresses the entire mental health care system of Montana. It is impossible to separate out specific treatment options but rather the entire system needs to be evaluated.

- This proposal closes the gaps between different service providers in the child and adolescent system and in the transition to the adult system by creating an independent case-management company that provides services across the human life-span.
- It provides potential cost savings via:
  - Improved case-management decreasing level of care necessary.
  - Decreasing out-of-state placement of children and adolescents via improved coordination of care among in-state programs.
  - Diversion of funding streams from Montana General Fund to Medicaid.
  - Decreased cost of travel for patient who would have gone to MSH but now would have care provided at local 16-bed units.
  - Detecting suicidal individuals early and providing care thereby decreasing higher levels of care including potential ICU stays from gunshot wounds and overdose.
  - Decreasing recidivism among mentally ill felons and have them reintroduced to community care.
  - Improving primary care detection and treatment of mental illness and suicide.

We would like to thank NAMI-MT for the opportunity to create a proposal for the MIR contest. We are confident that the above suggestions would create an improved system, and one that self-monitors for ongoing improvements of care and care delivery.

On behave of my students and myself, I again thank you, NAMI-MT, for your efforts in providing ongoing advocacy and assistance to the mental health care system and those suffering from mental illnesses in the State of Montana. Your efforts are greatly appreciated.

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- References:

  - Berghofer, A, Hartwich, A, Bauer, M, Unutzer, J, Willich, SN, and Pfenning, A. Efficacy of a Systematic Depression Management Program in High Utilizers of Primary Care: a Randomized Trial. 2012. BMC Health Services Research. 12, 298-308.
  - Davidson, L, Bellamy, C, Guy, K, and Miller, R. Peer Support Among Persons with Severe Mental Illnesses: A Review of Evidence and Experience. 2012. World Psychiatry. 11:123-128.
  - Dumesnil, H, Verger, P. Public Awareness Campaigns About Depression and Suicide: A Review. 2009. Psychiatric Services. 60(9) 1203-1213.
  - Hunkeler, EM, Hargreaves, WA, Fireman, B, Terdiman, J, Meresman, JF, Porterfield, Y, Lee, J, Dea, R, Simon, GE, Bauer, MS, Unutzer, J, and Taylor, CB. A Web-Delivered Care Management and Patient Self-Management Program for Recurrent Depression: A Randomized Trial. 2012. Psychiatric Services. (in press).
  - Mental Disabilities Board of Visitors Site Review Report: Montana Developmental Center, Assessment & Stabilization Unit. January 27-28/February 10, 2009
  - Mental Disabilities Board of Visitors Site Review Report: Montana State Hospital, Warm Springs, Montana, June 17-18, 2010.
  - Patel, V. Lay Health Worker Led Intervention for Depressive and Anxiety Disorders in India: Impact on Clinical Disability Outcomes over 12 months. (2011). British Journal of Psychiatry. 199(6), 459-466.
  - Report to the State of Montana: Legislative Mental Health Study, November 18, 2008
  - Rosston, K. Suicide in Montana: Facts, Figures, and Formulas for Prevention. Department of Public Health and Human Services. Montana, 2012.
  - Schrank, B, Bird, V, Rudnick, A, and Slade, M. Determinants, Self-Management Strategies and Interventions for Hope in People with Mental Disorders: Systematic Search and Narrative Review. (2012). Social Science & Medicine. 74, 554-564