

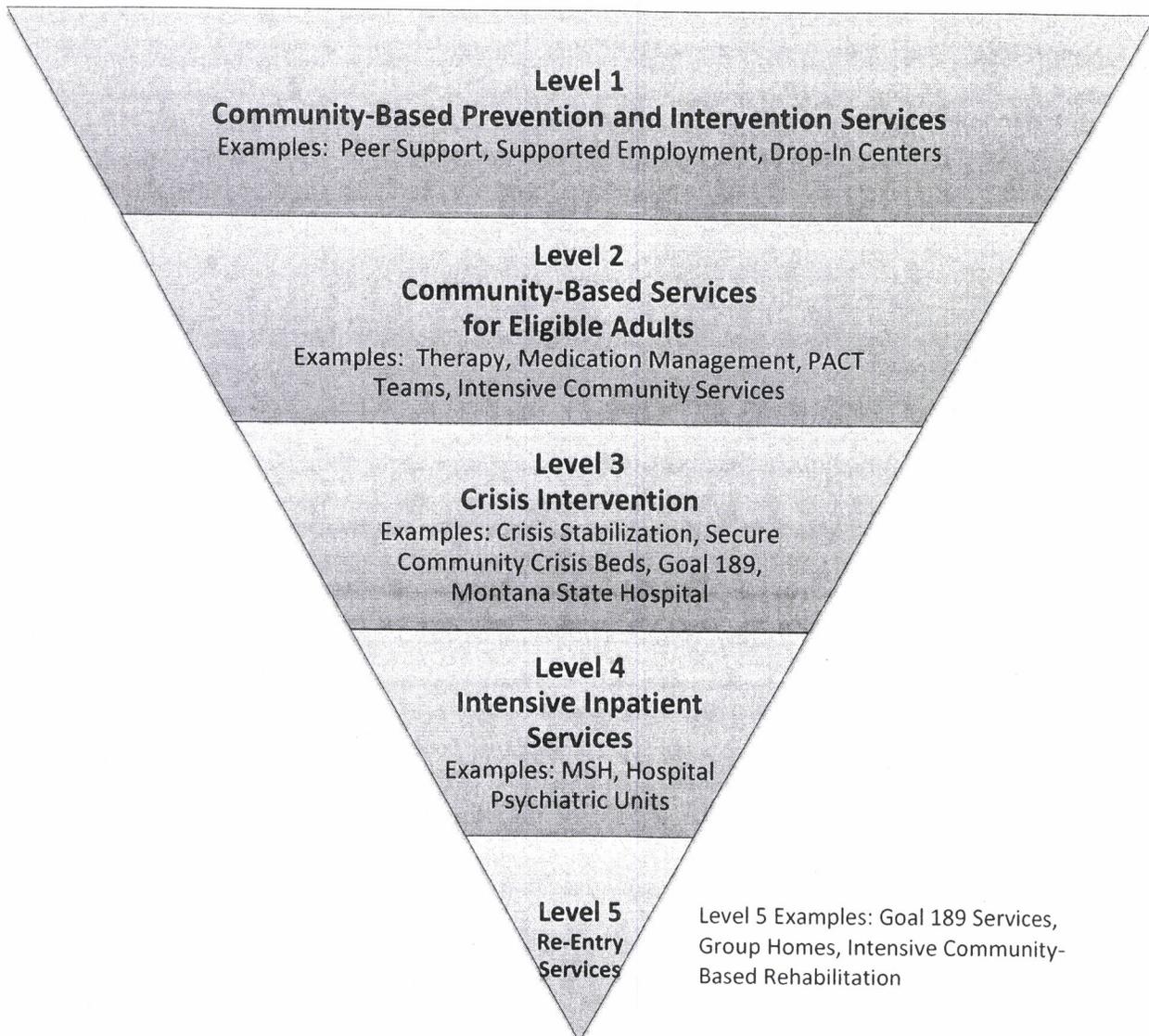
## HJR 16 Study: State-Operated Institutions *Continuum of Mental Health Services*

Prepared for the Children, Families, Health, and Human Services Interim Committee  
November 2013

### Background

Montana's publicly funded mental health system serves about 22,000 adults, with services that range from outpatient programs provided in the community to intensive inpatient treatment provided at the Montana State Hospital to individuals who have been involuntarily committed because they pose a danger to themselves or others.

The inverted pyramid below provides a general overview of the continuum of mental health services and – for purposes of this briefing paper only – describes “levels” of services. Level 1 and Level 2 services are provided in the least restrictive setting possible. As services go up in the level of intensity, the number of people receiving the services decreases and the services are provided in more restrictive settings. The levels are described in more detail on P. 2.



### Eligibility for Community Mental Health Services

Most community-based mental health services are provided to individuals who qualify for either:

- the Montana Medicaid program, because they meet income guidelines and are blind, disabled, 65 years of age or older, have dependent children, or meet other eligibility criteria; or
- the Mental Health Services Plan (MHSP), because they are ineligible for Medicaid but have an income at or below 150 percent of the federal poverty level and also have a Severe Disabling Mental Illness (SDMI). To be considered SDMI, individuals must have one of several specific mental disorders and must have experienced at least two out of five specific functional difficulties for at least six months.

A few services are provided to any uninsured or underinsured Montanan if they have a need for the services – primarily crisis intervention, stabilization, and jail diversion services offered through contracts with community providers and through programs developed by counties that have received state grants to develop specific jail diversion or crisis intervention programs.

### About the Levels of Services

This briefing paper divides the continuum of services into five general levels and indicates the types of services provided at each level. Following is a brief description of the levels.

- Level 1 includes a range of evidence-based programs that are provided in the community to people with a serious mental illness regardless of eligibility for Medicaid or MHSP. Services include drop-in centers, peer support, and supported employment.
- Level 2 includes community-based treatment services for individuals enrolled in Medicaid or MHSP. Services range from individual and group therapy to medication management to more intensive services, such as Program for Assertive Community Treatment teams and psychiatric rehabilitation services.
- Level 3 includes intensive treatment provided to individuals who are in crisis. These services often are provided in a secure setting to individuals who are under an emergency detention or court-ordered detention or who may be in danger of being involuntarily committed to MSH. Services include crisis stabilization, secure community-based treatment, emergency detention at MSH, intensive services to prevent re-admission to MSH, and Crisis Intervention Team training for law enforcement officers.
- Level 4 includes intensive inpatient services for individuals who pose a danger to themselves or others. Treatment could occur at the Montana State Hospital or a hospital psychiatric unit.
- Level 5 includes intensive outpatient services or supports provided to help individuals successfully return to the community after inpatient treatment and avoid readmission to the Montana State Hospital. Services range from short-term support for expenses related to housing or medication to services such as therapeutic group homes and intensive rehabilitation beds.

**Interim Committee on Children, Families, Health, and Human Services - Recommendations to Fund Various Community Mental Health Services**

Department/Service System/Bill	FTE*	Annual Funding Change*	FY 2015 Base	Ongoing Level	Level of Care
<b>Department of Public Health and Human Services</b>					
<i>Adult Mental Health Services</i>					
HB 24 State-run Mental Health Transitional Group Home		\$1,500,000	\$0	\$1,500,000	5
HB 33 New or Expanded Mental Health Crisis Intervention		1,000,000	848,358	1,848,358	3
HB 34 Additional Secure Psychiatric Detention Beds		600,000	205,000	805,000	3
HB 35 Short-term Voluntary Mental Health Treatment		500,000	-	500,000	4
<i>Developmental Disability Mental Health Crisis Services</i>					
HB 22 Crisis and Transition Technicians	5.00	345,000	365,000	710,000	3
<i>Children's Mental Health Crisis Services</i>					
HB 47 Youth Crisis Diversion Pilot Projects		600,000	-	600,000	2/3
<b>Department of Corrections</b>					
<i>Adult Mental Health Services</i>					
HB 23 Contracted Forensic Community Corrections Facility		1,500,000	-	1,500,000	5
<b>Total</b>	<b>5.00</b>	<b>\$6,045,000</b>	<b>\$1,418,358</b>	<b>\$7,463,358</b>	

\*The appropriations in the bills are biennial appropriations, but are divided in half to show an annualized cost. However, if a department spends more from the biennial appropriation in the first year of the biennium, the annualized cost could be higher than shown. Also, there may be FTE associated with the state run transition group home that are not reflected in this table.

**HB 22**

## **HJR 16: State-Operated Institutions**

### ***Increasing Crisis Response for Individuals with Developmental Disabilities***

Prepared by Sue O'Connell, Research Analyst  
for the Children, Families, Health, and Human Services Interim Committee  
May 2014

#### Background

The Department of Public Health and Human Services (DPHHS) has created a team of people who work with local providers and families to stabilize developmentally disabled individuals who are in or approaching a crisis situation. The effort is designed to keep people in the community and avoid placement in a higher level of care, including the Montana Developmental Center in Boulder. The team consists of five crisis and transition specialists supported by a psychiatrist who consults with the Developmental Disabilities Program one day a week.

In March, the Children, Families, Health, and Human Services Interim Committee asked staff to estimate the costs of increasing the number of crisis response teams. This briefing paper outlines potential costs.

#### Current Costs of Services

DPHHS expects to spend about \$374,000 in this fiscal year for the six-member crisis response team, including \$77,200 for the contract with the psychiatrist. The bulk of the remaining cost is for salaries and benefits for the five employees who travel around Montana to work with providers and clients.

The amount includes only three months of salary for one of the employees, so costs for a full six-member team for a full year would be higher.

#### Expansion Options and Potential Costs

The costs of increasing the staff for mobile crisis response would depend largely on the number of new employees and the salaries they're paid.

Adding five employees would double the size of the staff and allow team members to focus on separate halves of the state. Adding more than five employees would allow DPHHS to split the state into smaller regions for crisis response.

The state uses a pay scale that groups jobs into nine "bands" for the purposes of establishing salaries. Jobs in higher bands require a higher level of education and experience, and the salaries for those jobs are higher than salaries for lower pay bands. The crisis response employees now on staff have master's degrees, which would place them in at least Pay Band 6.

The table on the following page shows the potential costs of adding five, 10, or 15 staff members at that pay band. Costs were calculated by:

- using the average hourly rate paid to DPHHS employees who are in Pay Band 6;

- using the salary, health insurance, and benefit costs expected in FY 2015, when executive branch employees are scheduled to receive a 5 percent pay raise and health insurance costs are expected to increase above the FY 2014 levels;
- including the current year "standard office package" of \$3,042 for each employee; and
- assuming that none of the employees would have supervisory duties and that the level of contract psychiatric support would not change.

	Number of Employees		
	Five	Ten	Fifteen
Salary	\$235,976	\$471,952	\$707,928
Health Insurance	\$53,220	\$106,440	\$159,660
Other Benefits	\$37,756	\$75,512	\$113,268
Office Package	\$15,210	\$30,420	\$45,630
<b>Total</b>	<b>\$342,162</b>	<b>\$684,324</b>	<b>\$973,266</b>

Costs could vary if any of the assumptions above changed or if the 2015 Legislature increases pay or benefit levels for the next biennium.

#### Committee Decision Points

If the committee wants to support an increased level of mobile crisis response in the developmental disabilities system, members may want to consider and decide the following questions.

1. Should the committee draft legislation to appropriate money for additional crisis response employees?
  - a. How many employees does the committee feel are necessary to provide for an improved crisis response?
2. Alternatively, should the committee encourage the governor to include money in the executive budget for an expansion of the existing crisis response team? If so, does the committee want to:
  - a. make a recommendation on the number of additional employees needed to provide for an improved crisis response?
  - b. encourage members of the House Appropriations Committee and Senate Finance and Claims Committee to support any request by the executive branch for additional crisis response employees?

#### Next Steps

If the committee decides to request a bill draft, the draft bill would be presented to the committee for review and public comment at the June 20 meeting.

If the committee decides to encourage the governor or the 2015 budget committees to include an appropriation in the executive budget, staff would draft a letter for review and approval by either the presiding officer or the full committee.

**HB 23**

**HB 24**

## **HJR 16: State-Operated Institutions**

### ***Potential Costs and Considerations for Forensic Community Facilities***

Prepared by Sue O'Connell  
for the Children, Families, Health, and Human Services Interim Committee  
June 2014

#### Background

During the House Joint Resolution 16 study of state-operated institutions, much of the testimony has focused on options for people who have been convicted of a crime but found to be mentally ill at the time the crime was committed. These individuals are sentenced to the custody of the Department of Public Health and Human Services (DPHHS) for placement in an appropriate correctional or mental health facility. Most are placed at the Montana State Hospital (MSH) in Warm Springs.

Unlike people who are involuntarily committed to MSH for periods of up to 90 days, these forensic patients are serving criminal sentences that are measured in years. They cannot be released from custody until they have served their sentences or been paroled. The Children, Families, Health, and Human Services Interim Committee has heard about the pressures created by the growing forensic population at MSH.

In May, committee members asked for information about the costs of operating a prerelease center or group home to serve forensic patients outside of an institutional setting. This briefing paper provides information about Montana's community corrections system, steps taken in other states to establish forensic community facilities, and options and estimated costs for using this approach in Montana.

#### Montana's Current Community Corrections System

The Department of Corrections oversees a system of community corrections that includes six prerelease centers. The centers provide housing, treatment, and supervision of individuals who have been:

- paroled and are making the transition from a correctional setting to the community; or
- sentenced to the center as an alternative to placement in a prison.

The department contracts with providers to operate the facilities and pays a flat daily rate for each offender. The department remains responsible for the offenders' medical costs and makes some special payments for certain offenders. For example, offenders must pay a daily amount toward their room and board. However, if a person is unable to work or has other extenuating circumstances, the state pays those costs in addition to the daily rate.

The centers are located in Billings, Butte, Bozeman, Great Falls, Helena, and Missoula. They serve more than 800 offenders, about three-fourths of whom are male.

The Legislature tried to expand prerelease options to northwest Montana in 2007. Lawmakers appropriated \$1.2 million to build and operate a 40-bed prerelease center in the region. The department awarded a contract to a company that planned to build a center in Kalispell. However, local residents opposed the proposed prerelease, and it was never built.

#### Local Control in Community Corrections

State law gives local communities a clear role in the siting of prerelease centers and requires the Department of Corrections to adopt rules for placing a prerelease center in a community. Among other things, the rules must prohibit siting of a prerelease in any location without community support, must create a mechanism for determining that local support exists, and must require a public hearing on the proposal.

Rules adopted by the department require the agency to:

- determine if local officials are interested in having a prerelease center in the community;
- notify the media if local officials express an interest;
- create a working committee with local officials to provide public education and gauge the level of public support; and
- conduct a comprehensive and statistically valid survey to determine the level of support.

If a nongovernmental agency operates a prerelease center, state law requires that the community create a local board to set standards for the program. The local board, as well as the provider, may accept or reject any proposed resident or reject a person after acceptance into the program.

#### Approaches in Other States

Mental health advocates have suggested that many forensic patients at MSH or Montana State Prison could be paroled if appropriate community services were in place. They note that other states have created community forensic programs, pointing to Colorado, Louisiana, Washington, and West Virginia as examples.

Following is a summary of approaches in those states.

- **Colorado:** Over time, the state has created a system of designated community corrections beds for people who have been charged with or convicted of a crime and who have co-occurring mental illness and substance abuse disorders. The state makes enhanced payments to private contractors who provide specified treatment services for these individuals. Some providers set aside 10 percent or so of a facility's beds for this purpose, while one 40-bed facility in Denver serves only individuals with co-occurring illnesses. The facilities have the secure features of a correctional prerelease center but also have mental health professionals on staff or under contract to provide ongoing mental health and substance abuse treatment.

The state pays the facilities a daily rate of \$76.04 per offender for the designated treatment beds. The facilities receive the flat rate of \$41.34 paid to all community corrections facilities, as well as an additional \$34.70 for providing the treatment services. The state general fund also pays the full cost of psychiatric medications.

Operating costs for the 40-bed Denver facility were not available. However, the state's enhanced daily rate for 40 offenders would total about \$1.1 million per year. Medication costs were estimated in the range of \$18,000 to \$36,000.

- **Louisiana:** The state has created a system of services for people found not guilty by reason of insanity. The system includes inpatient treatment at state psychiatric facilities, placement and treatment in community residential facilities, and supervised community release. A person who obtains a conditional release from a state psychiatric facility is considered to be on probation and is under the supervision of both the Division of Probation and Parole in the Department of Corrections and of the Department of Health and Human Services. Louisiana contracts for 111 forensic residential beds for people who have been conditionally released from state facilities. It also operates community programs that include forensic coordinators who supervise people who have been conditionally released to the community.

The state pays \$104 per day per person for a 22-bed facility that provides in-house mental health services, for an annual cost of \$835,120. It pays \$98 per person per day for 85 beds in another facility, where half of the residents receive mental health treatment in house and the other half receive services in the community. Annual costs for the facility would be slightly more than \$3 million, with additional payments to the community mental health providers. And it pays \$68 per day, or slightly less than \$100,000 a year, for a four-bed facility in which all mental health services are provided in the community, rather than in the residential setting.

- **Washington:** Under Washington law, people who have committed crimes but are mentally ill are found not guilty by reason of insanity and are sent to a state psychiatric hospital for treatment. Once there, they are treated in the main hospital until they are ready for a transitional program designed to prepare them for eventual return to the community. The transitional program is housed in a separate area of the hospital with its own treatment staff. When a person enters the transitional program, Department of Corrections staff members become involved in monitoring the person's treatment and progress. Those staff members develop the conditions that a person must follow when released to a community. When a court approves a person's release to the community, the court also can require that the person continue to be supervised by the Department of Corrections. The state does not operate or contract for community-based forensic facilities.

In western Washington, about 95 people are in the transitional program at Western State Hospital. The estimated costs of serving those individuals, including staff members who work with them after return to the community, is \$6 million to \$7 million a year.

- **West Virginia:** The state Department of Health and Human Services is responsible for people who have committed a crime but who have been found to be incompetent to stand trial or not guilty by reason of insanity. They are first admitted to a state psychiatric hospital until they are determined by treatment professionals, an administrative review board, and a court to be stable enough for community placement. At that point, a community treatment plan is developed, similar to a parole plan for a person in the corrections system. A person may then be placed in one of four privately operated forensic group homes, a state-run halfway house, or an independent community placement with oversight from a forensic community coordinator. The group homes and halfway house have alarms, and group home residents must be within eyesight of a staff member at all times, even when working.

Three of the four forensic group homes have seven beds, while the fourth has eight beds. The state budgeted an average of \$583,400 per group home for the upcoming fiscal year. Personnel costs make up the bulk of the budgets, ranging from 65 percent to 72 percent of the total budget. Building-related and other operational costs — such as utilities, maintenance, and supplies — make up anywhere from 8 percent to 13 percent of the budgets.

#### Potential Costs in Montana

Because a community facility would serve people who have been criminally committed to DPHHS custody, the offenders would be served through the community corrections system operated by the Department of Corrections.

Costs for creating community options would depend on whether the state contracted for a forensic facility or operated its own facility. Costs also would vary depending on the factors involved. For instance, if the state contracts for beds, the cost would depend on the daily rate paid per offender and the number of beds in the facility. If the state operated a facility, the staffing, food, utility, and maintenance costs would depend on the number of people served and the size of the facility.

Potential costs are outlined below.

- **Contract for a designated forensic prerelease center:** The department pays varying rates to prerelease centers based on contracts with each provider. Rates currently average \$56.41 per day for male offenders and \$67.06 per day for female offenders.

If Montana were to contract with a provider for a forensic prerelease center and pay an enhanced rate similar to Colorado's rate, the per-day rate would increase by about \$35. That would result in rates of \$91.41 per day for male offenders and \$102 a day for female offenders.

Currently, 87 people who have been found to be guilty but mentally ill are at either MSH or correctional facilities — 66 at MSH, 10 at the Montana State Prison, and four in regional prisons. The table on P. 5 shows an estimated cost of serving various percentages of the forensic patients in a forensic community facility. The cost is based on a daily rate of \$91.50 per day.

**Potential Costs of Contracted Forensic Community Beds**

Percentage	# of Residents	Potential Cost	
		Annual	Biennial
10%	9	\$300,578	\$601,155
20%	17	\$567,758	\$1,135,515
30%	26	\$868,335	\$1,736,670
40%	35	\$1,168,913	\$2,337,825
50%	44	\$1,469,490	\$2,938,980

Initial costs may be higher if the provider incurs — and passes on to the state — costs to build a facility. The selected community also would need to support the proposal.

- **Establish a state-operated forensic prerelease center or group home:** If the state were to operate a forensic community facility, it would need to hire employees with a correctional background for secure supervision and hire or contract with mental health staff for the treatment component. The 2007 attempt to develop a new prerelease center in northwestern Montana gives an idea of potential costs of creating a new facility. The Legislature appropriated \$1.2 million for the biennium to contract with a private provider to build and operate a 40-bed facility. Because a forensic facility would include a mental health treatment element not required for a nonforensic prerelease, operating costs would be higher.

Using staffing ratios similar to those for the 40-bed facility in Colorado, staffing costs for a 20-bed Montana facility could total about \$400,000-500,000 a year. The estimate includes costs for around-the-clock staffing by a correctional officer and psychiatric aide, as well as one advanced practice registered nurse, 1.5 social workers, a case manager, and a psychiatrist working under contract at least one day a week.

Other costs would include lease or construction costs, furnishings for a new facility, maintenance, and food costs.

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Sources:

- Discussions and e-mail correspondence with:
  - Dan Tapia, Director, Office of Community Corrections, Colorado Department of Public Safety
  - Glen Mauro, Community Corrections Director, Denver Department of Public Safety
  - Rose Rodriguez, Chief Operating Officer, Independence House Fillmore, Denver
  - Georgette Bradstreet, Statewide Forensic Coordinator, West Virginia Department of Health & Human Resources
  - Michelle Bonnelycke, Community Corrections Officer, Washington Department of Corrections
  - Jen Katzman, Director of Research & Special Projects, Office of Behavioral Health, Louisiana Department of Health and Hospitals
  - Pam Bunke, Administrator, Adult Community Corrections Division, Department of Corrections
  - Jill Buck, Mental Health Director, Montana State Prison
  - Cathy Orrino, Montana State Hospital

- "Introduction to Eastern Louisiana Mental Health System (ELMHS)," *Louisiana Department of Health and Hospitals*, available at <http://new.dhh.louisiana.gov/index.cfm/directory/detail/219>, accessed June 10, 2014
- Articles 654-658, Louisiana Code of Criminal Procedure
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- Rachel Weiss, "The 1990 Criminal Justice and Corrections Advisory Council," *Legislative Services Division*, February 2014
- Rachel Weiss, "Supervision Fees and Administrative/Programming Costs Charged to Parolees," *Legislative Services Division*, April 2014
- "Sex Offender Services," Procedure No. ACCD 3.5.100, Adult Community Corrections Division Standard Operating Procedures, *Montana Department of Corrections*, July 1, 2005
- Title 53, Chapter 30, Part 3, MCA, and 53-1-203, MCA
- Title 20, Chapter 7, Subchapter 500, Administrative Rules of Montana

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HB 33

HB 34

HB 35

## **HJR 16: State-Operated Institutions *Crisis Intervention and Diversion***

Prepared by Sue O'Connell, Research Analyst  
for the Children, Families, Health, and Human Services Interim Committee  
March 2014

### Background

In recent years, the Legislature has supported development of local crisis response and diversion services in an effort to treat individuals in the community and avoid admission to the Montana State Hospital (MSH) or Montana Developmental Center (MDC). The services meet several goals, including:

- relieving pressure on the state-operated institutions for the mentally ill and seriously developmentally disabled;
- providing treatment to an individual before a crisis becomes so severe that the person must be admitted to a state facility;
- reducing the need for law enforcement officers to transport individuals to MSH for emergency or court-ordered detentions; and
- allowing individuals to be treated in the community, in closer proximity to family members and others who can provide important support systems.

This briefing paper outlines some of the key state-funded crisis services currently in place for Montanans who have a mental illness or intellectual disability.

### The "House Bill 130s": Jail Diversion and Crisis Intervention

Mental health providers have created and maintained a number of services under what are often referred to as "the House Bill 130s" — three bills developed by the 2007-2008 Law and Justice Interim Committee and approved by the 2009 Legislature. The three bills were:

- HB 130, which established a grant program for counties or regions that create jail diversion or crisis intervention programs or short-term treatment options;
- HB 131, which allowed the Department of Public Health and Human Services (DPHHS) to contract with mental health facilities for secure crisis beds and services to use as an alternative to treatment at MSH; and
- HB 132, which allowed a person to opt for voluntary inpatient treatment in a community facility for up to 14 days in lieu of a hearing for involuntary commitment at MSH.

The 2009 Legislature appropriated \$1.2 million for HB 130 and HB 131 in the 2011 biennium. The amount of funds devoted to the programs has fluctuated somewhat in subsequent years but currently stands at about \$1.25 million a year.

The funds have supported secure crisis beds in Bozeman, Butte, and Hamilton, as well as other community-based services around Montana.

HB 130: County Grant Funds

The HB 130 grant money has funded a variety of intervention and diversion efforts in several areas of the state since 2009. Most of the counties that received the first round of grant funds in fiscal year 2010 — Lewis and Clark, Missoula, Ravalli, and Yellowstone — have continued to receive grant funds. Meanwhile, additional counties have gained funding as they developed proposals designed to create local community-based crisis intervention programs and to divert people from the criminal justice system.

In all, DPHHS has awarded \$3.67 million in grant funds since passage of HB 130. The use of grant funds by county is summarized below.

- **Blaine County:** The county received grant funds for the first time this fiscal year, with a grant of \$14,000 for jail diversion efforts that will include developing a mental health steering committee, meeting the immediate mental health treatment needs of people who are incarcerated or facing incarceration, and providing training to key stakeholders.
- **Gallatin County:** The county received grant funds for the first time this fiscal year, with a grant of \$72,500 to provide Crisis Intervention Team (CIT) training to law enforcement officers, health care providers, and others in Gallatin, Park, and Madison counties.
- **Hill County:** The county received grants funds for the first time this fiscal year, with a grant of nearly \$60,600 to train Hill County Detention Center staff in the signs of addiction and mental illness and reduce the repeated detention of people with addiction or mental illness.
- **Lake County:** The county received \$125,000 this fiscal year to help with the design and construction of Lake House, a facility planned for Polson that will provide both voluntary crisis stabilization and emergency detention services.
- **Lewis and Clark County:** In partnership with Jefferson and Broadwater counties, Lewis and Clark County was awarded a grant of \$116,400 in FY 2010 to conduct strategic planning for mental health services in the three-county region, create a county-appointed Mental Health Authority, and create jail diversion policies. It also received \$54,400 for CIT training and for video conference equipment for the behavioral health unit at St. Peter's Hospital. In FY 2012, the county received a \$115,000 grant; the bulk of the funds were used to provide Crisis Response Team services in a four-county region. In FY 2013, the county was awarded \$105,000 to provide Crisis Response Team services in Lewis and Clark and Jefferson counties and to provide CIT training to law enforcement officers in the service area.
- **Missoula County:** Since FY 2010, Missoula County has been receiving grant funds of about \$169,800 per fiscal year to pay for the services of mental health professionals in targeted locations, such as the Missoula County Detention Center, the public defender's office, and St. Patrick Hospital's inpatient psychiatric unit.
- **Ravalli County:** The county has received HB 130 funds since the grant program's inception, for a variety of projects. The county received \$250,000 in FY 2010 for one-time construction costs of West House, a facility in Hamilton that provides both crisis stabilization and secure emergency detention services. Since then, it has been awarded \$251,700 in fairly equal annual payments for a variety of efforts that include

improvements at the Ravalli County Detention Center for enhanced screening for mental health and co-occurring disorders, suicide prevention training for detention officers, case management assistance, and CIT training.

- **Valley County:** In FY 2011, Valley County was awarded a \$12,300 grant to retrofit a room at the Frances Mahon Deaconess Hospital in Glasgow as a secure crisis room, train law enforcement officers, and pay for costs related to commitment proceedings. The county received about \$10,600 in both FY 2012 and FY 2013 and was awarded a \$20,000 grant in this fiscal year to continue those efforts.
- **Yellowstone County:** Since FY 2010, Yellowstone and a consortium of 16 other counties have obtained about \$300,000 a year in grant funds to pay for costs related to the Billings Community Crisis Center. The center provides outpatient treatment to individuals experiencing mental health problems who may otherwise be taken to jail or to a hospital emergency room. The grant award for FY 2014 is \$315,200.

The state money is used to match local investments in the projects. The state grants can vary from 50 cents to 70 cents for each \$1 of cash or in-kind investment the community dedicates to crisis intervention and jail diversion. The matching rate is based upon a county's use of MSH in the previous fiscal year. A county with a utilization rate that is higher than the state average may receive a match of only 50 percent of the local investment, while a county with a lower utilization rate may ask for matching funds of up to 70 percent of their local investment.

#### HB 131: Secure Crisis Beds

The HB 131 funds are used to ensure that crisis stabilization services exist at the local level by paying a facility when secure crisis beds go unused. The payments have allowed private providers to set up the facilities, knowing that some of the ongoing costs of staffing and operating the local facility will be covered even if the beds are unoccupied.

Currently, the state makes HB 131 payments of \$500 per day to three facilities when their secure crisis beds are not in use — the Hope House in Bozeman, the Hays Morris House in Butte, and the West House in Hamilton. When the beds are occupied, the facilities bill the appropriate payer for the costs; payer sources include private insurance, Medicaid, Medicare, the state-funded Mental Health Services Plan, and the state-funded 72-hour crisis stabilization program.

Western Montana Mental Health Center owns and operates the three existing crisis facilities, as well as the one under construction in Polson. It also will operate a fifth crisis facility under construction in Helena. Lewis and Clark County is paying for construction costs, and the facility is being built on land owned by the Center for Mental Health.

From FY 2010 through FY 2013, the state spent about \$912,000 in HB 131 funds for the crisis facilities.

#### Crisis Stabilization Services

The Legislature has also funded a crisis stabilization program in an effort to reduce admissions to state facilities and treat individuals in their communities. The 2007 Legislature appropriated \$4 million in general fund to provide services for up to 72 hours to stabilize individuals who are experiencing a mental health crisis and who are uninsured or underinsured.

The types of services available for reimbursement include psychiatric diagnostic interviews, individual and family psychotherapy, coordination of care, and crisis management services.

The 72-hour presumptive eligibility program has allowed providers to begin treating a person without knowing whether the person is covered by any type of insurance program, including Medicaid. If a person has insurance or is covered by Medicaid, the provider bills the insurer. If a person is uninsured or underinsured, the state will reimburse the provider.

The Legislature has continued to fund the program since its inception in 2007. Most recently, the 2013 Legislature appropriated about \$1.5 million in each year of the current biennium.

#### Crisis Response in the DD System

Many intellectually disabled Montanans also have a co-occurring mental illness. During the 2009-2010 interim, the Children, Families, Health, and Human Services Interim Committee conducted a study of the barriers to providing community services to these dually diagnosed individuals. The study was authorized through passage of House Joint Resolution 39 in 2009.

At the time, stakeholders identified as one barrier the difficulty that many providers have in averting or responding to crisis situations. They noted that when providers are unable to handle crises, they may seek to have the person committed to MDC. In addition, they may not want to accept the person back into services after the condition has been treated and the person is no longer in crisis.

During the HJR 39 study, stakeholders identified four potential solutions to addressing this barrier. The suggested solutions and their current status are summarized below.

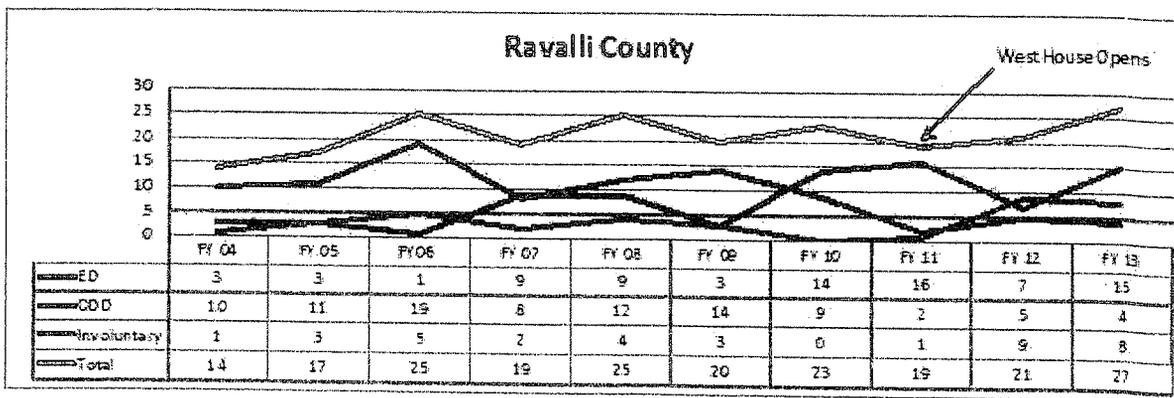
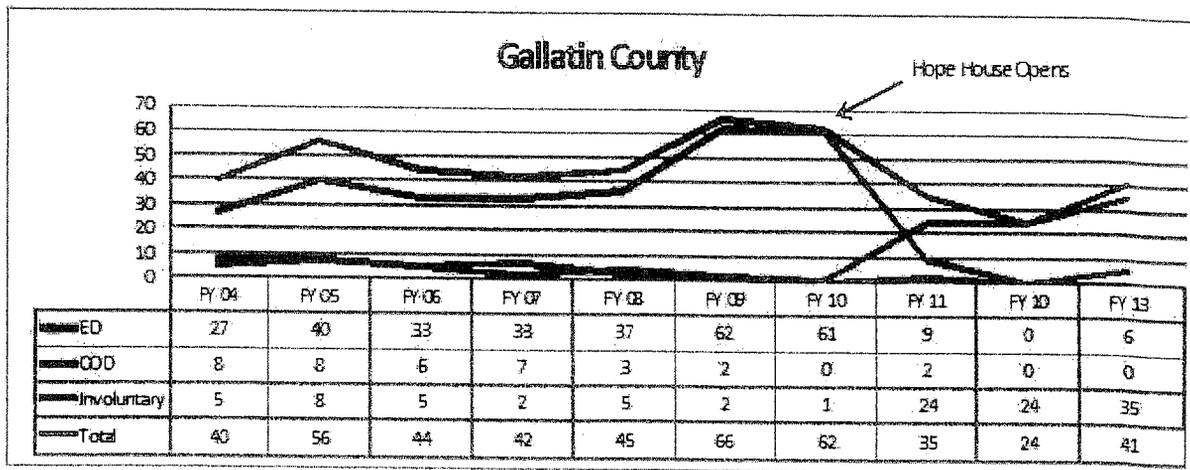
- Establish a mobile crisis response capability, where either the state or DD providers have mental health professionals who are able to respond to crisis situations. *At the time of the study, DPHHS had recently created a position for a crisis and transition specialist who worked with DD providers to stabilize individuals who were in or approaching a crisis situation. During FY 2014 and FY 2015, DPHHS added four more crisis and transition specialists to the staff; three are currently located in Helena, while another is in Billings and the fifth is in Missoula. The team is supported by a psychiatrist who consults with the Developmental Disabilities Program one day a week.*
- Train DD staff to recognize behavioral health triggers so direct-care workers can provide appropriate interventions when a client's mental health condition is worsening and before the person is in crisis. *DPHHS has partnered with others to provide training on the dually diagnosed population to DD providers, law enforcement, and mental health professionals. It also has provided training for DD providers on developing positive behavior plans that meet standards established by the Institute of Applied Behavior Analysis.*
- Establish community-based crisis beds, in locations such as hospitals, existing group homes, or mental health centers. The beds could be modeled after the secure crisis beds funded by HB 131. *No action has been taken on this idea, but interest in the concept remains.*
- Create a resource directory of mental health services so DD providers know who to call when necessary. *The state has not taken steps to create a directory.*

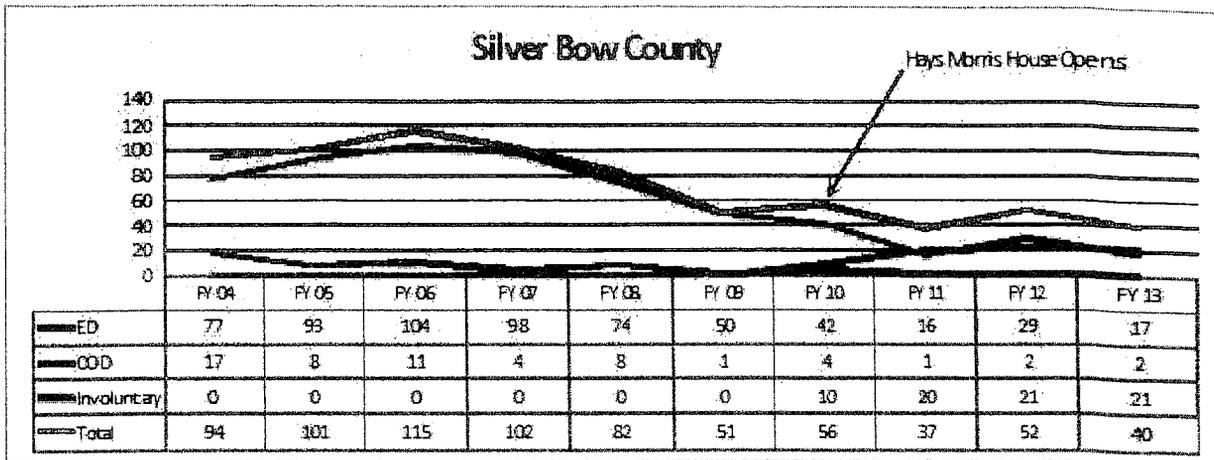
Effectiveness of Crisis Services

Many of the new crisis services have been in existence only a short time, making it difficult to evaluate their long-term effectiveness. However, the HB 130 grants and the funding of secure crisis beds through HB 131 were designed to avoid short-term admissions to the Montana State Hospital and the problems often associated with those admissions, such as increasing the census at MSH and using law enforcement officers to transport individuals to MSH for short-term treatment or evaluation and then back to their county of residence for commitment hearings.

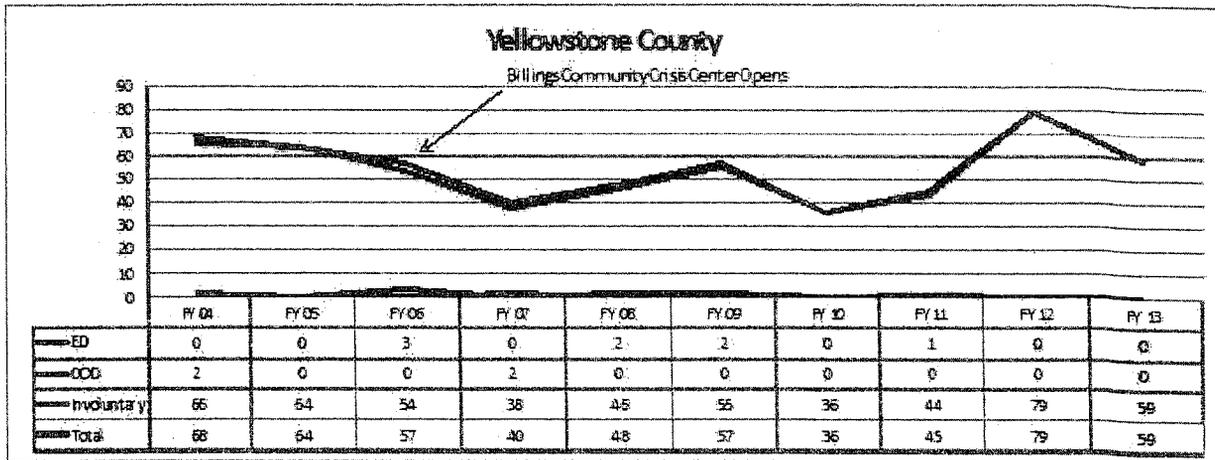
Looking at whether and how short-term admissions to MSH have changed in the counties receiving HB 130 and HB 131 funds may provide some clues as to the effectiveness of the services developed as a result.

The following graphs show the number of admissions for emergency detentions (ED), court-ordered detentions (COD), and involuntary commitments from the three counties that have received funds to develop emergency detention and crisis stabilization facilities. Emergency detentions occur when a law enforcement officer believes an emergency situation exists because of a person's mental disorder and detains the person for evaluation. A court-ordered detention occurs when a professional person documents a need for involuntary commitment, a county attorney files a commitment petition, and a judge orders treatment for up to five days. If a judge orders a person to be involuntarily committed, the person is transferred to the Montana State Hospital for up to 90 days of treatment.





The graph below shows the number of admissions from Yellowstone County, which has received continued HB 130 funding for the Billings Community Crisis Center. That facility is an outpatient crisis response facility that provides treatment for less than 24 hours to individuals with mental illness and co-occurring substance abuse disorders.



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**Sources**

- Interviews and e-mails with the following Department of Public Health and Human Services staff members, January and February 2014: Mental Health Services Bureau Chief Deb Matteucci, Disability Services Division Administrator Rebecca de Camara, Developmental Disabilities Program Director Jeff Sturm
- DPHHS Memos on FY 2014 County Matching Grants for Crisis Intervention and Jail Diversion
- Montana State Hospital Admissions Data, FY 2004 through FY 2013

**HB 47**

**PROPOSAL TO THE  
INTERIM CHILD, FAMILY, HEALTH & HUMAN SERVICES LEGISLATIVE COMMITTEE  
APPROPRIATION BILL FOR YOUTH CRISIS DIVERSION SERVICES IN MONTANA**

**Legislative Appropriation Request**

The Children's Mental Health Bureau (CMHB) is currently funding four (4) youth crisis diversion projects. The projects located in Missoula, Helena, Billings, and throughout eastern Montana, have been funded through the Montana Mental Health Trust Fund and continue through June 30, 2015. The project in Great Falls and a state-wide training project are both supported with other limited funds and they will end on September 30, 2014. The purpose of the grants is to develop youth crisis diversion models that will help stabilize and divert youth from higher levels of care. The projects are requesting that the Interim CFHHS Legislative Committee consider forwarding an appropriations bill to the 2015 MT Legislature for funding directed to DPHHS to continue the development of youth crisis diversion in the state. With assistance from CMHB and through an analysis of current costs and experience, the projects are recommending funding of \$100,000 in each year of the biennium for six projects throughout the state for a total of \$1.2 million. Funds would be managed by CMHB through a competitive process. Following is the rationale for this request.

**Introduction**

Crisis response and immediate access to services for youth in crisis is an area of extreme need in the State of Montana. Addressing this requires a collaborative effort, an array of options, and adequate, accessible funding for effective services. The cost of developing an improved crisis response system will be offset by stabilizing families, saving lives and saving money by reducing the costs of youth being served in higher levels of care across systems. Most importantly it is an investment in the future of each child who faces such hard and traumatic emotional challenges.

**Children's Mental Health Current Spending**

In testimony at the June 25, 2014 Interim CFHHS Legislative Committee meeting Zoe Barnard, Bureau Chief for the CMHB stated that *"One study found that individuals who used hospital-based criteria services were 51% more likely to be subsequently hospitalized than users of community based services. In Montana, my staff recently noted that many youth receive limited mental health services prior to a residential treatment stay. Thirteen (13) of 95 youth (about 14%), in one snapshot fit these criteria: they received few or no services prior to placement in out of state facility. There are many potential reasons for this including lack of access, stigma, and not knowing who to ask for help until a crisis is truly acute. Community crisis services may address these gaps."*

- In FY '13 Medicaid spending for Psychiatric Residential Treatment Facility (PRTF) placements was \$16,280,000 and Therapeutic Group Home (TGH) placements, \$18,750,000.
- There are currently 53 youth in \*Out-of-State PRTF at an average cost of \$400 per day and average Length of Stay of 292 days
- There are currently 125 youth were In-State PRTF at an average cost of \$304 per day and average Length of Stay is 116 days

\*Contributing factors related to out of state placement include lack of bed availability, lower levels of care unavailable at the time of admission, and history of multiple placements without a clear response to treatment. Once a youth leaves their home and/or community in crisis, this becomes the default solution for future crisis and placement in the highest and most expensive level of care, PRTF.

### **Youth Crisis Diversion Access Alternative (Example)**

- 30 days of Intensive Case Management – 15 hours @ \$60 per hour = \$900
- Assessment by a licensed clinician - \$300
- Crisis stabilization shelter - \$200 current per day ( most placements average of 3 days = \$600) and (a maximum stay of 14 days = \$2,800)
- 3 months of weekly Home Support Services at \$46 per day x 12 = \$552
- Total costs average between \$2,352 - \$4,552 per youth
- Each youth diverted from In-State PRTF treatment could save the State around \$30,000
- Each youth diverted from Out-of State PRTF treatment could save the State around \$50,000
- Based on past Medicaid data, there are between 40 to 70 Seriously Emotionally Disturbed youth in each of the targeted communities that now have crisis diversion projects.
  - If each project diverts 6-8 youth from PRTF placements the savings would pay for the cost of all of the projects for 2 years.

### **Youth Crisis Services Continuum**

Youth crisis response projects must include a community coalition component and crisis services will be limited to:

- Twenty four (24) hour crisis lines availability and immediate response to de-escalate and provide immediate solutions to resolve crisis, assess for immediate safety and stabilization.
- Crisis case management/facilitation begins with a youth and family in crisis within 24 hours of identification and provides up to 15 hours or 30 days of service.
- Evaluation and assessment includes specialized assessments such as the Child and Adolescent Needs and Strengths (CANS) or more general assessments to determine risk and eligibility for follow up services. This consists of assessment of strengths and needs, exploration of crisis behavior/situation, development of a safety plan, appropriate referral and linkage, and teaching family skills to anticipate and plan for future crises.
- Short-term residential crisis stabilization consists of placements designed to specifically address crisis and bring the family along to facilitate replacement back home whenever possible. This proposes presumptive eligibility for 3 days to insure safety above all, including financial responsibility, and for a period of up to 14 days if needed in residential crisis stabilization in the community, using existing shelter group homes, therapeutic group homes, or foster care for up to 14 days.
- Each project may employ a Part Time Project Coordinator to assist in coalition building, managing the grant and building referrals for the duration of the grant.

Communities will be enabled to develop individualized, local approaches to crisis diversion using an array of some or all of these services.