

Proposal to Contract for Care of Involuntary Civil Mental Health Patients

Proposed by the Montana Community Mental Health Centers (Eastern Montana Community Mental Health Center – Center for Mental Health – South Central Mental Health Center – Western Montana Mental Health Center)

Current system

Currently care for civilly committed mental health patients is a fragmented network of services and service responsibilities. These services are divided among the following:

- state government at Montana State Hospital,
- county government which is responsible for the emergency detention piece (72 hour) of the commitment process,
- local community hospitals with psychiatric beds who provide some compensated and uncompensated care for voluntary and involuntary patients and
- local community mental health programs that provide care under contract for patients committed through the use of community commitment options but primarily provide care on a voluntary basis to 97% of the persons identified as SDMI.

The fragmentation of the current system and the financial incentives to over use the state hospital, coupled with the severe underfunding of community alternatives, leaves individuals with severe mental illness in an unpredictable and precarious situation. It depends on a daily basis as to what **local** alternatives are available. For instance, if a “slot” is not open for a person in the midst of their psychiatric episode the options are:

- local or general hospital emergency room; or
- stay at home to further burden their already over taxed family; or
- get arrested and sent to jail.

They may have had committed multiple crimes and/or due to the lack of availability of a local treatment response they enter the **state** alternatives. Those include prison and, oftentimes, are sent back to the homeless system to continue to bounce around or they get sent to Montana State Hospital for an indefinite period and an equally indefinite future.

Major mental health problems do not resolve themselves through benign neglect. They only fester and present in more serious fashion in some other setting. Treatment engagement, which is often difficult but not impossible with resistive patients, is the best “evidence based” path to recovery for persons with serious mental illnesses. The individual’s entire life and stability is always in jeopardy due to the current fragmentation and perverse financial incentives.

Financing Concerns

Care at Montana State Hospital (MSH) is currently financed by state general funds in the annual amount of \$32,237,475. Approximately 65% of that budgeted amount is dedicated to civil involuntary patients. Care for persons during the emergency detention and court ordered evaluation time spans are financed by the responsible county of residence. Funding for community services for persons with an SDMI diagnosis comes from a variety of sources:

- Medicaid being the major payer source
- State general funds (MHSP)

- Veterans Administration and other third party insurances
- County property tax levies
- Contributions from hospitals, write offs of charitable care, cost shifting to other third party payer sources,
- United Ways and other local charities
- Self-pay by clients and families
- Grants and donations etc.

No Fixed Point of Responsibility

Given the complexity and unevenness of service availability, coupled with the hodgepodge of funding streams supporting these services, and compounded by the fact that no single entity is responsible for care of the most seriously disabled adult mental health cohort, it is small wonder that the “system” appears broken and unworkable all too often. It could be argued that AMDD, a division within the State Dept. of Health and Human Services, is the fixed point of responsibility. But the reality is they have no “boots on the ground” when and where these psychiatric problems arise. Their primary role is to provide the institutional backup for all the community psychiatric crises when all local efforts have not panned out. A management maxim taught in business school classes is that when you have more than one person responsible for a problem, you have no one responsible. That is currently the case with services provided in Montana for persons with an SDMI diagnosis. No single entity is responsible for their care so individuals fall through the cracks of a badly fragmented service system every day. It cost taxpayers, consumers, families, law enforcement, legal systems, hospitals, service providers, too much money and anguish to continue as it is now exists.

A proposal

Mental health care should be contracted to local entities that would be responsible for providing, arranging for and paying for care for persons who meet civil commitment criteria under existing Montana statutes. These fixed points of responsibility would utilize the full range of treatment and service options available through purchase and contract arrangements to insure that persons are served in the least restrictive and most cost effective setting. If MSH is deemed the most appropriate setting for that person, the “entity” would be responsible for purchasing care in that setting, or using any of the other treatment options that could clinically meet that client’s need. Care in the state hospital would be charged to the local “entity” at the going rate is for a bed day at MSH.

Financing

The logical answer is that the current funds supporting care for involuntary patients at MSH should be made available to the new fixed point “entities.” Because those funds are largely state general funds, there are few to no federal restrictions/rules on how those funds are deployed. It is conceivable that all counties in the state would not become members of an “entity,” so state

wideness would not be mandated in the beginning. Having an adequate funding base with certainty of future funding would incentivize local entities to build their local capacity to manage services for the population who would otherwise be headed for the state hospital.

What does a local entity look like who qualifies?

The state should consider using the recently negotiated Intergovernmental Transfer Agreements (IGTs) with all 56 counties as a possible mechanism to designate “entities” that would be willing to take on this new responsibility. The agreement could be with a single county but more likely should be with a geographical cluster of counties that might utilize regional resources to manage their new responsibilities. Why local government? Local county government is currently responsible for a portion of this involuntary process. Those local units have, in some parts of the state, developed local crisis responses. Local alternative solutions to institutional care will continue to be part of a community response. Therefore, local intergovernmental units are the most logical partners for the state. It may be that another type of “entity” could be commissioned through contract to perform this function. Managed care companies may be interested in this role. However, the reason to have a local “entity” in control is because the fall out of a poorly administered system lands on the laps of local officials who run jails and support homeless shelters, fund law enforcement and county attorneys. All of whom are negatively impacted when cost shifting occurs. Locally elected officials are in a position to hear and respond to concerns from consumers, families, and other individuals about access problems – voters count.

Benefits

- Individuals with serious mental illnesses will not be bounced around and treated poorly.
- Families and other advocates who have long pleaded for adequately funded community options will be heard and respected.
- Local government will be recognized for the role selected counties have already taken on to better manage their local services and may encourage similar behavior statewide – true replication.
- Allows/ encourages/incentivizes the development of new cost effective local alternatives.
- Creates a single point of responsibility- an “entity”.
- Transfers institutional financial resources to the communities for service provision and care management.
- Frees up beds at MSH that can be used to better meet the needs of forensic clients.
- Gives the state an answer and response to the lawsuit they are facing for inadequate services to forensic clients.
- Models what other states have done to build their community based systems of care
- Allows for the maximization of the state-federal Medicaid program dollars.