Senate Joint Resolution No. 41
A Study of the Development of Community Mental Health Crisis Response Systems: Overview and Draft Study Plan

Prepared by Susan Byorth Fox, Research Analyst
For the Children, Families, Health, and Human Services Interim Committee
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This overview and study plan provides a brief look at the study resolution, what the mental health system looks like, background on the Interim Committee and mental health public policy, a history and background of the public mental health system, a briefing on crisis response services, identification of study issues, and a work plan to accomplish the study. A history and background of the public mental health system is offered to illustrate the magnitude of the changes experienced over the past decade and to emphasize the need to develop a crisis response system in the broader context of the need to develop stabilization of the current public mental health system.

Senate Joint Resolution No. 41 (SJR 41) was requested during the 2005 Legislature by the Joint Select Committee on Mental Health after controversy over Senate Bill No. 499. Senate Bill No. 499 had been introduced as a general revision of public mental health laws and included providing for crisis response services. Crisis response emerged as an issue in a Department of Public Health and Human Services (Department or DPHHS) Addictive and Mental Disorders Division listening tour across the state in early 2004 at the same time the Executive Planning Process began for the 2005 Legislature, so no department legislation was offered.

There was no consensus on the crisis response portion of Senate Bill No. 499 and it was amended out by the Senate Public Health Committee. The Joint Select Committee on Mental Health held four hearings on crisis response, which resulted in this study resolution. SJR 41 requested a study and monitoring of the development of community mental health crisis services across the state and response to any underlying issues that have prevented crisis services from being developed. The study is directed towards the following subjects:

(1) where the responsibility lies or should lie for providing mental health crisis

services at the community level;

(2) planning and development of community mental health crisis services;

(3) what mental health crisis services should be provided at the community level;

(4) how mental health crisis services should be provided at the community level;

(5) what populations should be served by community mental health crisis services;

(6) ways to encourage cooperation between and within communities in the planning, development, and provision of community mental health crisis services;

(7) whether the provision of community mental health crisis services should be prioritized in any way;

(8) funding and cost consideration in the provision of community mental health crisis services; and

(9) any other subjects considered by the committee to be necessary or helpful in the provision of community mental health crisis services.

Concurrent with the Joint Select Committee's study and proposal, the Addictive and Mental Disorders Division was presenting its strategic plan for development of crisis intervention and stabilization/detox sites to the Health and Human Services Appropriations Subcommittee. The goals of the plan are to keep people closer to home, decrease admissions to the Montana State Hospital, decrease suicide rates, maximize third-party payments, increase control of county funds, decrease contact with law enforcement and provide a reliable diversion from jail, provide a close relationship between physical and mental health, provide a secure placement for both detoxification and mental health assessment, evaluations, and treatment, and provide community linkages to develop long-term relationships for the path toward recovery. The service model they are researching includes a continuum of screening, assessment, mobile crisis teams, face-to-face short-term intervention, and stabilization and detoxification in local crisis stabilization beds.

The 2005 Legislature approved funding for 2.00 new FTE to be used to help develop community crisis services. The field staff have been classified and the Division will be posting the jobs in early August of 2005. The Legislature also approved language

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for inclusion in House Bill No. 2 that was eventually line item vetoed by the Governor regarding reporting to the Legislative Finance Committee. The information sought included the hire dates for the new FTE, the plan adopted by the Division for development and implementation of community crisis services, and the progress towards implementation of the plan. The study plan is designed for that information to be presented to the Interim Committee during the course of the study.

Other legislation passed in the 2005 session that is integrally linked to this study includes House Bill No. 395 (Ch. 480, L. 2005). House Bill 395 was concerned with the payment of the costs (detention, examination, and treatment) before a person is committed to the Montana State Hospital that are the responsibility of counties. (53-21-132, MCA.) The bill provides that the person involved in the proceeding (the respondent), private insurers, or public assistance programs may be billed prior to the counties. The bill also directs a cost study:

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

The cost study is vital because crises happen in communities and the intent of the development of crisis response is to keep people in the community and to prevent commitment to the state hospital. The counties are vital stakeholders who are currently responsible for paying for some of the public mental health services, especially related to mental health crises. Any plan for the development of crisis services will have to struggle with balancing the responsibilities for costs of crisis services, and this cost study will provide vital information.

The Division's current efforts are plans to hold an August 19, 2005 MET-NET conference with Service Area Authorities (SAAs), local advisory councils, and other stakeholders. The conference is intended to inform the stakeholders of the Department's efforts and intentions and to receive information from them on the needs for a crisis response system prior to the Interim Committee's August 22, 2005, meeting. The Division will be surveying communities for information to prepare

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background on the state of crisis response in the state.

It is the intent of the study plan to integrate the SJR 41 study parallel to the Department's development of crisis services and the cost study in order for the legislators to be informed and monitor the development of the plan, provide a forum for stakeholders and constituents, and lastly, be able to shepherd any recommendations through the 2007 Legislature.

The Mental Health System Today

Department of Public Health and Human Services
Addictive and Mental Disorders Division
The Division manages community programs including mental health for adults funded through Medicaid and state general fund and chemical dependency programs for children and adults funded through Medicaid, other federal funds, and alcohol tax revenues. The Division also manages three institutions: the Montana State Hospital (for mental illness) in Warm Springs, the Montana Mental Health Nursing Care Center in Lewistown, and the Montana Chemical Dependency Center in Butte. The three institutions account for 96% of the employees in the Division. The remainder of services are provided through community-based providers. About 43% of the mental health budget is spent on institutional services.

In addition to the state-run mental health facilities, the Addictive and Mental Disorders Division is responsible for planning, funding, and evaluating community mental health services. The mental health service delivery system consists of over 1,000 licensed practitioners, such as independent private providers and licensed mental health centers, including the four comprehensive regional community mental health centers, providing a core of mental health services. Eleven of the 17 licensed mental health centers provide services to only children and adolescents with serious emotional disturbance.[1]

(Note: The Department of Labor and Industry licenses individual mental health professionals: physicians, including psychiatrists, psychologists, advanced practice registered nurses who practice psychiatric nursing, social workers, professional

counselors, and addiction counselors, who may have involvement in mental health services, public or private. The DPHHS Quality Assurance Division licenses facilities who provide emergency/mental health services including hospitals, mental health centers, residential treatment facilities, chemical dependency facilities, and youth care facilities.)

The Division's budget for the 2007 biennium is $183,385,328, approximately 48.5% general fund, 10% state special revenue (some of that county contribution), and 41.5% federal revenue. The mental health function comprises 83% of the Division's budget. The 2005 Legislature approved 2.00 new FTE to work on crisis services in the next biennium to help maintain persons in the community and to help lower admissions to the state hospital.

Health Resources Division

The Health Resources Division is charged with children's mental health services following a reorganization in 2003. The circumstances of youth in crisis are complicated and may present to emergency rooms at the hospital, may present in behavior that results in problems at school, home, or in the community, may involve child protective services or juvenile probation, and may also be complicated by drug or alcohol abuse.

Statistics provided by the Health Resources Division indicate in that fiscal year 2004, 175 youth received Medicaid mental health crisis hospital services. This does not include non-Medicaid or nonhospital crisis response. Fourteen percent of the youth were transferred to a residential treatment center or admitted to hospital services. Montana does not have a state-run hospital for persons under the age of 18, so they must be committed to licensed private facilities in Montana or out of state. The state only has to pay if the children are eligible for Medicaid. Youth may not be admitted to the Montana State Hospital.

Senate Bill No. 342 (Ch. 574, L. 2005) clarified that it is the system of care and not the SAAs that have responsibility for children's mental health services. However, each entity must take others' policies, plans, and budgets into consideration in the development of their respective systems.

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House Bill No. 183 (Ch. 72, L. 2005) authorized the Department to seek a home and community-based services waiver from the Secretary of the Department of Health and Human Services for services to seriously emotionally disturbed children, and that waiver may also have an impact on the provision of crisis services to children and the development of a continuum of care that transitions into adulthood.

The Division has actively worked on developing a system of care for children, including kids management authorities. This study will incorporate information on its development to understand what crisis services are present within the system of care, and to ensure that a continuum of care for all ages is coordinated between the two divisions' efforts.

Montana State Hospital

The Montana State Hospital is the state facility for inpatient psychiatric treatment. It is licensed as an Institute for Mental Disease. Its population is significantly lower than in the days before deinstitutionalization when up to 2,000 patients were in residence in the 1940s and 1950s. Mental hygiene clinics were established in the 1950s and community mental health centers were established in the 1960s with the intent of decreasing institutional populations in favor of community-based services. A new hospital building was built and occupied in February 2001. It was intended to have a capacity of 135 beds, far lower than the census at the time, and a number that has never been realistically met. The facility is licensed for 189 beds. About half of the civil commitments were eligible for Medicaid or the Mental Health Services Plan. The half that were not eligible for public funds did not have access to services provided in the community mental health system. Of those, about 25% have Medicare or private insurance and almost 30% did not have any eligibility for reimbursement.

Montana Mental Health Nursing Care Center

The Mental Health Nursing Care Center in Lewistown is a licensed and Medicaid-certified residential facility that provides long-term care and treatment for people who have mental disorders and who require a level of care unavailable in the community. The population served is generally stable and would not benefit from the intensive psychiatric treatment available at the Montana State Hospital. The Nursing Care Center has experienced declining population in recent years and its future is

under discussion.

Community Mental Health Centers

The state statutes governing community mental health centers were enacted in 1967 (Ch. 246, L. 1967) in response to the Federal Community Mental Health Centers Act of 1963 which created and funded the construction and startup of the centers. Prior to that time, the federal government had partially funded the building of mental hygiene clinics. Medicaid was also created in the mid-1960s and changed the way services could be rendered and reimbursed in communities. The creation of community services never materialized to the extent that was envisioned, in part due to the lack of limited funding by the federal government. In the early 1980s, the federal government reverted to funding mental health services through block grants to the states rather than funding them directly.

Initially, there were mental health regions promulgated under the State Board of Health with regional board members designated by county commissioners in each county in a region. At that time, the definition said that to be a community comprehensive mental health center, the facility must offer at least the following five basic mental health services: (a) 24-hour inpatient care; and (b) part-time hospitalization, outpatient services, emergency service, and consultation and education in mental health. There was a prohibition that state funds could not exceeds 50% of the total expenditures, and counties were given authority to levy a tax to pay for mental health if their general fund was not sufficient. The Department was allowed to accept federal and private money as well. There was also a provision that the services of the Division of Mental Hygiene were to be made available without discrimination on the basis of race, color, creed, or ability to pay. (sec. 7. Ch. 246, L. 1967.)

The community mental health centers were changed in 1975 and required to be private nonprofit corporations. Prior to that they were governmental entities. A sixth criterion was added to be considered a community mental health center--the requirement that precare and aftercare be offered. This definition was changed in 1991 and again in 2003 (effective July 1, 2005).

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Originally there were five mental health regions and five community mental health centers that served all 56 counties. The parent organization for the fourth region, which included Lewis and Clark County, was dissolved following financial crisis in 1990s, and the Golden Triangle Community Mental Health Center absorbed much of the former fourth region.   The four community mental health centers and their headquarters are: Eastern Montana Community Mental Health Center (Miles City), Golden Triangle Community Mental Health Center (Great Falls), Western Montana Mental Health Center (Missoula), Region III Mental Health Center (Billings).

Service Area Authorities/Local Advisory Councils

The term "service area authorities" was coined in the development of a regional mental health system. It was placed in statute in 2003 following passage of Senate Bill No. 347 (Ch. 602, L. 2003). The Addictive and Mental Disorders Division and the Mental Health Oversight Advisory Council (MHOAC) following extensive study and 2001 recommendations by the Technical Assistance Collaborative, Inc. (TAC) adopted the basic concept for a recovery-based, community-based, regional system that provides consumer choice, flexibility, accountability, improved access, and a "homegrown" approach and is evidence-based for improved consumer outcomes.

Organizational summits, leadership committees, and incorporation for all three SAAs was completed this July (2005). The SAAs are in various stages of development and have different compositions of participants. The transition to the regional authorities will see the leadership committees in a lead role in the fall of 2005. Each regional SAA receives an annual grant of $15,000 from the state to support its development. The DPHHS states as one of its goals for the 2007 Biennium to have SAAs fully functioning in two of the predefined geographical regions of the state.

The counties within each service area are as follows:

1. Western Service Area consisting of Lincoln, Flathead, Sanders, Lake, Mineral, Missoula, Ravalli, Granite, Powell, Deer Lodge, Silver Bow, Beaverhead, and Madison Counties.
2. Central Service Area consisting of Glacier, Toole, Liberty, Hill, Blaine, Pondera, Teton, Choteau, Lewis and Clark, Cascade, Jefferson, Broadwater, Meagher, Gallatin, and Park Counties.

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3. Eastern Service Area consisting of Phillips, Valley, Daniels, Sheridan, Roosevelt, Judith Basin, Fergus, Petroleum, Garfield, McCone, Richland, Wibaux, Dawson, Prairie, Wheatland, Golden Valley, Musselshell, Rosebud, Custer, Fallon, Sweetgrass, Stillwater, Yellowstone, Treasure, Carbon, Big Horn, Powder River, and Carter Counties.

Local advisory councils (LACs) have been authorized in statute since 1999 (Ch. 577, L. 1999) and are in 27 communities. LACs are considered the backbone of the SAAs and are volunteers who are working at improving the design and delivery of services. Most meet monthly. The communities that have LACs are:

1. Western Region: Butte, Dillon, Hamilton, Missoula, Ronan, Polson, Thompson Falls, Kalispell, and Libby.

2. Central Region: Conrad, Choteau, Helena, Great Falls, Bozeman, and Livingston.

3. Eastern Region: Big Timber, Columbus, Red Lodge, Billings, Hardin, Roundup, Lewistown, Miles City, Glendive, Sidney, Glasgow, and Scobey.

Mental Health Oversight Advisory Council

The 1999 Legislature created this council (Ch. 577, L. 1999) to provide guidance to the Department of Public Health and Human Services in the development and management of an effective public mental health system.

The role of the council is to:

- Provide an ongoing forum for mental health providers and consumers.
- Provide leadership and advocacy for the mental health system.
- Foster cooperative relationships among consumers, providers, the Department, and other interested parties.
- Make specific recommendations to the department and the Legislature.
- Monitor, evaluate, and continuously seek to improve the public health system.

The Mental Health Oversight Advisory Council will be an important partner in the development of crisis response services because of its composition of consumers and family members, advocates, providers, and the public. In 2002, the MHOAC adopted working principles for mental health system change that may be an interesting tool in

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the analysis of recommendations for the development of a crisis response system.

Mental Health Ombudsman

The Mental Health Ombudsman was created by the Legislature in 1999 as a response to the multitude of complaints in response to the failure of the mental health managed care system. The position is attached to the Governor's Office. The Interim Committee has sponsored legislation in the last two sessions to make changes as the Ombudsman function became clearer and in response to changes in the public mental health system. The Ombudsman "shall represent the interests of individuals with regard to the need for public mental health services, including individuals in transition from public to private services." (2-15-210, MCA.)

The Interim Committee sponsored legislation in the 2005 session to clarify that the Ombudsman was a health oversight entity authorized to assist individuals in obtaining health care information and to clarify the Ombudsman role and duties. The Governor vetoed the legislation. The veto message and an analysis of the veto message by the Director of Legal Services are available.

Board of Visitors

The Board of Visitors has been in statute since 1975, historically as a function of protection for persons who were admitted to a residential facility or mental facility. Codified under the statutes for both developmental disabilities and the mentally ill, the Board monitors the Montana Developmental Center and the Montana State Hospital and has expanded its areas of concerns over the years to other types of facilities such as a hospitals, behavioral health inpatient facilities, mental health centers, residential treatment facilities, or residential treatment centers that provide treatment to children or adults with a mental disorder.

Committee Background

The Legislature has studied mental health issues regularly as interim studies because of the mental health managed care situation. During the 1999-2000 and 2001-2002 interims, the Legislative Finance Committee had a subcommittee devoted to studying the public mental health system and staff and members from the Children, Families, Health, and Human Services Interim Committee also served. The

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Interim Committee monitors mental health through the Addictive and Mental Disorders Division and the Health Resources Division as integral parts of DPHHS.

Public Mental Health System History and Background

The public mental health system has experienced at least a decade of turmoil and change. Before that, the system had experienced deinstitutionalization over the past 35 years moving from high numbers of people committed in a primary state-run mental health institution to more community-based services. It is important to realize that crisis response services are but a part of the larger public mental health system and to the extent the larger system has not stabilized and is still in transition. The development of crisis response services must be integrated within the transition.

The state mental health system used to consist of the Montana State Hospital that housed up to 2,000 people. In the 1960s, mental hygiene clinics then the community mental health centers (CMHCs) began. Until 1997, public mental health services were provided mainly by CMHCs and the Montana State Hospital and the Montana Mental Health Nursing Care Center. A 2000 final report of the Technical Assistance Collaborative reported that the CMHCs had "a franchise, either in actuality or in practice, to provide publicly-funded non-Medicaid services and specific Medicaid services in their region." They represented a single point of accountability in a region and supplemented the state and federal funding received through state agencies with local funds. There was no systematic form of accountability and the historic relationship "memorialized the expectations between the state and the community mental health centers". There was no single data system for utilization or expenditures.

Road to Managed Care

In the 1990s, the Legislature enacted legislation, at the request of DPHHS or its predecessor agencies, allowing the Department to develop and adopt rules for Medicaid managed-care systems (Ch. 460, L. 1991). At that time, the discussion centered around targeted case management and general relief medical assistance. Medicaid services at that time included "mental health center services administered and funded under a state mental health program authorized under Title 53, chapter 21, part 2" (community mental health centers). (53-6-101, MCA.)

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Legislation passed during a special session in 1993 (Ch. 31, Sp. L. 1993) allowed for capitated health care and the ability to contract for the management of comprehensive mental health services and required submitting any proposals to the Legislative Finance Committee. It also authorized a mental health advisory group to develop a mental health managed care plan. In 1995, legislation (Ch. 590, L. 1995) authorizing managed care mental health services under the Medicaid program was authorized, based on the recommendation of the mental health advisory group. The eligibility limit was raised to 200% of the federal poverty level. At that time in 1995, the Department was seeking (and subsequently received) federal waivers of certain Medicaid rules which allowed for capitated funding within a contract for managed care mental health services.

In 1997, the state contracted for mental health services from a single mental health managed care company (CMG-Merit-Magellan). The contract allowed new private providers into the system providing greater consumer choice and wider array of services. The implementation of the contract proved to be flawed and underfunded. Corporate acquisitions, speedy implementation, federal waiver requirements, and the sheer magnitude of the situation seemed to condemn it. The vendor sought to end the contract in late 1998, but agreements kept it in place into the 1999 Legislative Session. Ongoing problems and dissatisfaction by consumers, advocate, providers, and legislators grew. The contract was discontinued by the vendor and the Department in April 1999, after various alternatives were considered. The Legislature was determined to keep a regional risk-based system. However, the federal Health Care Financing Administration (HCFA) did not believe there was sufficient time to plan and implement a system that would not exacerbate the same problems as the existing contract had, and subsequently would not continue the waiver. The system defaulted to a fee-for-service system and the Department was to plan for a transition to a regional, risk-based, managed care system for the future.

The Road to Transition

Legislation in each session from 1999 to 2005 has continued to make changes to the public mental health system; many of the changes have not been implemented or were not able to be implemented.

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Senate Bill No. 534 (Ch. 577, L. 1999) was requested by the Joint Subcommittee on Human Services and Aging during ongoing discussions with the Department, the vendor, and HCFA. Senate Bill No. 534 required the DPHHS to incrementally implement a mental health managed care system and to require any contractor to comply with Medicaid managed care laws; created the Mental Health Ombudsman and the Mental Health Oversight Advisory Council; required the department to formally evaluate contract performance for specific outcome measures; and required the contract with an independent consulting firm (TAC mentioned above) to develop a managed care system.

By fiscal year 2000, the state abandoned the Medicaid waiver program to a fee-for-service environment with DPHHS contracting for preauthorization and payment of claims. In less than a 4-year period, the public mental health system went from a predominantly CMHC-controlled regional fee-for-service system to a single statewide tightly controlled, risk-based management system to a semimanaged fee-for-service system with more providers and consumer choice, higher eligibility requirements, and still with little data or management information.

(Executive reorganization occurred as a backdrop to all of this. The Department of Social and Rehabilitation Services, the Mental Health Division of the Department of Corrections and Human Services (formerly Institutions), the Department of Health and Environmental Sciences, and the Department of Family Services each had various responsibilities in these systems. In 1995, the responsibilities were consolidated under the current Department of Public Health and Human Services with mental health responsibilities in at least two divisions.)

The Legislature passed study resolutions House Joint Resolution No. 35 in 1999 and Senate Joint Resolution No. 1 in 2001, and the Legislative Finance Committee formed a mental health managed care subcommittee with members and staff of the Children, Families, Health, and Human Services Interim Committee participating. The subcommittee was intended to monitor the transition out of the managed care contract and into the future. SB 534 contemplated reinstituting a statewide managed care system, but the mental health managed care plan was not implemented. The 2001 Legislature responded by passing several bills, many approved by Children and

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Families Interim Committee and requested by the Legislative Finance Committee.

The Committee's legislation did not involve crisis services but remained concerned with the system at large and made further changes to the managed care statutes, consolidating the responsibility for fiscal solvency of any managed care company to DPHHS and lowering the eligibility for non-Medicaid mental health services from 200% to 160% of the federal poverty level. The bill also provided for tracking of children who need mental health services. In addition, another bill, Senate Bill No. 454 (Ch. 416, L. 2001) was the first bill for the multiagency initiative for high-cost seriously emotionally disturbed children, the precursor to the "system of care" (Senate Bill No. 94, Ch. 118, L. 2003). The need for targeting children's services was highlighted in the 2001 TAC Report: of the 8% heaviest users of the system, 63% were children. The 8% of heaviest users used two-thirds of the dollars spent, primarily in hospital and out-of-home placements (p. 26, TAC).

From Management by Community Mental Health Centers to Service Area Authorities

In 2003, the Legislature again attempted to provide direction to the public mental health system in the creation of "service area authorities" (SAAs) as a regional concept in managing mental health services (Senate Bill No. 347, Ch. 602, L. 2003). The need for creating regional structures for a single point of financial and clinical care accountability had been mentioned in the TAC Final Report of January 15, 2001, and were anticipated by the 2003 Legislature. The SAAs were contemplated as risk-bearing entities that would administer contracts and services with local and regional providers based on the assessment of the needs and character of the region. Senate Bill No. 347 required the Department to develop a plan for the transition to the administration of the delivery of public mental health services by SAAs over a 4-year period.

In a January 22, 2004, report to the Children and Families Interim Committee, the Department abandoned the idea of requiring SAAs to be risk-bearing and instead decided that they would function in an advisory, planning, and steering capacity. The Department would retain responsibility for financial management and risk. The Department outlines the roles and responsibilities of the Mental Health Services

Bureau and the SAAs and a schedule for implementation. The Department had expected to allocate its budget among each of the service areas for the fiscal year 2006. The Department reported that consideration would be given to full collaboration with children's mental health services provided through the Health Resources Division, the inclusion of substance and chemical abuse services, and the sharing and management of risk.

Senate Bill No. 347 proposed that the former distinction for "community mental health centers" be deleted because they are required to be licensed mental health centers, as are other providers. This was a controversial move with great opposition from the centers and the county commissioners because of the historic relationship, noted by the TAC report. The 2003 House Human Services Committee decided to place a delayed effective date on those provisions and required the Department to "define the role of existing community mental health centers as a part of the transition plan." If the rule was to include a special designation, the Department was to define the special designation and the reasons for any special designation.

Senate Bill No. 347 proposed that on July 1, 2005, there would no longer be a separate definition of "community mental health center" and that some of the provisions regarding county financial participation in community mental health centers be moved to the SAA section of law. A new section would allow boards of county commissioners to include funding to any licensed mental health center (not solely community mental health centers as previously) in a budget for contracting for mental health services, and to include county commissioners in the SAAs. This was highly controversial and opposed by the community mental health centers and the county commissioners. The effective date was delayed to allow for a determination to be made, for proposals to be developed, and to give the 2005 Legislature a chance to address any desired changes.

In a June 29, 2004, memo to the committee, the Department stated:

"Currently, Community Mental Health Centers are responsible to provide comprehensive public mental health services in a multi-county area, that includes outpatient services for individuals with serious mental illness; crisis response and emergency services; psychosocial rehabilitation services; and screening for patients

being considered for admission to state mental health facilities."

The Department stated that the designation of CMHC provides no preferential status with the Department and they proposed to continue to study the issue, acknowledging that although the designation was not necessary for Department purposes, it carried special meaning to county governments.

Despite the determination that the designation of CMHC provides no preferential status, it was the four CMHCs that were granted the contracts to provide non-Medicaid Mental Health Services Plan services, which includes nonsecure crisis intervention facilities, mobile crisis teams, and crisis phone services for adults with serious and disabling mental illness under 150% federal poverty level.

For the 2005 Legislature, neither the Department, the community mental health centers, or the county commissioners proposed any legislation to retain the definition of "community mental health center". The definition prior to 2003, which is similar to what the Department reported in its memo, had included a list of "comprehensive mental health services that include at least the following services to the public:

(a) outpatient services, including specialized outpatient services for children, the elderly, individuals who have serious mental illness, and residents of its service area who have been discharged from inpatient treatment at a mental health facility;

(b) 24-hour-a-day emergency care services;

(c) day treatment or other partial hospitalization services or psychosocial rehabilitation services;

(d) screening for patients being considered for admission to state mental health facilities to determine appropriateness of admission; and

(e) consultation and education in mental health." (53-21-201, MCA.)

There was a difference of opinion as to what extent the services were rendered as outlined in the definition. Because the requirements were in the definition instead of specifically directed by law, it was believed that those responsibilities were better outlined in contract so that there could be enforcement, financial incentives, and outcome performance measures for those services from any willing provider.

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In the 2005 Legislature, Senator Bob Keenan introduced Senate Bill No. 499 (Ch. 553, L. 2005). Because the Department had not offered legislation to change the statutory requirements for SAAs despite their status change from risk-bearing administrators to advisory, planning, and steering capacities, he included those changes in the legislation. He also included provisions for crisis response services by the Department in conjunction with the counties. Definitions of crisis response, crisis screening and assessment, and mental health crisis were included. Current statutes for crisis intervention programs were amended to crisis response systems. It required each county to have a crisis response plan and required an SAA to review and monitor the plans. It also included eliminating any definition of or provisions for community mental health centers. None of the crisis response or community mental health center amendments stood and the bill as enacted only cleaned up the SAA statutes to reflect the Department's decisions and transition plan.

Crisis Response Services

Mental illness is often brought to a person's, their family's, and their community's attention in a crisis. Mental illness often strikes in young adulthood or in childhood, but it may not be recognized until it peaks in behavior that proves to be so out of the ordinary or dangerous that attention is focused on the person's mental state. Webster's dictionary[2] indicates that a crisis may be a "turning point of a disease, for better or worse, a decisive or crucial time, a time of great danger or trouble, often one that threatens to result in unpleasant consequences."

Information from Addictive and Mental Disorders Division indicates that over half of the new admissions to the Montana State Hospital are people previously unknown to the public mental health system, previously unknown to the community mental health centers, and who have not received Medicaid or mental health services plan reimbursement. The fact that these people first receive public services away from their home community in the most restrictive and highest cost service is an indication that there is a lack of sufficient local crisis services available to everyone who needs them. Law enforcement and community hospitals experience the effects regularly. A commitment may bring relief through treatment, but at a great cost physically, socially, and economically.

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One tragic outcome of mental health crisis is suicide. A DPHHS suicide prevention website states: "The intermountain western states have the highest rates of suicide as a region and Montana ranks persistently near the top of the rate chart annually. For the past fifteen years we have not fallen out of the top three rankings. Often we are number two on the yearly charts second only to Nevada."[3] Development of any crisis response system should coordinate and integrate with suicide prevention efforts. Currently, suicide prevention is included in the Public Health and Safety Division of DPHHS. Legislation (Senate Bill No. 428, Ch. 548, L. 2005) was pursued by the Suicide Prevention Task Force for a 2-1-1 disaster, emergency, safety, health, and human services referral phone service that should provide statewide service information and a referral database. Currently, volunteers receive calls from a 1-800-SUICIDE line. Information about crisis response services is vital to suicide prevention and the mental health crisis lines should be coordinated with the suicide prevention lines.

Another default place to receive a form of services is the criminal justice system in jails, detention centers, and prisons. Services and treatment are provided to persons whose actions have brought them to a highly restrictive, high-cost placement. The bottom line is that a person in a mental health crisis will receive services eventually, by one system or the other, or face an alternative of death.

The goal of this study and any development of a crisis response system could make the mental health crisis the turning point, the crucial time, when resources are accessed to make the outcome better, not worse. We experience the worse outcomes currently in many, but not all, cases: suicide, incarceration, exacerbation of the mental illness, or loss of family, jobs, and economic security. A true crisis *response* system could have many positive results:

(1) mental illness identified and treated earlier resulting in less suffering and less damage physically and socially to the person with mental illness;

(2) savings to society in terms of preventing crises, in fewer expensive treatment and criminal justice costs, less court intervention, and relieving state hospital overcrowding.

As the history and background would indicate, crisis response services are but a part

of the whole public mental health system and may prove to be a lynchpin or foundation in turning the system to the community recovery-based model that the Department, advocates, and consumers of mental illness are now focusing on.

The public mental health system has always included at least a reference to crisis services. As noted above, "24-hours-a-day emergency care services" and "screening for patients being considered for admission to state mental health facilities to determine appropriateness of admission" were, by definition, considered to be a part of community mental health centers. The Department has stated that currently crisis response and emergency services are part of the current responsibilities of the community mental health centers.

In 1991, House Bill No. 103 (Ch. 636, L. 1991) enacted provisions for diversion of certain persons suffering from mental disorders from detention centers (jails) and required the Department (subject to available appropriations) to establish crisis intervention programs. This legislation made it unlawful to detain a person with a mental illness in a jail pending a hearing or trial to determine whether the respondent should be committed to a mental health facility. Clearly, there was a population of persons with mental illness ending up in jail and they needed to be served in the community or a mental health facility. In the absence of an alternative and sufficient or available appropriations, the default was and is the state hospital, whose history of overcrowding is outlined above, or the criminal justice and corrections system.

This legislation complemented other legislation (Senate Bill 391, Ch. 460, L. 1991, described above) to allow for targeted case management through the Medicaid program. (At this time, Medicaid was administered through the Department of Social and Rehabilitation Services and mental health services were administered by the Department of Institutions.) No specific crisis services legislation had been offered since 1991.

The TAC Final Report and Crisis

As a part of the transition during managed care, the Legislature required the Department to contract with an independent consulting firm to develop a managed

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care system. The firm was The Technical Assistance Collaborative, Inc. Throughout its January 21, 2001, Final Report, crisis services were mentioned. The report is 169 pages long and the richness of the recommendations may be lost in excerpt; nevertheless it may be valuable to remind the Committee of the findings to illustrate what is already known or believed and what may be useful in developing recommendations for the future.

Under *Findings: Service System Culture and Capacity*:

- mobile crisis services were identified as either unavailable or underutilized in many parts of the state (p.7, TAC).

Under *Recommendations:*

- *Planning* -- It was identified that a needs assessment or gap analysis should be conducted to identify unmet or inadequately met service needs and costs, with the analysis to begin after the system has stabilized and infrastructure changes have begun (it could be argued that is where the system is at to date). (p. 9)
- *Service Delivery Changes* -- Crisis services that are mobile, respite, and peer in nature are also needed. The link between crisis and admission to inpatient services should be strengthened through the regional structure. ...Partial hospitalization should be used only for short-term crisis services to prevent hospitalization. Pre- and post-booking jail diversion should be available to prevent hospitalization. (It was noted that the expanded service array was needed as soon as possible but acknowledged many impediments; adjusted rates and halting development of bed-based services were noted as places to start.) (p. 11, TAC).

In exploring data for the Montana State Hospital, the TAC report summarized the traditional look of our public mental health system "with long hospital lengths of stay and few community resources that are specifically designed to prevent crisis and hospitalizations, and to get people out of the hospital as quickly and effectively as possible. ...In addition, the lack of a single point of accountability for individuals in the system makes it both easy and likely that people will fall through the cracks and end up in crisis and on a pathway to being hospitalized." (p. 28, TAC)

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