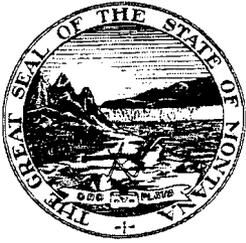


**DEPARTMENT OF
PUBLIC HEALTH AND HUMAN SERVICES
ADDICTIVE & MENTAL DISORDERS DIVISION**



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January 18, 2006

Greetings:

For the past few months, the Addictive and Mental Disorders Division has been actively working on the development of service options that would address the census at Montana State Hospital as well as the need for community crisis response services. What brought us to this point? Here are some of the main events:

- AMDD conducted a listening tour in the winter of 2004. Our staff traveled around the state and met with about 200 people – consumers, providers, advocates, law enforcement, county commissioners and other stakeholders. Many ideas came from those meetings, but the overriding concern at that time was a lack of crisis response services in communities.
- In the summer of 2005, the census at Montana State Hospital (MSH) climbed above licensed capacity and has remained there. Emergency actions had to be taken at MSH, such as providing more licensed beds, more staff, more options that would facilitate discharge from the hospital to the community.
- In the fall of 2005, we conducted another listening tour and talked with about 300 people across the state. Crisis response services continue to be a major concern but additionally, we learned that we must do something about recruitment and retention of mental health and addiction professionals; that lack of payment coverage for these services in community settings forces people into higher levels of hospital care; and that if we want to impact the census at Montana State Hospital we must develop services in the community that are accessible physically (service providers are available) and available to people who do not have a source of payment for their care.

These events, and the input we have received about what needs to be done, clearly show that we cannot fix one issue (high census at MSH) without dealing with the need for development of services and access to those services in community settings.

The accompanying document "Adult Mental Health System - Crisis Management Initiative" is provided as a discussion document to address these needs. Some items are self-explanatory, others are not. Here are explanations of some of the terms:

- Upgrade crisis beds to secure: Several communities have facilities that provide crisis stabilization beds. Individuals currently remain in a crisis stabilization bed on a voluntary basis. This initiative would add a new mental health center endorsement for a higher level of crisis stabilization bed to include a secure level of care. These services have the potential of providing short-term detention and other crisis services.
- Peer support services: This service would be beneficial in alleviating admissions and in transition of individuals following discharge from MSH. The services are highly valued by consumers because those delivering the services are regarded as having real experiences with the illness and system of supports.
- Community sponsor/advocate: Creation of a service that utilizes a community person to act as sponsor or advocate for an individual being discharged from MSH. The sponsor would meet the discharged consumer and act as a community resource in assisting the consumer to follow through with the discharge plan and keep community appointments. This may be a role for the peer support program.
- 72-hour presumptive eligibility: regardless of eligibility, grant a 72-hour period to serve any individual presenting in need of crisis services. This initial period would allow for an immediate response to anyone exhibiting crisis behavior and could result in diversion from MSH admission. These services were part of state-paid services prior to 1997.
- Suicidal enrollment: individuals who are at imminent risk of self-harm are automatically eligible for 30 days of services, regardless of income (also pre-1997 state policy).
- Increase MHSP poverty level: this option would increase the income eligibility level from 150 to 200% of poverty. This change would align the mental health program income level to the addiction program income level. Another option would be to eliminate the income guidelines for MHSP, reinstate sliding fee charges and provide a state fund to make up the difference between charges and collections.
- Assistance to community hospitals: Most community hospitals in the state are unable or unwilling to provide behavioral health services due to lack of appropriate professionals to treat individuals who are experiencing a psychiatric crisis, or they have determined that serving this population is a financial risk for the organization. There are several options proposed which could encourage community hospitals to treat this population, such as providing 24/7 evaluation and assessment services via telemedicine video from MSH staff, providing emergency room personnel with specialized training, paying for aide services and increasing the reimbursement for crisis services.

We invite your input on these options including what combination of options would be most effective. Some of you receiving this information will have an opportunity to discuss these options with AMDD staff, as we are already scheduled to meet with you. If we are not already scheduled, we invite you to set a date so we can get together to gain your input.

I look forward to hearing from you.

Sincerely,

Joyce De Cunzo, Administrator