

OFFICE OF THE GOVERNOR
MENTAL DISABILITIES BOARD OF VISITORS



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TO: Children, Families, Health, and Human Services Interim Committee

FROM: Gene Haire, Executive Director
Mental Disabilities Board of Visitors 

RE: "... development of community mental health crisis services across the state..."
"... underlying issues that have prevented crisis services from being developed..."¹

- **The premise of SJ 41, that the lack of adequate mental health crisis services in Montana is the predominant cause of predicaments such as counties' unpredictable pre-commitment costs and Montana State Hospital's census, misses the continuing overarching point relative to public mental health system 'problems'.**
- **The issue that must be addressed is the inadequate capacity of the system – at all levels – not just crisis services.**
- **The fundamental unanswered questions are:**
 1. *How many adults are there in Montana who have severe, disabling mental illnesses and who qualify for and need services from the public mental health system?*
 2. *What are the most effective treatments – across the complete spectrum of services?*
 3. *What is the difference between what we have and what we ought to have?*
- **Whether we answer these questions or not, people with severe, disabling mental illnesses will not go away. If we do not provide adequate levels of evidence-based services – illness management and recovery, medication management, assertive community treatment, family education, supported employment, treatment for co-occurring psychiatric and substance use disorders, housing supports – as well as crisis response services - they will continue to show up in increasing numbers in community psychiatric inpatient units and Montana State Hospital, as well as in county jails, Montana State Prison, and on the streets.²**

CHILDREN, FAMILIES, HEALTH & HUMAN SERVICES
AUGUST 22, 2005 MEETING

EXHIBIT 14

CONSIDER:

- 60% of admissions to Montana State Hospital are entering the system for the first time - via emergency rooms and courtrooms - at this highest level of care.
- There are significant waiting lists, reduced capacity, and overload in almost every mental health facility in the state:
 - closure of the psychiatric inpatient unit in Helena.
 - reduction of psychiatric inpatient beds in Billings
 - reduction of group home beds in Billings
 - 50 person waiting lists for case management programs
 - two to four month waits for first appointments with psychiatrists
 - psychiatrists with caseloads of from 300 – 600 patients
 - up to seven week waits for first appointments with therapists
 - 30+ caseload sizes for adult case management – double the caseload sizes of 10 years ago
- The number of adults with severe, disabling mental illnesses living in Montana who need - and who qualify for - services is significantly higher than the number served currently and historically by the public mental health system.³

THE NUMBERS:

- In each of the fiscal years 2003 and 2004, the total unduplicated number of adults served in Montana's public mental health system - Medicaid and MHSP - was ~ 18,000.
- The Surgeon General's Report on Mental Health (1999), states that 2.6% of the adult population has a *Severe and Persistent Mental Illness* (SPMI)^{4 5}.
- The Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Mental Health Services states that 2.7% of the adult population has SPMI. 2.7% of Montana's adult population (680,000) is 18,360.
- The Surgeon General's Report on Mental Health (1999), states that 5.4% of the U.S. adult population has a *Serious Mental Illness* (SMI)⁶.
- The Substance Abuse and Mental Health Services Administration (SAMHSA) states that 9.84% of Montana's adult population has SMI^{7 8}.
- Montana's definition of *Severe Disabling Mental Illness* (SDMI)⁹ is somewhat broader than the federal SPMI definition, but narrower than the federal SMI definition - therefore Montana's percentage of SDMI can be expected to be higher than the 2.7% for SPMI but lower than the 9.84% for SMI.

EXACERBATING FACTORS:

- According to the Centers for Disease Control, Montana's suicide rate is 19.3 per 100,000 population - second highest suicide rate in the U.S. - second only to New Mexico and 1.8 times the national suicide rate¹⁰.
- A report by the U.S. Census Bureau in 2002 states that Montana is 12th in the percent of its population in poverty¹¹.

The Board of Visitors believes that - based on nationally recognized illness prevalence statistics, exacerbating factors, and reports from the field throughout Montana's mental health programs:

4% of the adult population at any given time meets the clinical and functional criteria for the state's definition of Severe Disabling Mental Illness.

4% of Montana's adult population is 27,200 or 1.5 times the number of individuals served in FY 2003 and 2004.

BOTTOM LINE:

- 1) We must clearly define what we are trying to accomplish in our adult public mental health system.
- 2) We must measure the number of adults in Montana who have Severe Disabling Mental Illness.
- 3) We must ensure that service and budget planning respond to this measurement.
- 4) We must begin comprehensive, long-range efforts to close the gap that exists between what is needed and what is funded.

Without quantifying the need and pursuing a comprehensive approach to building service capacity across the spectrum, increased crisis services will actually exacerbate the system overload problem by opening this door wider without necessary increases in other community services to serve more people as their crises abate.

¹ 2005 Montana Legislature. Senate Joint Resolution No. 41.

² "Untreated mental disorders not only incur costs to affected individuals but also have high social costs. Many factors contribute to these indirect costs, including lost work productivity, homelessness, and expenses to the criminal justice system. It has been estimated that lost productivity alone constitutes 45 percent of the total economic costs of mental disorders." **National Mental Health Association: *General Mental Health*. Available at www.nmha.org**

³ "The usual approach to modeling service needs is to invoke the US notion of "Serious and Persistent Mental Illness" to discount the prevalence down to the estimated level of about 2.8 per cent of the population. A 'more of the same' model can then be applied to plan specialist public sector services, assuming a similar client group to the one already in care. In models of that type it is simply assumed that others receive care elsewhere, or have 'mild and self-limiting' conditions. [This] would not generally be regarded as a meaningful account for (say) cardiovascular disease, or other physical health conditions.... implicit priorities for service provision ... are reflected in the form of unmet need." **Andrews G, Henderson S (Eds) *Unmet need in psychiatry: problems, resources, responses*. (Scientific symposium of the World Psychiatric Association Section of Epidemiology and Public Health, Sydney, 1997). Cambridge: Cambridge University Press, 2000.**

⁴ National Advisory Mental Health Council. (1993). Health care reform for Americans with severe mental illnesses: Report of the National Advisory Mental Health Council. *American Journal of Psychiatry*, 150, 1447-1465.

⁵ Kessler, R. C., McGonagle, K. A., Zhao, S., Nelson, C. B., Hughes, M., Eshleman, S., Wittchen, H. U., & Kendler, K. S. (1994). Lifetime and 12-month prevalence of DSM-III-R psychiatric disorders in the United States. Results from the National Comorbidity Survey. *Archives of General Psychiatry*, 51, 8-19.

⁶ Kessler, R. C., Berglund, P. A., Zhao, S., Leaf, P. J., Kouzis, A. C., Bruce, M. L., Friedman, R. M., Grossier, R. C., Kennedy, C., Narrow, W. E., Kuehnel, T. G., Laska, E. M., Manderscheid, R. W., Rosenheck, R. A., Santoni, T. W., & Schneier, M. (1996). The 12-month prevalence and correlates of serious mental illness. In Manderscheid, R. W., & Sonnenschein, M. A. (Eds.), *Mental health, United States, 1996* (DHHS Publication No. (SMA) 96-3098, pp. 59-70). Washington, DC: U.S. Government Printing Office.

⁷ Serious Mental Illness (SMI) is defined as having a diagnosable mental, behavioral, or emotional disorder that met the criteria found in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV) and resulted in functional impairment that substantially interfered with or limited one or more major life activities.

⁸ SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2002 and 2003.

⁹ Administrative Rules of Montana (2004). 37.89.103(15).

¹⁰ Centers for Disease Control, National Center for Health Statistics: *National Vital Statistics Report* (2003). Vol. 52. No. 3. p. 91.

¹¹ U.S. Census Bureau (2003). *Poverty in the United States: 2002*. p.10.