MINUTES

MONTANA HOUSE OF REPRESENTATIVES
52nd LEGISLATURE - REGULAR SESSION

SUBCOMMITTEE ON INSTITUTIONS & CULTURAL EDUCATION

Call to Order: By WM. "RED" MENAHAN, on February 4, 1991, at 8:00 A.M.

ROLL CALL

Members Present:
Rep. Wm. "Red" Menahan, Chairman (D)
Sen. Dick Manning, Vice Chairman (D)
Sen. Gary Aklestad (R)
Sen. Tom Beck (R)
Rep. Dorothy Cody (D)
Rep. Chuck Swysgood (R)
Sen. Eleanor Vaughn (D)

Staff Present: Sandra Whitney, Associate Fiscal Analyst (LFA)
Mary LaFond, Budget Analyst (OBPP)
Mary Lou Schmitz, Secretary

Please Note: These are summary minutes. Testimony and discussion are paraphrased and condensed.

Dan Anderson, Administrator of Mental Health Division, Dept. of Institutions, discussed three components of the Mental Health System; the operations, the inpatient services and the community mental health service.

The operations component consists of staff and activities of the Mental Health Division. There is a 20-member state Mental Health Planning and Advisory Council appointed by the Department Director. The Council includes consumers of services, family members of consumers, providers of services and one state legislator. This group has responsibility for helping the Department plan the mental health system, determines direction and helps set priorities for spending resources effectively.

There are two modified budget requests. The first is a request for a .25 FTE and the authority to spend federal grant money under the CASSP (Child and Adolescent Service System Program). Funds will be used to organize and coordinate the various state and local agencies that have some responsibility to serve severely emotionally disturbed children and adolescents. The

second is a request for federal Mental Health Data Grant funds.

Mr. Anderson said they have done a better job accessing Medicaid funding. They have worked closely with SRS to make sure all legitimate Medicaid reimbursement services are, in fact, reimbursed by Medicaid and through this have expanded some programs. The Mental Health Centers have become more efficient and have cut down on administrative overhead expenses.

Kathy McGowan, Representative, Community Mental Health Centers of Montana, read from Exhibit 1. The mission of the Montana Council of Mental Health Centers is to restore, improve, enhance, develop or maintain the abilities of people who are or who may become emotionally disturbed or mentally ill, and to ensure that they have the opportunity for maximum participation in the life and resources of the community.

Dr. Mike McLaughlin, Golden Triangle Community Mental Health Center, said the wrap-around service is for individuals who have special needs that cannot be addressed by traditional programs and services. The Mental Health Center provides a therapist, a case manager, and a psychiatrist who prescribes medication. Treatment takes place with cooperation of all agencies involved.

SEN. VAUGHN asked if most insurance plans pay for this type of care. **Dr. McLaughlin** said no but it might pay for the individual therapy.

Carol Harwood, Sunburst, spoke about her child's illness and problems and described the CASSP project, or wrap-around in-home care and the success, support and help they have received. Her son was the first child in the state to be put in this program. She asked the subcommittee to continue support of community based services. **Jana Christian** is one of four Aides who works in the Harwood home two days a week, approximately 6 hours a day. She received excellent training provided by Region II Mental Health Center. There are two high school boys and another woman who help in the Harwood home. She gives the boy exercise on a daily basis.

John Harwood, Sunburst, spoke in support of community based mental health services and said they provide treatment to individuals and families who are ill. Their programs are government's vaccination program to prevent more costly illnesses. The mental health systems provide counseling and help the families. The wrap-around service is designed to meet all the needs of that family as there is little coordinated support for them in the state now. That is where the CASSP project has come in to serve SED (Severely Emotionally Disabled) kids.

REP. MENAHAN asked how many agencies were contacted to get services. **Mr. Harwood** said they started at the Governor's Office and **Marilyn Miller** from that office sent them to SRS where their son became SSI eligible. There was a lot of inter-agency collaboration with the Department of Family Services. There were Title 19 funds, which are federal dollars, in a program that needs to be matched with general funds. The Office of Public

Instruction provided an Aide with a Federal Grant. Westmont is a care-provider who provided four hours of treatment.

Jeffrey Krott, Consumer, River House, Missoula, said he is very thankful for the support and help he has received from community based services throughout his mental illness.

Mitzi Anderson, Havre, spoke on behalf of her mentally ill son and the support he has received from community based services. New medications are now available for chemically imbalanced brain problems in the mentally ill which enables them to function in society quicker and progress to their potential.

Frank Laine, Director, Eastern Montana Community Mental Health Center, said a crisis situation in the Eastern Montana service delivery system is the problem of funding. Because of this problem they have had to cut staff and are no longer competitive for recruiting to fill vacancies.

An employee of the Mental Health Services, Inc. Helena, handed out Exhibit 2, Cost comparison figures for treatment alternatives, Southwest Adolescent Day Treatment Center.

John Lynn, Director, Community Support Programs in the Western Regional Mental Health Center, and River House located in Missoula, said there are comprehensive systems offering an array of services consisting of case management, day treatment, residential, vocational and certain crisis responses. Services being offered now in the community are more responsive to the individual consumer of services and needs of family members.

Candace Butler, Director, Gilder House Stabilization Program, Region IV. Gilder House is one of the pilot projects funded by the Department of Institutions to develop community based programs as alternatives to hospitalization. They believe they are providing more normalized treatment with community based residential crisis service. Residents feel they are less stigmatized and have better linkage to community resources and support programs. Treatment is provided in a less restrictive manner and is less disruptive to the individual.

Judy Garrity, representing Montana Children's Alliance which is a group of 47 sponsoring organizations, who put together the 1991 Children's Agenda. In the mental health and social services section, there are a number of issues they support. They are striving to bring children out of state placement into homes in the communities and adolescent day treatment centers involving the concept of flexible funding through agencies.

Patrick Pope, consumer, Mental Health Services, said he first became involved with the mental health system in July 1988. He was suffering from severe depression and was very suicidal. After several weeks of hospitalization and no treatment plan, he went from crisis to crisis. Crisis intervention and case

management services were not then and still are not readily available in Helena and most Montana communities. A private counselor took charge of his therapy and case management services. He needed a highly structured environment and was introduced to and attended a local community mental health transitional living center, the Montana House. He has regular treatment review meetings with people involved in every aspect of his life.

Marty Onishuk, lobbyist for Montana Alliance for the Mentally Ill, read from Exhibit 3.

Gene Haire, Director, Montana House, Helena said they provide day treatment services, case management, transitional living and supportive employment. All five mental health regions have cooperative arrangements with SRS to provide supportive employment services.

Dick Hruska, Director, Region II, Golden Triangle Commission, Mental Health Center, said there are nine counties in the region with a population of 143,000. The client load is approximately 1700 people and of those 814 are seriously mentally disabled. He asked for an increase in state general funding to maintain current level services.

Harold Gerke, Montana Council, Mental Health Center said they are asking for only 5% more in the budget and to be flexible to improve the service for the clients who need the services.

ADJOURNMENT

Adjournment: 11:05 A.M.

WM. "RED" MENAHAN, Chair

MARY LOU SCHMITZ, Secretary

WM/mls

HOUSE OF REPRESENTATIVES

INSTITUTIONS AND CULTURAL EDUCATION SUBCOMMITTEE

ROLL CALL DATE 2-4-91

NAME	PRESENT	ABSENT	EXCUSED
REP. WM."RED" MENAHAN, CHAIRMAN	✓		
SEN. DICK MANNING, VICE-CHAIRMAN	✓		
REP. DOROTHY CODY	✓		
SEN. ELEANOR VAUGHN	✓		
REP. CHUCK SWYSGOOD	✓		
SEN. GARY AKLESTAD	✓		
SEN. TOM BECK	✓		

HR:1991
CS10DLRLCALIN&C.MAN

The mission of the Montana Council of Mental Health Centers is to restore, improve, enhance, develop or maintain the abilities of people who are or who may become emotionally disturbed or mentally ill, and to ensure that they have the opportunity for maximum participation in the life and resources of the community.

Good morning. My name is Kathy McGowan and I represent the community mental health centers of Montana. One of your colleagues stopped me in the hall the other day and asked me what I was doing since I had left the Citizens' Advocate Office. When I told him that I was working for the mental health centers, he surmised that I probably needed some mental health counseling after so many years of listening to everyone else's problems. I had never thought about it quite like that...perhaps he was correct.

In all seriousness, it was not difficult for me to step from a role of counseling individual citizens about their problems to advocating for community mental health. My roots in eastern Montana and some early personal experiences instilled in me a value that has remained with me to this day: that families and communities take care of their own. But those same families and communities sometimes need the assistance of a larger community, the state or even the federal government, in solving their more extreme problems.

Two particular experiences have left an indelible mark on me. When I was in the third grade, one of my classmates in our small country school was stricken with tuberculosis. Alice was an only child who was sent 500 miles away from her family, her friends, and everything that was familiar to her to be treated at Galen. A few years later, as a worldly junior in high school my first love suffered a traumatic head injury in football practice. Eventually, he, too, was transported the many miles across the state where he spent several months at the State Hospital. Both experiences were traumatic for me but certainly not nearly as traumatic as they were for those individuals and their families.

The point of my relating these personal experiences to you is to emphasize my commitment and the commitment of community mental health centers to serve Montanans in their communities whenever it is possible. We recognize that it is not always possible to keep our family, our friends at home or in the community we believe that those circumstances are few and far between. We do ask for the opportunity, through proper funding and integrated, statewide planning, to carry out our mission and to serve our many Montana communities in the best way possible.

Dan Anderson, in his presentation today and in the overview of the mental health system he delivered a couple of weeks ago, described some of the services mental health centers provide in their communities. You learned that mental health

centers have gone far beyond delivering the more traditional one-on-one types of outpatient care with which we all are familiar. Mental health centers increasingly are committing a larger portion of their resources to adults with disabling mental illness and to children with severe emotional disturbances.

Did you know:

•That mental health centers have created three adolescent day treatment programs in the state in response to the crisis we are experiencing in Montana with this population? You all are familiar with the out-of-state placements and with the burgeoning inpatient psychiatric caseload. Adolescent day treatment, with its carefully coordinated therapeutic and educational components, is a wonderful example of what can be done when several players in a community get together in the best interest of a difficult-to-serve population of youth.

•That mental health centers provided in FY 1990 case management, day treatment, outpatient and emergency services, and crisis intervention for 4,343 adults with disabling mental illness?

•That mental health centers have established therapeutic foster care programs, again in response to the state's need for non-institutional, in-state services for severely emotionally disturbed children?

•That mental health centers have been involved in providing "wrap around services" for individuals who have special needs that cannot be addressed by traditional programs and services?

Some of the other people who will speak after me will tell you more about these services and will be happy to answer any questions you may have.

I have spent several hours during the last several weeks observing the proceedings of this subcommittee. I have taken note of some of the themes and comments that have I have observed here.

I have heard repeatedly that members of the Institutions Subcommittee would like to see more interagency cooperation and coordination. I have heard that agencies should do more long term planning.

First, I wish to take this opportunity to commend and thank Curt Chisholm for his efforts during the past two years in taking the bull by the horns and doing just that. Through the mental health management meetings he initiated, we as a mental health community---agency people, providers, advocates and consumers---have assembled on a regular basis to plan for the future of mental health in Montana. Don't get me wrong: those sessions were not love-ins. But we all sat down and talked and planned. We were angry, we agreed and disagreed, we were excited about the possibilities, we re-visited old hurts and wounds. The important thing we have

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realized is that we agree on the most basic points. Again, I think most of those basic points are embodied in the mission statement I read to you earlier. We wish to provide the best possible quality of life for the people we serve.

Again, I would like to thank Curt and the Mental Health Division for their efforts in creating the three pilot projects in Butte, Missoula and Kalispell. They are to be commended for their attempt to better manage the available resources at their disposal. The Montana Council of Mental Health Centers urges this subcommittee's support for flexibility and discretion in order that the department can continue to manage its resources in the best interests of the consumer of mental health services and the taxpayer alike.

I wholeheartedly support this subcommittee's commitment to better coordination and cooperation between and within departments. The outstanding work done by the departments, the provider groups, and many others in regard to the Boulder planning is an excellent example of what can happen when we all work together. The one important element I have not heard mentioned, however, is you, the Legislature. Without your involvement, your sanction, your display of confidence that the plan will work, one critical leg of the stool would be missing.

Interagency planning is taking place in the area of mental health as well. The Department of Institutions, the Department of Social and Rehabilitation Services, and the mental health centers are working together to enhance case management services for adults with disabling mental illness. By matching general fund dollars to federal Medicaid dollars, it will be possible for us to deliver case management services to a greater number of those adults with disabling mental illness.

Finally, but certainly not least, I will address the area of funding. On Saturday, as I was pondering the best way to present our proposal in a clear, concise manner, my eye caught the painting I bought several years ago. It depicts a rundown farm, and it is entitled, "Maybe Next Year." It occurred to me that human service agencies like the mental health centers have a great deal in common with those who make their living tilling the earth. We always are hoping that the next year will be a better one, that something miraculously will happen to make life a little easier.

During the 1980s we, indeed, became more efficient operators, better managers, as we endured budget cuts, reductions and freezes. We did more with less. But I submit to you that the point of maximum efficiency was reached and the law of diminishing returns took over some time ago. Like our counterparts in agriculture, it is time stop repairing our machinery with baling wire and it is time to begin to rebuild our programs, to renew our commitment to quality services to the people we serve, and to rekindle in ourselves the sense of pride in the work we do. I request that this committee take positive action in pursuit of that goal.

On behalf of the five mental health centers, I request that you consider and grant a 5% cost of living allowance for community mental health programs. This amounts

to approximately $280,000 for FY '92 and $293,000 for FY '93. A COLA will enable us to continue to deliver services at the current level.

Second, I request that you appropriate additional dollars to community mental health centers for the purpose of serving 30 additional youth per year in adolescent day treatment programs. Your action will help to address the problem I mentioned earlier: to serve these youth in-state and in a program that is far less costly and less restrictive than other available settings. Serving 30 additional youth per year would amount to about $207,000 for FY '92 and $217,000 for FY '93.

As I was completing these remarks at my office on Saturday, I received a telephone call informing me that due to miscommunication between the Office of Budget and Program Planning and the Department of Institutions, the budget for the community mental health centers would be $600,000 less for the biennium than had been previously understood. While I do not pretend to understand why or how this happened, I do understand the implications for our programs. I sincerely hope you will correct the deficiency.

I thank you for the opportunity to present our issues to you today. The persons who follow me, those who work in the trenches and those who are the recipients of the services and programs, will share with you the positive difference community mental health has made in their lives.

The Directors of the five mental health centers are here today and are available to provide you with more specific information about programs or to answer your questions. Please call on any one of us.

Thank you.

MENTAL HEALTH SERVICES, INC.

STUART KLEIN, MA
EXECUTIVE DIRECTOR

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Center for Sexual Wellness
512 Logan
(406) 442-0649

Montana House
422 N. Last Chance Gulch
(406)443-0794

Transitional House
1101 Missoula Avenue
(406) 443-4922

Southwest Adolescent Treatment Center
32 South Ewing
(406) 442-9902

LIVINGSTON
P.O. Box 119
126 South Second
Livingston, Montana 59047
(406) 222-3332

Mountain House
126 S. Second
(406) 222-3335

Southwest Adolescent Day Treatment Center

COST COMPARISON FOR TREATMENT ALTERNATIVES

		Cost per day		Ed costs
Shodair	Inpatient *	$535		
	Partial Hosp	223		
Rivendell *		900		
Mountain View		90		
Pine Hills		72		
YBGR	157(med), 117(DFS)	203		
Excelsior		109	99 +	$10
Griffith		145	99	45
Susan Talbot		70		Public
Southwest		87	65 +	22

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* Both Shodair Inpatient and Rivendell are considered short term hospitalization, not long term residential care. The costs associated with these programs reflect their more intense nature due to additional staffing, supervision, and evaluations.

Montana Alliance for the Mentally Ill

MonAMI

EXHIBIT 3
DATE 2-4-91
SB Instit. Subcomm.

Feb. 4, 1991

To Institutions and Cultural Education Subcommittee
From the Montana Alliance of the Mentally Ill.

Chairman Menahan and Members of the Subcommittee:

I am Marty Onishuk of Missoula representing MonAMI. This organization of people with mental illnesses and their families is ten-years-old. In Montana there are eight chapters and we're growing. Nationally, we have over 1000 chapters.

We are here today to support community-based services for our members. When good local services are available, consumers' needs and wants can be handled quickly and they will not need to go to Warm Springs in most cases. They will be able to stay in their homes, see their friends and family, and maintain a routine of living their lives.

When Montana became a state in 1889, the attitude was to place people who were "different" in out-of-the-way institutions, so Boulder and Warms Springs were built. Now, thank goodness, this is changing. Consumers are urged to live in the "least restrictive environment" possible. To do so, community-based supportive services are essential. This includes day treatment centers, intensive case managers, crisis intervention teams,and medication clinics.

The biennial publication, Care of the Seriously Mentally Ill, a Rating of State Programs, a joint publication of Public Citizen Health Research Group and National Alliance of the Mentally Ill, ranks Montana 46th, tied with Mississippi with only Idaho, Wyoming and Hawaii lower. This report (also called the "Torrey Report" after E, Fuller Torrey, M.D., senior author) judges states on five areas: state hospitals, community support, vocational rehabilitation and children's services on a scale of 1 (poor) to 5. Montana received one point in the first four, and no points in housing.

But Montana ranked 28th in per capita expenditure, a good amount when we were only 41th in per capita income. More money is not needed--just a reallocation of current money. Now 80% of the mental health budget goes to Warm Springs State Hospital which has about 300 patients. The community mental health centers serve about 6500 on the other 20 percent.

Montana's rural nature is no excuse for poor services. The number

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one state is Vermont which scored 17 out of a possible 25 points. Vermont ranks 13th in per capita spending and is the first state to work to close the state hospital. Admissions are screened by the community mental health centers and many are diverted to local general hospitals, patients are kept very short times and placement of long-term patients in the community is progressing. The number of patients is half what is was five years ago at 400 per year. Montana's state hospital is not even accredited because, primarily, psychiatrists and psychologists cannot be attracted. We would hope one or two new facilities to serve this function be built in the state perhaps in connection with the U system.

We hope the community mental health centers will continue to improve the services offered to the seriously mentally ill. We want peer and family counseling, consumers as hired staff members, consumer-run drop-in centers at a location other than the day treatment programs.

We urge the funding of more case managers for those now in day treatment and new programs to serve consumers who now are not being served. We salute the state for 3 pilot programs: one in Kalispell for crisis intervention to divert patients from jail and the state hospital; in Butte to provide a group setting as an alternative for admission to Warm Springs; and one in Missoula to return long-time residents of the state hospital to the community with very intensive case management. We hope these will become state-wide programs.

Children with emotional disturbances are being served with contracts with school districts to provide counseling by mental health center staff. Cooperation among mental health centers, school districts and DFS is essential to serve the needs of these children who have been overlooked in the past.

In summary, MonAMI believe community-based services best fit the needs of the seriously mentally ill. Cooperation between the state Mental Health Bureau, the regional Mental Health Centers and advocacy groups like AMI has improved and will continue to improve. We will continue to push for services we want for ourselves and our family members.

Thank you for the opportunity to comment.

Martha L. (Marty) Onishuk
5855 Pinewood Lane
Missoula, Mt. 59803
25102754

services are virtually nonexistent, with the exception of one joint day program in Region 10, although other regions have plans to improve; the juvenile justice has just as few services and no plans. Aside from the new Medicaid funding for case management and day programs, the only promising sign is the establishment of a State-Level Case Review Team earlier this year; like case management, however, such a team will have little impact without services to allocate.

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Mississippi is trying to improve. The governor has been fairly supportive, although not a vocal advocate for people with mental illness; a few legislators have also been helpful. Leadership in the state department of mental health department is fairly competent, with a few excellent officials leading the way in system improvements. Still, CMHC officials resistant to change and cooperation remain firmly entrenched in their positions of power, which will make further progress difficult. And as always, the bottom line for any hope of progress is going to be money: Mississippi spends less per capita than all but three states to serve people with mental illness, with its spending amounting to about half the national average. Even poor states have some ability to fund new programs and must decide which needs to prioritize. Mentally ill Mississippians have waited long enough.

47. Montana (tie)

Hospitals	1
Outpatient/community support	1
Vocational rehabilitation	1
Housing	0
Children	1
Total points	4

Per capita income (1987):	$12,341
Per capita income rank:	41
Per capita mental health spending (1987):	$35.63
Per capita spending rank:	28
Direction:	○ Going nowhere

In February 1990, Montana's Department of Institutions issued a paper entitled "A Vision of a Comprehensive Treatment and Support System for Adults With Severe and Disabling Mental Illness." Like most such documents, it is an enlightened plan which, if put into effect, would substantially improve services for Montana's mentally ill residents. Whether this "vision" will be any more than that, however, remains to be seen, for the state appears to be going nowhere fast.

Hospitals

Public inpatient services for mentally ill Montanans center on the State Hospital in Warm Springs. Situated 20 miles north of Butte, this isolated hospital, which currently has 288 patients, lies in a mountain-fringed valley in a town that consists of the hospital and a single gas station. The hospital is not accredited, and the nursing care unit, which appears to deliver good services, is the only part that is HCFA certified. Although physically pleasant, other units have a variety of problems, including a shortage of psychiatrists despite the fact that the job pays $95,000 and offers free housing. Allegations of patient abuse in the 100-bed forensic unit led to a class action suit by a coalition of advocates that is currently being litigated. Similar allegations have been made elsewhere in the hospital, including against one staff member who has been linked to several cases of patient sexual abuse but who continues to be employed; corrective personnel actions come very slowly in rural communities where everybody knows everybody. The state is currently discussing the possibility of closing the hospital altogether, although where the patients would go is a mystery.

A major problem is that patients can be sent directly to the hospital by any physician in the state without being prescreened by one of the five regional CMHCs; such patients often arrive with grossly inadequate clinical information. Although in theory admission could be refused, in reality there is no alternative once they have arrived in town, except to send them to the gas station which is not considered to be a reasonable alternative treatment plan even in Montana. Another serious problem in Montana is the detention of mentally ill individuals in county jails, especially in Kalispell and Helena, while awaiting transportation to Warm Springs. That this should continue to take place in the state's capitol city despite speeches in the legislature that such practices are inhumane is a sad commentary.

The paucity of psychiatric beds in local hospitals is also remarkable in a state in which the state hospital may be hundreds of miles away from the person needing hospitalization. The Deaconess hospitals in Great Falls and Billings are helpful. On the other hand, the private Glacier View Psychiatric Hospital in Kalispell obtained permission to build from the state after promising to make some beds available to public patients, but, once constructed, reneged on the offer; that the state tolerates such corporate misbehavior is inexplicable.

Outpatient and Community Support

The state's five regional CMHCs vary widely in providing outpatient services. The Region II CMHC in Great Falls is highly regarded. Region I CMHC in Miles City, on the other hand, is among the worst CMHCs in the nation; it sees four patients with adjustment disorder or no mental disorder for every patient with a diagnosis of schizophrenia. Great Falls' New Directions Center is a noteworthy clubhouse that even has a special program for mentally ill adults who are parents. Riverhouse in Missoula is also said to be a good clubhouse. Case management services are improving, although the state has not yet implemented the Medicaid special option for targeted case management services.

Vocational Rehabilitation

Vocational rehabilitation services in Montana have made little progress. Despite increased training, most vocational rehabilitation counselors seem skeptical of developing job opportunities for mentally ill individuals. Individuals who could be rehabilitated languish instead in boring day programs. The major exception to this has been Region II, where programs such as New Directions in Great Falls have made a commendable effort. The lower end of the spectrum is Region I, where vocational rehabilitation is not even part of the vocabulary of the professionals who are in charge. It is easy to blame everything on the rural character of the state, but there are job opportunities in rural areas as well.

Housing

If it were not for Wyoming's equally complete lack of interest in providing housing for people with mental illness, Montana would be the clear winner of this year's Apathy in Housing award. After examining the state of the art in housing for people with mental illness, and the innovations occurring in states such as Ohio and Rhode Island, one is hard pressed to believe that Montana's housing for people with mental illness consists of about 100 group home beds and a few dozen beds in shared supported apartments. Period. That's all. The group homes, some of which offer extremely poor living conditions, nonetheless have waiting lists since they are virtually the only option available. They are supposed to be transitional but are used as long-term housing because their residents have nowhere to go when they leave. Boarding homes — the usual fall-back housing nationwide for people with mental illness who have nowhere else to live — are almost nonexistent, and those that do exist are in terrible condition.

As for independent living and supported housing, the state does not appear to have heard of them. It's no wonder that the state hospital is forced to discharge patients to the rescue mission. Montana provides no rent subsidies to mental health consumers and has made no efforts to obtain HUD funding, to start a housing development corporation, to assist consumers in obtaining Section 8 rent subsidies, or to collaborate with the state housing authority. With such a lack of options, one wonders where on earth Montana's several thousand mentally ill residents are living. Wherever it is, it is clear that the state does not care.

Children

Montana's services to seriously emotionally disturbed (SED) children exemplify more clearly than those in any other state what happens when the state's mental health agency offers no leadership in meeting the needs of SED kids. Instead of creating a system of services for emotionally disturbed children, the mental health agency has essentially left it to other child-serving agencies to provide what these kids need, offering only outpatient counseling and a few supplemental services itself.

For example, Montana has 40 state-funded inpatient beds for emotionally disturbed children — but they are available only to children judged delinquent by the courts. Not one state-funded bed is available to a child without a court order. The state has two residential treatment centers and four group homes for children and adolescents, but these are not funded by the mental health system and serve a mixed population of children in need — abused, neglected, developmentally disabled, and so forth, rather than just emotionally disturbed. Home-based services are funded by the Department of Family Services, and therefore are available only to abused and neglected children, never to SED children who have not been abused or neglected. In this kind of a non-system, SED children are consistently deprived of the specialized attention and services they need.

The list of problems goes on and on. Case management, one service in which the state mental health department should take a leadership role, does not exist. Crisis services are wholly inadequate. There are no day treatment programs for children below age 12. About 50 children are receiving residential treatment out of state for lack of services within Montana's borders. The criminal justice system is grossly inadequate in its treatment of SED youth; one recent tragedy involved a 14-year-old emotionally disturbed boy who died, allegedly as a result of police beatings and inadequate treatment, shortly after a brief confinement in Flathead County jail. There are a few signs of hope: Montana recently received its first CASSP grant and is beginning a pilot project to put mental health staff in the schools, and the education system is said to be improving in its identification of SED children. But Montana is starting from so little that most of its SED kids may be adults by the time the state pieces together its scraps of service into a system it can be proud of.

◆

One of the biggest assets in Montana's system is the useful role that family and consumer groups are playing. There is also leadership potential in the Department of

Institutions, and there are some helpful individuals in the legislature (such as Rep. Tim Whalen and Sen. Chet Blaylock) and on the Board of Visitors (Kelly Morse). Montana's fiscal condition is relatively good, so the only constraint in translating its "vision" into reality is its collective will.

49. Idaho (tie)

Hospitals	1
Outpatient/community support	1
Vocational rehabilitation	0
Housing	0
Children	1
Total points	3

Per capita income (1987):	$11,868
Per capita income rank:	46
Per capita mental health spending (1987):	$16.74
Per capita spending rank:	51
Direction:	▲ Improving slowly

In September 1962, at a state conference on mental illness, Governor Robert E. Smylie assured Idahoans: "We are making progress ... Our mentally ill citizens are at last being afforded the opportunity for happy and useful futures ... [We are making] a world that will brighten their hearts and minds for a brighter tomorrow." Twenty-eight years of tomorrows later, the mentally ill residents of Idaho are still waiting, and waiting, and waiting. The state has distinguished itself by (1) being the stingiest state, spending only $16.74 per capita on public services for people with mental illness as of 1987 (New York state, by contrast, spent $140.08 per capita); (2) being the only state in which individuals with mental illness are *routinely* taken to county jails for their initial evaluations; and (3) having the worst housing in the nation for people with mental illness. Although there are recent indications of improvement, the overall situation in 1990 for the state's mentally ill residents is, in one word, disgraceful.

Hospitals

Public psychiatric inpatient care is provided primarily by State Hospital South (140 beds) in Blackfoot and State Hospital North (30 beds) in Orofino. The former, which opened in 1886 as the Idaho Insane Asylum, moved into a new building in 1989 and is quite acceptable as state mental hospitals go. It has partial HCFA certification and probably could achieve JCAHO accreditation if it invested the additional funds that would be necessary. State Hospital North, on the other hand, is often without any psychiatrist at all and ranks as one of the worst state hospitals in the nation. Very few general hospitals in Idaho will accept psychiatric patients unless they have insurance.

The most extraordinary aspect of public psychiatric care in Idaho is the route of hospital admission. It is standard practice throughout Idaho to take mentally ill individuals needing hospitalization first *to jail* where the person is fingerprinted, put in a cell, and held until seen by a "designated examiner" within 24 hours. Following the examination a search for a bed commences, a search which may take another two or three days in rural areas. Idaho shares with some counties in Montana this outrageous practice of jailing mentally ill individuals who have been charged with nothing other than being sick; the practice was stopped in most states 150 years ago.

Outpatient and Community Support

This issue leads directly to the heart of the problem — the seven community mental health centers. Since the state owns and operates them, there is no reason why they should not provide priority services to individuals with serious mental illnesses, and they claim to do so. Reality, however, is often something else; for example, the state's federally required P.L. 99-660 plan shows the Region V CMHC as having 12 percent of its caseload diagnosed with schizophrenia but 25 percent diagnosed with "adjustment disorder" or "no mental disorder." There are virtually no crisis beds nor services for patients dually diagnosed with substance abuse. Mentally ill homeless people are routinely offered "bus therapy," especially in northern Idaho where they are given one-way tickets to Spokane. Case management was finally implemented in 1989. A new focus on clubhouses is also a hopeful sign (Club Inc. in Idaho Falls is nice); it should be remembered, however, that Idaho had seven Fairweather Lodges a few years ago but allowed them to wither away.

Vocational Rehabilitation

Vocational rehabilitation for people with mental illness in Idaho is like the mythical yeti — rumored to be out there somewhere, but nobody has actually seen it. Supported employment Programs were not implemented until late 1989. A few consumer-run operations, such as a thrift store and greenhouse, are a very modest start. Sightings of actual vocational opportunities for people with mental illness should be reported immediately to the state Division of Vocational Rehabilitation.

Housing

Idaho is about a decade behind most other states in providing housing for people with mental illnesses. Until

TABLE 3

RATING OF STATES ACCORDING TO 1989 POPULATION

Total points	Small states (up to 1.2 million)	Medium states (1.2-3.5 million)	Large states (3.5-6.0 million)	Very large (over 6 million)
17	1. Vermont			
16	2. New Hampshire 2. Rhode Island			
15		4. Connecticut		4. Ohio
14		6. Colorado		
13				
12			7. Wisconsin	7. New York 7. North Carolina
11		10. Utah		
10	11. Delaware	11. Maine 11. Oregon		11. Pennsylvania 11. Virginia
9		16. Nebraska	16. Alabama 16. Kentucky 16. Maryland 16. Massachusetts 16. Minnesota 16. Missouri 16. Washington	16. New Jersey
8	26. Arkansas 26. North Dakota		26. Arkansas 26. South Carolina	26. Georgia 26. Michigan
7	31. District of Columbia	31. Kansas 31. Oklahoma	31. Indiana 31. Tennessee	31. California 31. Illinois
6	38. South Dakota	38. Arizona 38. Iowa 38. New Mexico 38. West Virginia	38. Louisiana	38. Florida
5	45. Nevada			45. Texas
4	47. Montana	47. Mississippi		
3	49. Idaho 49. Wyoming			
2	51. Hawaii			

1990 STATE PER CAPITA INCOME, MENTAL HEALTH SPENDING, AND "GENEROSITY INDEX"

State	Per Capita Income (1987)	Per Capita Income Rank	Per Capita Mental Health Spending (1987)	Per Capita Spending Rank	"Generosity Index"
Alabama	$11,940	44	$28.96	38	24
Alaska	$18,230	5	$52.69	10	29
Arizona	$14,315	27	$19.76	50	14
Arkansas	$11,507	47	$26.54	41	23
California	$17,821	8	$36.89	23	21
Colorado	$15,584	17 (tie)	$35.81	27	23
Connecticut	$21,266	1	$68.02	4	32
D. of Columbia	$20,457	2	$128.61	2	63
Delaware	$16,696	10	$57.41	7	34
Florida	$15,584	17 (tie)	$33.75	30	22
Georgia	$14,300	29	$35.83	26	25
Hawaii	$15,679	15	$24.68	43	16
Idaho	$11,868	46	$16.74	51	14
Illinois	$16,442	12	$24.48	44	15
Indiana	$13,914	33	$43.94	18	32
Iowa	$14,236	30	$32.46	32	23
Kansas	$15,126	22	$43.51	19	29
Kentucky	$12,059	42	$22.97	46	19
Louisiana	$11,473	48	$25.09	42	22
Maine	$13,954	32	$52.58	11	38
Maryland	$18,124	6	$53.76	9	30
Massachusetts	$19,142	4	$61.69	6	32
Michigan	$15,393	20	$66.94	5	43
Minnesota	$15,927	14	$54.47	8	34
Mississippi	$10,292	51	$21.81	48	21
Missouri	$14,687	24	$31.41	33	21
Montana	$12,347	41	$35.63	28	29
Nebraska	$14,328	26	$28.41	39	20
Nevada	$16,366	13	$27.67	40	17
New Hampshire	$17,529	9	$50.90	14	29
New Jersey	$20,352	3	$50.62	15	25
New Mexico	$11,875	45	$23.78	45	20
New York	$18,004	7	$140.08	1	78
North Carolina	$13,314	35	$40.40	21	30
North Dakota	$13,004	36	$41.65	20	32
Ohio	$14,612	25	$45.33	16	31
Oklahoma	$12,551	39	$30.50	36	24
Oregon	$14,041	31	$34.35	29	24
Pennsylvania	$15,212	21	$68.40	3	45
Rhode Island	$15,555	19	$52.34	12	34
South Carolina	$12,004	43	$44.42	17	37
South Dakota	$12,550	40	$30.67	35	24
Tennessee	$12,880	37	$36.46	24	28
Texas	$13,866	34	$20.53	49	15
Utah	$11,366	49	$33.20	31	29
Vermont	$14,302	28	$51.61	13	36
Virginia	$16,517	11	$39.44	22	24
Washington	$15,599	16	$36.37	25	23
West Virginia	$11,020	50	$22.96	47	21
Wisconsin	$14,742	23	$31.11	34	21
Wyoming	$12,709	38	$29.92	37	24

*The "Generosity Index" is a measure of the state's generosity in funding mental health services. It literally represents the number of cents each state spends on mental health per $100 of per capita income. The higher the index, the more generous the state; the lower this figure, the less generous the state. The "Generosity Index" is equal to the state's per capita mental health spending, divided by its per capita income, multiplied by 10,000.

VISITOR'S REGISTER

Institutions SUBCOMMITTEE

AGENCY(S) _____ DATE 1-4-91

DEPARTMENT _____

NAME	REPRESENTING	SUPPORT	OPPOSE
John L Nesbo	Mental Health Center	X	
Frank Louis	E. Mont Mental Health	X	
DICK HRUSKA	GOLDEN TRIANGLE COMM. MENTAL HEALTH CENTER, REG II	X	
CAROL HARWOOD	SELF	X	
Kathy McDowan	MCMHC	✓	
PATRICK POPE	SELF	X	
Jeff Christian	SELF	X	
Harold Leske	Mont Council MH Ctr	X	
John Harwood	Self + Parents	X	
Judy Jarrett	Montana Children's Alliance	X	
Jeffrey Krott	Open Minds - Msla.	X	
Dr. Mike McLaughlin	Golden Triangle Community Mental Health Center	X	
Milana Marzenich MSW	Mental Health Services	X	
Nona Chambers	Dept of Institutions	X	
John Lynn	Reg II CMHC	X	
Mitzi Anderson	Havre Mon Ami	X	
Carlene Butler	Gilder House Stabilization Program	X	
Tom Herzog	Gilder House Stabilization	X	
Gene Haire	Montana House - Helena	X	
Marty Onishuk	Mon AMI	X	

IF YOU CARE TO WRITE COMMENTS, ASK SECRETARY FOR WITNESS STATEMENT.
IF YOU HAVE WRITTEN COMMENTS, PLEASE GIVE A COPY TO THE SECRETARY.

FORM CS-33A
Rev. 1985

HOUSE OF REPRESENTATIVES
VISITOR REGISTER

Institutions SUBCOMMITTEE DATE 4-4-91

DEPARTMENT(S) _____ DIVISION _____

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NAME	REPRESENTING	Support
Kelly Moore	Board of Visitors	X

PLEASE LEAVE PREPARED TESTIMONY WITH SECRETARY. WITNESS STATEMENT FORMS ARE AVAILABLE IF YOU CARE TO SUBMIT WRITTEN TESTIMONY.