MINUTES

MONTANA HOUSE OF REPRESENTATIVES
53rd LEGISLATURE - REGULAR SESSION

JOINT SUBCOMMITTEE ON INSTITUTIONS & CULTURAL EDUCATION

Call to Order: By REP. ED GRADY, Chairman, on February 8, 1993, at 8:00 am

ROLL CALL

Members Present:
Rep. Ed Grady, Chair (R)
Sen. Eve Franklin, Vice Chair (D)
Sen. Gary Aklestad (R)
Sen. Tom Beck (R)
Rep. Red Menahan (D)
Rep. Linda Nelson (D)

Members Excused: SEN. J.D. LYNCH

Members Absent: NONE

Staff Present: Sandra Whitney, Legislative Fiscal Analyst
Mary LaFond, Office of Budget & Program Planning
Judy Murphy, Committee Secretary

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

Committee Business Summary:
Hearing: DCHS GLOBAL ISSUES CONTINUED AND COMMUNITY MENTAL HEALTH
Executive Action: NONE

HEARING ON DCHS GLOBAL ISSUES CONTINUED

Tape No. 1:A

Questions, Responses, and Discussion:

Sandra Whitney, Legislative Fiscal Analyst, discussed **EXHIBIT 1** regarding the language which was approved by the committee regarding mental health, developmental disabilities and HB 333.

SEN. GARY AKLESTAD feels if the committee goes with the increase in HB 333 it will drive up the budget base.

Ms. Whitney said HB 333 generates revenue to the general fund.

REP. RED MENAHAN said the bill has not been passed.

Ms. Whitney suggested perhaps the committee would like to eliminate the language regarding HB 333 and watch the bill to see what happens.

Motion/Vote: **SEN. TOM BECK** made the motion to accept the figures in **EXHIBIT 1** regarding HB 333 which were discussed on Feb. 5, 1993. The motion **CARRIED** with **SEN. AKLESTAD** voting nay.

REP. MENAHAN said he would like to know the time frame MSP is using in their plans to downsize, how many people are in jails awaiting to be admitted, the time frame for community programs and what types of programs are being established in the communities.

REP. LINDA NELSON asked the committee if the WCC could stay in its present location?

SEN. BECK asked to have some figures which would reflect the costs of moving the women to Wyoming and Billings.

REP. MENAHAN told the committee he called Lusk and they do not want our prisoners.

HEARING ON COMMUNITY MENTAL HEALTH

Tape No. 1:A

Informational Testimony:

Dan Anderson, Administrator Mental Health Division, presented the information the committee had requested from the department. The information covered: a part of the contract with the community mental health centers which defines client groups, a mental health client profile, a list of counties which have and have not submitted plans regarding the detention of mentally ill people pursuant to HB 103, copies of two reports done by the Ihler Oversight Committee, re-admission data, and the CMHS Primary Diagnosis of Clients. **EXHIBIT 2**

Questions, Responses, and Discussion:

Hank Hudson, Department of Family Services, said the youth population is not ignored. There are several departments which work together in dealing with this population and team work is required. The Department of Family Services is mandated to serve youth who need protection and youth involved with the correction system. The Department of Family Services manages the general fund match for inpatient psychiatric services and residential treatment services for people under 21 years of age. He feels the targeted case management approach shows promise in dealing with adolescents.

REP. MENAHAN asked if his department was developing a division to

deal just with problem children? He asked if there is a way to identify a child, in his/her earlier years, with problems which will eventually cause them to be sent to Pine Hills or to Mountain View?

Mr. Hudson told the committee there is not a plan at this time.

REP. MENAHAN feels something needs to be done regarding the younger children who are in trouble with the law.

CHAIRMAN GRADY asked how many children are being sent out of state and what is the cost per child?

Mr. Hudson said in the Department of Family Services and Youth Probation there are 80 children who have been placed out of state for various reasons. There is a population being served out of state who are under the Medicaid program and are not under the custody of the department. The out-of-state Medicaid program, which is the general fund share, is $65 which is 28% of the total cost.

CHAIRMAN GRADY asked why the department sends most of the youth out of state?

Mr. Hudson said some children are sent out of state because they will be closer to home, such as North Dakota and Idaho, costs are less, and some have very specific or unique diagnoses. The children have been placed out of state because the department could not find in-state placements. If the department cannot find in-state placements it is because the state facilities are full or they do not deal with a certain type of youth population.

Informational Testimony:

Peter Serdock, Department of Corrections and Human Services and Child Adolescent Service System Project (CASSP) Coordinator, said a SED child or adolescent is one who has an emotional behavior or mental illness which is expected to continue for six-months or more. The illness is diagnoseable according to the diagnostic and statistical manual of mental disorders. The illness has resulted in functional impairment in family, school, peers, or in community activities. Functional impairments are problems in the youth's achieving or maintaining developmentally appropriate behavior in one or more areas after considering cultural and ethnic norms. The illness requires multiple services. The illness most likely will not be cured. The SED youth come from all economic strata of our society.

The department feels SED's youth can and should be treated in the community with appropriate child focused and family centered services directed toward:

Preserving the family whenever appropriate
Treatment which enables the youth to reach their highest functional level.

The department believes the implementation of the community system of services accompanied by early identification and flexibility in the system and service design is the key to appropriate use of in-patient care. They also believe reduction in the growth of in-patient psychiatric care and the cost of such care will only occur with the development of the community continuum. **EXHIBIT 3**

Kathy McGowan, Montana Council of Mental Health Centers representative, said the coucil's major objective is simple. They want the committee to have a clear understanding of the importance of community-based mental health services. The council asks that funding for community mental health not be diminished. **EXHIBIT 4**

Patrick Pope, Director of the Meriwether Lewis Institute, said that untreated mental illness can rob people of the ability to respond to the world around them. Community-based services enable the mentally ill to come out of their isolation. **EXHIBIT 5**

Kathy Standard has a mental illness and is an ex-patient of the Montana State Hospital. She told the committee because of the community-based service in Kalispell, Lamplighter House, she was able to obtain a community commitment in 1991 instead of being committed to 90 days at Warm Springs. **EXHIBIT 6**

Candice Butler, Employee of Region Five Kalispell Community Support Program, said the primary reasons for the success of the program are the availability of a 24-hour crisis response team, a six bed crisis stabilization program, an intensive case management team, psychosocial rehabilitation through day treatment services, a transitional living group home and medication management. **Ms. Butler** supports the community-based mental health facilities.

SEN. BECK asked how many people are employed at the MH facility in Kalispell?

Ms. Butler told **SEN. BECK** there are 38 FTE employed at Kalispell and 140 people actively enrolled.

John Lynn, Mental Health Center - Missoula, represents the Missoula Transition Team. The main objective of MTT is to take the patients out of the state hospital and support them through very intensive case management in the community. There are similar programs in Butte, Helena, Bozeman, Anaconda and Livingston. The state general fund cost to run this program is approximately $100,000. MTT can provide wrap-around services 24-hours a day. Nine of the eighteen patients have found part-time employment since they have been discharged. **EXHIBIT 7**

Questions, Responses, and Discussion:

REP. MENAHAN asked how many of these patients are on medications?

Mr. Lynn said almost 100%. They are on antipsychotic, lithium and mood stabilizing medications.

REP. MENAHAN asked if once the medications have stabilized the patients, do the patients keep returning?

Mr. Lynn said yes, these people are patients who did not get discharged from the state hospital. Prior to this type of program their medications have never kept them stabilized.

REP. MENAHAN asked if these people would be out of the hospital without their medications?

Mr. Lynn told the committee absolutely not. These people have come from the state hospital and chosen not to take their medications and have continued to function in the community.

CHAIRMAN GRADY asked what percentage of patients are taken off medications?

Mr. Lynn said the majority of the patients will do better if they continue taking the medications but the decision is up to the individual.

Informational Testimony:

Dr. Noel Drury, Western Montana Regional Community Mental Health Center Director, told the committee he is convinced the program at the center is a state-of-the-art program. The center deals with patients who are seriously mentally ill, have brain illnesses and chronic illnesses. The center is a team work oriented organization. He believes certain types of people with mental illness work very well in community-based mental health centers.

Bill Hensleigh, Client Western Montana Regional Community Mental Health Center, said the community-based mental health center in Kalispell has kept him from having to be treated at the state hospital. He supports the community-based mental health centers.

Howard Gipe, Western Montana Regional Community Mental Health Center Chairman, feels the center's intervention and crisis teams work very well with the youth of this region. The work the center does helps to prevent troubled youth in later years.

Ken Kleven, Golden Triangle Community Mental Health Center, has worked in mental health centers for 18 years. He believes the community mental health centers have not been appropriately funded. The state mental health budget has not been sufficient to support the state hospital and community mental health programs. Families must be involved in treatment and social support should be increased. There needs to be an adequate

medication program and health care available to all patients. There are 600 people who are being served in a nine county area. The major goal of the community support program is to provide individuals with the opportunity to maximize their potential for community living. This involves placement or assistance in securing suitable living arrangements in the least restrictive environment, re-orientation and education to the community resources, assistance in finding the appropriate entitlement which can maintain the person in the community, development of individualized treatment plans to facilitate the clients receiving training, activity skills which raise their level of functioning, and efforts to avoid returning people to the environment which contributed to their original state of disfunction.

Marty Onishuk, Montana Alliance for Mentally Ill, told the committee families are considered secondary consumers. The Alliance offers family support. Mental illness is a biological-based brain disease. It is important to have psychologists who can diagnose the disease of mental illness. Housing is a critical issue in most communities. Emergency service is critical and crisis intervention is important.

Ken Accord, Great Falls Consumer of the New Directions Center, is a patient who has been put on clozaril. This drug has made his life manageable. Every person going to the New Directions Center is given a case manager. The case manager helps the person find housing and acquire skills which help them function in their homes and in the community. He supports the community-based mental health centers.

Art Kleinjan, Golden Triangle Community Mental Health Board Member and Blaine County Commissioner, said he is going to talk about the rural satellite clinics. He said if funding is not available it is doubtful the rural clinics will be able to survive. He stated some patients need to see a clinician only once a month, once a week or once a year. If these programs lose their clinicians they will lose their clinics. The clinician for the facility in Blaine county believes if the programs are discontinued the patients will turn to alcohol. The clinician's case load is approximately 75 patients. They have an alcohol counselor who comes to the community once a week.

Neal Best, New Directions Center, was diagnosed in 1980 with depression and immediately retreated to the woods. He has been involved with the New Directions Center for the last four years. He strongly supports the New Directions Center and all community-based mental health centers.

Barbara Mueski, Butte Community Mental Health Center, had worked at the state hospital for 14 years and has been with the community health center for the past four months. She found it was very difficult to go from the state hospital to a community program. The state hospital is very institutionalized. She feels

the community programs allow the clients to live more normal lives.

Lorene Frigaard, Administrative Office Director for Mental Health Services Inc. - Anaconda, said her organization deals with clients who are in groups four and five because Anaconda is in an economically depressed area. People from this area cannot afford to pay the full fee for their mental health services so they receive an ability to pay fee which is subsidized by tax dollars.

Gordon Wooden, Warm Springs Client, said medications have saved his life. He will be on them forever but they make his life manageable.

Barbara Barr, Consumer Anaconda Mental Health Center, said there is a vital need in communities across Montana for the services of the community health centers. Mental health centers help the clients use the proper tools to help them solve their emotional problems. She asked the committee to continue the sliding fee program.

Steve Neil, Ihler Consumer, has received case management services in the Anaconda community and has found these services beneficial and complete. **EXHIBIT 8**

Ann Miller, Client of Butte Silver House, has spent 11 years at the state hospital and is now attending Silver House and the Meriwether Lewis Institute. She feels if there were no community support programs she would be back in the state hospital. **EXHIBIT 9**

Sharon Gregor, Client of Butte Silver House, said clozaril and the community programs have saved her life. **EXHIBIT 10**

Linnia Wang, Southwest Adolescent Day Treatment Program, stated the program is an intense, highly structured form of treatment for seriously emotionally disturbed adolescents (SED) serving 18-24 youth (12-18 years of age) and their families in their home community. The program resembles partial hospitalization in its intense individual, family, and group therapy, and in its therapeutic milieu. SWAT is a cooperative program utilizing resources from Helena School District #1 and Mental Health Services, Inc, which enables students to receive intense treatment in a "less restrictive" and cost effective environment. **EXHIBIT 11**

Rachel, SWAT Member, came from a dysfunctional family. SWAT helped her to become the person she is now.

Janelle Wells, SWAT member, was chemically dependent. SWAT diagnosed her problems. At the present time she is living with a foster family and attending PAL. She is planning to attend college in the fall.

Christine Jacques, SWAT member, is a recovering alcoholic parent and the mother of three children. SWAT has been a very positive influence for her son and her whole family.

Kathy Weingard, SWAT parent, said she and her family could not have survived had it not been for SWAT. The SWAT program kept the family involved with her daughter.

Questions, Responses, and Discussion:

SEN. EVE FRANKLIN asked **Mr. Kleven** if Golden Triangle Mental Health Center helps other people other than the seriously mentally ill? He said the center helps severely and persistent mentally ill. **SEN. FRANKLIN** asked what the staff/patient ratio is at the center? He said the ratio in case management is 1-17 and therapists is 1-105. She asked **Mr. Kleven** what kind of tools he would need to continue the wonderful work which he has done since 1975? **Mr. Kleven** said the tools are many, varied and depend on the cities and locations of the mental health centers. He does not believe state hospitals should be played against community programs. He believes there will always be a need for state hospitals, group homes, crisis teams, transition homes, therapists, psychiatric nurses, educational programs, family work and more money to run programs. He feels case management is a quick fix to the community mental health issues. **SEN. FRANKLIN** asked if he has decreased staff in the last two of years? He said that nine staff members were laid off two years ago and none have been hired.

REP. MENAHAN wants to know how many people are employed in the five MH regions in the state and what each person does?

Mr. Kleven feels recruiting will always be a challenge for the state of Montana.

Informational Testimony:

Frank Lane, Executive Director of the Eastern Montana Mental Health Center, said his center serves the most rural area of the state. They serve an area of 90,000 people. His staff consists of 19 MH professionals, 13 clinical workers, three intensive case managers, 10.5 clinical secretaries, 2.5 in accounting, one secretary in administration, one business manager, one administrative officer and himself. There is a total of 50 staff members. The area is so large travel is extensive.

Paul Meyer, Director of the Mental Health Center in Missoula, does not feel the state would eliminate the clients who are considered "Group 4's". The "group 4" clients have been considered the non-seriously mentally ill. The "group 4" consists of adult victims of incest, suicides, traumatization, domestic violence, family disruptions, and the correction system. Low-income people who require treatment are also a part of this group. The cost for this service is approximately $600,000 per

year of general fund. The MH centers collect fees from clients, insurance payments and Medicaid. If "group 4" were cut the state would lose the above revenue. The Missoula center receives $154,000 of the $600,000 per year. The care the center provided last year was $576,000 which would be the extent of the cut if "group 4" was eliminated. The Missoula center serves approximately 1000 people per year.

Questions, Responses, and Discussion:

REP. MENAHAN said the people who are being referred cannot go to Warm Springs.

Mr. Meyer said yes they can go to Warm Springs.

REP. MENAHAN asked the five regional directors if the DCHS staff in the central office could perform some of their work.

Mr. Meyer told the committee they are trying to expand the revenue through the collection of fees. The "group 4" clients are in the current budget but the proposal is to eliminate this group.

REP. MENAHAN asked if the therapists' loads could be increased?

Mr. Meyer said the workloads have been increased.

REP. MENAHAN said the committee does not want to eliminate any group.

Mr. Meyer said the facility will continue to see patients who come to the center but that means keeping "groups four and five".

Informational Testimony:

Barbara Barnes, Intensive Case Manager Ihler Program, said in the past the individuals who were on their caseloads were able to stay out of Warm Springs State Hospital for no longer than four days to two months. Now these same people have been out of the hospital and living in the community for nearly six months. They are living independently, receiving treatment at Montana House and intensive support from their case manager. She supports community-based programs. **EXHIBIT 12**

Ramona Shepard, Mental Health Consumer - Ihler Case Management, told the committee the Ihler Program has helped her more in the last six months than any treatment she has received in the last 43 years. **EXHIBIT 13**

Michael Fraser, Member/Staff of the Montana House. said with the help of a very supportive case manager he began to learn to live again without hospitalization. He asked the committee to continue to invest in community-based MH programs. **EXHIBIT 14**

Cindy Bartling, Executive Director of the Friends to Youth, stated several agencies in the Missoula area did a needs assessment on the Severely Emotionally Disturbed (SED) youth they were working with. Their cases are very complicated and the SED children will need intervention over a long period of time. Each child needs specialized services from two or more providers. She believes this program and its funding should be continued. She asked the committee for their support and sanction to apply for a Medicaid waiver.

Questions, Responses, and Discussion:

REP. MENAHAN asked the consumers to tell the committee members what they as consumers need.

REP. NELSON thanked the consumers for coming before the committee with their testimonies.

SEN. BECK asked for information regarding the funding for medications and how Medicaid is involved.

A motion was made to adjourn.

ADJOURNMENT

Adjournment: 10:00 am

REP. ED GRADY, Chair

JUDY MURPHY, Secretary

EG/jm

HOUSE OF REPRESENTATIVES

INSTITUTIONS/CULTURAL EDU. **SUB-COMMITTEE**

ROLL CALL **DATE** 2-8-93

NAME	PRESENT	ABSENT	EXCUSED
SEN. GARY AKLESTAD	✓		
SEN. TOM BECK	✓		
SEN. EVE FRANKLIN, VICE CHAIRMAN	✓		
SEN. J.D. LYNCH			✓
REP. RED MENAHAN	✓		
REP. LINDA NELSON	✓		
REP. ED GRADY, CHAIRMAN	✓		

EXHIBIT 1
DATE 2-8-93

Language Approved by the
INSTITUTIONS AND CULTURAL EDUCATION SUBCOMMITTEE

DCHS

Item [Mental Health] contains $82,280 in fiscal year 1994 and $130,900 in fiscal year 1995, which must be transferred to the energy conservation program account and used to retire the general obligation bonds sold to fund energy improvements through the state building energy conservation program.

Item [Developmental Disabilities] contains $4,675 in fiscal year 1995, which must be transferred to the energy conservation program account and used to retire the general obligation bonds sold to fund energy improvements through the state building energy conservation program.

If House Bill 333 is passed and approved, the general fund in item [Mental Health] is increased by $84,263 in fiscal 1994 and $136,823 in fiscal 1995, and the general fund in item [Veteran's Home] is increased by $78,537 in fiscal 1994 and $103,357 in fiscal 1995.

EXHIBIT 2
DATE 2-8-93

DEPARTMENT OF CORRECTIONS AND HUMAN SERVICES

MARC RACICOT, GOVERNOR

1539 11TH AVENUE

STATE OF MONTANA

(406) 444-3930
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PO BOX 201301
HELENA, MONTANA 59620-1301

MEMORANDUM

TO: JOINT SUB-COMMITTEE ON INSTITUTIONS AND CULTURAL EDUCATION

FROM: DAN ANDERSON, Administrator
Mental Health Division

RE: INFORMATION REQUESTED

DATE: FEBRUARY 5, 1993

I have assembled some information in an attempt to answer questions that have been raised during our presentation of the mental health system budget:

1) Attachment E. This is the part of the contract with the community mental health centers (CMHC) which defines client groups. Under the budget reduction proposal to not subsidize services for non-seriously mentally ill adults, the Department would provide funding only for client groups 1, 2 and 3. Individuals who fall into client groups 4, 5 and 6 would not have their services subsidized by the Department.

2) Mental Health Client Profile. This provides some comparisons of the three major client groups we serve (children/adolescents, adults with serious mental illness, and adults with non-serious mental illness). This data is based on a review of a sample of CMHC clients we did in 1990.

3) List of counties which have (and have not) submitted plans regarding the detention of mentally ill people pursuant to HB 103 from the 1991 Session.

4) Copies of the two reports done by the Ihler Oversight Committee on implementation of the new services created as part of the Ihler court decision compliance plan.

5) Re-admission Data. This shows admissions and re-admissions for CMHCs and Montana State Hospital for FY90 through FY92.

6) CMHC Primary Diagnosis of Clients. This is a breakdown of CMHC caseloads by major diagnostic categories for the years 1985, 1989 and 1992. The right hand column shows changes in frequency of categories between 1985 and 1992.

DA/jeb

EXHIBIT 2
DATE 2-8-93
SB

EXHIBIT 2
DATE 2-8-93

EXHIBIT 2
DATE 2-8-93
SB

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t in client groups 2 and 3.
f 6 and below as determined

EXHIBIT 2
DATE 2-8-93

Client Group 5

Adult with Mental Health Problem, FAS >6

Adults who have mental health problems but who are not in client groups 2 and 3. Individuals in this client group have a functional rating of 7 and above as determined by the Functional Assessment Scale (FAS).

Client Group 6

Unknown

Clients who have not been assigned to a client group at the time of the report.

MENTAL HEALTH CLIENT PROFILE

	CHILDREN AND ADOLESCENTS	ADULTS WITH SEVERE AND DISABLING MENTAL ILLNESS	ADULTS WITH NON-DISABLING MENTAL ILLNESS
	Sample Size: 20	Sample Size: 42	Sample Size:31
Estimate of Population in Need of Mental Health Services **(See Note)	31,593	6,020	77,598
Clients Served by CMHCs (FY 1990)	2,999	3,944	5,817
Most Frequent Diagnosis	Depression (25%) Adjustment Disorder(25%) Conduct Disorder(10%)	Schizophrenia (29%) Major Mood Disorders (24%) Personality Disorder (21%)	Mood Disorders (19%) Adjustment Disorders (16%) Anxiety Disorders(13%)
Typical Services Received During FY 1990:	% Receiving Avg Hours per Year	% Receiving Avg Hours per Year	% Receiving Avg Hours per Year
Inpatient (MSH)	N/A	7% 121 Days	None
Outpatient Therapy	100% 9 Hours	100% 10 Hours	100% 7 Hours
Outpatient Rehabilitation	5% 250 Hours	57% 293 Hours	None
Residential Group Home	N/A	10% 130 Days	None
Specialized Case Managment	N/A	17%	None
Cost per Client per year (Community Services Only)	$649	$2,017	$459

EXHIBIT
DATE 3-17-93

MENTAL HEALTH CLIENT PROFILE

	CHILDREN AND ADOLESCENTS	ADULTS WITH SEVERE AND DISABLING MENTAL ILLNESS	ADULTS WITH NON-DISABLING MENTAL ILLNESS
Montana State Hospital History	N/A	- 25% have had one or more MSH admits at some time in their life - 7% had one or more admissions in FY 90 - Average of 3.2 MSH admissions since 1985 (clients with admissions)	- One member of sample had one admission since 1985
Length of Time in System:			
1 YR or Less	60%	17%	45%
3 Years or More	5%	69%	32%

Note: Based on national prevalency estimates

EXHIBIT 2
DATE 2-8-93
SB

COUNTIES THAT HAVE SUBMITTED PLANS: (AS OF 1/1/93)

BLAINE
CARTER
CUSTER
FERGUS
GALLATIN
HILL
MUSSELSHELL
PONDERA
POWDER RIVER
PRAIRIE
STILLWATER
TETON
TREASURE
PETROLEUM
SWEET GRASS
RAVALLI
ROSEBUD
VALLEY
YELLOWSTONE
CASCADE
DANIELS

JUDITH BASIN (10/23)
MADISON (10/23)
LEWIS AND CLARK (10/29)
TOOLE (11/1)
McCONE (11/1)
PHILLIPS (11/5)
MISSOULA (11/10)
BUTTE-SILVER BOW (11/19)
CARBON (11/20)
RICHLAND (11/27)
WHEATLAND (12/7)
BIG HORN (12/24)
FLATHEAD (12/30)
PARK (12/30)
MEAGHER (12/31)

LIBERTY (1/21/93)
ANACONDA-DEER LODGE (1/28/93)

COUNTIES THAT HAVE NOT SUBMITTED PLANS:

BEAVERHEAD

BROADWATER

CHOUTEAU
DAWSON
FALLON

GARFIELD
GLACIER
GOLDEN VALLEY
GRANITE
JEFFERSON
LAKE

LINCOLN
MINERAL

POWELL

ROOSEVELT
SANDERS
SHERIDAN

WIBAUX

EXHIBIT 2
DATE 2-9-93

SITE VISIT REPORT
on
SPECIAL COMMUNITY SERVICES EXPANSION (IHLER) PROGRAMS
in BILLINGS

MENTAL HEALTH CENTER
BILLINGS, MONTANA

Introduction

On November 16, 17, and 18, 1992, an Oversight Committee established by the Mental Health Division of the Department of Corrections and Human Services conducted a site visit evaluation in Billings to monitor the implementation of Mental Health Center's new services funded under the Special Community Services Expansion (Ihler) Programs.

The Committee was formed at the recommendation of the Montana Mental Health Planning and Advisory Council to monitor and oversee development of the new services. The Committee was convened in May and carried out initial monitoring via reports from providers and interviews with staff. On-site evaluation was delayed until programs were fully operational. In order to insure objective review of services, site visit participants were selected to represent a variety of perspectives, notably including those of both consumers and family members. Specifically, the individuals asked to participate included Helen Sampsel, Board Member and former President of the Montana Alliance for the Mentally Ill; Kelly Moorse, Executive Director of the Mental Disabilities Board of Visitors; Pat Pope, Director of Meriwether Lewis Institute; Kathy Standard, President of Meriwether Lewis Institute; Randy Vetter, Admissions Coordinator at Montana State Hospital; John Lynn, Community Support Program Director for the Western Montana Community Mental Health Center in Missoula; Grace Edwards, Chairperson for Mental Health Center in Billings; Bill Warfield, Chairperson for Mental Health Services, Inc., in Helena; and Rusty Redfield, Mental Health Division, Planning and Program Development Manager.

It should be noted that committee members' roles were defined so that Board Chairpersons (Mrs. Edwards and Mr. Warfield) would be essentially passive observers in the site visit to their own Region but would participate actively in the visit to the Region with which they had no administrative responsibilities. In the visit to Region III (Billings), Mr. Warfield was the active participant and Mrs. Edwards the observer.

The Committee's primary evaluation activities included interviews with recipients of services, family members of recipients of services, and staff at the programs, as well as review of policies and documents, records, and physical environments. Additionally, an interview was conducted with the Rescue Mission. The review focused on quality and appropriateness of service, contract compliance and the implementation of the original program proposal.

The Review Team recognizes, as the readers of this report should, that these are new programs, implemented over a very short time span, serving many people who have long duration, difficult to manage mental illness. The numerous issues and concerns identified reflect the fact that in new and evolving programs the need for change and improvement is normal and to be expected. The team trusts that its comments will provide assistance in shaping the ongoing development of the new services.

The team also believes it is important for the reader to recognize that community mental health centers and the specific expansion services covered in this report are all part of a larger statewide system of publicly funded mental health services. While it is true that community programs have recently been expanded and the census at Montana State Hospital (MSH) has been reduced, it is clear that a balanced and comprehensive mental health system will continue to require strong inpatient psychiatric services from MSH.

Issues Relating to Quality and Appropriateness of Services

Staff

Staff appeared to be knowledgeable and caring. Consumers indicated they liked and appreciated the staff who worked with them. Staff members were notably appreciative of support from supervision and management. At the time of the visit the center had completed its anticipated hiring.

Training

The training and/or orientation outline focuses primarily on orientation to services and to other agencies. It does not seem to assure training in several important areas, e.g., philosophy, attitude, the "strengths" model of case management, client empowerment, crisis intervention, and risk assessment. Recognizing that the staff are obviously caring and competent individuals, the committee recommends that group home staff and intensive case managers receive specific training in the areas identified. Noting that there are in-state community mental health programs with well developed training and strong personnel in these areas, it is suggested that the center consider seeking assistance from one of those programs.

It was noted that records reflect some pathologizing of normal behavior and that the behavioral component of the program does not seem to be clear. For example, when an individual got a ride home from Rainbow House, the progress note described it as "manipulative behavior" and a pass was denied. In another case, a client's status was reported to the court as "AWOL" even though the case manager apparently felt and had noted in the chart that the client was free to move about.

Service Model

Recognizing that the original proposal referred to both stabilization and treatment functions, the model seems to need some clarification. References made by staff at various times include a stabilization program, a crisis intervention facility, a group home, and a residential treatment facility.

Intensive case managers (ICMs) seem to provide services more in line with those of group home staff. Interviews with case managers as well as review of progress notes indicates that ICMs are involved in the level system, initiation of voluntary commitments, granting of passes, leaves, etc.. All of these activities seem more like those of group home managers than case managers.

EXHIBIT
DATE 2-8-93
SB

The Center has acknowledged that movement through the program is slower than expected. This is due, in part, to a lack of vacancies in another group home which was expected to provide placement options for some of the "Ihler" group home's clients. The committee believes the problem relates directly to the issue of how program ICMs are used. It is recommended that housing alternatives other than group homes be considered, and specifically that private housing with ICM support be developed. It is felt that as ICMs get more involved in traditional or "community" ICM activity, they will naturally become more involved in developing housing and support alternatives.

The committee suggested that the Center seek consultation from Missoula or Kalispell ICM Programs to learn more about the development and use of community housing resources with intensive support.

Recordkeeping

The records also reveal the lack of clarity of the existing model. While case managers have generally developed treatment plans built on a "strengths" model, the case management treatment plan being used in the new Billings program appears to be more of a "problem oriented" plan than a "strengths" plan.

The progress notes document activities which do not necessarily fall within the identified case management service elements of planning, assessment, linking, activities of daily living, etc. Additionally, consumer participation in the planning is not always clear and in some cases there was a question as to whether consumers actually saw their treatment plan.

Progress notes need to relate back to treatment plans. They should show a sense of progress toward the plan goal, however this was not evident from our random record review.

Group home ICMs are not using the same medical necessity format that community ICMs use. Incorporating the medical necessity into the record keeping as well as bringing group home ICM recordkeeping more in line with community ICM record-keeping might assist in clarifying the role of the group home ICMs.

Although not a pervasive problem, some charts had no up-to-date treatment plan or up-to-date social history. A team member suggested implementing an interim social history in order to provide current information to Mental Health Center staff involved in providing services.

The ICM plans are written primarily for Medicaid review with emphasis on pathology. While this does not necessarily preclude effective case management, it is in direct contradiction with the use of the strengths model which is the accepted model for Intensive Case Management in Montana. In several cases there were no treatment plans in the file. Evidence of treatment programming for a dually diagnosed MI/CD (mentally ill/chemically dependent) client was noted in the well documented therapy progress notes of a Chemical Dependency Counselor who works for the Center.

Coordination of Services

It was noted that while case managers may provide important services in the group home, increased effort should be made in linking the client with services and/or opportunities outside of the Mental Health Center.

With regard to communication with the State Hospital, it was suggested that ICMs initiate direct contact with the social workers and consumers at the hospital. To date, communication with the hospital has been filtered through the Alternative Services Director. Direct contact with consumers, in person, via the mail or by phone, would be beneficial. Review team members suggested that such contacts could include a discussion of what to bring to the community and information regarding what to expect in terms of daily schedule, living environment, transportation, etc.

Consumer Issues

Consumers reported liking the home and clearly appreciated the opportunity to be living in it and receiving services from the center. As reported earlier, they also made positive comments about the staff who work with them. The opportunity for MSH patients to visit the Billings program prior to a placement decision is seen as a very positive and important aspect of consumer involvement in planning services. Acknowledging the overall positive feelings of the review team regarding the services consumers are receiving, there are several consumer related issues on which the team felt obliged to comment. Some consumers were not aware of the name of their case manager. Some gave the name of the Alternative Services Director and/or the Residential Services Director as their case manager. More clarification needs to be provided to consumers in this regard.

Consumers would like more money from their disability checks in order to buy clothing, household furnishings, etc. Currently they receive 25% of their monthly allotment. In addition, the level system provides a means to earn extra money each week. The suicide contract needs to be revised. Current language is confusing and the team felt there was a sense that a consumer might be punished for being honest.

It was noted that in one case a container of medication was left on a staff person's desk. Further, one consumer came to receive medication and someone else's medication was in the first consumer's designated storage area. The consumer appropriately pointed this out to the staff. Clearly, ongoing attention should be given to medication issues.

In one case, a release of information was obtained on October 27, 1992 and yet the progress notes indicated group home staff had contacted family members on October 11, 1992. Care should be taken to obtain the necessary releases in a timely fashion.

Additionally, consumers seemed to lack information with regard to medications they were taking. The team believes that specific and systematic training should be provided to keep consumers as knowledgeable as possible with regard to their medications.

While attendance at day treatment is probably most often agreeable to, and in the interest of the client, rigidly required attendance is of concern. It raises questions regarding flexibility, individualized planning, consumer participation in planning, and staff convenience vs. consumer interest. Without making "doing nothing all day" an acceptable alternative, it should be possible to encourage or even require acceptable directed activity within the context of choice from more than one possibility.

EXHIBIT 2
DATE 2-8-93
SB

Facility

The group home (Parkhill) is attractive and located in a pleasant residential community. It is clean and well kept and provides a very homey environment. It is decorated nicely. The labeled storage areas in the kitchen provide a sense of organization. Given the turnover of consumers with whom the home is involved, this provides for a very functional work space.

Suggestions for environmental improvement include:

The single bedroom in the basement could be made more inviting and warm. A rug or carpet would be particularly helpful and pictures or other decorations are also suggested.

The open ceiling panel in the downstairs bathroom is seen as a potential suicide risk. It should be repaired promptly.

Attention needs to be given to improving ventilation in the smoking room.

The home is not accessible to people who have physical mobility limitations.

Contract Compliance

All positions were reportedly filled at the time of the site visit.

Initially, reports were late in getting to the Mental Health Division. Initial reports raised the following issues:

Three case managers are funded by the contract. The number of hours of case management services reported is in excess of what a case manager can provide.

A very large proportion of case management services are in the Activities of Daily Living (ADL) category.

Clients appear to be receiving an average of less than 1 hour a month of outpatient individual therapy. Since this would include medication management, the question is raised as to whether this is a sufficient level of service.

Meeting the Primary Objective of the Special Community Services Expansion Programs

The specified purpose of the Special Community Services Expansion (Ihler) Programs is to provide support and treatment services needed by adults with severe and disabling mental illness in order to successfully live in a community setting and avoid or shorten stays at Montana State Hospital. It is anticipated that these services will play a major role in reducing the average daily population at Montana State Hospital to approximately 200 patients.

As of 11-15-92, Montana State Hospital had discharged 6 people to Mental Health Center's Ihler services in Billings. Also, services have been provided to several additional individuals who may otherwise have been admitted to the hospital.

The primary numerical indicator of the success of the programs in meeting the objective is the population at Montana State Hospital. This has been reduced from 272 prior to the implementation of any "Ihler" related activity (April 30, 1992), to 200 as of the last data period prior to the site visit (October 31, 1992).

In Region III specifically, comparing the months of April and October, total voluntary and civil involuntary bed day utilization at Montana State Hospital is down by 29%. Voluntary and civil involuntary admissions were reduced by 37% (from eight in April to five in October). It is difficult to predict a long range trend in admissions from the rather low admission figures and the relatively short time span. However, the reductions in both admissions and bed day utilization are encouraging indicators and on the basis of the reduced hospital population noted in the preceding paragraph, it is clear that the numerical objective is being met. Most importantly, it was clear to reviewers that the new program provides supports and services which offer people with severe and persistent mental illness an alternative to long-term hospitalization. Several people in the program came directly from Montana State Hospital and others almost certainly would have been admitted if not for the new services. While providing an alternative to hospitalization was expected, it was particularly gratifying to note that consumers appreciated and were benefitting from the services. The team did not identify anyone for whom they would recommend a return to Montana State Hospital.

Conclusion

The review committee concluded that consistent with the intent of the decision to shift funds to selected communities for program expansion, services have been developed which enable people with severe mental illness to receive the support and services necessary to allow them to live appropriately in local communities. Although the committee identified numerous areas where improvement should be expected, and made several suggestions and/or recommendations, the overriding findings were that: (1) consumers are receiving services they like and appreciate, (2) they appear to be benefitting from the services, and (3) admissions and bed day utilization at MSH are down. While we will continue to monitor the programs and expect to see improvement, it is clear that Mental Health Center's Special Community Services Expansion Program is achieving what was anticipated.

EXHIBIT L
DATE 2-8-93

SIGNATURES OF PARTICIPANTS IN SITE VISIT
TO
MENTAL HEALTH CENTER

EXHIBIT 2
DATE 2-8-93

SITE VISIT REPORT
on
SPECIAL COMMUNITY SERVICES EXPANSION (IHLER) PROGRAM
in BUTTE, ANACONDA and HELENA

MENTAL HEALTH SERVICES, INC.
HELENA, MONTANA

Introduction

On November 23, 24 and 25, 1992, an Oversight Committee established by the Mental Health Division of the Department of Corrections and Human Services conducted a site visit evaluation in Helena and Butte to monitor the implementation of Mental Health Services, Incorporated's new services funded under the Special Community Services Expansion (Ihler) Programs.

The Committee was formed at the recommendation of the Montana Mental Health Planning and Advisory Council. It was convened in May and carried out initial monitoring and implementation via reports from providers and interviews with staff. On-site evaluation was delayed until programs were fully operational. In order to ensure objective review of services, site visit participants were selected to represent a variety of perspectives, notably including those of both consumers and family members. Specifically, the individuals asked to participate included: Helen Sampsel, Board Member and former President of the Montana Alliance for the Mentally Ill; Kelly Moorse, Executive Director of the Mental Disabilities Board of Visitors; Pat Pope, Director of Meriwether Lewis Institute; Kathy Standard, President of Meriwether Lewis Institute; Randy Vetter, Admissions Coordinator at Montana State Hospital; John Lynn, Community Support Program Director for the Western Montana Community Mental Health Center in Missoula; Grace Edwards, Chairperson for Mental Health Center in Billings; Bill Warfield, Chairperson for Mental Health Services, Incorporated in Helena; and Rusty Redfield, Mental Health Division Planning and Program Development Manager.

It should be noted that committee members' roles were defined so that Board Chairpersons (Ms. Edwards and Mr. Warfield) would be essentially passive observers in the site visit to their own Region but would participate actively in the visit to the Region with which they had no administrative responsibility. Unfortunately Ms. Edwards, who was scheduled to be the active participant in the Butte Helena visit, was unable to participate in the evaluation. Mr. Warfield participated as an observer.

The Committee's primary evaluation activities included interviews with recipients of services, family members of recipients of services, and staff at the programs, as well as review of policies and documents, records, and physical environments. Additionally, interviews were conducted with the Salvation Army in Butte, Hearthstone in Anaconda, and God's Love in Helena. The review focused on quality and appropriateness of service, contract compliance and implementation of the original program proposal.

The Review Team recognizes, as the readers of this report should, that the expansion of services involved new programs, implemented over a very short time span, serving many people who have long duration, difficult to manage mental illness. The numerous issues and concerns identified reflect the fact that in new and evolving programs, the need for change and improvement is normal and to be expected. The team trusts that its comments will provide assistance in shaping the ongoing development of the new services.

The team also believes it is important for the reader to recognize that Community Mental Health Centers and the specific expansion services covered in this report are all part of a larger statewide system of publicly funded mental health services. While it is true that community programs have recently been expanded and the census at Montana State Hospital (MSH) has been reduced, it is clear that a balanced and comprehensive mental health system will continue to require strong inpatient psychiatric services from MSH.

Issues Relating to Quality and Appropriateness of Service

Staff

The expansion project case management teams in Butte and Helena were interviewed by members of the Review Team. They have received quality training and are knowledgeable about the needs of the consumers they are serving. The formal and informal interactions observed between consumers and case managers indicate that a good working relationship has been established. Consumers report that they like their case managers and appreciate their availability. The enthusiasm and spirit of the case managers was also readily apparent, both in interviews and observations.

Intensive case management staff in both programs have structured their work time so that case management services will be available seven days a week, ten hours a day.

The Review Team expressed concern about the single crisis response worker in Helena. The vacant crisis worker position in Helena needs to be filled as soon as possible. Additional training, particularly on the strengths model and the role of intensive case managers, was suggested for the Butte crisis response workers.

One of the strengths of the new programs in Anaconda, Butte and Helena is the administrative support staff. The office director in Anaconda is very familiar with the consumers and has a good sense of the community. In Butte, support staff who were formally with the outpatient office and have several years of experience are now working in the community support program. The case management program in Helena has moved to a separate location and thereby resolved substantial space and telephone problems and has added an administrative support person. All of these people seem to genuinely like consumers and relate well with them.

The crisis response team in Helena reportedly will be working closely with the support unit of St. Peter's Hospital. This is a vital link for consumers and their ability to remain within the community.

EXHIBIT 2
DATE 2-8-93

Training

Staff training was video taped and is available for new staff members. Staff commented on the positive nature of the training and also referenced how valuable the comments from Meriwether Lewis Institute (MLI) representatives were. Ongoing issues, such as clinical supervision and the conflict created between medical necessity and the strengths model of case management, need to be addressed.

Team members noted that not all crisis workers were provided the well developed training package which new case managers received. Training in areas such as client empowerment, crisis intervention, risk assessment, the strengths model of case management, etc. should be part of each crisis workers preparation. Training in the strengths model and a review of the staff training video tapes would also be extremely important for the new program director of the Helena Community Support Program.

Community training and education need to be ongoing within Anaconda, Butte and Helena. Ongoing outreach and assessment with community resources is vitally important to the success of the expansion projects. The Salvation Army in Butte was aware of the new programs in Butte, but was not aware of the emergency phone numbers. The ongoing work in Anaconda presents a challenge, but must be continued to ensure the safety and quality of life issues for consumers who choose to live in that community.

Facilities

Staff at Gilder House in Butte have gone to considerable effort to make the facility homey and comfortable. The living and dining areas are nicely furnished. Individual rooms are a particularly nice feature. On the negative side, it was noted that the downstairs bathroom is not generally accessible and the home is clearly not accessible to people with physical mobility limitations. Some need for routine maintenance was indicated, i.e., repair of screen door and reinstallation of storm windows.

The T-House in Helena leaves much to be desired as a residential facility. It is need of ongoing maintenance and the rambling layout makes it somewhat difficult to supervise. A physical plant maintenance schedule needs to be put in place immediately. To its credit, the building does offer ample living space for its residents.

Case management offices have been relocated from Montana House in Helena to a separate office suite. The new location provides a much more pleasant working environment for staff, as well as consumers. The office space is conveniently located in downtown Helena, within easy access to Montana House and other social service agencies.

Crisis Response Workers

Within the Helena program at the time of the review, there was only one crisis response worker. Care must be taken to be sure that this individual does not "burn out". Efforts have been made to divide the on call duty between other clinically privileged staff members. The role of the crisis response worker during program hours at Montana House needs to be clarified. If a crisis occurs with a member at Montana House, we do not believe it is always the responsibility of the crisis worker. Issues arising with Montana House should first be addressed by Montana House staff.

Recordkeeping

Records in Butte were generally well organized and material was easy to locate. Intake summaries were timely. Documentation of medical necessity was frequently not clear and some files lacked a day treatment plan. SOAP charting was brief and often weak in the assessment area.

Some of the Helena records used a face sheet within the case management portion of the file. The face sheet includes the name of the consumer, identifying information (height, weight, etc.), emergency contacts, physician contacts, lists of medications, social security number, etc. Since the form contains information which is extremely helpful, we recommend its use throughout the region's intensive case management services. Intensive case management progress notes were often very brief, SOAP charting did not appear to be well understood, medical necessity was often not well documented and sometimes treatment plans could not be located for some elements of a consumer's program, i.e., day treatment, case management, or residential. This may relate in part to having three separate charts which was found to be very confusing. A master medical record which contains all of the medical information and case management information is imperative. Training, particularly including the use of the SOAP method and documentation of medical necessity, is needed in both Butte and Helena programs.

In Anaconda, the three charts reviewed lacked intake or opening evaluations, and the notes did not relate back to the plans. Plan goals tended to be global rather than specific. Additionally, the charts did not indicate that the consumer had been seen by any staff other than the case manager.

Supported Housing

Housing is a critical area of consumer need. The supportive housing component of the region's services, including the matching of consumers with one another, has been extremely successful. One consumer in Butte, who had lived in supported housing when first released from Montana State Hospital, stated that supported housing "got my feet on the ground and now I'm living in my own place".

Consumer Issues

Consumers knew their case managers by name and knew who to contact if their primary case manager was not available. The majority of consumers interviewed were able, when asked, to indicate what their diagnosis was and what medications they were taking. Perhaps most important, the consumers appeared to be happy and stated that they liked living in the community.

The consumers on the Oversight Review Team offered several suggestions regarding rewording some of the current policies. It is suggested that, when appropriate, staff from the Helena community support program involve current consumers in reviewing draft policy changes which directly affect consumers (i.e., rights information, confidentiality policy for the crisis stabilization program, random room inspection policy, etc.). Rights information needs to be distributed as part of the information packet from the crisis stabilization programs.

EXHIBIT 2
DATE 2-8-93

Consumers in both Helena and Butte stated they enjoyed the pre-placement visits from the State Hospital. In Butte, consumers from MSH visit the day treatment program at least twice a week and/or have stayed at Gilder House as part of their transition into the community. In Helena, pre-placement visits involved staying at the T-House for varying lengths of time. These are meaningful and effective ways of including consumers in their service planning and delivery.

Program Strengths

The number of nurses within the programs in Butte and Helena is a positive addition. The nurses prepare the daily and weekly medication organizer packets and provide oversight of medication issues. Further, they are a key link for the consumer and his or her contact with the physician.

Physician daily contacts at Gilder House are extremely important to consumers. Regular monitoring of medications and daily assessment of a consumer's psychiatric condition help make this an excellent program.

Role functions of Gilder House as a crisis facility are readily apparent. Moreover, the program clearly meets the mandate of providing treatment within the least restrictive alternative.

Case managers from within the region are making routine (in some cases weekly) contacts with consumers at MSH. This is an important link prior to discharge.

Program weaknesses

Helena is desperately in need of a psychiatrist for the crisis home and Montana House. Efforts to fill this position must be a top priority. The absence of adequate psychiatric services in the Helena mental health programs is a longstanding problem which must be solved.

The supervision of case managers in Helena is still unclear. The current model in Helena of involving the program director and the two clinically privileged mental health staff is confusing. Currently a clinically privileged person is assigned to every case. This model becomes confusing when providing supervision if the clinically privileged individual is seeing the person individually and supervising the case manager. The strengths model would seem to be compromised with this system. Additionally, it appears that the system may cause a case manager to have different supervisors for different consumers.

Given the number of case managers in Butte and Helena, it is felt that each program needs a supervisor or team leader. All intensive case managers (Ihler and regular) in a community could be supervised by the same individual.

With the addition of a new clinical director for the Helena community support program, there is a need to clarify the division of labor and establish a specific organization chart as soon as possible. Clear lines of supervision need to be established. Supervision of the crisis response team position in Helena is currently not clear.

The documentation of medical necessity can always be improved. The records in Helena appeared to do a better job in this area than did those in Butte or Anaconda. Medical necessity, if identified within the treatment plan, is a continual reminder and guide for the SOAP notes which are done daily. Recordkeeping issues include the need to tie progress notes to the treatment plan. It was observed that the assessment and the plan portion of the SOAP notes were frequently interchanged. Some further expansion of the "subjective" portion of the notes would also help link the assessment to the plan.

Currently within the community support programs, there can be as many as three medical records (day treatment, intensive case management, and crisis stabilization). In order for there to be a comprehensive medical record, one record, in a main secured storage area, needs to be maintained. The current system is very disjointed and does not present a complete picture of the consumer.

Moreover, the medication portion of the files, particularly in Helena, is disjointed. Information is compiled by the nurse and presented to the doctor, but that process is quite time consuming. With a number of consumers seeing physicians outside the center, it is also important to keep a list of current medications within the medical record.

Although not specifically a part of the expansion programs, it was noted that Montana House treatment plans and monthly summaries have been revised to a checklist format. These plans and summaries are not felt to be individualized and we would recommend that the format be revised to meet CMHC standards for day treatment.

System Needs

The Committee believes that the entire service system could benefit from the development of CMHC standards for crisis stabilization programs and crisis workers. It is recommended to the Department of Corrections and Human Services that a statewide task force be established to work on this issue.

Contract Compliance / Implementation

At the time of the site visit, the only project funded position vacant was for a crisis response worker in Helena. We commend the Center for recruiting and selecting competent individuals and for providing the orientation and training necessary to fill 21 of 22 positions in approximately six months.

Although the psychiatrist position being recruited in Helena will not be funded via special project authorization, the status of psychiatric services in Helena is a contract compliance issue. Additionally, several reports were initially late in getting to the Mental Health Division.

Meeting the Primary Objections of the Special Community Services Expansion Programs

The specified purpose of the Special Community Services Expansion (Ihler) Programs is to provide support and treatment services needed by adults with severe and disabling mental illness in order to successfully live in a community setting and avoid or shorten stays at Montana State Hospital. It is anticipated that these services will play a major role in reducing the average daily population at the Hospital to approximately 200 patients.

EXHIBIT 2
DATE 2-8-93
SB

As of 11-15-92, Montana State Hospital had discharged 32 people to Mental Health Services, Inc.'s Ihler programs. Of those, only one was readmitted to Montana State Hospital. Additionally, although diversions from hospital admissions cannot be positively identified, it is clear that many individuals had been served who might otherwise have been hospitalized.

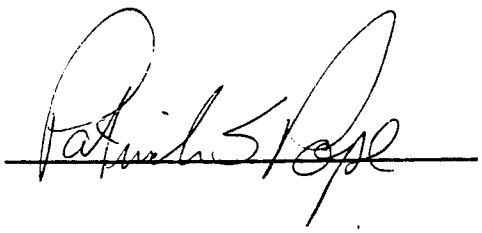
The primary numerical indicator of the success of the programs in meeting the objective is the population at Montana State Hospital. This has been reduced from 272 (April 31, 1992) prior to the implementation of any "Ihler" related activity, to 200 (October 31, 1992) as of the last data prior to the site visit.

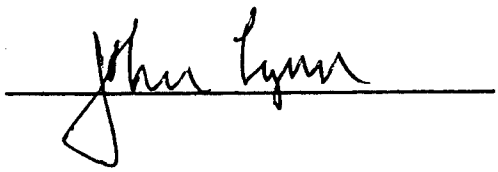
For Region IV specifically during that period, total voluntary and civil involuntary bed day utilization at Montana State Hospital is down by 25%. Voluntary admissions have been reduced from eight in April to zero in October, and civil involuntary commitments from five in April to one in October. It is difficult to predict a long range trend in admissions from the rather low admission figures and the relatively short time span. However, the reductions in both admissions and bed day utilization are encouraging indicators and on the basis of the reduced hospital population noted in the preceding paragraph, it is clear that the numerical objective is being met. Most importantly, it was clear to reviewers that the new program provides supports and services which offer people with severe and persistent mental illness an alternative to long term hospitalization. Several people in the program came directly from Montana State Hospital and others almost certainly would have been admitted if not for the new services. While providing an alternative to hospitalization was expected, it was particularly gratifying to note that consumers appreciated and were benefiting from the services. The team did not identify anyone for whom they would recommend a return to Montana State Hospital.

Conclusion

The review committee concluded that consistent with the intent of the decision to shift funds to selected communities for program expansion, services have been developed which enable people with severe and disabling mental illness to receive the support services necessary to allow them to live appropriately in local communities. Although the committee identified numerous areas where improvement should be expected, and made several suggestions and/or recommendations, the overriding findings were that 1) consumers are receiving services they like and appreciate, 2) they seem to be benefiting from the services, and 3) admissions and bed day utilization at Montana State Hospital are down. While we will continue to monitor the programs and expect to see improvement, it is clear that Mental Health Services Inc.'s special services expansion programs are providing the services and having the impact that was anticipated.

SIGNATURES OF PARTICIPANTS IN SITE VISIT
TO
MENTAL HEALTH SERVICES, INC.





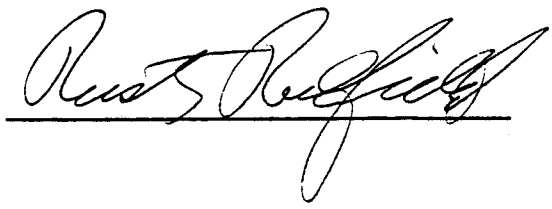


EXHIBIT 2
DATE 2-8-93
SB

RE-ADMISSION DATA

COMMUNITY MENTAL HEALTH CENTER ADMISSIONS - ALL REGIONS					
	FY 90	FY 91	FY 92	AVG ANNUAL	PERCENT
FIRST ADMISSIONS	6215	5736	5880	5944	78.3%
RE-ADMISSIONS PRIOR FY	1267	1308	1307	1294	17.1%
RE-ADMISSIONS SAME FY	370	339	344	351	4.6%
TOTAL ADMISSIONS	7852	7383	7531	7589	100.0%

MONTANA STATE HOSPITAL (WARM SPRINGS) ADMISSIONS					
	FY 1990	FY 1991	FY 1992	AVG ANNUAL	PERCENT
FIRST ADMISSIONS	333	294	325	317	49.1%
RE-ADMISSIONS	376	321	291	329	50.9%
TOTAL ADMISSIONS	709	615	616	647	100.0%

Note: Re-admissions Prior FY are readmissions of people who were discharged prior to the start of the fiscal year. Re-admissions Same FY are re-admissions of people who were discharged during the same year they were re-admitted.

EXHIBIT 2
DATE 2-8-93
SB

CMHC – PRIMARY DIAGNOSIS OF CLIENTS ON ACTIVE CASELOAD (1985, 1989, 1992)

	June 1985		June 1989		Dec 1992		Increase/(Decrease) 85–92	
PRIMARY DIAGNOSIS OF CLIENTS ON ACTIVE CASELOAD	#	%	#	%	#	%	#	%
DISORDERS FIRST EVIDENT IN CHILDHOOD, ADOLESCENCE	659	8.0%	511	7.4%	649	8.7%	-10	-1.5%
ORGANIC MENTAL	228	2.8%	236	3.4%	163	2.2%	-65	-28.5%
PSYCHOACTIVE SUBSTANCE ABUSE	375	4.5%	297	4.3%	357	4.8%	-18	-4.8%
SCHIZOPHRENIA	749	9.1%	840	12.1%	864	11.6%	115	15.4%
PSYCHOTIC, NOT ELSEWHERE CLASSIFIED	131	1.6%	181	2.6%	235	3.1%	104	79.4%
MOOD	1439	17.4%	1334	19.3%	1729	23.1%	290	20.2%
ANXIETY	634	7.7%	639	9.2%	693	9.3%	59	9.3%
SOMATOFORM	24	0.3%	13	0.2%	10	0.1%	-14	-58.3%
DISSOCIATIVE	9	0.1%	6	0.1%	19	0.3%	10	111.1%
SEXUAL	97	1.2%	62	0.9%	43	0.6%	-54	-55.7%
FACTITIOUS	1	0.0%			1	0.0%		
IMPULSE CONTROL NOT ELSEWHERE CLASSIFIED	64	0.8%	45	0.7%	107	1.4%	43	67.2%
ADJUSTMENT	1708	20.6%	1477	21.3%	1057	14.1%	-651	-38.1%
PSYCHOLOGICAL AFFECTING PHYSICAL	45	0.5%	12	0.2%	7	0.1%	-38	-84.4%
PERSONALITY	579	7.0%	439	6.3%	427	5.7%	-152	-26.3%
DELUSIONAL (PARANOID)	17	0.2%	21	0.3%	36	0.5%	19	111.8%
CONDITIONS NOT ATTRIBUTABLE TO A MENTAL DISORDER	1073	13.0%	441	6.4%	431	5.8%	-642	-59.8%
ADDITIONAL CODES	255	3.1%	270	3.9%	442	5.9%	187	73.3%
SLEEP			1	0.0%	3	0.0%	3	
UNKNOWN	187	2.3%	94	1.4%	204	2.7%	17	9.1%
TOTAL	8274		6919		7477			

EXHIBIT 3
DATE 2-8-93
~~SB~~

INFORMATION ON CHILDREN AND ADOLESCENTS WITH SEVERE EMOTIONAL DISTURBANCE/DISORDERS (SED)

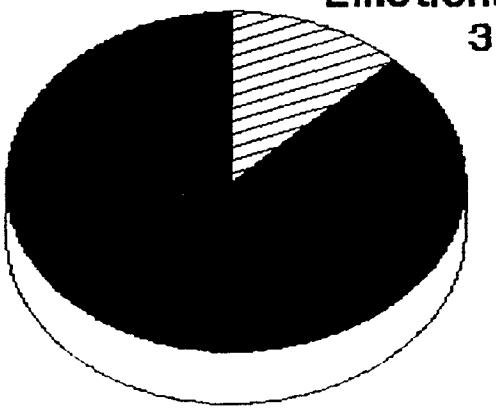
DCHS

MENTAL HEALTH DIVISION CASSP

2/5/93

SEVERE EMOTIONAL DISTURBANCE (SED)

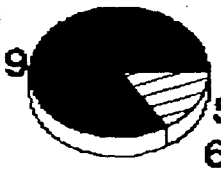
Based on 1990 Census



Emotional Disorder
31109

Pop Under 18 yrs
222204

Emotional Disorder Portion



ED
31109

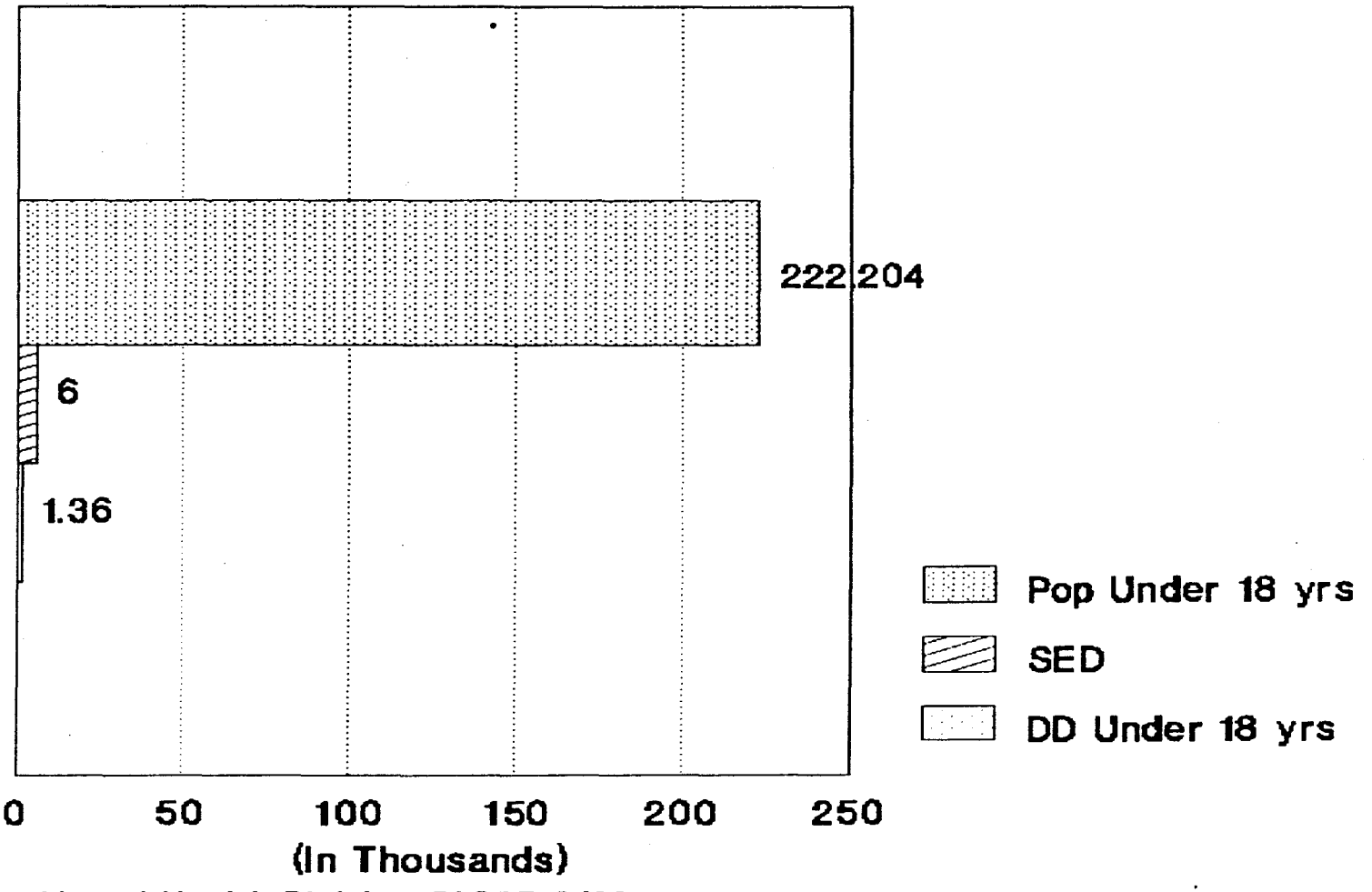
SED
6000

SED Portion

DCHS - Mental Health Division CASSP 2/93

EXHIBIT 3
DATE 2-8-93
SB

SED PEVELANCE
Based Upon 1990 Census



DCHS - Mental Health Division CASSP 2/93

EXHIBIT 3
DATE 2-8-93

WHO IS THIS CHILD OR ADOLESCENT WITH SEVERE EMOTIONAL DISTURBANCE?

HE OR SHE HAS AN EMOTIONAL, BEHAVIOR OR MENTAL ILLNESS THAT IS EXPECTED TO CONTINUE FOR 6 MONTHS OR MORE.

THE ILLNESS IS DIAGNOSEABLE ACCORDING TO THE DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (DSM-III-R).

THE ILLNESS HAS RESULTED IN FUNCTIONAL IMPAIRMENT IN FAMILY, SCHOOL, PEER, OR COMMUNITY ACTIVITIES.

FUNCTIONAL IMPAIRMENTS ARE PROBLEMS IN THE YOUTH'S ACHIEVING OR MAINTAINING DEVELOPMENTALLY APPROPRIATE BEHAVIOR IN ONE OR MORE OF THE FOLLOWING AREAS AFTER CONSIDERING CULTURAL AND ETHNIC NORMS:

1. ROLE AND TASK PERFORMANCE,
2. COGNITION AND COMMUNICATION,
3. BEHAVIOR TOWARD SELF AND OTHERS, OR
4. MOOD AND EMOTIONS.

THE ILLNESS REQUIRES MULTIPLE SERVICES FROM MULTIPLE SERVICES PROVIDERS BOTH PRIVATE AND PUBLIC.

THE ILLNESS MOST LIKELY WILL NOT BE CURED. THAT IS TO SAY THERE IS NO QUICK FIX.

THE ILLNESS CAN AND FREQUENTLY IS DEVASTATING TO THE FAMILY.

THE SED YOUTH COMES FROM ALL ECONOMICAL STRATA OF OUR SOCIETY.

LEFT UNTREATED OR UNDETECTED, THE COURSE OF THE ILLNESS WILL MOST LIKELY RESULT IN THE YOUTH BEING PLACED OUTSIDE THE FAMILY INTO INPATIENT PSYCHIATRIC CARE OR CORRECTIONAL FACILITIES.

SIMILAR TO OTHER MAJOR ILLNESSES THE EARLIER THE IDENTIFICATION, THE HIGHER THE POTENTIAL FOR A POSITIVE IMPACT OF TREATMENT. ADDITIONALLY, TREATMENT IS COSTLY AND THE LONGER THE ILLNESS GOES UNTREATED THE GREATER THE COST.

SED YOUTH CAN AND SHOULD BE TREATED IN THE COMMUNITY WITH APPROPRIATE CHILD FOCUSED AND FAMILY CENTERED SERVICES DIRECTED TOWARD:

PRESERVING THE FAMILY WHENEVER APPROPRIATE, AND

TREATMENT WHICH ENABLES THE YOUTH TO REACH THEIR HIGHEST FUNCTIONAL LEVEL.

SED YOUTH IN MOST SITUATIONS WILL REQUIRE ONGOING SUPPORT.

PARENTS AND FAMILY ARE FREQUENTLY SEEN AS THE CAUSE OR SIGNIFICANT CONTRIBUTOR OF OR TO THE ILLNESS. **THIS IS NOT TRUE IN MANY CASES.**

IN SFY 92 - COMMUNITY MENTAL HEALTH CENTERS IDENTIFIED AND SERVED 1087 SED YOUTH.

IN SCHOOL YEAR 91-92 OPI REPORTED THAT 149 SCHOOL DISTRICT SERVED 845 SED YOUTH.

DFS SERVED 990 SED YOUTH IN FOSTER CARE WHICH IS APPROXIMATELY 28% OF THE YOUTH WHO WERE IN FOSTER CARE IN SFY 92 AND REPRESENTS 16.5% OF THE ESTIMATED 6000 SED YOUTH IN MONTANA.

WHAT HAS BEEN THE ROLE OF THE DEPARTMENT OF CORRECTIONS AND HUMAN SERVICES MENTAL HEALTH DIVISION'S CHILD AND ADOLESCENT SERVICE SYSTEM PROJECT (CASSP)?

CASSP IS A FEDERALLY FUNDED PROJECT DIRECTED AT THE DEVELOPMENT OF A COMMUNITY BASED FULL SYSTEM OF SERVICES TO MEET THE TREATMENT AND SUPPORT NEEDS OF SED YOUTH AND THEIR FAMILIES. THE PROJECT WILL END IN SEPTEMBER 1993 UNLESS A NEW FEDERAL GRANT IS AWARDED TO MONTANA.

THE MENTAL HEALTH DIVISION'S CASSP PROJECT HAS STIMULATED THE DEVELOPMENT OF A VARIETY OF SERVICES FOR CHILDREN AND ADOLESCENTS WITH SEVERE EMOTIONAL DISTURBANCE TO INCLUDE BUT NOT LIMITED TO:

WRAP-AROUND SERVICES IN THE YOUTH'S OWN HOME IN COLLABORATION WITH MULTIPLE AGENCIES, I.E. DFS, OPI, SRS, PRIVATE PROVIDERS, ETC.

DAY TREATMENT SERVICES PROVIDED AS A JOINT PROGRAM BY COMMUNITY MENTAL HEALTH SERVICES AND SPECIAL EDUCATION.

CASE MANAGEMENT SERVICES TO DEVELOP AND MANAGE A COORDINATED MENTAL HEALTH SERVICE DELIVERY TO SED YOUTH AND THEIR FAMILIES.

IN COLLABORATION WITH DFS AND LOCAL GOVERNMENT, HAS ESTABLISHED A MODEL DEMONSTRATION FOR COMMUNITY DESIGNING AND IMPLEMENTING OF A FULL CONTINUUM OF SERVICES TO MEET THE SERVICE NEEDS OF SED YOUTH AND THEIR FAMILIES.

THE COMPLETION OF A PLAN FOR THE DEVELOPMENT OF A FULL CONTINUUM OF SERVICES TO MEET THE MENTAL HEALTH SUPPORT AND TREATMENT NEEDS OF SED YOUTH AND THEIR FAMILIES UTILIZING REFINANCING METHODS WHENEVER POSSIBLE.

EXHIBIT 3
DATE 2-5-93

WHAT SERVICES DO WE BELIEVE ARE NECESSARY TO SERVE SED YOUTH IN THEIR HOMES OR AT A MINIMUM IN THEIR COMMUNITIES?

WE BEGIN BY ASKING YOU TO REMEMBER THAT THE COMPONENTS WE LIST BELOW ARE INTERDEPENDENT SERVICES. THEREFORE, FAILURE TO PROVIDE ONE OR MORE MEANS THE OTHERS MAY HAVE A CORRESPONDING INCREASE IN DEMAND WHICH ALTERS THE EFFECTIVENESS OF THE SYSTEM AND ENDANGERS ATTAINMENT OF THE OBJECTIVES INTENDED FOR THE SYSTEM.

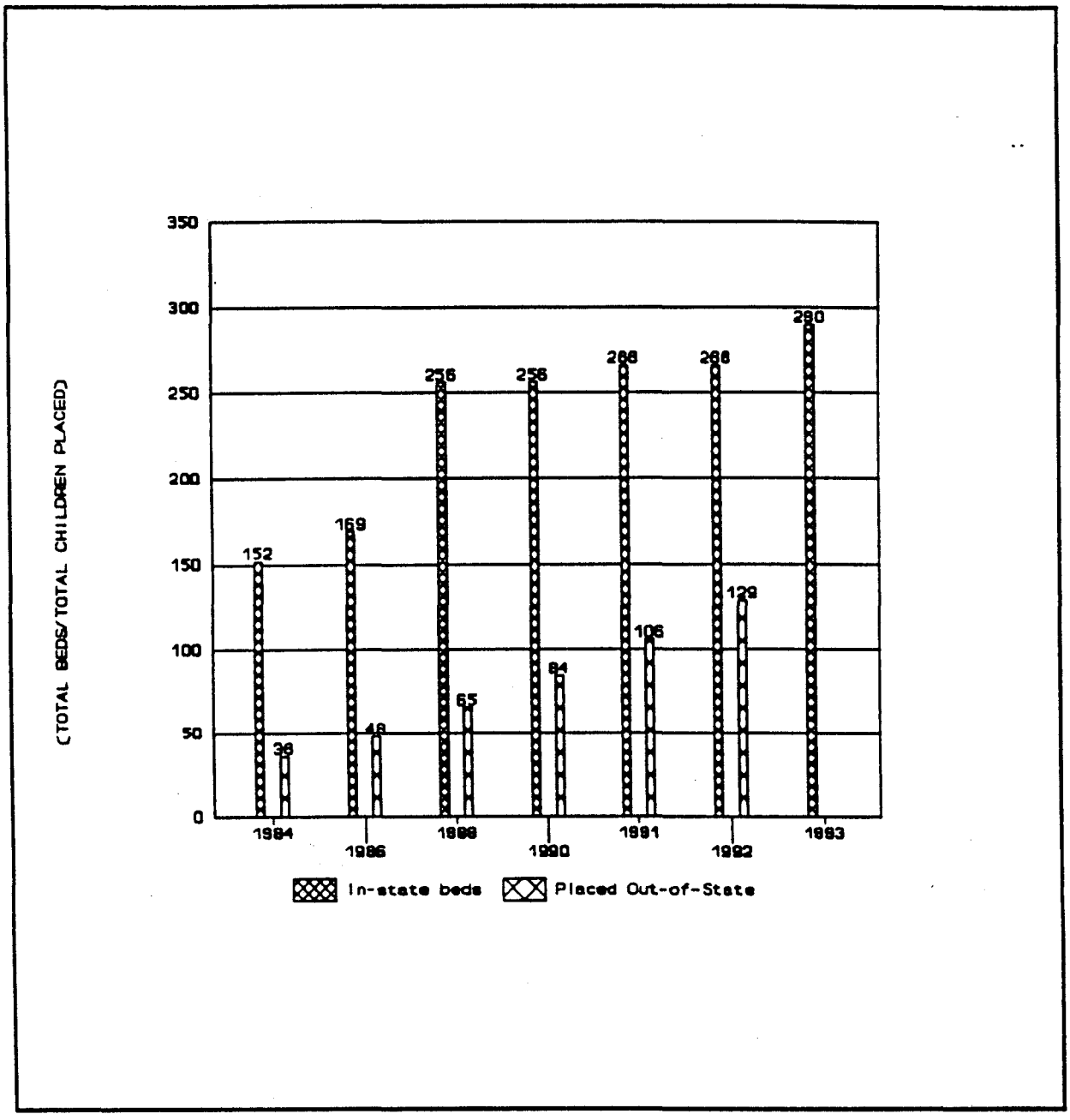
WE ALSO ASK THAT YOU NOTE WE ARE NOT RECOMMENDING THE ELIMINATION OF INPATIENT PSYCHIATRIC HOSPITAL OR RESIDENTIAL SERVICES IN THE CONTINUUM. BUT RATHER, WE ADVOCATE THAT THESE SERVICES NEED TO BE PLANNED AND MANAGED. ADDITIONALLY THESE SERVICES NEED TO BE VIEWED AS A PART OF THE SYSTEM.

WE BELIEVE THE IMPLEMENTATION OF THE COMMUNITY SYSTEM OF SERVICES ACCOMPANIED BY EARLY IDENTIFICATION AND FLEXIBILITY IN THE SYSTEM AND SERVICE DESIGN IS THE KEY TO APPROPRIATE USE OF IN-PATIENT CARE.

IN ADDITION, WE BELIEVE THAT REDUCTION IN THE GROWTH OF IN-PATIENT PSYCHIATRIC CARE AND THE COST OF SUCH CARE WILL ONLY OCCUR WITH THE DEVELOPMENT OF THE COMMUNITY CONTINUUM. THE FOLLOWING GRAPH INDICATES IN PART WHY WE BELIEVE THIS TO BE THE CASE.

WE BELIEVE THAT EQUALIZATION OF THE FUNDING FOR INPATIENT CARE WITH THAT FOR COMMUNITY BASED SERVICES IS NECESSARY IF THE COMMUNITY SYSTEM IS TO BE DEVELOPED.

IN-STATE IN-PATIENT BEDS COMPARED TO NUMBER OF YOUTH PLACED IN OUT-OF-STATE RESIDENTIAL TREATMENT BY STATE FISCAL YEAR



DCHS - MENTAL HEALTH DIVISION 9/92

EXHIBIT 3
DATE 2-8-93

Detail explanation of chart on in-patient beds compared to out-of-state placements:

1984 BED COUNT INCLUDES: state hospital kids unit - 30 beds
Yellowstone Boys & Girls Ranch - 92 beds
Intermountain Deaconess - 30 beds
152 beds

1986 BED COUNT INCLUDES: Montana Youth Treatment Center - 45 beds
Yellowstone Boys & Girls Ranch - 92 beds
Intermountain Deaconess - 32 beds
169 beds

1988 BED COUNT INCLUDES: Yellowstone Treatment Center - 96 beds
Intermountain Deaconess - 32 beds
Rivendell of Butte & Billings - 108 beds
Shodair Psychiatric Hospital - 20 beds
256 beds

1990 BED COUNT INCLUDES: Yellowstone Treatment Center - 96 beds
Intermountain Children's Home - 32 beds
Rivendell of Butte & Billings - 108 beds
Shodair Psychiatric Hospital - 20 beds
256 beds

1991 BED COUNT INCLUDES: Yellowstone Treatment Center - 104 beds
Intermountain Children's Home - 32 beds
Rivendell of Butte & Billings - 108 beds
Shodair Psychiatric Hospital - 22 beds
266 beds

1992 BED COUNT INCLUDES: Yellowstone Treatment Center - 104 beds
Intermountain Children's Home - 32 beds
Rivendell of Butte & Billings - 108 beds
Shodair Psychiatric Hospital - 22 beds
266 beds
(does not include 24 residential beds for Shodair approved in June of 92)

1993 BED COUNT INCLUDES: Yellowstone Treatment Center - 104 beds
Intermountain Children's Home - 32 beds
Rivendell of Butte & Billings - 108 beds
Shodair Psychiatric Hospital - 22 beds
Shodair Residential Facility - 24 beds
290 beds

DATA FOR OUT-OF-STATE PLACEMENTS IS PROVIDED BY DFS.

NUMBER OF BEDS IS BASED UPON LICENSE ISSUED EITHER BY HES AND OR DFS.

DCHS - MENTAL HEALTH DIVISION 9/92

THE RECOMMENDED COMPONENTS OF THE COMMUNITY BASED CONTINUUM OF CARE:

SERVICE:	PLAN NEED CAPACITY
HOME BASED SERVICES	422
RESPITE FOR PARENTS	91
CASE MANAGEMENT	884
DAY TREATMENT	442
VOCATIONAL EDUCATION	68
VOCATIONAL EVALUATION	41
VOCATIONAL PLACEMENT	39
OUTPATIENT THERAPY	1769
PARENT SUPPORT SERVICES	177
INPATIENT/RESIDENTIAL TREATMENT:	247
HOSPITAL	22
RESIDENTIAL	22
THERAPEUTIC GROUP CARE	203
THERAPEUTIC FOSTER CARE	111
SUPERVISED INDEPENDENT LIVING/LONG TERM SUPPORT SERVICE	8
EMERGENCY STABILIZATION	84
THERAPEUTIC FOSTER CARE	111
SUPPORTED EMPLOYMENT	39

THE IMPLEMENTATION OF THE CONTINUUM REQUIRES CLEAR DIRECTION PROVIDED BY A PLAN AND THE RESPONSIBILITY FOR IMPLEMENTATION ASSIGNED TO A SINGLE ENTITY. THE SINGLE ENTITY SHOULD INCLUDE A POSITION THAT IS CLEARLY IDENTIFIED AS THE CHILD AND ADOLESCENT MENTAL HEALTH AUTHORITY RESPONSIBLE FOR THE PLANNING, DEVELOPMENT, DIRECTION AND EVALUATION OF SPECIFIC STATEWIDE COMMUNITY BASED CHILDREN'S AND ADOLESCENTS' MENTAL HEALTH PROGRAMS.

SERVICE DEFINITIONS:

EXHIBIT 3
DATE 2-8-93

HOME BASED:

An intensive method of service delivery providing services in the home directed at preventing family dissolution. The service focuses on the family and is direct at strengthening the family by utilizing family members strengths as basis upon which to build.

RESPITE CARE:

A service provided by trained parents(s) who assume the duties of child care giving and supervising for a planned brief period thereby providing the parent a break from the constant strain of parenting.

CASE MANAGEMENT:

A service provided by a single individual or a team of individuals which includes coordinating and monitoring of a case plan; identification, location, and arrangement of services in response to identified needs for the child and family; and a advocacy.

DAY TREATMENT:

A service that is frequently provided in a school setting and provides an integrated set of educational, counseling and family interventions which enable the youth to remain in the school and community.

VOCATIONAL:

A group of services directed toward gainful employment including career education, vocational assessment, job survival skill training, vocational skills training, work experience, job finding, retention services, and sheltered employment.

OUTPATIENT:

Services provided in a variety of community based settings including individual, group and family therapy; psychotherapy; chemotherapy; behavior therapy, etc.

PARENT SUPPORT:

Services provided to enable parents to care for their child in their own home and/or to participate fully in the treatment of their child. Services may include parent training, parent counseling, parent aides/assistants in the home, homemaker services, etc.

SUPERVISED INDEPENDENT LIVING:

A transition service to assist in preparing youth to be able to live on their own including limited supervision of living

arrangement and support services. The support services are to enable development of basis skills (e.g. apartment finding, opening checking accounts, budgeting, purchasing clothing, food, utilities, etc.).

EMERGENCY STABILIZATION:

A service provide at the community level in a group facility with a capacity to serve 6 children or adolescents with severe emotional disturbance. Service is provided 24 hours a day. In addition to basic care, the service provides treatment, case coordination while the youth is in facility, and utilization child or adolescent psychiatrist consultation in treatment. This is a service for youth in crisis but who do not require medical care or 24 hour medical supervision or detoxification. The service would have the capacity to provide intensive youth supervision/observation. The service is directed at keeping the youth in the community, returning the youth to his/her home, and to networking the family with other community services essential to a successful retention of the child in the home.

SUPPORTED EMPLOYMENT:

A service provided to the SED youth and the employer which assist the youth in adjusting to the job including training for the job, maintaining good work habits, and assures the employer of reliable help while assisting the employer in skill development for the management and supervision of the employee.

IN-PATIENT HOSPITAL:

A service provided in a psychiatric hospital or a psychiatric unity of a community hospital which is used as short-term treatment and crisis stabilization requiring medical care and supervision for youth in acute distress, presenting a danger tho him or herself or others.

IN-PATIENT RESIDENTIAL:

A service provided in a highly secure and licensed psychiatric facility which is not a psychiatric hospital or community hospital unit. Treatment is provided for a moderate to long-term time period. Services are provided within the confines of the facility and may include individual, group and family therapy, chemotherapy, education, behavior management, etc.

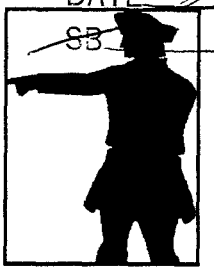
THERAPEUTIC GROUP CARE:

A mental health service which is provided in a home-like environment and may include all of the services of a residential care facility. The home may have from 2 to 12 youth residing in the home at one time. Supervision of the treatment is provided by a qualified mental health professional.

EXHIBIT 6
DATE 2-8-93
SB

Meriwether Lewis Institute

324 Fuller Ave. Suite S-12
Helena, Montana 59601
406-442-7416
1-800-823-7234



Funded in part by NIMH

2/8/93
Testimony for the Institutions and Cultural Education Subcommittee.

Mr. Chairman & Members of the Committee:

My name is Kathy Standard, I have a mental illness, and I'm an ex-patient at Montana State hospital. Last week, when we all toured Warm Springs and Galen, marked a very emotional anniversary for me. It was exactly 3 years since I saw Warm Springs for the first time. On that day, I'd been yanked awake in the predawn darkness of the Kalispell jail. Someone threw clothes at me and yelled at me to hurry and change from jail uniform to street clothes. They quickly handcuffed me and attached my handcuffs to a heavy waistbelt. I was pushed into a sheriff's van that had no heater and I was wearing only jeans & a lightweight jacket. The three hour drive to Missoula through a blinding snowstorm was mighty cold and uncomfortable. At the Missoula jail, I was reminded that I was a prisoner, my waistbelt was removed, and I was put in a cold metal holding cell that was splattered with blood and feces. A few hours later, handcuffed once again, I was CHAINED to 5 large male prisoners who were being transferred to Montana State Prison, and we were crammed into a station wagon. A pistol was waved at us to remind us who was in charge, and we stayed chained until we were inside the prison gates. When I eventually reached the State Hospital, the cops had to pull me from the car and help me walk. I was shaking in terror, both in fear of what was to come and in shock over what had just happened to me. I had NO dignity or self-respect whatsoever left. I'd been isolated in the jail for 7 long days without a shower, I was filthy and I knew that I stunk. My shame was overwhelming.

And my crime? WHAT was my CRIME?? I had relapsed in my mental illness and had become severely depressed and suicidal. I was NOT dangerous to anyone else nor was I in any way violent. I had NOT committed a crime...but I was still treated just like a criminal.

A year & a half later, I made my 2nd trip to Warm Springs - only this time

EXHIBIT 4
DATE 2-9-93

I rode in an airplane. I was calm, clean and fed; I had my own clothes with me; and I enjoyed every minute of the flight. The officer who escorted me was very kind and treated me with dignity, which enabled me to keep my self-esteem.

What made such a DIFFERENCE possible for me? Community-based services are the answer. I was no longer isolated. I had the necessary support to figure out what kind of services would best help me recover. I get teased because I so frequently extoll the virtues of Kalispell's community-based services - but I know them WELL, and those services have twice saved my life. Because these services existed in Kalispell, I was able to obtain a community commitment in 1991, instead of being committed to 90 days at Warm Springs. My community commitment meant that I was able to stay in my <u>own</u> home while receiving the community-based services I so desperately needed... day treatment at Lamplighter House, private psychotherapy, frequent visits with a psychiatrist to stabilize my medication, and PLENTY of support from both staff and my fellow consumers.

Now I'm able to advocate for my fellow mental health consumers. One of the concerns I have is how, especially lately, the media has been taking liberties in bashing people with mental illness. I, for one, am finally getting ANGRY. The Montana public is being told repeatedly that all of us who have a mental illness are dangerous, unpredictable, and crazy. This kind of inflammatory prejudice can make it very difficult for mental health consumers to be accepted in our own communities. I believe everyone in this room knows the REAL statistics - we are no more dangerous than any one of you.

The testimony you will hear today is about REALITY, not about the fiction that is being reported in the press. You will hear from REAL people who struggle with mental illness every day of their lives. Please listen carefully to my fellow consumers as they tell you about the various community-based services that enable us to enjoy life in our own communities. Some of us are even starting new lives after spending years in Warm Springs. Mental health consumers have the RIGHT to receive treatment in the least restrictive environment. We are only asking for the CHANCE to reach our full potential as human beings. WE are the experts on living day in & day out with mental illness. If you will just LISTEN to us, we can tell you what we need to be able to take charge of our own lives and REACH our individual potential.

Thank you ...

EXHIBIT 5
DATE 2-8-93

THERAPEUTIC FOSTER CARE:

A service which provides treatment within the context of the treatment home with the foster parents serving as the primary therapists and supervision of the treatment provided by a qualified mental health professional. This service is limited to no more than 2 youth in the home at one time. Support services provided by community resources may include individual and group psychotherapy, chemotherapy, education, parent training, etc.

CONCLUSION:

OUR EXPERIENCE IN PROVIDING SERVICES TO CHILDREN AND ADOLESCENTS WITH SEVERE EMOTIONAL DISTURBANCE HAS FOUND THAT NO SINGLE AGENCY OR PROVIDER IS ABLE TO MEET ALL THE NEEDS ESSENTIAL TO EFFECTIVE TREATMENT OF THE SED YOUTH.

OUR EXPERIENCE HAS FOUND THAT PARENTS OR PARENT SUBSTITUTES CAN AND SHOULD AND MUST BE A FULL PARTNER IN THE PLANNING AND DELIVERY OF SERVICES TO SED YOUTH BASED UPON THEIR STRENGTHS.

OUR EXPERIENCE HAS FOUND THAT AN EFFECTIVE SYSTEM WILL ONLY BE DEVELOPED THROUGH A PARTNERSHIP COMPRISED OF STATE AND LOCAL GOVERNMENT, PARENTS, EDUCATION, AND PRIVATE PROVIDERS.

OUR EXPERIENCE AND THAT OF OTHER STATES INDICATES WE ARE IN THE SITUATION OF "PAY ME NOW OR PAY ME LATER" AND WHEN IT IS LATER IT IS VERY LIKELY IT WILL BE "PAY ME MORE".

EXHIBIT 4
DATE 2-8-93
SB

MONTANA COUNCIL OF
MENTAL HEALTH CENTERS
324 FULLER AVENUE
HELENA, MT 59601
(406) 442-7808

February 8, 1993

Testimony to the Joint Appropriations Subcommittee on Institutions & Cultural Education
by Kathy McGowan
Representing the
Montana Council of Mental Health Centers

Mr. Chairman and members of the Subcommittee, my name is Kathy McGowan. I am here representing the Montana Council of Mental Health Centers. I thank you for the opportunity to be here today.

My remarks will be brief because what you will hear from those who have joined me here today will be much more meaningful and informative than anything I could tell you.

Our major objective today is simple. We want you to have a clear understanding of the importance of community-based mental health services. You will receive that information from a variety of perspectives. We additionally ask that funding for community mental health not be diminished. If we are supplied with the tools to do the job, we know we can meet your expectations.

We are pleased and proud of the progress we have made in establishing community programs in response to a variety of needs: Programs to accommodate consumers moving from the State Hospital to a community setting; community programs for children, adolescents, and families in crisis; and services to those individuals and families that are experiencing temporary but very real crises in their lives.

We also are pleased to report that we have seen a steady move beyond the "we/they" mentality to an honest desire on the part of providers across the human services system to design and provide services that will best serve consumers. Mental health centers increasingly have joined in a partnership with the Montana State Hospital, with the Department of Corrections and Human Services, with the Department of Family Services, with law enforcement, with consumers and family members and many others. The results are gratifying.

We think that the most important perspective we can offer you today is that of the consumer of mental health services. It wasn't difficult for me to find consumers who wanted to come to share their stories and their very valuable insights with you. I especially appreciate their contributions and I know you will, too. Last week

EXHIBIT 7
DATE 2-8-93
SB

Senator Beck asked, "What is mental illness anyway?" These people are the experts who can answer your question, Senator Beck.

Because I have gathered that you like to hear from the "people who really do the work," several of them are present as well.

Two representatives of local mental health boards also are here to provide information. Howard Gipe from Kalispell and Art Kleinjan from Chinook will provide you with insight from a local perspective.

The Directors of the Mental Health Centers are present to answer either global questions or questions more specific to individual mental health regions. Paul Meyer, Director of the Western Montana Mental Health Center will specifically address the impact of a proposed cut to non-seriously ill adults.

Most of our emphasis today will be concentrated upon services to adults with serious mental illnesses because in recent times that has been the major focus of this Subcommittee. Most recently, during the January 1992 Special Session, you appropriated $1 million to community programs in order to be in compliance with the Ihler decision. We want you to know that we have worked hard at every level to make sure those programs are working. Consumers, family members, the State Hospital, advocates, community mental health centers and many others have invested a great deal of time and energy to help these folks succeed in the community.

Dan Anderson already has provided you with an overview of the mental health system and has distributed materials describing activities and statistics. I will not repeat what he has said because I think we should concentrate upon the human element today. That human element is here and they are anxious to share their insights and to answer your questions.

If you have questions in the coming days or weeks, please do not hesitate to call me or stop me in the halls. If I do not readily have an answer to your question, I will make sure to get it for you.

Again, thank you.

EXHIBIT
DATE 2-8-93
SB

Meriwether Lewis Institute

324 Fuller Ave. Suite S-12
Helena, Montana 59601
406-442-7416
1-800-823-7234

Funded in part by NIMH

2/8/93
Testimony for the Institutions and Cultural Education Subcommittee.

Mr. Chairman, members of the Sub-Committee, for the record my name is Patrick Pope. I serve as Director of the Meriwether Lewis Institute. I have a diagnosis of mental illness. I am an ex-patient of the State Hospital and also receive community based mental health services.

There are many consumers who wish to be heard by you today. As you listen to their testimony, I think two things will become very clear to you. The first is that untreated, mental illness can rob us of the ability to respond to the world around us. Many of us become very isolated and when we live in isolation we don't have the inner resources to manage everyday activities that most people take for granted. Like feeding ourselves, taking care of our hygiene, managing our money, finding housing or holding a job.

The second thing that will become clear is that community based services are most often the way that we learn to come out of our isolation. Services such as casemanagement, crisis intervention, and day treatment provide us the opportunities to build our inner resources and begin to take charge of our lives.

And that is all we ask as mental health consumers: **We want the opportunity to take charge of our lives.** **We do not want to be dependent on the system for the rest of our lives.** Without effective community based services many of us would retreat into isolation and lose the ability to manage our lives.

EXHIBIT 5
DATE 2-8-93
SB

Montana Consumers created and developed the Meriwether Lewis Institute. For those of us who founded the organization, it was Community Based Services that helped us take charge of our own lives and as a result we were able to see that our experiences could help other consumers. WE ARE LEARNING HOW TO SUPPORT EACH OTHER AS WE COPE WITH OUR ILLNESSES. Services from the Mental health Centers give us the strength to keep going. Our focus at the Institute has not been to overly criticize, or tear down the mental health system. Our efforts have been directed at working together with the system for positive change. I have been actively involved with the consumer movement for three years now. During that time I have witnessed first hand the thousands of volunteer hours provided by Montana consumers on a local, state and national level. We provide education, technical expertise and consumer perspective as we serve as members of Board of Directors, committees and task forces.

This is only one example of what happens when we are given the opportunity to take charge of our lives. We become concerned citizens. We learn that we have something to offer and that we can give something back to our communities. Where before we felt our lives have been hopeless, we have become hopeful.

I urge you to listen to the testimony of consumers here today. Remember our faces when you make your decisions. Remember that it is our lives that are at stake here.

We understand that Montana is having financial difficulties, But do not give into the temptation to cut any Community Based Services. Please, look at long term effects. Do not try and meet the short-term goal of balancing the state budget by forcing consumers back into isolation. Please, make the commitment to support us in our efforts to take charge of our lives. Each of us has the right to dignity, compassion and the chance to find our place in this world. Thank-you!

MISSOULA TRANSITION TEAM

EXHIBIT 1
DATE 2-8-93

MSH STATS

	CLIENT #	BED DAYS PRIOR	ACUTE CARE SINCE MSH	DAYS IN COMMUNITY	RETURNED MSH	RETURN COMM
1	22807	2843	37	667		
2	36005	1016	1	359		
3	22648	2363	19	725		
4	23314	776	0	781		
5	30585	7132	24	623		
6	30580	2406	0	878		
7	21343	697	8	724		
8	30583	8255	0	419		
9	30525	649	16	278	Oct-91	Disch Pend
10	22416	1321	19	699	Jan-93	
11	30570	14745	3	864		
12	30579	3774	0	174	Jul-91	Butte
13	36004	4567	10	63	Feb-92	Disch Pend
14	29175	5556	0	746		
15	30783	8197	0	6	Jan-92	Butte
16	30581	1192	0	416	MSP	
17	36006	211	7	383		
18	35620	1888	33	136		
	TOTAL DAYS	67588	177	8941		
	IN YEARS	185.2	0.5	24.5		

1 Of the 18 long term patients discharged, 5 have been rehospitalized at MSH. Of those 5, two have been discharged to Ihler programs and two others have discharges pending

2 Consumers report a good quality of life and have access to needed support services 7 days a week. Often these services are in their home.

3 Eleven of the 18 have needed short term community hospitalizations for which medicaid pays.

4 Nine of the 18 have achieved some form of part-time employment in the community.

EXHIBIT 8
DATE 2-8-93
SB

FEBRUARY 2, 1993

DEAR _____,

MY NAME IS STEVE NEIL. I AM A IHLER CONSUMER. I RECEIVE CASE MANAGEMENT SERVICES IN THE ANACONDA COMMUNITY. I HAVE HAD 10 ADMISSIONS TO THE MONTANA STATE HOSPITAL FROM 1985 TO 1992.

I FIND CASE MANAGEMENT SERVICES BENEFICAL AND COMPLETE. MY CASE MANAGER HAS ASSISTED ME WITH FINANCES, HOW TO GROCERY SHOP, ARRANGED MEDICAL SERVICES AND HOW TO, IN GENERAL,MANAGE A HOUSEHOLD.

IN ADDITION, IT HAS PROVIDED ME WITH BACK-UP COMMUNITY SERVICES IF THINGS GET BAD FOR ME SUCH AS PSYCHOLOGICAL COUNSELING, SILVER HOUSE, AND GILDER HOUSE, IF NECESSARY.

SINCERELY YOURS,

Steve Neil

EXHIBIT 9
DATE 2-8-93

Testimony of Ann B. Miller:

My name is Ann Miller & I'm from Butte I was commited to Montana State Hospital May 16, 1966. I stayed in the hospital for 11 years. I have been living in the community since 1976. I have belonged to Silver House in Butte since 1986. Before Silver House, I participated in the other community support system

I like Silver House as I get my medications there

I like to work as a helper in the Thrift Store. I can get acquainted with customers. I enjoy selling & sorting clothes.

I participate in the groups offered at Silver House. I learn from them & gain benefit from them.

I enjoy coming to Silver House for the fellowship, friendship & support from staff & members. I am a member of the Butte Chapter of the Meriwether Lewis Institute & attend all of their meetings

EXHIBIT 9
DATE 2-8-93

Pg 2

IF THERE WAS NO COMMUNITY SUPPORT PROGRAM IN BUTTE, I WOULD SIT & ARGUND AND MOPE & BE DEPRESSED AGAIN.

Tom B Muller
2-8-93

EXHIBIT 10
DATE 2-8-93
SB

MENTAL HEALTH SERVICES, INC.

OFFICES

REGIONAL HEADQUARTERS ADMINISTRATION
512 Logan
Helena Montana 59601
(406) 442-0310
FAX# (406) 443-7011

ANACONDA
(Rm. 211, First Security Bank Bldg.)
P.O. Box 978
Anaconda, Montana 59711-0978
(406) 563-3413

BOZEMAN
614 W. Lamme
Bozeman, MT 59715
(406) 586-4090

BUTTE
501 E. Front Street
Butte, Montana 59701
(406) 723-5489
FAX# (406) 782-4020

Gilder House
2460 Kossuth
(406) 723-7104

Silver House
106 W. Broadway Street
(406) 723-4033

DILLON
234 E. Reeder
Dillon, Montana 59725
(406) 683-2200

HELENA
512 Logan
Helena, Montana 59601
(406) 442-0640

Center for Sexual Health
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
815 Front Street
(406) 442-9902

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

Mountain House
124 S. Second, P.O. Box 119
(406) 222-8202

STUART KLEIN, MA
EXECUTIVE DIRECTOR

SHARON GREEN.

MY TESTIMONY

When I first went in to mental health I was only 18 years old and I had nothing wrong with me.

My mother had died of cancer, and I must mourn her death. Only I felt cheated by the system. I was given medications, and I decided right away they were making me ill. This was 22 years ago, in 1971.

It seemed as though I never could cry about my mother's death. Although I started to walk in her memory, about her, that forgiveness must come with wisdom and understanding.

I had promised that I would quit "street drugs" and even no coffee, no cigarettes, until I could cry and again .....a mysterious will came into the making.

I've had very, very bad luck with state institutions. Almost no help at all and severe punishments, mostly Warm Springs was like that.

For a long time I didn't believe in mental health. I didn't believe in the medications, and I thought they made me ill, and I didn't believe in the system at all. I often felt like a "lost soul" I thought in the state institutions I would never find the help I needed.

EXHIBIT 10
DATE 2-8-93
~~SB~~

A NEW LIFE IN 1986

WARM SPRINGS

At Warm Springs institution I was often thrown into isolation for no reason I would know of. I was locked up for days, weeks, and months, no kidding!! Even once for 3 months and once for 4 months. I was restrained until I was glad to be alone. Until I started "playing games" to get coffee and cigarettes in the seclusion room. This was my greatest fun.

I was driven and beat by staff until I started pulling hair of the staff and patients, but always for a reason that I must fight to survive. I was poor, cold, tired, hungry, and needy. I wasn't the only one. I was frozen to death in a seclusion room and forced to wait for hours for a blanket.

I often walked and lived....hysterically, scared, with exceeding fear of "what would come next?" I thought I was going to break.

I needed a way to escape, but I know I was locked in with no way out.

EXHIBIT 10
DATE 2-8-93
~~SB~~

Once they made us line up to brush our teeth, or we couldn't have a smoke. It was really hard, but I ran into the shower in my nightgown and turned the water on. I sat there yelling that I didn't want to brush my teeth and that I was sorry. It took 6 of them to drag me to the seclusion room, and they threw me in and locked the door. I didn't get out until the next morning. I slept on the floor that night by the door. There was no bedding, no pillow, no blanket, I was in a wet nightgown. After two hours they threw me a dry nightgown.

A terrible feeling of being isolated came to me again and again, as they locked me away repeatedly with no sign of light and for 3 days at a time. Again, they wouldn't tell me why.

Then one day I asked if I could rest in one of the seclusion rooms. For 3 days I had 2 puffs of 2 smokes that day. Then for 5 days I had no puffs at all.

They took me to a clinic and they asked me if I wanted to quit smoking for good. I replied "no thank you", but I do want to be a "Lady Jesus" in Russia.

This was during the Reagan administration.

EXHIBIT 10
DATE 2-8-93

After all I had been through the problems of survival in an institution had only begun.

They did not discharge me when I quit smoking for 5 days. Instead they decided to "treat me". They sucked out my mind, (a mind of Christ Jesus), and gave it to a mentally retarded girl. Then they put her brain in mine.

This was much like the cartoon when the psychiatrist put the chicken and man and pulled the switch to exchange their brains. This was very painful for me.

Almost immediately I started running wildly, drinking tap water. I couldn't stabilize. I drank 8 to 10 glasses of water at a time, several times a day. I was frantic. I needed coffee and cigarettes and I was wildly drinking this water.

I had to learn for my heart to take over because I couldn't depend on my mind at all. I must have worked my heart very hard, for a very long time.

Around this time the Law Courts began to make their move. The first thing they did was hang up the "Patient's Rights" on the wall.

EXHIBIT 10
DATE 2-8-93

I immediately began filing grievances on this highly illegal and abusive treatment. I was contacted by a lawyer Allen Smith, who walked with me the rest of the way to get out.

One of the first responses from the staff "to handle me" was to inject me with LSD, to make me one of them, instead of me and Jesus. I didn't think any of them knew Jesus personally. All they seemed to know was drugs and killings.

THE NEW BUILDING

This was a new hope and beginning for all of us, but eventually it was only a trap with no escape. We were highly secured and locked in.

Everyone liked it for the first year. Still I was often locked in seclusion security rooms. I kept reading my Bible and kept drinking water, now enormous amounts. Pretty soon 3/4 of the patients were drinking tap water because we were all so delusional it was our way of "freaking out". I drank until I threw up, so did they.

At one point Dr. X violated my body while I was in blood. He also put instruments in my hands because I had been reading Hebrew test with my hands.

EXHIBIT 10
DATE 2-8-93
SB

He said he was going to make me 2 years old, so he must put a machine on my heart and extract Jesus and God, so I could start all over. A 2 year old mustn't have this power.

I was terrified at this, I called my lawyer and I told him, screaming and bawling, I never had such a fear of God, though God wouldn't allow it. He is a great God.

This time the staff became hysterically insane about the patients. Their war cry was "We are not going to help them, we are going to kill them." So our black night started. They started targeting on the patients. Soon Satan entered in.

Night shift and a satan bible. They cast witches spells and incantations all night in their hearts. All day long staff killing with carpenter tools. Driving all the patient insane. The hard part was, was that staff wouldn't stop. My mind took a leave of absence, twice. One girl I knew died. Every single patient gave in to insanity. We gave our own battle cry...."Because He lives, we will live also" meaning Jesus Christ.

EXHIBIT 10
DATE 2-8-93

Page Seven: Sharon Gregor

After hundreds of grievances and hundreds of letters. I was given a break, and for this I am very thankful. They gave me a new medication, Clozoril. From the first time I tried it, it was my miracle. Immediately on the first day and now everyday I pick up my bed and walk with Jesus . The medication with Jesus has made me well.

This is my new resolution, "Lord, help me to remember that nothing is going to happen to me today, that you and me can't handle together." My boyfriend, Mike gave this one.

I have been walking with my new medication for 3 1/2 years and now I'm taking some more new medications, Lithium, Prozac, Zantac and I have faith that I will be well too.

The greatest thing that happened to me is Silver House. I finally got there. The people at Silver House are so great, as to how they help their clients. I think I'm believing now.

The groups I go to for therapy:

Open Discussion Group

Stress Reduction and Relaxation

Mental Illness Education Group

Habit Breakers

Imagery

EXHIBIT 10
DATE 2-8-93
SB

Page Eight: Sharon Gregor

Some new groups coming up are:

Quit Smoking

Budget Group

I also attend

Arts & Crafts

Aerobics

We also go on shopping trips and I have many other outside activities and Gilder House is always there for when we are alone.

I think the groups are very, very good for me, I feel feelings like I am getting well, when I attend them.

I feel like mostly all of the staff at Silver House and Gilder House are truly dedicated mental health workers. They have given me so much help. I truly feel loved on a patient/staff relationship and patient to patient too.

They know what they are doing and they know how to care. Everything about the program is brilliant. I want to tell you about my therapist, Joann Moon. She is so smart, she truly understands my problems and helps me with my disability. Sometimes I feel like she is the only one who will ever know how I feel. She even helps me and my boyfriend, Mike in co-therapy.

EXHIBIT 10
DATE 2-8-93
SB

Page Nine: Sharon Gregor

Now, thanks to Silver House I believe in the medication too. Just like a miracle.

Gloria, my ICM worker who runs me all around everywhere, every day or week helped me to buy a new trailer house. How could I ever thank her.

The friends I've made, I've made for a lifetime. God has greatly blessed me and I'm getting thankful for them.

I'm also thankful for the National Guard, who walked in and overtock the hospital at Warm Springs and worked as staff for 2 1/2 weeks in 1991.

I've never seen a greater day of God's Glory when they put the hospital under arrest.

Thank you

Sharon Gregor

EXHIBIT 11
DATE 2-8-93
SB

Southwest Adolescent Day Treatment Program

What? An intense highly structured form of treatment for seriously emotionally disturbed adolescents (SED) serving 18-24 youth (12-18 years) and their families in their home community. It resembles partial hospitalization in its intense individual, family, and group therapy, and in its therapeutic milieu. At the same time, however, it is a cooperative program utilizing resources from Helena School District #1 and Mental Health Services, Inc. so students are able to receive intense treatment in a "less restrictive" and cost effective environment.

Where? 815 Front Street, Helena Mt as part of the Front Street Learning Center of Helena School District #1.

How long? Southwest Adolescent was the <u>first</u> Adolescent Day Treatment program in Montana and has served as a model and resource to programs developed since then. Southwest opened its doors in May of 1986.

Costs? The cost of Day Treatment is considerably less than the cost of residential treatment while providing similar therapeutic services. Here is a comparison of treatment options and costs for typical stays:

SWAT	$75/day	for one year	$18,000

<u>Costs for short term "Crisis Stabilization" hospitals.</u>

Riverdell	$500-$900 /day	for 30 days	$15,000-$27,000
		for 60 days	$36,000-$72,000
Shodair	$750/day	for 30 days	$22,500
		for 60 days	$45,000

<u>Other Long term residential programs for one year.</u>

Yellowstone B&GR	$128/day	$46,600
Rivendell Utah	$170/day	$62,050
Excelsior	$103/day	$37,595
Colorado Boys Ranch	$300/day	$109,500

Total for one year at a residential placement $37,595-$109,500

Our students average four (4) residential placements before they are referred to Southwest at a cost to the state of up to $350,000, for essentially the same services that we provide. While this economic argument for day treatment is compelling we believe that community based day-treatment programs for SED youths is the most effective and least restrictive treatment option available.

EXHIBIT 12.
DATE 2-8-93
SR

February 8, 1993

My name is Barbara Barnes. I am an Intensive Case Manager with the Ihler program. I work for Helena Community Support Services through Mental Health Services. I am one of the case managers who works with persons re-entering the community from Warm Springs State Hospital. I also work with people who have been previously hospitalized and need extra support to avert further hospitalization.

Our caseload in Helena includes 8 women and 8 men, whose cumulative hospitalizations in Montana totals 123 years. It is my privilege to work alongside these individuals in order to prevent further hospitalizations. Eleven of those on our caseload are actively working toward re-joining their families, as siblings, parents, spouses, and children who were separated through the events of their hospitalization.

Since August, I have witnessed people come out of the hospital, get into their own apartments, and begin the long trek back into a community that previous to the Ihler program seemed overwhelmingly impossible to navigate with either no case management or limited case management and club house support.

In the past, the individuals who are on our caseloads were unable to stay out of Warm Springs State Hospital for longer than four days to two months. Now, these same people have been out of the Hospital and living in the community for nearly six months. They are living independently, receiving treatment at Montana House and intensive support from their case managers.

My job as a case manager is to assist in the empowerment of each person on my caseload. It is working. I see people who have come from the hospital after up to 15 years of hospitalization, now able to write their own checks, budget their own funds, successfully volunteer their help in the community, attend school and for some, begin the process of seeking employment. Empowerment means that eventually these individuals will require less and less assistance from their case managers, and will be able to live more confidently in the community. Another part of my job is preventing future costly hospitalizations. These are costly to all of us as taxpayers, and on a very real level, they can be extremely emotionally and spiritually costly to the person going back to the hospital. Through regular contact with persons on my caseload, I can spot problems and most times, assist in taking caring, proactive steps that will detour that costly hospitalization. It is working. It is less expensive, it is very humane.

EXHIBIT 12
DATE 2-8-93
~~SB~~

I want to leave you with a quote from a person that I am currently assisting in transitioning into our community after 12 years of nearly un-interrupted hospitalization. Not to long ago after balancing his own checkbook, arranging to purchase a vehicle and beginning to feel more a part of the "outside" world, he said to me, " Barb, I'm just a citizen waiting to happen." There are many citizens waiting to happen, and through our community based programs, I see them transforming each day, and each day, costing us less and less time and money to support, while they begin to successfully transition into their new and hopefully permanent homes.

Thank you for your time today.

Barbara Barnes

EXHIBIT 13
DATE 2-8-93
SB

February 8, 1993

My name is Mona Shepheard, I am a consumer of services from Mental Health Services Inc. through the Ihler Case Management Program.

With daily contact and daily support from the case management and the Montana I have successfully stayed out of the hospital and have been able to continue working on a more steady basis at the Mental Health Association, as a volunteer.

I realize I am not quite ready for a full time permanent job placement and with the fact that I've been hospitalized for about one third of my life, it may be awhile. But with the daily contact with my case manager and the support of the Mental Health workers that have been counselling me and seeing me I have been successful in ways I never knew I could.

The most important thing is that with just having psychiatric therapy once or twice a month, as it had been in the past I had no contact or help with emotional problems every day. If I at that time had a crisis I either ended up in the hospital or what might have been a successful attempt at suicide because the majority of the private therapists are not working on weekends, holidays or evenings as the Ihler case managers are.

Case management has helped me deal with the stress of family life and has involved my husband in my treatment. When I was hospitalized my family went to pieces and it really ruined us. With case management I'm learning about my dependencies on them and most important my steady improvement is putting my family unit back together in a normal way.

Thank you for your time.

Ramona J Shepard

EXHIBIT 14
DATE 2-8-93
SR

For the record, my name is Michael Fraser.
From the period of October of 1988-April of 1989 I experienced a period of severe depression and panic attacks and was hospitalized repeatedly in the Support Center at St. Pete's here in Helena. I had no money to pay for my time there and the hospital bills were picked up by the State Medical program. It became obvious that I needed long term services and came very close to going to the Warm Springs State Hospital. In April, I learned of the Montana House, a day treatment program for adults experiencing a mental illness. I became a member there, and with the help of my very supportive case manager, began to learn to live again without hospitalization. I could go to the Montana House during the day and connect with people and find something to do that got my focus of the depression I was experiencing. My point here is, COMMUNITY BASED SERVICES WERE VITAL TO MY RECOVERY AT THAT TIME, without them, I believe I would have required the much more restrictive and costly hospitalization. I was able to recover and grow within the community, to go home and night and be with members of my family, to stay connected with friends, and to things I loved to do, like go fishing.

There were very basic living skills that I had not learned, (even though at that time I had made it through two years of college) which I needed and I learned at Montana House-connecting with others who cared, asking for what I needed, managing my time, learning that I had gifts and could be a valuable part of a community, the value of work and play in life-- With the support of the Montana House program, I gradually began to build a life that I could call my own.
Eventually, I even returned to college and got my degree in psychology.

I have seen the lives of many like myself be transformed by state funded programs like Montana House. I am grateful to have the opportunity to pass on to others some of the support I got now as a staff member there. Every day I see miracles occur as people who have struggled with the deep wound of having a mental illness grow and blossom and see their gifts and live their lives. These people need fertile soil to grow in, in their own time and in their own way. Without services like Montana House provides, day treatment, case management and intensive case management and therapy, the people who need these services like I did several years ago, lives will be drastically affected. If the services provided by Montana House were not available to me when I so needed them, my life, especially the quality of my life would have been much different. And so it is with many like me right now, I believe to remove services like the Ihler funding would affect the quality of life of many individuals like day to night. The difference between living in a community with caring individuals that support and nurture you and help you LIVE life and living in a hospital or alone, or on the streets is undeniably extreme. To cut funding to

EXHIBIT 14
DATE 2-8-93
~~SB~~

community based services could create these very real very extreme changes in the lives of many people who deserve to live, and the support they need to do that.

Thanks for your time!
Mike Fraser

HOUSE OF REPRESENTATIVES
VISITOR'S REGISTER

_____ COMMITTEE BILL NO. _____

DATE 2-8-93 SPONSOR(S) _____

PLEASE PRINT **PLEASE PRINT** **PLEASE PRINT**

NAME AND ADDRESS	REPRESENTING	SUPPORT	OPPOSE
Kenneth Kleven	Golden Triangle Community Mental Health		
Kenneth L. Arnold	Great Falls		
John Lynn	Reg V CMHC		
Steve Kern	Region III CMHC		
Frank Shaw	Region I CMHC		
Neal Smith	Great Falls		
Kerry Moore	Board of Visitors		
KATHY STANDARD	MERIWETHER LEWIS INST		
Steve Nail	Eagle Consumer Advocacy		
Barbara Muske	Butte Community Mental Health		
Gordon Wooden	M.H.T.		
Art Kleinjan	Golden Triangle Reg 2 CMHC		
PAT FOX	MERIWETHER LEWIS INST.		
CANDACE BUTLER	KALISPELL COMMUNITY SUPPORT Program		

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

Visitor's Register

DATE 2-8-93

~~SENATE COMMITTEE ON~~

~~BILLS BEING HEARD TODAY~~:

Name	Representing	Bill No.	Check One Support	Oppose
Noel Drury M.D.	W. MT Reg. Com Mental Health			
Bill Hensleigh, Client	" " " " "			
Howard W Gipe Commissioner	" " " " "			
Paul Meyer	WMRCMHC			
Ann B Miller	[illegible]			
Ramona [illegible]	[illegible] case management program			
Barbara Barnes	Montana Mental Health Services			

VISITOR REGISTER

PLEASE LEAVE PREPARED STATEMENT WITH COMMITTEE SECRETARY

F10

HOUSE OF REPRESENTATIVES
VISITOR'S REGISTER

_____ COMMITTEE BILL NO. _____

DATE 2-8-93 SPONSOR(S) _____

PLEASE PRINT **PLEASE PRINT** **PLEASE PRINT**

NAME AND ADDRESS	REPRESENTING	SUPPORT	OPPOSE
LORENE FRIGAARD	Mental Health - Anaconda Services Inc.		
Barbara Barr	Consumer/Anaconda MHS.		
Harold E. Gerke	M.H. Center - Bldg.		
Hank Hudson	DFS		
[illegible]	DCHS CASSP		
Cliff Stockton	SWAT		
Kathy Weingart	SWAT		
Sarah R. Smith	SWAT		
Christine Jacques	SWAT		
Jeff Folon	SWAT		
Jessica Wang	MT Committee for ED Children		
DAN Anderson	[illegible]		
Fatima Amelkin	Mental Health Services / CSH Helena		
[illegible]	Silver Bow Lewis & Clark Butte		

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

HOUSE OF REPRESENTATIVES
VISITOR'S REGISTER

_____ COMMITTEE BILL NO. _____

DATE 2-8-93 SPONSOR(S) _____

PLEASE PRINT PLEASE PRINT PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	SUPPORT	OPPOSE
Cheriann (Sharon) Dreyer	Silver Bow Area Council		
Cindy Barting	Services-Friends To Youth Mslm. Co. SED Childrens		
Marty Onishuk	Mont. Alliance for Mentally Ill		

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