# MINUTES

## MONTANA HOUSE OF REPRESENTATIVES
## 54th LEGISLATURE - REGULAR SESSION

## JOINT SUBCOMMITTEE ON LONG-RANGE PLANNING

**Call to Order:** By **CHAIRMAN ERNEST BERGSAGEL**, on February 14, 1995, at 7:00 A.M.

### ROLL CALL

**Members Present:**
Rep. Ernest Bergsagel, Chairman (R)
Sen. Ethel M. Harding, Vice Chairman (R)
Sen. B.F. "Chris" Christiaens (D)
Rep. Matt McCann (D)
Rep. Tom Zook (R)

**Members Excused:** NONE

**Members Absent:** NONE

**Staff Present:** Nan LeFebvre, Office of the Legislative Fiscal Analyst
Jane Hamman, Office of Budget & Program Planning
Tracy Bartosik, Committee Secretary

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

**Committee Business Summary:**

| | |
|---|---|
| Hearing: | HB 15: DEPARTMENT OF LABOR AND INDUSTRY; DEPARTMENT OF CORRECTIONS AND HUMAN SERVICES - MT STATE HOSPITAL |
| Executive Action: | DEPARTMENT OF LABOR AND INDUSTRY |

### EXECUTIVE ACTION ON DEPARTMENT OF LABOR AND INDUSTRY

**Mr. Jim Hill, Job Service Division of the Department of Labor and Industry,** gave the committee a brief overview of the proposed expansion of the Havre Job Service. He stated that this project was originally in HB 5, but was removed from that bill to be amended into HB 15 because the Department didn't have the money to afford the project in one year out of operating expenses. **EXHIBIT 1.**

**SEN. CHRISTIAENS** asked how much the Department can afford to pay for the project per year. **Mr. Hill** stated that the Department is looking at a 15-year bonding program in which they would pay

approximately $35,000 per year in debt service, which he says the Department can afford to do.

**Motion**: **SEN. CHRISTIAENS** moved to approve the amendment authorizing the expansion of the Havre Job Service in HB 15 for $350,000.

**Discussion**: **REP. ZOOK** stated that this is a project that he can't support because he feels the Federal dollars will be flowing in slower and slower over time and he also feels that the Job Service is an area which can be privatized.

**SEN. CHRISTIAENS** stated that with the large move toward welfare reform and the emphasis on jobs, the functions of Job Service are extremely important.

**Vote**: **The motion carried 3-2 with REP. ZOOK and CHAIRMAN BERGSAGEL voting no.**

*{Tape: 1; Side: A; Approx. Counter: 198;}*

## HEARING ON
## DEPARTMENT OF CORRECTIONS AND HUMAN SERVICES

**Mr. Rick Day, Director of the Department of Corrections and Human Services,** gave the committee an overview of the proposed plan to improve and consolidate the Montana State Hospital. **EXHIBITS 2, 3 and 4** He stated there are three primary reasons for the Department's recommendation for the rebuilding of the Montana State Hospital. These are:

1) improved patient care through a new facility and accredited services,

2) cost savings by related FTE reductions and the ability to shift resources, and

3) this is the only project of its kind where one facility can be built to accomplish two goals: provide a new efficient State Hospital, and obtain a 200-bed correctional facility.

**Mr. Day** stated that the Department would be able to repay the loan through the savings which would result from operating from a consolidated facility. He also stated that the cost of the proposal would be approximately $21 million and the new facility would be completed around the year 1999. **Mr. Day** said the new facility could be completed without the need to relocate patients during construction. **Mr. Day** stated he wanted to emphasize that although managed care has been considered in this project, the project is not contingent upon managed care. He also stated that the FTE level over the term of this project will be reduced by at least 150 by the year 1999. Through consolidation of campuses and patient reduction, there will be a projected annual budget

reduction for the Montana State Hospital of $7 million starting the year that construction is completed.

**Mr. Dan Anderson, Administrator of the Mental Health Division of the Department of Corrections and Human Services,** provided information to the committee comparing Montana's mental health expenditures and programs to those in Western Massachusetts. **EXHIBITS 6 - 11**

*{Tape: 1; Side: B;}*

**SEN. CHRIS CHRISTIAENS** asked **Mr. Anderson** what states currently have managed care in place. **Mr. Anderson** stated he couldn't fully answer that question, but stated that certain states have different levels of managed care in place.

**CHAIRMAN ERNEST BERGSAGEL** questioned what the completion date of the project would be if the legislature were to approve it. **Mr. Anderson** stated that completion would occur in 1999, and that completion date reflects occupancy of the facility.

**Dr. Paul R. Ahr, Ph.D., National Mental Health Advisor for Ernst & Young,** testified and provided written informational testimony to the committee. **EXHIBIT 12.**

*{Tape: 1; Side: B; Approx. Counter: 565;}*

**SEN. CHRISTIAENS** asked for information regarding the Hawaii Quest Program. **Dr. Ahr** stated that the Hawaii Quest Program was put into place late last summer. This program is designed to help the seriously disabled mentally ill. An individual who is identified as seriously disabled mentally ill would be referred to a mental health managed care program. Anyone lacking that designation is treated in the regular managed care program. Those individuals who cannot be cared for in either one of those situations would be cared for in the state hospital. The Quest program is based on a community support program model. Hawaii is presented as a prototype situation for managed care because 96% of their population is already covered by insurance.

**SEN. CHRISTIAENS** asked how the state would be able to do both the community-based things that are being recommended, and also build a $21 million State Hospital. **Dr. Ahr** stated that studies show that reductions in funding for state hospitals tend to result in monies not going into community-based programs.

*{Tape: 2; Side: A;}*

<u>Proponents' Testimony</u>:

**Ms. Ginny Hill, Psychiatrist at Montana State Hospital,** spoke in support of the plan to rebuild the state hospital. She stated that the hospital needs improved safety and handicapped access.

She also stated having units closer in proximity to each other would improve staff responses to emergencies.

**Mr. Robert W. Olsen, Montana Hospital Association,** spoke and provided written testimony in favor of the new Montana State Hospital. **EXHIBIT 13. Mr. Olsen** also submitted letters of support from **Jack Burke, Vice-President Patient Care Services, St. Patrick Hospital; Libby Artley, Director Deaconess Psychiatric Services; Bonnie Adee, Manager, Behavioral Health Services at St. Peter's Community Hospital; William F. Diers, President, Kalispell Regional Hospital, and Kirk Wilson, Jeanne Garcia, K. Jane Bailey, and Randall L. Mee. EXHIBIT 14.**

In response to a question raised by **SEN. CHRISTIAENS, Mr. Olsen** agreed that mental health patients need to be treated in the least restrictive environment possible, but he said the treatment must also vary according to the patient's needs and the severity of their case.

*{Tape: 2; Side: B; Approx. Counter: 508;}*

**REP. ZOOK** questioned if **Mr. Olsen** would agree that there will always be a certain number of patients in need of a more secure environment, such as a state hospital. **Mr. Olsen** agreed.

*{Tape: 2; Side: B; Approx. Counter: 730;}*

**Ms. Linda Hatch, Executive Director, Golden Triangle Community Mental Health Center,** spoke in support of the campus reconstruction and redesign of the Montana State Hospital. She stated her center believes that there will always be a need for a state hospital, therefore the state hospital should supply the best care possible for those patients. She said the Montana State Hospital is not licensed by the Health Department, and will need to become licensed in order to obtain the Medicaid waivers that the SRS is asking for if the state is to operate under mental health managed care. It is the overall poor condition of the buildings and the campus which prevents the hospital from being accredited and receiving Health Department licensure.

**Ms. Hatch** stated that cost-effectiveness at the Montana State Hospital is a problem. The state is providing the staff to maintain 80 to 90 structures on a campus of 380 acres. This size of campus is no longer needed and hasn't been needed for years. The hospital is using 400,000 square feet to operate when only 150,000 is needed. The hospital also has very high energy, maintenance, housekeeping, and patient transportation costs.

**Mr. Dennis Lawlor, patient at Montana State Hospital,** stated he has lived at Montana State Hospital for approximately 30 years, and feels the aesthetic qualities of the facility are almost completely lacking. He stated that the buildings are approximately 100 years old, and are spread out over a large area, making it difficult to "do things under one roof."

*{Tape: 3; Side: A; Approx. Counter: 925;}*

**Ms. Terry Minow, Montana Federation of State Employees,** spoke in favor of the rehabilitation of the state hospital. She stated that although the proposal would result in a reduction of employees, the benefits and working conditions at the hospital would be much improved.

**Mr. Jeff Stern, Golden Triangle Community Mental Health Center,** voiced his support of the proposal and provided written testimony. **EXHIBIT 15.**

**Ms. Nancy Cobble, St. Peter's Community Hospital,** voiced her support of the proposed improvements at the Montana State Hospital campus.

*{Tape: 3; Side: A; Approx. Counter: 135; Comments: Some of the proponents' testimony is not recorded between tape 2 and tape 3 and, thus, is not reflected in these minutes.}*

Opponents' Testimony:

**Mr. James Larson, patient at Montana State Hospital and President of the Warm Springs Consumer Group,** provided the committee with written testimony in opposition of the proposed rehabilitation of the State Hospital campus. **EXHIBITS 16 and 17**

**Ms. Andree Larose, Montana Advocacy Program,** voiced opposition to the proposal and requested the committee listen to testimony provided by **Mr. Mark Mitchell.**

**Mr. Mark R. Mitchell, Deputy Area Director, Western Massachusetts Office of the Department of Mental Health,** provided informational testimony to the committee in regard to Massachusetts' programs and policies on mental health issues. **Mr. Mitchell** also felt the state of Montana should look at options other than the rebuilding of the Warm Springs campus. **EXHIBIT 18**

**Ms. Kayleen Jones** spoke in opposition to the reconstruction of the Montana State Hospital.

**Ms. Margaret Murphy, Member of the Montana Mental Health Planning and Advisory Council,** read a letter written by the council to **Mr. Rick Day.** The letter stated the Montana Mental Health Planning and Advisory Council opposes the present plan proposed by the Department of Corrections and Human Services given the unknowns of the development of the managed care system and the serious concerns regarding the location of the Montana State Hospital. **Ms. Murphy** stated that the Department did not consult the Council until after the plans were underway.

**Dr. Nathan Munn, Helena Psychiatrist**, spoke in opposition to the reconstruction of the State Hospital at Warm Springs. He stated that there are both risks and benefits on both sides of this

issue. With the advances in the mental health field, there is a need to provide treatments which emphasizes keeping those individuals with mental illnesses in the community.

**Mr. Patrick Pope, Executive Director of the Meriwether Lewis Institute,** stated that he was also a past patient of the Montana State Hospital. He read a letter of opposition from the Billings Chapter of the Meriwether Lewis Institute. **Mr. Pope** stated that it was time Montana moved from being "caretakers" of the mentally ill and start putting people back into the communities.

**Ms. Marty Onishuk, Vice President, Montana Alliance for the Mentally Ill,** provided written testimony to the committee opposing the rebuilding of the State Hospital. **EXHIBIT 19**

**Ms. Sophie Manley** submitted written testimony in opposition to the proposal. **EXHIBIT 20**

*{Tape: 3; Side: B; Comments: tape flips in middle of testimony.}*

**Ms. Winnifred Storli, Flathead Alliance for the Mentally Ill,** submitted written testimony to the committee in opposition to building a new, smaller, 110-bed state facility at Warm Springs. **EXHIBIT 21**

**Kathy Standard, President of the Meriwether Lewis Institute,** submitted written testimony to the committee in opposition to the reconstruction of the state hospital. **EXHIBIT 22**

**CHAIRMAN BERGSAGEL** announced that because **SEN. HARDING** would be leaving the meeting, executive action on this topic would probably take place on February 16th.

**Ms. Suzanne Taunt, member of the Helena Alliance for the Mentally Ill,** submitted written testimony to the committee. **EXHIBIT 23**

**Ms. Andree LaRose** submitted and read to the committee a letter in opposition written to **Ms. Mary Gallagher** by **Mr. Robert M. Ross. EXHIBIT 24**

A letter opposing the rehabilitation of the Warm Springs campus was submitted by **Mr. Paul Meyer, Executive Director Western Montana Mental Health Center. EXHIBIT 25**

**Mr. David Hemion, Mental Health Association of Montana,** spoke and submitted written testimony to the committee opposing the Montana State Hospital proposal. **EXHIBIT 26. Mr. Hemion** stated that no consumer, advocacy, or professional organizations support the DCHS plan and most oppose it outright. As an alternative to the proposal from the Department, **Mr. Hemion** stated that the Mental Health Association of Montana feels managed care should be given time to generate proposals on how to use Montana State Hospital as part of an integrated public-private mental health treatment system. This treatment system should emphasize less restrictive,

community-based treatment, as required by state law, and also be less expensive.

**Ms. Yvonne Snell,** submitted written testimony. **EXHIBIT 27**

*{Tape: 4; Side: A; Comments: tape flip during testimony.}*

**Ms. Kelly Moorse, Executive Director, Mental Disabilities Board of Visitors,** asked that any decisions regarding Montana State Hospital be delayed until the results and impact of managed care can be weighed.

**Ms. Mary Gallagher, Interim Director, Montana Advocacy Program Inc.,** spoke and provided written testimony to the committee opposing the proposal for the Montana State Hospital. **EXHIBIT 28.** She stated that at this time such a costly and permanent move should not happen without first evaluating the continuum of mental health services and determining how to best provide those services to Montana consumers.

**Mr. Bobby Walton, The Yellowstone Consumer Support Alliance,** submitted written testimony. **EXHIBIT 29**

*{Tape: 4; Side: A; Approx. Counter: 135;}*

Informational Testimony:

**Mr. Denzel Davis, Department of Health,** addressed the licensing issues of the Montana State Hospital. He stated the only current licensed and certified facility was the Spratt Building. The Forensic building is not currently licensed but could be. The Pintlar Lodge and the Intake Unit have some possibility of being licensed with some major renovation. **Mr. Davis** stated the worst building on the campus is the Warren Building, which would require extreme renovation to be in compliance with the current life/safety codes.

**SEN. CHRISTIAENS** asked what kind of a license the Forensic Building could receive. **Mr. Davis** replied the Building could be licensed and certified as a psychiatric unit. In reply to another question by **SEN. CHRISTIAENS, Mr. Davis** stated that the difference between certification and licensure is licensure refers to state statute, and certification refers to federal law. These are essentially the same in terms of criteria.

**CHAIRMAN BERGSAGEL** asked what renovations would need to take place for the Pintlar Lodge and the Intake Unit to be brought up to code. **Mr. Davis** stated an upgrading of the mechanical and electrical systems, additional fire protection, including sprinkler systems and alarm systems, and additional exits would be needed in order for the buildings to be compliance.

*{Tape: 4; Side: A; Approx. Counter: 460; Comments: tape flip during testimony}*

**Ms. Mary Dalton, Primary Care Bureau Chief, Medicaid Division of the Department of Social and Rehabilitation Services,** submitted a handout and provided testimony to the committee on the topic of managed care. **EXHIBIT 30**

*{Tape: 4; Side: B; Approx. Counter: 900}*

**SEN. CHRISTIAENS** asked what kinds of effects, if any, the proposed cuts to Montana Resources Management (MRM) would have in regard to managed care. **Ms. Dalton** stated that the proposed cuts bring the Governor's budget down to the 1994 amounts.

*{Tape: 5; Side: A;}*

In response to a question from **SEN. CHRISTIAENS**, **Mr. Rick Day** stated that the Department of Corrections and Human Services supports consumer advocacy groups, drop-in centers, community services, crisis intervention, and other such entities. The goal is to have an agency that is responsible for both in-patient and community services. The Department tries to balance both and allocate those services and those dollars accordingly. **Mr. Day** said the Department has not changed its perspective on that issue, but does recognize that in-patient service provision is a critical part of that, and the Department needs to ensure that it provides quality, accredited care.

**REP. ZOOK** asked **Ms. Gallagher** for the name of another state which doesn't have a state hospital for acute care patients. **Ms. Gallagher** replied that Vermont was one example.

**REP. ZOOK** stated that in **Ms. Dalton's** testimony she mentioned that managed care would reduce budget growth. He then asked **Ms. Dalton** to explain how. **Ms. Dalton** stated that SRS has taken the trends from 1994 and forecasted them for the next five years. Under the waiver request they will try to replace funding that is currently provided from state general funds with funding that the Department can get a federal match on. She stated that essentially what the Department would be doing is "refinancing" with federal funds. This will enable the state general fund costs to go down.

**REP. McCANN** asked for clarification on the split of the proposed $7 million savings from the rehabilitation of the Montana State Hospital. **Mr. Dan Anderson** said roughly $2 million per year would be used to repay the bonds issued to finance the construction, with the remainder going to alternative services.

**REP. McCANN** asked for an estimated number of "core unit" patients at the Montana State Hospital. **Mr. Anderson** stated the current estimate from the Department is roughly 135 people. The hospital currently has an estimated 200 people and the Department feels safe and appropriate alternative services can be provided for roughly 65 of the average daily population, keeping in mind that patients are admitted and discharged.

**CHAIRMAN BERGSAGEL** mentioned that the building isn't scheduled to be completed until the year 1999 and construction would probably start 1997. He questioned that because there wouldn't be any savings for approximately four years (during construction), and the bonds will be issued prior to occupancy, where are the savings in the two bienniums prior to occupancy that would be used to service the debt. **Ms. Cathy Muri** stated those costs would be covered through a general fund loan.

*{Tape: 5; Side: A; Approx. Counter: 560;}*

**CHAIRMAN BERGSAGEL** stated that the original estimated cost for this project was $18 million and it is now $21 million, and asked for an explaination regarding this increase. **Mr. Day** said the $18 million figure was an estimate which was put into the Governor's budget and had to be refined. The $21 million amount is the final amount.

**CHAIRMAN BERGSAGEL** asked if the criteria in order to have managed care coverage for patients must go to 200% of poverty level in order to cover the clientele of the Montana State Hospital and also obtain reimbursement from the federal government to community programs. **Ms. Dalton, SRS,** said that 200% was not a set amount, but the Department picked that number because it covers the majority of clients. She stated that the Department wanted to get the most client coverage they could in order to draw down federal match.

In response to a question from **CHAIRMAN BERGSAGEL, Ms. Dalton** stated that SRS does not have the staff or the expertise to accomplish all that another entity through managed care could.

**ADJOURNMENT**

Adjournment: 12:15 p.m.

ERNEST BERGSAGEL, Chairman

for TRACY BARTOSIK, Secretary

EB/tb

# LONG RANGE PLANNING

## Joint Appropriations Subcommittee

ROLL CALL DATE 2-14-95

| NAME | PRESENT | ABSENT | EXCUSED |
|---|---|---|---|
| Rep. Ernest Bergsagel, Chairman | X | | |
| Rep. Matt McCann | X | | |
| Rep. Tom Zook | X | | |
| Sen. Ethel Harding, Vice Chairman | X | | |
| Sen. Chris Christiaens | X | | |
| | | | |

EXHIBIT 1
DATE 2-14-95
HB 15

**Amendment #1**
**Offered by the Department of Labor and Industry**

HB 15 -- Introduced Bill
Long Range Building Committee

This amendment allows the Department of Labor & Industry to proceed with expansion of the Job Service Office in Havre, with the project to be funded through the issuance of debt. Debt service will be paid with federal special revenue. The Montana Job Service can only build if the cost of the building can be spread over a number of years, and a bond repayment schedule would accommodate the federal funding system allotted to the states.

Page 2, following line 16:

Insert: "Expand Job Service,
Havre 350,000 Federal Special Revenue"

NOTE: On page 2, Line 19: Under Section 3 - the total amount of bonding authority will need to be changed from $71,747,000. I have not included that change here, as other changes in HB 15 will need to be considered before a final amount is given.

EXHIBIT 2
DATE 2-14-95
HB 15

# Montana State Hospital Campus Redesign Project

**Mission:**
To review services, patient needs and facilities and propose a plan to improve and consolidate the Montana State Hospital campus.

**Considerations and Constraints:**

1. The primary consideration must be effective and appropriate patient services.
2. The Committee must determine, to the best of its ability, the types of patients which are likely to be served at the State Hospital in the future.
3. The design must be based on the concept of maximizing use of community services, providing the least restrictive environment and public, consumer and staff safety.
4. Changes must be consistent with and directed toward achieving accreditation by the Joint Commission on Accreditation of Healthcare Organizations (Accreditation Manual for Hospitals).
5. The plan must be directed toward reducing the overall size of the campus with a corresponding reduction in costs.
6. The plan must include facilities designed to serve a maximum of 200 patients with the flexibility necessary to adapt to changing health and mental health care environments—e.g. increasing regionalization of service; pre-paid mental health system; national and state health system reforms.
7. The plan must incorporate full automation of the Hospital and installation of interactive video communication equipment.
8. Although other alternatives may be determined by the Committee to be more appropriate, the Committee must specifically consider consolidation of the campus in the area around the current Administration Building and Multipurpose Building with conversion of the XTF into a correctional facility and discontinued use of the Warren Building.
9. The Committee will make recommendations for short-term improvements funded from the $1 million in bonds authorized by the 1993 Legislature. Among the short-term improvements to be considered is remodeling of the Receiving Hospital.

EXHIBIT 3
DATE 2-14-95
SB 15

**Public Discussions of MSH Campus Design Project**

| | | |
|---|---|---|
| February 4, 1994 | Anaconda | Announcement of Project by Rick Day, Dan Anderson |
| March 3, 1994 | Warm Springs | Campus Design Committee Met with staff from three CMHCs |
| April 20, 1994 | Warm Springs | Admission/Discharge Review Team Report by Archie McPhail |
| April 29, 1994 | Helena | MHPAC Presentation by Dan Anderson |
| May 24, 1994 | Helena | Consultant met with Helena CMHC staff |
| June 2, 1994 | Warm Springs | MSH Management -- BOV Meeting |
| June 15, 1994 | Warm Springs | BOV Site Visit Overview Meeting |
| June 20, 1994 | Helena | Consultant met with Helena CMHC staff |
| June 21, 1994 | Missoula | Consultant met with Missoula CMHC staff |
| June 21, 1994 | Great Falls | Consultant met with Great Falls CMHC staff |
| June 21, 1994 | Great Falls | Public Forum by Rick Day |
| June 22, 1994 | Billings | Consultant met with Billings and Miles City CMHC staff |
| July 12, 1994 | Helena | Meeting with CMHC Directors by Rick Day and Dan Anderson |
| July 15, 1994 | Warm Springs | MHAM Board Presentation by Dan Anderson |
| July 19, 1994 | Missoula | Public Forum by Rick Day |
| July 20, 1994 | Warm Springs | Admission/Discharge Team Discussion by Liana Schmidt, Rusty Redfield |
| July 22, 1994 | Warm Springs | MAP Board Presentation by Archie McPhail |
| July 26, 1994 | Anaconda | Public Forum by Rick Day |

EXHIBIT 4
DATE 2-14-95
SB 315

# Survey of Montana State Hospital Patients

On August 24, 1994, ballots were distributed to Montana State Hospital patients with the following question:

*"Plans are being discussed to build a new State Hospital. I would like to see the new Montana State Hospital . . . "*

Patients were asked to check one of three options:

"Built at Warm Springs"

"It doesn't matter where the hospital is located"

"Built at another location such as: _____"

**RESULTS**

A total of 130 responses were received.

| | | |
|---|---|---|
| **Built at Warm Springs** | | 66 |
| **It doesn't matter where the Hospital is located** | | 29 |
| **Built at another location** | | 25 |
| Other Locations Mentioned: | | |
| Billings: | 8 | |
| Missoula: | 4 | |
| Libby: | 1 | |
| Moore: | 1 | |
| Lewistown: | 1 | |
| Two Dot: | 1 | |
| Box Elder: | 1 | |
| Helena: | 1 | |
| Kings Hill: | 1 | |
| Disneyland: | 1 | |
| Livingston: | 1 | |
| Unspecified Other Location: | 4 | |

| | | |
|---|---|---|
| **Other Answers** | | 10 |
| Don't build at all | 4 | |
| "Not Interested" | 1 | |
| "The most financially feasible location with the best people. It can only be as good as the people who operate it." | 1 | |
| Build at Warm Springs or at another location with "more trees and wild life." | 1 | |
| Build at Warm Springs and "It doesn't matter" both checked | 1 | |
| Warm Springs or Billings | 1 | |
| All three choices checked. "If it is like this hospital - yes. You are all wonderful. The best institution-hospital I have ever been in." | 1 | |

EXHIBIT 5
DATE 2-14-95
SB 15

# MONTANA STATE HOSPITAL
## Campus Re-design Project

Total project cost of $21 million.

New facilities will be completed by 1999. The project can be done without the need to relocate patients during construction.

The anticipated average daily population of 135 by 1999 incorporates the impact of managed care. Managed care should keep the population at or below this level on a long term basis.

Due to consolidation of campus and reduction in patient population, FTE level at the State Hospital will be reduced by at least 150 by 1999.

Through consolidation of campus and patient reduction there will be an annual budget reduction at MSH of $7 million, starting the year construction is completed. These savings can pay for the project bonding and be used to serve patients in community based programs in order to keep the MSH population at 135.

The existing Xanthopoulis Treatment Facility will be transferred to Corrections. It can house up to 196 inmates, depending on their treatment/security needs, thereby reducing the need for new correctional construction.

Re-designed State Hospital will have 166 beds, very comparable to the sizes of facilities in neighboring states.

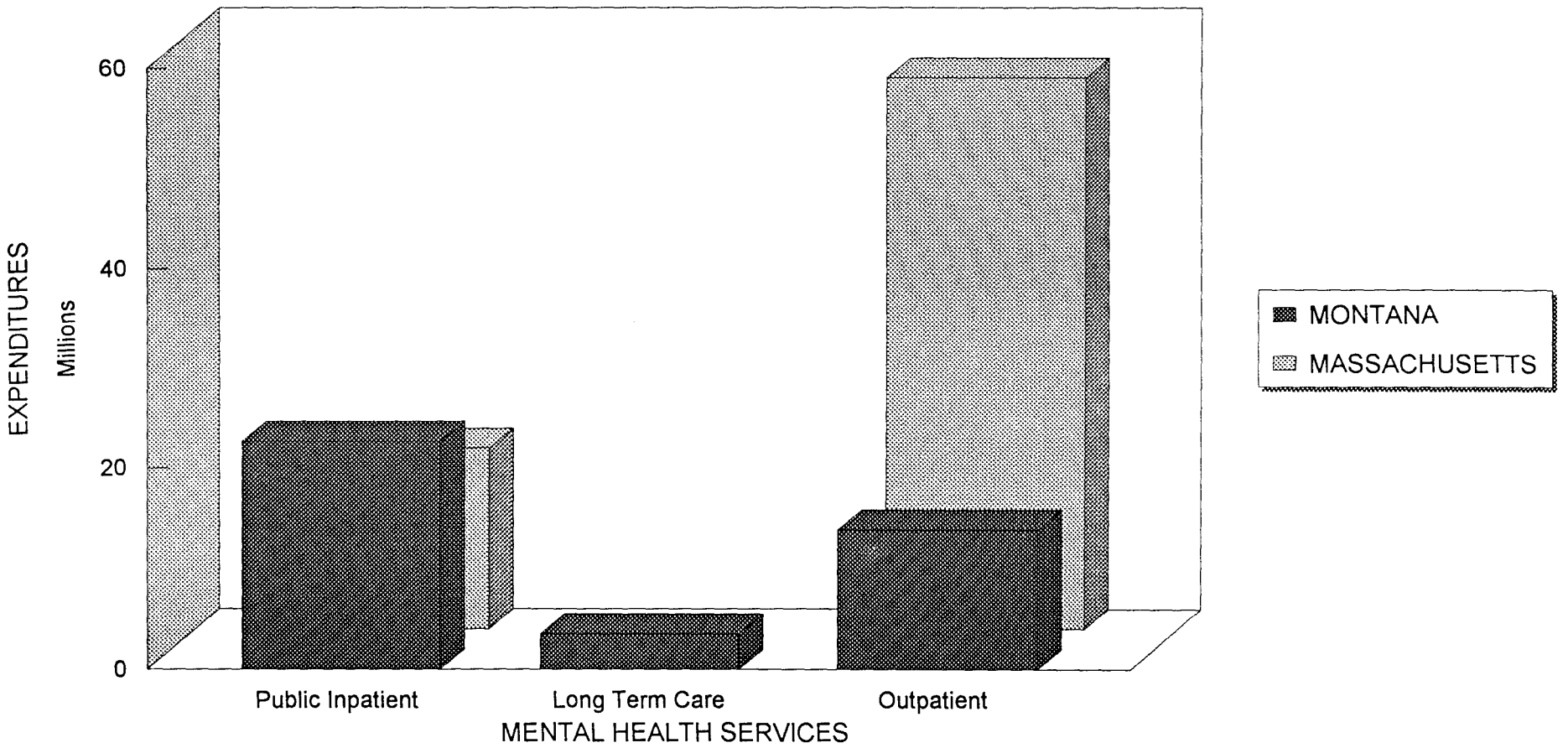
The ability to share services (e.g. laundry, food service, mental health) with the prison system allows both programs to operate more efficiently.

The re-designed campus will allow full licensure/certification/accreditation of the treatment programs and facilities. Montana State Hospital is currently the only state-operated health care facility in Montana which is largely unlicensed.

EXHIBIT 6
DATE 2-14-95
HB 15

# PUBLIC MENTAL HEALTH EXPENDITURES

MONTANA VS MASSACHUSETTS (Western Area)

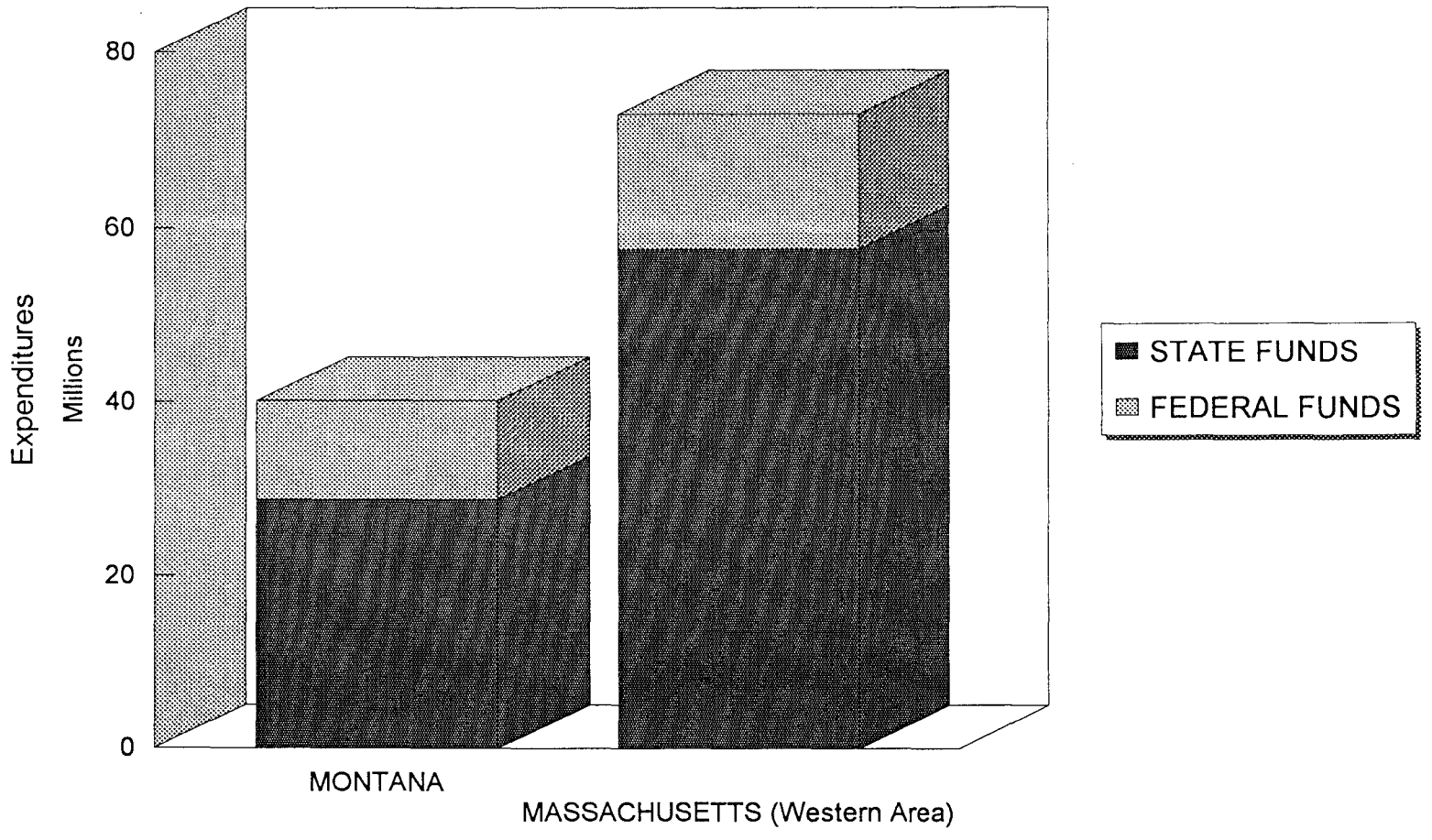



Source: MT: Public Mental Health Funding Estimate, FY 94
Source: MA: Memo (1/15/95) Mark Mitchell, Deputy Area Director

EXHIBIT 7
DATE 2-14-95
~~SB~~ 15

# PUBLIC MENTAL HEALTH EXPENDITURES

Montana vs Massachusetts (Western Area)




Source MT: Public Mental Health Funding Estimate, FY 94
Source MA: Memo (1/15/95) Mark Mitchell, Deputy Area Director, W.Mass.

ERNST & YOUNG LLP

■ 1600 Huntington Building
925 Euclid Avenue
Cleveland, Ohio 44115-1405

■ Phone: 216 861 5000

EXHIBIT 8
DATE 2-14-95
SB 15

FEB 6 1995

January 30, 1995

Mr. Dan Anderson
Administrator
Mental Health Division
1539 11th Avenue
Helena, MT 59620

Dear Dan:

It was a pleasure speaking with you on Thursday. I have been keeping posted on the progress of Montana State Hospital through Dave Ennis and John Klare, and am pleased that this important work continues to move along.

At Dave Ennis' request, I have read a copy of the memorandum addressed to Mary Gallagher from Mark Mitchell of the Massachusetts Department of Mental Health. As we discussed, I would like to add my perspective to this issue.

First, let me state that I have visited and maintained an interest in the programs described by Mr. Mitchell. In the late 1980's I was a member of the Wyatt Consultant Committee, established as part of the consent decree related to the historic Wyatt case in Alabama. In that capacity I visited and toured many of the programs in Western Massachusetts.

Despite my 13 years in State government, including half as Director of the Missouri Department of Mental Health, I learned quite a bit in those visits. I was truly impressed by the efficacy of the programs I saw, all serving persons with serious and persistent mental illnesses. In my eight years of practice as the National Mental Health Advisor for Ernst & Young, LLP I have tried to incorporate in my consulting as many of the lessons I learned in Western Massachusetts as local conditions would responsibly permit.

As I mentioned on the telephone, this experience also colored my consultation on the future of Montana State Hospital. One very prominent area of impact was in our original recommendation that training apartments be built on the grounds of Montana State Hospital, with identical units being built in several communities throughout Montana. This recommendation was based on my observation that the conventional wisdom of moving patients through a series of lesser restrictive settings was not as effective as establishing them, as soon as possible, in their most likely optimal setting, with the supports necessary to maintain them successfully. As patients gained skills, supports could be withdrawn.

EXHIBIT 9
DATE 2-14-95
SB 15

## Nearby State Hospitals

North Dakota State Hospital, Jamestown:

JCAHO Accredited

All patient buildings renovated or newly constructed in past 12 years

47.1 Beds Per 100,000

South Dakota State Hospital, Yankton:

Will Consider JCAHO when new facilities completed

Current building project to replace all patient buildings

52.9 Beds Per 100,000

Wyoming State Hospital, Evanston:

Will achieve JCAHO accreditation in 1995 or 1996

Has major building proposal before Legislature

33.1 Beds Per 100,000

Utah State Hospital, Provo:

JCAHO Accredited

Recently opened new 120 bed building, proposing a 100 bed forensic building project

19.9 Beds Per 100,000

Idaho State Hospitals, Blackfoot and Orofino:

Blackfoot facility one year from accreditation; Orofino may pursue

Blackfoot facility 7 years old; Orofino currently being replaced, spring 1995 comp.

19.4 Beds Per 100,000

EXHIBIT 10
DATE 2-14-95
SB 15

## Regional State Hospital Beds

### Total Beds

| | Beds | Per 100,000 |
|---|---|---|
| South Dakota | 368 | 52.9 |
| North Dakota | 301 | 47.1 |
| Wyoming | 150 | 33.1 |
| **Montana (proposed)** | **166** | **20.8** |
| Utah | 343 | 19.9 |
| Idaho | 195 | 19.4 |

### Adult Psychiatric, Geriatric and Forensic Only

| | Beds | Per 100,000 |
|---|---|---|
| South Dakota | 295 | 42.3 |
| North Dakota | 221 | 34.6 |
| Wyoming | 126 | 27.8 |
| **Montana (proposed)** | **166** | **20.8** |
| Utah | 271 | 15.7 |
| Idaho | 150 | 14.9 |

sthosp.bed

FEB 10 1995

EXHIBIT 11
DATE 2-14-95
SB 15

STATE OF WYOMING
# Wyoming State Hospital

LEON CLYDE PRUETT, Superintendent
P.O.Box 177 Evanston, Wyoming 82931-0177 (307) 789-3464

February 6, 1995

Representative Ernest Bergsagel
Chairman, Long Range Planning Subcommittee
Montana House of Representatives
State Capitol
Helena, Montana 59620

Dear Representative Bergsagel:

As President of the Western Psychiatric State Hospital Association, I have participated in many discussions on the changing role and mission of state hospitals in the 14 western states represented in the Association. My colleagues and I have been pleased to see the establishment of community services reduce the need for hospitalization, but we have also been strong advocates for state hospitals that have the staff and facilities necessary to provide the intensive treatment required for patients whose mental illnesses are too severe for community-based treatment.

All of the states surrounding Montana have recently or are currently making major facility improvements. For example, the South Dakota Human Services Center is rebuilding most of its facilities and the Idaho North State Hospital is being completely rebuilt. In Wyoming we are proposing a major state hospital building project to our Legislature. Utah State Hospital has recently occupied a new patient building and there are plans to replace other facilities there. In none of these states is there an expansion of state hospital capacity. Rather, the states are creating modern, efficient and safe environments for the same or a reduced number of patients.

The Montana State Hospital redesign plan is very much consistent with the trends in other western states. I understand that the proposal includes 110 new hospital beds and continued use of a 56 bed existing facility on the Warm Springs campus. I also understand that the proposed design will result in significant efficiencies and operational savings. The proposed bed capacity of 20 beds per 100,000 population will place Montana's state hospital capacity in the lower end of the range for western states.

I know that the Montana State Hospital staff looks forward to being able to provide accredited, state-of-the-art mental health services to Montanans with mental illness. Please call on me if you have questions about state hospital services in the western states.

Sincerely,

Leon Clyde Pruett

Leon Clyde Pruett, Superintendent
Wyoming State Hospital
and
President, Western Psychiatric State Hospital Association

xc: Dan Anderson, Montana Mental Health Division

EXHIBIT 12
DATE 2-14-95
SB 16

**Remarks by Paul R. Ahr, Ph.D., M.P.A**
**National Mental Health Advisor - Ernst & Young, LLP**
**Helena, Montana - February 14, 1995**

> It is expedient I should also recommend to your Consideration and Humanity a poor unhappy set of People who are deprived of their Senses and wander about the Country. ...Every civilized Country has a Hospital for these People, where they are confined, maintained and attended by able Physicians, to endeavor to restore them their lost Reason.

With these remarks to the Virginia House of Burgesses, on November 6, 1766, Royal Governor Francis Fauquier conceived this nation's public mental illness treatment system, and in so doing, set the Colonial (and later State) governments at its core. Two weeks later the Burgesses authorized the construction of a public hospital for "persons of insane and disordered minds" in Williamsburg, the Capital of the Virginia Colony.

The public hospital admitted its first patient nearly seven years later on October 12, 1773 - the earliest American example of the time it takes to bring good and needed improvements to fruition in the public sector.

During the next 150 years (1773-1923) the Colonial -- and soon State -- governments would become solely responsible for the care of the mentally ill in America. The era of sole State responsibility for the mentally ill started slowly. Only four public mental hospitals were built in the half century following the opening of the Williamsburg hospital. However, in the 60 years from 1827 until 1887 the number of hospitals increased 25-fold to more than 125. This growth was due in great measure to the untiring efforts of a retired school teacher, Dorothea Dix.

Miss Dix personally observed the inhumane treatment given to the mentally ill in Massachusetts jails and poorhouses. Echoing Horace Mann's claim that "the insane are the wards of the state," she convinced State lawmakers that local governments were incapable of caring for the mentally ill. In 1843 the Massachusetts legislature voted to terminate local responsibility for the mentally ill and made them wards of the Commonwealth.

Governors and legislators in other States heard Miss Dix's call for reform and assumed responsibility for the care of the mentally ill. The establishment and expansion of more than 30 mental hospitals can be traced to her efforts. In responding to Dorothea Dix's call for humane treatment of the mentally ill, State governments became solely responsible for their care.

Miss Dix's dream was the passage of the 12,225, 000 Acre Bill. This Bill proposed that the federal government grant to the States 10,000,000 acres of land for bettering conditions of the mentally ill.

First introduced in 1848, the Bill was predicated on the, then current, practice of making land grants to the States to improve public education, and on Miss Dix's assertion that the mentally ill were "through the Providence of God ... wards of the nation, claimants on the sympathy and care of the public ..." Although passed by Congress, President Franklin Pierce vetoed the Bill in 1854 arguing that the legislation would usurp the States' responsibilities for the mentally ill.

In the short period of eleven years (1843-1854), local governments were found unable and the federal government proved unwilling to assume responsibility for the mentally ill. State governments became solely and unequivocally responsible for their care and treatment.

With these lessons as backdrop, I would like to address the questions of whether States in general, and Montana in particular, should be in the public mental hospital business 141 years after the veto of the 12,225,000 Acre Bill, and if so, for how long?

I trust that my prior remarks have demonstrated what I consider to be the most critical point in answering these questions: that State governments - State Legislatures in conjunction with their respective Executives, are ultimately and thereby primarily responsible in the American system for the care and treatment of persons with mental illnesses. While *the care and treatment of these patients may be delegated* to community mental health centers or behavioral health managed care organizations, or to independent private practitioners, *the responsibility for that care cannot be delegated.*

This point was recently reasserted in the State of Hawaii where the Federal Justice Department brought suit against the State of Hawaii - not the Federal Department of Health and Human Services, not the City and County of Honolulu - for failure to provide adequate treatment for persons with mental illnesses in Hawaii. This same point served as the basis for the Northampton State Hospital Consent Decree in Massachusetts, where the State of Massachusetts, not the Federal government or any local governments, was sued.

I reference the Northampton case because of recent questions raised concerning the advisability of emulating the Western Massachusetts approach in dealing with persons with serious and persistent mental illnesses in Montana. As you may know, for many years the vast majority of services to persons with serious and persistent mental illnesses living in Western Massachusetts have been provided through community-based agencies and professionals. These agencies and professionals have supplanted the former Northampton State Hospital as the primary provider of mental health care to persons who would have otherwise been admitted to that State facility.

In 1988, while affiliated with the Wyatt Consultant Committee in Alabama, I visited the Mount Tom Institute in Holyoke, Massachusetts. After 20 years of clinical practice and 13 years in senior public mental health posts in Virginia and Missouri, I was very

impressed by the therapeutic results gained with persons with very serious mental illnesses. I have tried in my consulting work to incorporate, where appropriate, lessons learned from the Western Massachusetts program. And I have tried to isolate those conditions which I believe have made it so successful. I would like to share with you my understanding of these conditions.

First, the Western Massachusetts program has been blessed by its ability to retain a cadre of highly trained and highly committed mental health professionals, some, it seems, who have been there for the duration of the project.

Second, from its inception, and throughout its duration this program has been well funded on a per capita basis, at least in comparison to other programs in Massachusetts and throughout the country. It is my understanding, for example, that the current annual per capita funding in Western Massachusetts approaches $90, compared with $50 in Montana.

Third, from its inception, the Western Massachusetts program has had the relative luxury of focusing on an important, but narrow cohort of clients: those persons who would otherwise be patients at Northampton State Hospital. Other clients, more in numbers, and part of the regular mix of patients in other public mental health systems, have been relatively underserved in Western Massachusetts.

Fourth, the State of Massachusetts has long been a preferred locale for the training of mental health professionals, and for their practice. For example, according to the American Psychiatric Association (APA), there are 1903 APA members in Massachusetts, compared with 549 in Missouri and 55 in Montana. Other mental health professional groups are similarly available in good supply compared with States like Missouri and Montana. Although sub-State APA membership statistics are not available for Massachusetts, the Western part of that State is home to the Austen Riggs Center, one of the premier training programs for mental health professional in the country.

Western Massachusetts also has the advantage of greater population density (400 persons per square mile versus 6 persons per square mile in Montana) and more available housing which, when combined with a richer supply of mental health professionals, makes the Western Massachusetts approach more do-able there than in other locales.

Finally, the Western Massachusetts program has the luxury of operating within a larger State public mental health/public mental hospital system, which provides public mental hospital care to forensic and other patients who are extremely difficult to manage.

In summary, the State of Massachusetts, through its Legislative and Executive branches, carries out its responsibility for persons with mental illnesses and emotional disturbances through a system of mental hospitals and community-based public sector and private sector programs, which includes the well funded and very successful Western Massachusetts program for an identified class of clients.

At the present time, the State of Massachusetts is in the public mental hospital business. I expect that the State of Massachusetts will continue in the public mental hospital business, even though Massachusetts, like many other States continues to refine its estimates of needed public mental hospital beds.

One of the circumstances which propels Massachusetts to address the issue of bed need is the impact of behavioral health managed care in that State. This is a concern to many States. Last year I assisted the Honolulu Office of Ernst & Young, LLP in the design of the behavioral health component of the Hawaii QUEST program - that State's Medicaid managed care initiative.

The Hawaii State Medicaid agency recognized the critical role which Hawaii State Hospital continues to play in providing services to forensic and other difficult to manage patients, who were intentionally excluded from participation in QUEST in favor of continued treatment at Hawaii State Hospital.

I am aware of the behavioral health managed care initiatives being considered in Montana and applaud your vision in this area. However, I am cautious concerning the ability of managed care to seriously impact on the clinical conditions of a core group of the most seriously and persistently mentally ill in our States.

I base my caution on the common failure of three prior reform movements in this country in this century: the Child Guidance movement (roughly 1915-1930), the Mental Hygiene Movement (roughly 1940-1955), and the Community Mental Health Movement (roughly 1965-1980). Each of these movements built on and advanced the gains of its predecessors, as will managed behavioral health care. However, despite their many accomplishments, each failed to significantly impact on the availability of treatment services for this core group of seriously disabled mentally ill persons.

Commenting on these conditions, and the question concerning the future role of the State mental hospital in 1978, near the end of the last reform era, Dr. John Talbott wrote in his book, *The Death of the Asylum:*

> While (state hospital) closure seemed to present the ideal solution in the 1950s, the backlash against it and the failure to provide adequate and effective community alternatives to state mental hospitals have probably doomed its viability as an option at this point. On the other hand, increasing economic pressures and continuing state hospital scandals may precipitate its readoption. Since it is not likely that adequate community support systems will then be provided, the scandalous conditions that originally occurred at the height of de-institutionalization will reappear in the community.

In effect, I expect that for that core group of patients, who include those who are medically frail, those who are seriously behaviorally disordered, and those who have

been admitted and are retained under varying forensic statutes, the most cost and treatment effective option will be smaller, more compact and economical mental hospitals.

One other group of patients may likewise benefit from the specialized programs of the redesigned Montana State Hospital. These are patients who require careful medical psychiatric supervision to evaluate their need for psychotropic and other medications. Despite many advances in chemotherapy for persons with mental illnesses, some patients do require periodic re-evaluations of their condition to assure that they are receiving maximum benefit from their prescribed medications. In some cases these evaluations are best conducted in a hospital or similar setting.

Writing in the prestigious journal, *Hospital and Community Psychiatry* in 1986, Dr. Leona Bachrach observed:

> However, I must add that in the provision of care to chronic mental patients, some events are far more deplorable than the utilization of a state mental hospital. One of these is the notion that state hospital care should be eschewed even when the only available alternatives for chronic mental patients are no care at all, or else placement in a facility that fosters institutionalism as much as, or perhaps even more than, the state hospital of the past sometimes did. Until we learn to eliminate the lag between realizing program development objectives and program termination objectives, we must not abandon effective state mental hospital programs -- unless we mean to increase the ranks of the underserved and the undomiciled among the chronic mentally ill.

Based on her investigations, Dr. Bachrach completes her article, "The Future of the State Mental Hospital," with the following four predictions:

1. The state mental hospital will in fact survive as an integral part of the psychiatric service system for many years to come.

2. The state mental hospital of the future will continue to vary greatly from state to state, and from community to community in the United States.

3. The state hospital of the future will serve as one of several loci for care for chronic mental patients.

4. The state mental hospital will continue to experience financial and identity crises in the foreseeable future.

I believe that these four predictions will be sustained even in the era of managed care for one reason: that the best strategy available to State Legislatures and Governors for assuring that they, and you, properly carry out your moral and statutory obligations to all

persons with mental illnesses within limited State financial resources is the operation of a properly sized and staffed public mental hospital.

Having met with representatives of the fine Community Mental Health Centers in Montana, I believe that a redesigned Montana State Hospital will continue to be an essential and important provider of tertiary-level psychiatric care in the Montana mental health system.

But what if Dr. Bachrach is wrong for the United States as a whole, and I am wrong in the case of Montana? What is the best short-range strategy available to you?

Build a smaller, more economical hospital at Warm Springs, one which will pay for itself in a few years, while freeing up funds to guarantee against the failure of community-based programs warned of by Drs. Talbott and Bachrach. Provide incentives for persons with emerging mental illnesses to be treated in their home communities, provide incentives to keep persons with deteriorating mental illness conditions in their home communities, foster a treatment philosophy which promotes skill building and early, and successful, return to the community with hospital stays which are short and treatment focused.

And that is the proposal which has been presented to you by the Campus Design Committee at Montana State Hospital.

EXHIBIT 13
DATE 2-14-95
SB 15

# TESTIMONY OF THE MONTANA HOSPITAL ASSOCIATION REGARDING MENTAL HEALTH MANAGED CARE

The Montana Hospital Association, on behalf of its 57 member health care facilities, including five hospitals with distinct part psychiatric units, and two freestanding children's psychiatric hospitals, appreciates the opportunity to comment on the development of a statewide capitated mental health managed care program.

**Hospitals are on record as supporters of managed care systems, provided these programs treat facilities and their patients fairly.** MHA, along with several hospital representatives, has followed the progress of the Department's proposal to significantly alter the way mental health care is delivered in Montana. MHA believes the system proposed by the Department of SRS is ambitious, but moves in the right direction. There are still numerous details yet to be worked out, but hospitals are supportive of the Department's efforts.

The table below lists the seven Montana hospitals which provide mental health care to adults and children. **Managed care may mean some of these hospitals have more patients, some may close and some may restructure their resources to some other purpose.** The only thing we know for sure at this point, is that things will probably change dramatically.

| HOSPITAL | LIC BEDS | ADULTS | CHILDREN |
|---|---|---|---|
| Deaconess Hospital-Billings | 60 | Yes | Yes |
| St. Peters-Helena | 14 | Yes | No |
| St. Patrick-Missoula | 21 | Yes | Yes |
| Deaconess MC-Great Falls | 27 | Yes | Yes, 6 beds |
| Kalispell Regional Hospital | 14 | Yes | Yes, 7 beds |
| Shodair Hospital-Helena | 22 | No | Yes |
| Rivendell Hospital-Butte | 32 | No | Yes |
| | | | |
| TOTALS | 190 | | |

**In responding to that change, Montana hospitals ask that the decision makers consider that these facilities serve all patients in a community, not just those the state helps pay for. Changes made to the system in pursuit of saving dollars affects the services available to everyone.**

THE MONTANA STATE HOSPITAL

**MHA, and its member hospitals, believe it is appropriate for Montana State Hospital to continue providing key mental health services at this time.** If this Legislature decides to continue services at MSH, hospitals also support the Department of Corrections and Human Services efforts to achieve certification of the state facility. All other Montana hospitals providing psychiatric care are required to meet state and federal licensure and certification standards, and meet the requirements of JCAHO.

Montana hospitals play an important role in providing stabilizing care for certain types of patients. Hospitals envision themselves continuing in this role under a managed care setting. Patients who are acutely ill, and are able to respond to short term, stabilization care are appropriate for community hospitals who offer psychiatric care.

**Patients who are physically dangerous, who need long term stabilization care, forensic admissions and those who are in need of long term hospital or residential care are not considered appropriate for the existing psychiatric units. These patients should continue to be served at the Montana State Hospital.**

There is some discussion about terminating services offered at Montana State Hospital, and shifting those services to the community. Hospitals believe some patients, given the financial support of managed care, may be retained in the community. **But hospitals cannot support closure of MSH at this time.**

It is not impossible to relocate services provided at MSH in community hospitals. Such a move would, however, require creation of a secure hospital environment for difficult patients needing specialized treatment currently unavailable in community based facilities. **Such a change would require considerable advance planning, investment in new or remodeled physical plant, and the creation of needed treatment programs.** Transfer of these services should not (and probably could not) be accomplished simultaneously to creation of managed care.

MHA believes the existence of the state hospital is important. The location, however, poses an access problem to Montanans living in Central and Eastern Montana. Typically, these patients receive inpatient treatment at Billings Deaconess Hospital. Transportation to and from Billings and destinations to the East and North is expensive. Transitioning patients released from the Montana State Hospital to community aftercare is more difficult because of the distance.

**For this reason, hospitals suggest that the development of adult residential care be located regionally, and be available to transition MSH patients into community care.**

**Were the state to desire to privatize the services currently provided by the Montana State Hospital, MHA believes these services would need to be excluded from mental health managed care, and that a separate proposal be prepared to investigate such a proposal in detail.**

GAPS IN SERVICE, HOSPITAL ISSUES

Shodair and Rivendell Hospitals currently provide a great deal of free care to children who are Medicaid eligible, but not served by MRM. These children are not high enough on the priority list for MRM to address their needs. But these children find their way into treatment, oftentimes being dropped off at the emergency room door by police officers. Still others are admitted by MRM, and are paid for by 100 percent general fund dollars. Hospitals also provide inpatient care to adults who are moved into the community setting, but whose hospital needs are not covered by state resources. General, acute care community hospitals provide stabilizing treatment in their emergency rooms and provide transportation services to psychiatric hospitals.

**MHA believes that these services must be included in the managed care system. Hospitals are concerned that if these services are not included, more people will be shifted into these service areas as a cost saving measure for the managed care organization.**

**MHA appreciates the opportunity to present our comments to the committee. MHA is available to answer committee questions.**

Executive Offices

St. Patrick Hospital

EXHIBIT 14
DATE 2-13-95
SB 15

January 20, 1995

Robert W. Olsen
Vice-President
Montana Hospital Association
P.O. Box 5119
Helena, Mt. 59604

Dear Bob:

The Administration of St. Patrick Hospital is very concerned about the potential closing of Montana State Hospital at Warm Springs as part of a mental health managed care system implementation.

Our primary concerns are that patients receive proper and appropriate treatment, care and supervision. Currently Warm Springs manages the care of a specific segment of the Mental Health population not served by Acute Inpatient Psychiatric Facilities. Communities have been able to mobilize local services to provide for the needs of the vast majority of patients not requiring the level of care at Warm Springs.

In consideration of a continuum of care for Mental Health clients, we believe the State Hospital at Warm Springs fills a vital and necessary role. Patients who are cared for at Warm Springs would not find comparable care in community based facilities. By definition, patients requiring long term psychiatric care, would be compromised in the acute care setting. We would be concerned for the safety of patients and the community if acute care criteria was utilized for patients in need of long term comprehensive, intensely supervised psychiatric care. Acute Care Inpatient Psychiatric Units currently do not have the staffing, programming, physical plant arrangements or security to meet the special needs of the long term psychiatric population. Patients in this population no longer require acute hospitalization, and are not appropriate for Nursing Home Care.

The special needs of the forensic population would also not be addressed by acute inpatient hospitalization programming. The length of stay for patients continues to decrease for our inpatient psychiatric patients. Our programming is similarly changing to meet the needs of patients given this short length of stay. Mixing patients of the chronic nature who are currently at Warm Springs with the patient population of acute inpatient facilities would be detrimental to all patients. The acute stabilization milieu and efforts for those needing brief interventions would be compromised.

The niche that Warm Springs fills is so defined, that we are not aware of any state that does not have a similar facility. Further, we believe that patients that do not require the level of supervision at Warm Springs, have already been discharged to community based programs. We would estimate the expense to be greater than $7 Million per year at St. Patrick Hospital alone, to only serve a fraction of the population at need, and to do so at a level that would be less beneficial to the patient and to the community.

We support the State studying the feasibility and practicality of rebuilding the State Hospital at Warm Springs or some other location. We believe that the special needs of the long term chronic and forensic populations would be best served by the development, maintenance and funding of facilities and programming that are designed specifically to meet their unique needs. We are also concerned about the financial burden on local communities and facilities to care for a chronic population without appropriate funding. In the same manner that the State does not want to bear the financial consequences for Federal Government policy, neither do local communities want to bear adverse economic consequences of State policy.

We urge careful consideration of this issue. The needs of the clientele cared for at Warm Springs cannot currently be managed at acute care inpatient psychiatric facilities, therefore we do not support the closing of the State Hospital at Warm Springs.

Thank you for your consideration, and please contact me if I may be of assistance in anyway. I look forward to continued dialogue in this matter.

Sincerely,

Jack Burke, RN, MS
Vice-President
Patient Care Services
St. Patrick Hospital

JJB:seh

Deaconess
Medical
Center

TO: Bob Olsen, Vice President
Montana Hospital Association

FROM: Libby Artley, Director
Deaconess Psychiatric Services

RE: Warm Springs State Hospital
Legislative Position

DATE: January 24, 1994

It is my understanding that the discussions in the legislature have accelerated regarding the future of Montana State Hospital at Warm Springs. I present the following position on behalf of Deaconess Medical Center.

We neither support nor oppose the proposed rebuilding of the State Hospital. It is not necessary or desirable that Warm Springs provide the same level of care currently provided by the local general hospitals with psychiatric services. Additionally, it would be a serious and expensive disservice to eliminate the moderate to long-termed care and forensics currently provided at the State Hospital.

If asked, Deaconess Medical Center would be willing to provide limited additional care for some patients currently sent to the State Hospital. Although it is the State's responsibility to provide necessary care and treatment, we would be happy to contract for local psychiatric beds. This population requires Secure beds; specifically, an area that meets patient and staff needs for safety, respect, and confidentiality regardless of patient volatility and reality orientation. Deaconess Medical Center currently has five such beds, but they are often full. We would need to extensively remodel existing space to accommodate additional Secure beds. I would guess that we could convert

2800 Tenth Avenue North
P.O. Box 37000
Billings, Montana 59107-7000

Telephone 406-657-4000

6-8 beds for Warm Springs patients, but architects would have to confirm and assess feasibility. Construction is likely to take 4-6 months following agreement of terms.

Let me emphasize that, as our psychiatric facility currently exists, we cannot accommodate additional State Hospital patients. Neither patients or staff could be safe.

Another central issue in caring for this seriously ill population is reimbursement. We are currently paid on a DRG basis. The costs associated with care for the Warm Springs population would far exceed the DRG reimbursement. Our current average length of stay for our adult psychiatric unit is 6.32 days. Because the State Hospital patient in many cases would need significantly more inpatient days, we would require a different method of reimbursement. A per diem arrangement would be one equitable model to discuss.

Although we are willing to make changes to accommodate these patients, and we believe they should be served when feasible in the community, there are additional cautions. First, we are unable under any circumstances to provide psychiatric beds for the forensics patient. Second, our community needs expanded services to care for the outpatient needs of this population in order to provide successful discharge planning and prevent re-hospitalization. We need additional day treatment, group homes and non-medical crisis stabilization to effectively manage the needs of this population locally and to keep costs down. Region III mental health care providers have worked diligently to function collaboratively. We will continue this effort toward reduced costs and a more complete continuum of care.

ST. PETER'S COMMUNITY HOSPITAL

(406) 442-2480 • 2475 Broadway, Helena, Montana 59601

January 13, 1995

To: The Helena Delegation
1995 Legislative Session

From: Bonnie Adee, Manager
Behavioral Health Services
St. Peter's Community Hospital
Helena, Montana

Re: House Bill 2

Our understanding is that a part of this bill involves funding for the Montana State Hospital at Warm Springs. We also understand that part of the debate is whether to close the state facility and deliver care in community hospitals with psychiatric units. As a community hospital with a psychiatric unit, St. Peter's Hospital would like to express its position on this matter.

1) We believe we should be involved in the planning process for mental health services in Montana. Since we provide a continuum of services from acute inpatient to long term outpatient, have five psychiatrists on staff, and are centrally located in Helena, we are a resource for the State in determining an effecitve, cost-efficient mental health delivery system.

2) We do not support closure of the State Hospital. It serves a special population which requires a long term hospital setting.

3) We are not convinced that one facilty located in Warm Springs best serves the population in a state as large as Montana.

4) We are not opposed to taking people for longer stays in our psychiatric unit. However, it is important that we have adequate time to plan programming and resources for such a shift, so that we can also still accommodate acute cases with short lengths of stay.

5) It is imperative that mental health care dollars accompany whatever plan is adopted. If community hospitals are needed for longer patient stays as well as for acute cases, reimbursement would have to be made available.

We hope you will call on St. Peter's Hospital administration and Behavioral Health Services staff to provide information and to assist with planning for the best mental health care system possible for Montana.

KALISPELL REGIONAL HOSPITAL
*"We care for your health."*

January 27, 1995

Robert Olsen
Vice President
Montana Hospital Association
1720 Ninth Avenue
P.O. Box 5119
Helena, MT 59606

Dear Bob:

This letter is being written to reinforce the position verbally given to you by the Administrative Manager of Pathways Treatment Center (Kalispell Regional Hospital's psychiatric treatment center) on January 24, 1995.

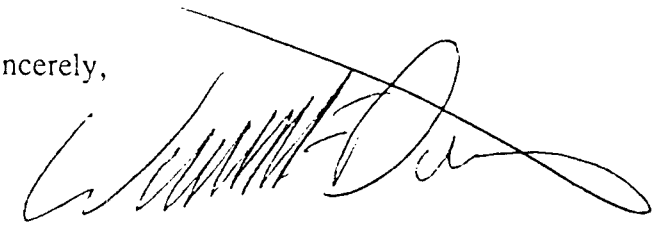
Kalispell Regional Hospital is very concerned about the proposed closure of the state hospital, particularly its direct effect upon the quality of care and perhaps even upon Kalispell Regional Hospital's continued ability to provide all forms of psychiatric care. The types of patients transferred to the state facility require longer-term care than an acute-care hospital is designed to provide. Especially with the emphasis upon psychiatric stays being a week or less, all of the aspects of the program are designed with this in mind (staffing, assessment, treatment planning, group content, individual and family counseling, discharge planning, and the actual physical layout of the unit). Accepting this type of patient into an acute-care program would not clinically be feasible because of the design of the program and treatment for both the acute and longer-term-stay patient would be seriously compromised.

In addition Pathways Treatment Center has only the physical capacity for three "Intensive Care Patients," and even this unit has limits to the type of behavior it can safely accommodate, so high-risk patients (violence risks especially) could not be treated within the present program and safety would be jeopardized.

The only feasible way that Kalispell Regional Hospital could accept the patients currently treated at the state hospital would be through establishing a new psychiatric program, complete with remodeled space and separate program components. This would require a large amount of capital and could put in question Kalispell Regional Hospital's ability to provide both adult and adolescent psychiatric care in the future. Accepting patients currently treated at the state hospital locally would only be feasible if the state chose to invest

significant dollars in local hospital programs for the creation of programs for these patients as an alternative to investing in the state hospital system.

Sincerely,



WILLIAM F. DIERS
President/CEO

WFD:bgs
bd\olsen195.ltr

January 23,1995

Robert Olsen
Vice President
Montana Hospital Association
1720 9th Avenue P.O. Box 5119
Helena, Montana 59604

Subject: Mental Health Manage Care - Warm Springs

Dear Mr. Olsen:

In recent discussions with the Department of Psychiatry at Montana Deaconess Medical Center (MDMC) regarding the potential closure of Montana State Hospital at Warm Springs (WSSH), the following concerns were raised:

1. MDMC is licensed for twenty-seven (27) acute psychiatric beds with an average occupancy of twelve (12) patients and a average length of stay of seven (7) days. Six (6) beds are reserved separate treatment of children from adults. Currently, we do refer some patients to WSSH for longer term treatment and cannot recommend caring for these long-term patients at Montana Deaconess without new physical space designed for that patient population.

2. As WSSH lower functioning patients have chronic, more acute psychiatric illnesses, separate, more appropriate treatment areas would be needed so as to not impinge on the rights of voluntary patients, yet provide the level of security needed for the type patient usually receiving care at WSSH.

3. Currently, we are planning to consolidate with Columbus Hospital. The best location of the psychiatric unit in this consolidation will not be decided for at least six (6) months and construction/renovation may take another 2-3 years.

4. Operational costs, as well as construction, will add to the financial needs of this service. If the financial risk of moving this patient population is shifted to the community, state funding for this service would also need to flow to the community.

5. Forensic and/or sexual conduct disorder patients would not be appropriate candidates for admission to community-based services.

Considering the type of patient, the facilities and resources required to provide appropriate care and the associated costs, Montana Deaconess Medical Center and the Department of Psychiatry do not recommend elimination of Warm Springs Hospital.

Sincerely,

Kirk Wilson, FACHE
President/CEO

Jeanne Garcia, M.D.
Medical Director, Psychiatry

K. Jane Bailey CHE
VP Patient Care Services
Chief Operating Officer

Randall L. Mee
Director, Restorative Services

WSSH.MH/rlm

Golden Triangle Community
Mental Health Center

REGION II ADMINISTRATIVE OFFICES
&
CASCADE COUNTY CLINICAL OFFICES
Holiday Village Mall - 2nd Level
P.O. Box 3089
Great Falls, Montana 59403
Phone: 406-771-8648
Fax: 406-761-0554

EXHIBIT 15
DATE 2-14-95
SB 15

January 19, 1995

Rick Day
Dept of Corrections & Human Services
1539 Eleventh Avenue
Helena, Mt. 59620

Dear Mr. Day:

The members of the Admission and Discharge Review Team (who are the representatives of the five Regional Mental Health Centers) would like to endorse the Campus redesign plan of Montana State Hospital.

For many years the State Hospital staff have worked diligently to provide quality inpatient treatment in an environment of decaying old buildings. Many of the existing buildings were not designed to meet the treatment needs of existing patients. There are many clinical, safety, financial and environmental benefits to the proposed new campus. It does appear that patients would be served in an environment that recognizes personal privacy and dignity, continuity of care, efficient utilization of space, financial savings and quality clinical services.

The plan, as it was explained to us, would be able to treat 135 consumers with a cost savings of nearly 7 million dollars over the next five years. The ADRT committee strongly supports the physical changes as well as the plan to reduce the population of the state hospital. With the reduction of the population at the state hospital, we feel it is essential that the 7 million dollar savings be used to provide community support services to provide treatment for the increased number of patients who will be needing (CSP) services. This money should be available to communities as savings occur to facilitate proper development of programs and services to a growing population of severely mentally ill people living throughout the state.

We commend the leadership within the Department for the time and effort to bring forth such a plan.

Sincerely,

Admission & Discharge Review Team
Ken Kleven
John Lynn
Candy Butler
Roger Scarborough
Jeff Sturm
Barbara Mueske

cc: Dan Anderson

February 13, 1995

EXHIBIT 16
DATE 2-14-95
SB 15

Representative Ernest Bergsagel
Joint Appropriations Long-Range
Planning Subcommittee
State Capitol
Helena, Montana 59620

RE: Montana State Hospital Re-Building

My name is James Larson and I am a patient at the Montana State Hospital and President of the Warm Springs Consumer Group. I would, at this time, like to address the matter of building a new psychiatric hospital in the state of Montana.

There is a consensus of all parties involved changes needs to be made in the State Hospital. There are also many different opinions in what these changes are.

It seems that the state consumer advocacy groups, MonAmi, the Planning and Advisory Council, Meriwether Lewis Institute, all have one opinion and the state government have another. Why is it not possible for a solution to be concluded? It would seem that with the proper information, a satisfactory conclusion should be as obvious as right and wrong, left or right, regardless of all the bickering there are elements of true or false that need to prevail here.

So, in conclusion, it is my position that more study and more talk are necessary until an honest to goodness solution is derived in this matter or whatever decision needs to be made so that a solution may be reached.

Also, it is the concern of many others that retaliation in some form is always possible when patient speak against authority figures in all levels of state government.

Thank you very much.

James Larson

JAMES E. LARSON

EXHIBIT 17
DATE 2-14-95
SB 15

# *Meriwether Lewis Institute*

562 5th Avenue
Helena, Montana 59601
406-442-7416

Warm Springs Consumer Group

2/11/95

We the Consumers of Warm Springs chapter feel that we have not been provided with enough Information on the State hospital Building Plan and possable alternative sites, we feel that more time is needed to study the Issues. We suppor Reliesentitive Simmons Bill to Study these Issues further.

Jens L. Larson: President, Warm Springs chapter M.L.I.

Cody Purdy Sec & Treasure

Ross Michael Stone Vice President

Charles L. Norman

Darrell W. Mason

Paul Woods

Darlene J. Tintinger

Juliette Suzanne Allen

THE DEPARTMENT OF MENTAL HEALTH

WESTERN MASSACHUSETTS OFFICE
P.O. Box 389
Northampton, Massachusetts 01061

EXHIBIT 13
DATE 2-14-95
SB 15

Mark R. Mitchell
Deputy Area Director

(413) 584-1644
FAX (413) 784-1255

**TESTIMONY OF MARK R. MITCHELL**
**MONTANA LEGISLATIVE HEARING**
**FEBRUARY 14, 1995**

I have reviewed most of the documents regarding the present structure of the Montana Mental Health System and the proposal to construct a new state hospital at Warm Springs. Subsequent to my review, it is my professional opinion that such an alternative is neither in the best interests of Montana mental health consumers nor the state of Montana. I am encouraging the state explore other alternatives prior to embarking on such a costly and permanent solution, which will so dramatically affect the lives of the mentally ill and the structure of health and mental health care delivery in this state.

As an example of one such alternative, I am offering you some comparative perspectives from a system which has eliminated its state hospital in the provision of care for mental health consumers.

Approximately 3 years ago, Western Massachusetts had through an aggressive community mental health initiative (which actually began 14 years prior) reached a decision threshold similar to the one which now faces Montana - whether to reinvest in an antiquated state hospital with and/or without new construction, or to pursue other alternatives. At that point in time, our state hospital (Northampton State Hospital) had an average daily census of 130

patients, which is not substantially different from the 135 average daily census against which Montana has developed a proposal for construction of a new state inpatient facility. The alternative we chose was to continue to invest in our community system of care, and to privatize acute and extended inpatient care services.

The **major outcomes** of this decision in Western Massachusetts to date have been:

(1) **Improved quality of care** closer to home, and

(2) A net **savings to the Commonwealth** of $4.0 million.

Additional benefits have been:

(1) A **reduction in overall inpatient bed need** by 45%;

(2) A **decrease in the average length of stay** in acute care from 44 days to 28 days;

(3) A much **more rapid turnover in our extended care inpatient** population than had been expected (50% placement into community programs within the first year of operation);

(4) An 40% **decrease in incidents of seclusion and restraint;**

(5) An 80% **reduction in escapes**, and

(6) **No increase in recidivism** rates.

Within a year of initiating the decision to privatize state hospital care, the Division of Medical Assistance within our Department of Public Welfare (our Medicaid agency), recruited an MCO to manage mental health and substance abuse benefits for Medicaid recipients. This initiative has resulted in a reduction in general hospital psychiatric inpatient bed use by 25% in Western Massachusetts and a concomitant savings of approximately $5.0

million.

We continue to see the demand for inpatient care decreasing. In fact, we will be reducing acute beds this coming fiscal year.

Although there are some obvious differences between Montana and Massachusetts, there are a number of meaningful similarities between Western Mass. and Montana which lead me believe that some of these alternatives would be workable in this state.

Montana is a very rural state compared to Massachusetts. The size of Montanas' population (although not the cultural mix) at 803,000 is comparable to that of Western Massachusetts at 820,000. Point prevalence estimates for adults with severe and disabling mental illness for Montana are 6014 persons, and estimates for Western Massachusetts are 6116 persons. Both the general size of the population and prevalence estimates allow relevant comparisons of need, leading me to the opinion which I have offered above.

Given the general comparability of Montana and Western Massachusetts on population size and prevalence, I offer a series of observations for your serious consideration.

(1) The overall use of inpatient care (acute and extended) for "public sector" patients in Western Massachusetts is dramatically less than will exist in Montana should both the state hospital be constructed and general hospital inpatient units continue to exist. Total range of Western Massachusetts bed use is between 140 and 170 beds for all payors (80-90 public sector beds and 60-70 beds for

other payors). By comparison, after construction, Montana would have a total in excess of 315 inpatient beds (135 to 166 beds under the state hospital rebuilding plan, plus about 180 beds in psychiatric units in general hospitals, plus an unknown number of beds in private hospitals.) This means that, based upon valid population comparisons, **Montana will have at least 145 more inpatient beds than needed.**

(2) Managed Care Organizations (MCO) make their money by reducing both the reimbursement rates and the use of inpatient care. Montana should expect the same outcomes which have been realized in other states with an MCO initiative. This means that in order to survive in the future, general hospital units will be competing for many of the same acute and intermediate care patients which Montana State Hospital is presently serving and would continue to serve should the new facility be constructed. The choice will then be between a central state operated facility or dispersed units in general hospitals, **both will not survive as acute care providers in the mental health system.** Lengths of stay will be reduced in the acute care arena, funding only "medically necessary" days of care. These actions will create great pressure for discharge of patients from acute units. This raises the second major dilemma - Does Montana wish to use a "state of the art, JCAHO accredited" hospital to provide what is essentially "domiciliary" care and pay at hospital rates for this care, or will it reinvest existing resources in more appropriate community care at much lower costs?

(3) National trends in acute inpatient mental health care reveal, and continue to project, approximately a **6% annual decrease**

**in bed utilization.**

(4) Montana will require an extended care facility for the most difficult to manage and certain long-term forensic patients. If no private facilities are interested or available which are able to tap into the medicaid funding for chronic care, then it is at this level Montana may wish to begin exploring a state operated facility. To provide a perspective, Western Massachusetts DMH has a contract for a 30 bed unit (which we call our Secure Rehabilitation Unit) in a city owned Municipal Hospital. Although considered a "long-term" unit, we designed the program to be an intensive rehabilitation delivery, and secured both the clinical and rehabilitative services through a subcontract with the University of Massachusetts Medical School, Department of Public Sector Psychiatry.

If there is interest and support in a new vision for the care and treatment of the mentally ill in Montana, as well as for a cost effective and efficiently designed and managed mental health structure, I recommend consideration of the following alternatives at this time:

(1) **Plan for a system of public sector acute inpatient care for no more than 100 beds,** with flexibility to be adjusted downwards with changing trends and the introduction of new therapies. Preferably this development would be within the general hospital system for a variety of reasons:

(a) avoidance of large capital investment in the construction and maintenance of a new state facility;

(b) avoidance of the continued fostering of a dual system of inpatient mental health care;

(c) increased accessibility by providing care closer to home (and avoidance of transportation costs which currently may not reflected in overall operating costs);

(d) general hospital units are already JCAHO accredited;

(e) general hospital units are likely under-utilized;

(f) consumers remain connected with the community system of mental health care for discharge planning, continuity of care, support and more rapid reintegration; and

(g) flexibility (buy a certain portion of beds only on a demand basis).

Preferred provider relationships can be developed with each of the general hospitals operating these units. The relationship would include: enriching the unit rate, directing all inpatient referrals, no reject stipulations up to unit capacity, and lengths of stay based on "medical necessity". Transfers from acute to extended inpatient care would be approved by a Medical Director (either at the extended care unit or with a statewide MCO working on behalf of the Division of Mental Health).

(2) **Plan for a single unit of no more than 30 beds for extended inpatient care.** This unit could be operated by the state if no other suitable licensable facility existed where care could be purchased. It would be most advantageous if such a unit were part of a larger facility in order to defray administrative, maintenance and support costs, therefore reducing the unit rate.

(3) **Redirect resources for the development of more comprehensive community mental health care,** particularly residential and residential support (intensive case management) services.

(4) **Redirect resources to establish crisis intervention** services located within each Region to provide mobile assessment short term intervention and support, as well as a 40 bed capacity for inpatient diversion and rapid step-down from inpatient care. The crisis services should also be the sole point of authority for all civil inpatient admissions. These crisis teams could operate as part of the CMHC's in each region.

(5) Discontinue all "voluntary admissions" to MSH.

(6) **Develop a "care management" system** that is based on individual client service plans and inclusive of consumer participation. This system should be responsible for coordinating the care and managing the utilization for all clients and services in the system (ie. intake, assessment, eligibility determination, individual service planning, level of care determinations, coordination of services, discharge planning from any inpatient unit, community utilization management with "no reject" referral authority to the CMHC and any other contracted or sub-contracted DMH services).

(7) Develop the systems of services at a regional level that are "no reject" for referrals from the "care management" system.

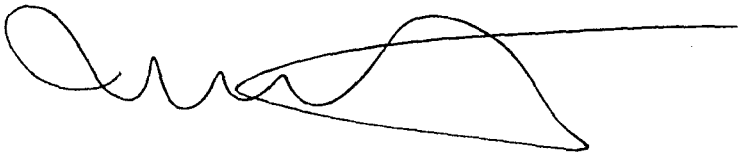
(8) **Redirect more of the resources presently being utilized for community mental health services to the priority population.** Presently, in Montana only between 43% and 64% of Mental Health Division resources are expended on the Seriously Mentally Ill (SMI) population, and only 22%-39% are schizophrenic or have a Major Mood Disorder (FY92-94 Montana Public Health System - Revised State Plan). By comparison, in Western Massachusetts, approximately 90% of the $54 million adult services DMH budget is expended on what

are Montanas' Criterion 1a and / or 1b, as outlined in the mental health plan. I would propose increasing the percentage of resources for the most severely disabled population **not** by shifting present expenditures, but rather through targeting the reuse of inpatient resources for priority population.

(9) Pursue a Rehabilitation Option Waiver in the State Medicaid Plan to permit optimal Medicaid reimbursement of community mental health services.

Clearly, the Mission outlined in the Montana State Plan is consistent with that of developing such a system. Given the documents I have had the opportunity to read regarding the Montana Mental Health system, I believe that the state has the ability to develop what has been envision as the "ideal" system as outlined in the Mental Health Plan. However, such development will require the consideration of alternatives to the proposed rebuilding of the state hospital.

Respectfully Submitted,



Mark R. Mitchell

EXHIBIT 19
DATE 2-1-95
SB 15

Montana Alliance for the Mentally Ill

MonAMI

To Long Range Planning Subcommittee

OPPOSE BUILDING A NEW STATE HOSPITAL AT WARM SPRINGS

MonAMI is a family and consumer group advocating for services for family members who have serious mental illnesses--schizophrenia, bipolar disorder (manic-depression) and major depression as well as other neurobiological brain diseases. I'm Marty Onishuk, vice president. We have eight chapters in Montana.

Treatment in an accredited hospital is central to coping with neurobiolical brain diseases. This facility must care for those who do not respond to current medications and cannot live on their own in communities and those who have decompensated and need adjustments of their medications. For these reasons MonAMI is greatly concerned where the new state hospital is built.

We oppose the current plan to build a new hospital at Warm Springs for the following reasons:

1. By 1996 mental health services in Montana will be contracted out to a managed care corporation. The new system will offer a spectrum of care for the mentally ill. The state hospital will be an important part but only one part of the system, not standing alone in state funding and responsibility as under the present system. Until managed care is in place and operating, we will have no idea what size hospital facilities are needed. The hospital is scheduled for completion three years after managed care begins. It makes no sense to at start construction of a hospital at Warm Springs that may not be adequate when completed.

2. Eighty percent of state general fund money for mental illness services goes to the hospital at Warm Springs. This leaves little to fund community-based services that could eliminate the need for hospitalization at Warm Springs. Community services would include crisis intervention, safe houses,case management, local hospitalization, and so on. Building a new hospital at Warm Springs will freeze this inefficient spending pattern.

3. The Warm Springs facility is based on an 1877 notion of how to treat mental illness, namely an isolated "insane asylum." Current thinking is to provide treatment in a community setting using community resources. Warm Springs does not provide a community, only an institution.

4. At Warm Springs, forensic and civil patients are treated. We oppose mixing these populations together on the same campus. Montana is the only state with prisons and mental illness in the same department. (We recognize the need for treating prisoners at Deer Lodge and are pleased that at least 140 are being treated there. We also recognize that many are sent to Deerlodge because their mental illness is not treated promptly and this results in criminal behavior.)

5. The very name "Warm Springs" constitutes a stigma to the mentally ill. Moving the facility to a true community would do much to erase this handicap.

6. With fiscal conservatism in fashion, the new facility should be built where one can take advantage of existing infrastructure,namely, streets, sewers, lighting, and so on. This would focus available money on the hospital itself,not on infrastructure Moreover, the hospital could be put up for bid to various communities, just as was donefor the women's prison.

7. The needs of consumers should prevail in selecting a site for the hospital. Above all, consumers need a community where they can walk to stores, restaurants, banks, and housing, as part of their transition from hospital to society. The same facilities should be available to their families who come to visit or support them. The community should be socially and professionally attractive to the hospital staff. Warm Springs simply doesn't offer these kinds of facilities and amenities.

8. The Montana Constitution calls for citizen participation in governmental decisions. The decision to build the new hospital at Warm Springs was made without citizen consultation. They were merely asked to approve this decision after it had been made.

9. Ideally, the new hospital should be built in a community that houses part of the university system. This would help attract high-quality professional staff and facilitate advanced training of hospital personnel.

10. The facilities now in place at Warm Springs should be turned over to the prison system. This would allow for expanded but segregated treatment of prisoners and it would provide jobs for those who chose not to relocate to a new hospital site.

This bill is premature and should be rejected until two important issues are resolved: (1) the needs and functioning of the managed care system to be implemented in 1996 and (2) providing a hospital site that more fully meets the needs the mentally ill, their families, and the hospital staff. Please vote "Do not pass."

February 2, 1995
5855 Pinewood Ln
Missoula, MT 59803

EXHIBIT 20
DATE 2-14-95
SB 15

For: Long Range Planning Committee

Date: February 14, 1995

Mr. Chairman and members of the Committee:

My Name is Sophie Manley. I am a consumer and also the secretary of the Horizon's Consumer Help Group in Great Falls. We are a chapter of the Meriwether Lewis Institute and have been meeting regularly for four years.

We are a support and advocate group aimed toward helping those with Mental Illness improve their lives. As a group, we have accomplished a great many things but our proudest accomplishment is the opening of the Blue Haven Drop- in-center in Great Falls. We opened the doors thirteen months ago. The Drop-in-center is staffed entirely by people with mental Illness and is the first in the state to be completely Consumer run. We feel that Blue Haven is one example of the new types of services that need to be offered in the Community if we are to adequately meet the needs of Mental Health Consumers. We've seen on a daily basis how successful the Blue Haven Drop-in-Center is and that insight has made us aware that there are other alternatives to the rebuilding of the State Hospital.

I have with me today a brief letter that states the position of the Horizon's Consumer Help Group regarding the rebuilding of Montana State Hospital at Warm Springs. It states:

(See attached)

2-14-9

Mr. Chairman and esteemed members of the Committee:

The Horizon's Consumer Help Group is opposed to the current plan, by the Department of Corrections and Human Services, to rebuild the Montana State Hospital at Warm Springs. The Hospital at Warm Springs is isolated and stigmatizing as it is.

If a new hospital needs to be built, we would rather see it in a community setting where the hospital activities could be coordinated with the community based services already provided. Please, Do Not support the current plan to rebuild.

Thank you.

Sylvia Manley Sec. Betty Duke V.P

Mark Smith Treas. Penny Oxford C.S.K.

EXHIBIT 21
DATE 2-1-95
SB 15

To The Right Honorable Members of the Appropriation Committee

Rebuilding of Smaller State Hospital at Warm Springs H.B 15

From Winnifred Storli FLAMI (Flathead Alliance for Mental Illness)
P.O.Box 249,Kalispell
MT 59901 2/2/95

Key

CMH Community Mental Health
SMI Serious Mental Illness
FLAMI Flathead Alliance for the Mentally Ill
NBD Neurobiological Brain Disorder

We of FLAMI want to go on record as being opposed to building a new,smaller,110 bed,state facility at Warm Springs, for the following reasons:-

1. Managed Care appears to be coming in and nobody knows what changes this will bring therefore this is no time for irrevocable change.

2. New frontiers of scientific discovery are being opened and as Representative Fisher has remarked there may very well be a cure for schizophrenia.

3. CMH seems unable to provide timely,treatment intervention for the non-responding chronic,serious NBD patient. We refer to the increasing incidence of community violence,suicide and emergency jail evaluations. Thus reducing beds from 200 to 100 makes no sense.

3.b) Patients are now virtually refused admission to Warm Springs on a voluntary basis. They are now left to detiorate to the extent that they live on the streets,commit violent acts and if and when involuntary committed have detiorated mentally and physically.

3.C) The longer NBD patients remain untreated the greater the brain damage, the greater the stigma, the more the anguish for families and loved ones, the more danger for society, the more increase in expense and economic loss to society.

4.With the increasing population in Montana the incidence of SMI will grow.

5. Since State Law mandates the "least restrictive setting for patients,"if a new hospital is built it should not be built in isolation, where there is no place for families to visit, no motel or even cafe. Patients have no opportunity to mingle in the community, "T" Houses"have been closed in Regions V and IV. How then can patients prepare to return to their communities?

6. A new facility should be state of the art and be near an university and medical center where there is a pool of professional talent, research, resources that Warm Springs does not have.

7. If 80% of funding goes towards Warm Springs there is not much left to reform or improve Community Mental Health services.

8. We have seen no calculations on improving the present structure to meet with codes. It appears that no alternate studies or plans have been submitted.

9.So far there has been a great deal of comment about how much the new 20 million dollar facility will save in heating and staff costs to the state. However, there has been no cost analysis on what savings there will be for the **taxpayer,county,federal government and citizens.** After Ihler and the downsizing of Warm Springs from 300 to 200 the budget in Region V rose from (C) $2,500,000/ in 1990 to $6,300,000/ and Medicaid from $680,000 to $3,326,000/-!!! the cost of placing a patient in a psyhiatric ward is astronomical. In a group home or "T" house(which are now being shut down) the cost Monday to Friday was approximately $90/- a day, crisis centers for cooperative (D) patients $380/- a day, while severely disabled clients now.living independently cost even more!!! Surely it is the duty of the department to bring these costs before this board?

Consumers,family members and myself want to state that the doctors, staff and treatment at Warm Springs have often been the only place where severely ill patients have been successfuly treated and stabalized. In my own family our daughter returned to society after over a dozen hospitalizations and Warm Springs has earned the gratitude of our family and many others. This,however does not change our opposition to tearing down and rebuilding the state hospital at Warm Springs.

Sincerely yours,

Winnifred Storli

Winnifred Storli

Vice President FLAMI
MONAMI Board Member
Ad Hoc Member of the Mental Health Association
Member of the Montana Association of School Psychologists

# Whitefish woman holds police at bay w

By NANCY WOODRUFF
The Daily Inter Lake

Authorities this morning were trying to talk to a Whitefish woman who had kept family, police and SWAT team members at bay with a pistol and a stun gun at her home since shortly after 2 p.m. Monday.

Authorities were bringing a shield called a body bunker from Missoula and were considering using it to try to disarm the woman, who was reportedly sitting on her bed with a small-caliber semi-automatic pistol pointed at the doorway.

Officers were called to her Texas Avenue mobile home after a court hearing in which the woman, 58, was judged not competent to handle her own affairs; her sister was appointed her legal guardian.

The woman brandished the weapons and refused to come out of her bedroom, where she had reportedly been living for some time.

Whitefish police and six members of the sheriff's tactical weapons team entered the home and stood watch during the night. Three negotiators, two from the Kalispell Police Department and one from the FBI, tried to talk to the woman, but she had not spoken during the standoff, authorities said.

Officers watched the woman with the aid of mirrors. They said she stood in her bedroom doorway with a weapon in each hand for eight hours without moving. She had not slept and had not accepted offers of food or drink, officers said.

Authorities feared the woman might harm someone if left alone, said Sheriff Jim Dupont.

"It's one of those things you can't walk away from. She's not a criminal, she is mentally ill," Dupont said. "We're just going to hold off and take as long as it takes" to bring the woman out safely, he said.

A psychiatrist who has cared for the woman said she is not likely to kill herself but might shoot others if appro

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A public
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## Residents worried about hospital releases

ANACONDA (AP) — Residents here are circulating petitions seeking to have former Montana State Hospital patients returned to the counties they were sentenced in.

"We want a community where our children are safe," said Jayne Boston of Anaconda, who helped start the petition drive.

Late last week, Henderson Houghton was released from the state hospital and rented an apartment in Galen operated by the Anaconda Deer Lodge city-county government.

Houghton, 55, was committed to Warm Springs in 1981 after he was acquitted of a charge of deviate sexual relations in Great Falls. The acquittal was based on a finding that Houghton had a mental disorder.

Their position is that people released from Warm Springs should go back to the counties they came from," said Sherry Davis of Anaconda.

There could be several more patients released from Warm Springs. A recent U.S. Supreme Court ruling said people acquitted of crimes because of mental illness could not continue to be held in institutions unless they still were both mentally ill and a danger to society.

Davis said many residents of Anaconda, Warm Springs and Galen are concerned about former prison inmates and mental patients in their midst.

Davis and Deaton said the petitions will be presented to the city-county commissioners at a meeting Tuesday night.

GREAT FALLS CASE

Great Falls Tribune 10/26/94

## Accused cop killer dies of heart attack

McDONALD suspect dies

GREAT FALLS (AP) — The accused of shooting and killing Great Falls police officer in a hospital emergency room Tuesday after suffering an apparent heart attack in his jail cell, authorities said.

Bobby McDonald, 48, went into convulsions in his cell Tuesday morning and an ambulance was called to the Cascade County Jail, but McDonald stopped breathing before it arrived, according to Undersheriff John Hall.

Emergency crews were able to revive McDonald but he died a short time later in the Columbus Hospital emergency room. Stran-

hospital, McDonald was charged with murder and five counts of attempted murder, the latter charges stemming from shots he allegedly fired at police during the siege at his apartment building.

Last Friday a judge for a second time postponed McDonald's arraignment on the criminal charges. McDonald did not speak

Associated

October 15, 1994 - The Missoulian

## Hospital employees allege attacks

■ WARM SPRINGS — Union members at the Montana State Hospital are complaining that working conditions are unsafe, and that they're being attacked by patients.

Members of the Warm Springs Independent Union discussed the issue at their regular meeting this week.

Jeannie Buhl, a special duty aide in the secure treatment program, said there have been 80 attacks on staff members in her unit since Jan. 1.

"Daily all of us are working in unsafe working conditions," she said.

Union Treasurer Charles Wandler suggested that the statistics in all of the units were high enough to constitute unsafe working conditions, and raised the possibility of a class-action lawsuit.

Attacks by patients are not unexpected, Dan Anderson,

MSH ADMISSIONS BY REGION - FY 91 - FY 93

| | REGION I | REGION II | REGION III | REGION IV | REGION V | Other | State |
|---|---|---|---|---|---|---|---|
| Population | 57831 | 139691 | 164674 | 193448 | 213421 | | 799065 |
| FY 91 ADMISSIONS | | | | | | | |
| Voluntary | 16 | 26 | 45 | 100 | 45 | 29 | 262 |
| Civil Involl | 13 | 11 | 51 | 70 | 51 | 5 | 201 |
| Total | 29 | 37 | 97 | 170 | 96 | 34 | 463 |
| Admission per 10000 | 3.30 | 2.65 | 5.89 | 8.79 | 4.50 | | 5.79 |
| FY 92 ADMISSIONS | | | | | | | |
| Voluntary | 9 | 24 | 45 | 80 | 44 | 7 | 209 |
| Civil Involl | 18 | 11 | 70 | 67 | 53 | 12 | 231 |
| Total | 27 | 35 | 115 | 147 | 97 | 19 | 440 |
| Admission per 10000 | 3.07 | 2.51 | 6.98 | 7.60 | 4.55 | | 5.51 |
| FY 93 ADMISSIONS | | | | | | | |
| Voluntary | 2 | 3 | 5 | 7 | 4 | 4 | 25 |
| Civil Involl | 23 | 9 | 48 | 47 | 47 | 11 | 185 |
| Total | 25 | 12 | 53 | 54 | 51 | 15 | 210 |
| Admission per 10000 | 2.85 | 0.86 | 3.22 | 2.79 | 2.39 | | 2.63 |
| 91-93 Reduction | -13.8% | -67.6% | -45.4% | -68.2% | -46.9% | -55.9% | -54.6% |
| 92-93 Reduction | -7.4% | -65.7% | -53.9% | -63.3% | -47.4% | -21.1% | -52.3% |
| VOLUNTARY ADMISSIONS | | | | | | | |
| % Decrease 92-93 | -77.8% | -87.5% | -88.9% | -91.3% | -90.9% | -42.9% | -88.0% |
| INVOLUNTARY ADMISSIONS | | | | | | | |
| % Decrease 92-93 | 27.8% | -18.2% | -31.4% | -28.9% | -11.3% | -8.3% | -19.9% |
| TOTAL VOL & INVOL | | | | | | | |
| % Decrease 92-93 | -7.4% | -65.7% | -53.9% | -63.3% | -47.4% | -21.1% | -52.3% |

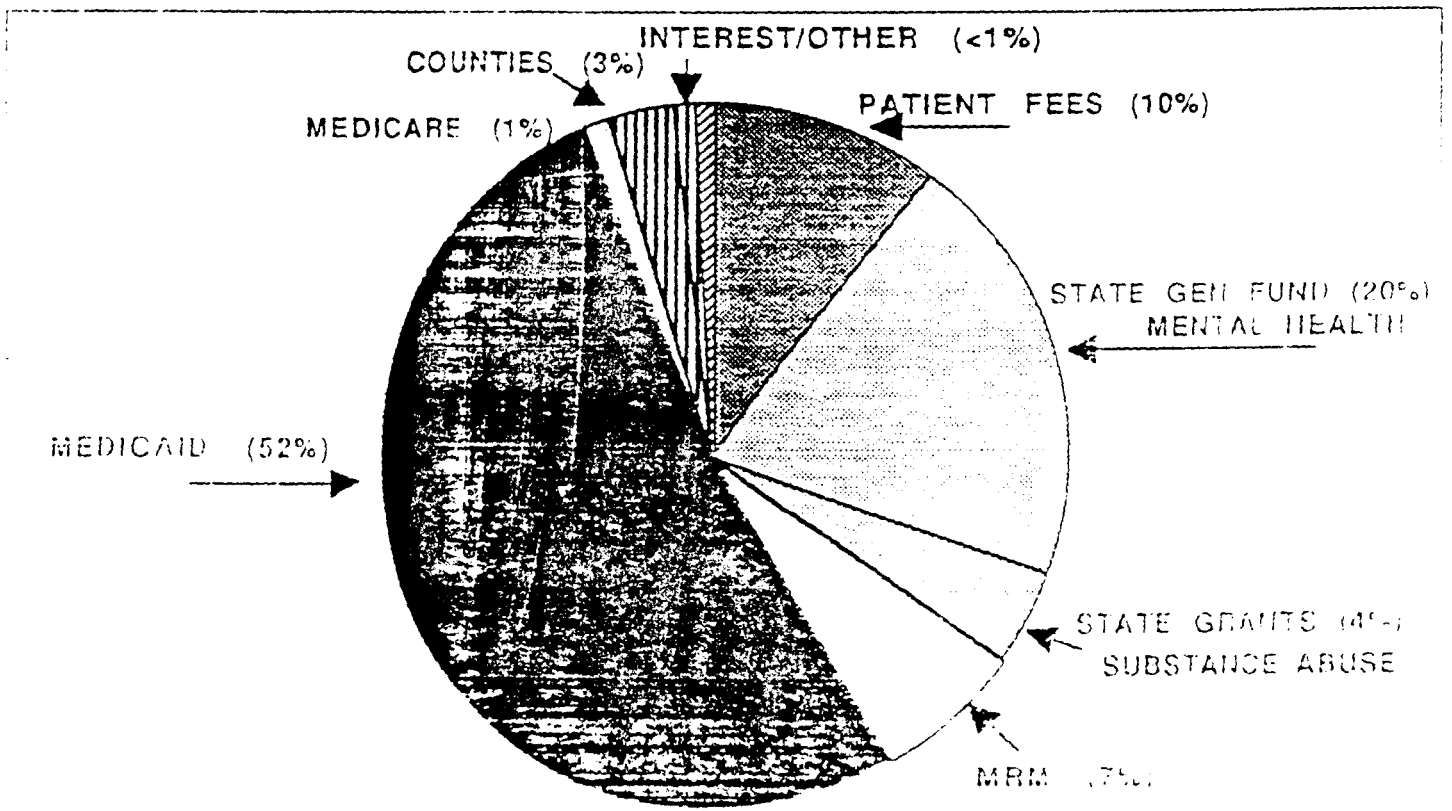
Voluntary Admission

WSADMSO.WK1

# WESTERN MONTANA MENTAL HEALTH CENTER

## REVENUE SOURCE ANALYSIS FY 89-94

| | FY 89 | FY 90 | FY 91 | FY 92 | FY93 | FY94 |
|---|---|---|---|---|---|---|
| PATIENT FEES | $443,332 | $440,565 | $482,414 | $398,045 | $518,160 | $682,111 |
| STATE GEN FUND | $1,050,563 | $1,074,989 | $1,027,523 | $1,072,017 | $1,013,090 | $1,270,559 |
| STATE OTHER | $159,825 | $179,236 | $277,375 | $655,145 | $838,516 | $266,058 |
| STATE MRM | $0 | $0 | $0 | $0 | $0 | $427,802 |
| MEDICAID | $637,151 | $684,539 | $1,007,034 | $1,828,827 | $2,364,351 | $3,326,602 |
| MEDICARE | $18,324 | $34,306 | $36,573 | $53,321 | $102,641 | $62,319 |
| COUNTIES | $107,481 | $107,727 | $107,597 | $173,771 | $244,710 | $209,877 |
| UW COALITION | $0 | $0 | $3,460 | $55,367 | $60,710 | $60,000 |
| INTEREST | $27,202 | $22,641 | $23,323 | $15,743 | $9,760 | $9,461 |
| OTHER | $21,883 | $10,113 | $13,877 | $16,994 | $54,386 | $37,662 |
| | $2,465,763 | $2,554,116 | $2,979,185 | $4,269,230 | $5,206,324 | $6,352,451 |



D

1993-94

REGION V MISSOULA, KALISPELL, LIBBY, PLAINS, POLSON COMPARATIVE COST

"T" House (Transitional Group) Per day (8 Patients) 24 Hr. Care

| | | |
|---|---|---|
| Room & Board | 36.62 | (General Fund) |
| Day X M-Friday | 32.30 | |
| Group Therapy | 11.91 | |
| Com. Living | 12.06 | |
| Total | 92.82 | |

(Client on S.S.I pays $300 monthly)

Crisis House (Up to 2 weeks) Per day 24 Hr Care

| | | |
|---|---|---|
| Room & Board | 181.00 | (Gen. Fund) |
| Day X Mon-Fri. | 32.30 | |
| O.P Group | 23.82 | |
| O.P. Physician ½ Hr. | 46.00 | |
| Ind. Therapy | 57.76 | |
| Case Management | 41.58 | |
| | 382.46 | |

Clients pay $20/- per episode.
Have to be cooperative + can leave anytime

Independent Living (8 Patients)
With ICM (Intensive Case Management)
Unsupervised after 9 p.m.
80 hrs ICM a week at 41.58 per hr.
= 80 X 41.58 = $3326.40 for 11 hr. day.
per week.

Warm Springs
$250 - 300 daily

Annual Costs

T House 36.62 X 8 X 365
= $106,930.40 State Gen Fund

Ind-Living
80 X 52 X 41.58
= $172,972.80 Medicaid
+ Section 8 Housing
+ Fuel Assistance

# *Meriwether Lewis Institute*

562 Fifth Avenue
Helena, Montana 59601
(406) 442-7416

EXHIBIT 22
DATE 2-14-95
SB 15

For: LONG RANGE PLANNING COMMITTEE
Date: February 14, 1995

Mr. Chairman and members of the Committee:

My name is Kathy Standard and I serve as President of the Meriwether Lewis Institute. Our organization focuses on education about mental illness and advocacy for all of us who have a mental illness. Much of our work involves advocating for the greatly-needed improvements in our mental health system that could enable Montana's mental health consumers to live longer, more productive and higher quality lives.

On April 20, 1994, I first became aware that a Campus Design Committee was meeting regularly at Montana State Hospital. I wrote a letter to Archie McPhail the same day, with a copy to Dan Anderson, expressing our concern that there was no mental health consumer representation on their Committee. I have yet to receive any response at all to my letter.

On September 13th, the MLI Board of Directors met and voted to take the following position regarding Montana State Hospital: **"The MLI Board of Directors adamantly opposes the plan currently being proposed by the Dept. of Corrections & Human Services to rebuild Montana State Hospital at the Warm Springs site."** A great deal of discussion went into the choice of words used in MLI's position statement; back in September, we still held out some hope that reasonable discussions could ensue with the Dept. regarding their proposal, and that changes which would be acceptable to MLI's Board might be suggested.

Members of the Board in various communities attended the September Public Meetings on the MSH Campus Design plan; in fact, MLI was the only advocacy organization to have at least one member in attendance at all 7 of the Meetings. I mention that fact not to brag, but to remind everyone once again that this is our hospital being discussed - we are the patients,

the people who are supposed to benefit from the hospital's services. All those numbers of admittances and discharges at the State Hospital represent me and people just like me. Among my many hospitalizations, I have been committed to Warm Springs twice. I became involved in the mental health consumer movement because of being hospitalized there, and I have a major investment in the decision your Committee must make.

On October 11th, following the Public Meetings on redesigning Montana State Hospital, Rick Day sent out an 11-point letter supporting the Department's firm decision to rebuild the MSH campus at Warm Springs. On October 25th, Mr. Pope and I wrote a lengthy letter to Mr. Day, discussing his letter point-by-point and asking him to please respond to 16 specific questions by November 11th, so the MLI Board could discuss his responses by teleconference and re-evaluate our position. We did not hear from Mr. Day until November 17th, 6 days beyond our deadline; his letter referenced our letter of Oct. 25th, but did not address the contents or our questions whatsoever. Instead, he invited us to a meeting of the Campus Design Committee on December 1st.

On November 28th, Senator Mignon Waterman wrote a 12-point letter to Rick Day, with 22 specific questions or requests for specific data. On January 4th, 5 weeks later, Dan Anderson, not Rick Day, finally responded to Senator Waterman's letter. Mr. Anderson's letter answered only a small portion of her questions, and failed to supply some of the specific data she requested.

I believe the Department's refusal to answer letters in a timely manner, if they answer them at all, speaks eloquently to their total lack of concern for the opinions and issues of both mental health consumers and of legislators. Has the Dept. of Corrections & Human Services forgotten who pays their wages, who approves their proposals, and who it is they are mandated to protect and care for with their services? Why have they doggedly refused to allow people from outside Institution Valley to be involved in their planning process regarding MSH?

There are many mental health consumers who wanted to be here today to address your Committee. Given the weather and the financial constraints of traveling for consumers, most of them cannot be here. Therefore, I would like to read you the names of the Directors of the Meriwether Lewis Institute, whom I hope I have adequately represented: Joyce Anderson of Hamilton; David Broadway of Great Falls; Jaoma Graves of Great Falls; Deb Hemmer of Missoula; Henderson Houghton of Billings; Irvin Moen of

Kalispell; Mark Morin of Butte; Scott Small of Helena; and Fred Waters of Kalispell. Other consumers who asked to be mentioned as opposing the Department's current plan are: Laura Johnson of Bozeman; Jim Kistler of Bozeman; Betty Duke of Great Falls; Mark Krakowski of Great Falls; and Richard Bucher of Kalispell.

We ask that you oppose the plan to rebuild Montana State Hospital at Warm Springs until such time as those of us who are the most deeply affected by this project - mental health consumers and our families - are invited to sit at the planning table and actively participate in shaping the future of our mental health system. Long after we are gone, people in Montana will continue to need - and deserve - effective, high quality mental health care in the least restrictive and most appropriate setting possible. Stastically speaking, it is highly probable that your children and grandchildren will be among those needing care for mental illness. Please, let's make sure that the decisions made now are what is best for future generations also, not just a brick and mortar monument to someone's power and bullheadedness.

Thank you.

EXHIBIT 23
DATE 2-14-95
SB 15

Representative Bergsagel
Joint Appropriations Long-range Planning Sub-committee

February 14, 1995

Dear Representative Bergsagel and members of the Committee:

My name is Suzanne Taunt. I live in Helena. I have a family member with a severe and persistent mental illness. I am a member of the Helena Alliance for the Mentally Ill. I have been associated with the Montana Advocacy Program for over 9 years, first as a member of the Advisory Council and currently as a member of the Board.

My sister has suffered from schizophrenia for 28 years. She is one of the fortunate ones who was helped by the drug Clozapine. With the effective drug therapy and the help of her case manager and my father's unwavering determination and support my sister is able to live independently.

I find the idea of re-building a new state hospital at the same site premature. An adequate needs assessment has not been done. DCHS has proceeded with a pre-determined agenda for re-building the hospital. I would hate to think that the jobs of Deer Lodge Valley residents were more important than cost effective, up-to-date care for individuals suffering from mental illness; care and treatment that could most likely be achieved in a less restrictive environment closer to the individual's home community.

Proposing to build a new hospital to the tune of $20 million without adequate planning in place or consideration of consumers' needs is tantamount to the absurd - at a time when the Legislature is examining the need and appropriateness of every dollar spent.

> Has DCHS been in consultation with all of the community hospitals in the state which offer in-patient psychiatric services to examine the viability of buying services from them?
>
> Has DCHS considered establishing a continuum of care utilizing already existing in-patient care around the state at a time when the need for in-patient beds is decreasing nationally because of new medications and treatment modalities?
>
> Could DCHS expand the already existing regional community mental

health care system and could it be more closely linked with the already existing community hospital in-patient psychiatric services?

Could more crisis intervention services be funded with mobile assessment units?

Couldn't DCHS develop and improve community-based services, thus insuring treatment in the least restrictive setting for individuals suffering from mental illness?

Finally, is DCHS more interested in protecting jobs than in providing high quality, cost effective care for individuals suffering from mental illness?

I oppose this building proposal and I support a proposal that examines all the alternatives and provides for consumer input.

Please vote against this proposal and VOTE FOR HB468 with the proposed amendments.

Thank you.

Suzanne Taunt

Suzanne Taunt
1890 Colorado Gulch Dr.
Helena, Mt. 59601

**MHC**
Mental Health Center

EXHIBIT 24
DATE 2-14-95
SB 15

February 13, 1995

Mary Gallagher
Montana Advocacy Program
P.O. Box 1680
Helena, MT 59624

Dear Mary:

I would like to express my concern in regard to the Department of Corrections and Human Services' attempts to redesign the campus of Montana State Hospital at Warm Springs.

Initially, I would say, in defense of the Department, if it is the intent to continue serving Montana citizens in the Warm Springs model, then we have an obligation to provide the best quality care possible at that location. As we all know, we are currently treating people in buildings that have been identified as being unsuitable. I would also say that if it is the Department's intent to continue providing such a service in a single location, perhaps the Warm Springs campus is as good a location to provide care as any in the State. Any *single* location for a State Hospital will present the same kind of geographic problems that Warm Springs has at present.

My first comment in regard to this issue would be that the decision about redesigning the Warm Springs campus should not be made in isolation of other issues. We have spent years emphasizing community care and the state has put a great deal of energy and funding into providing services through community providers. A question here would be, does this redesign model inhibit the possibility of future community services? Does redesigning the State Hospital campus require such a long-term commitment to that facility that it will become impossible to provide a similar service in other communities? In Billings, Deaconess Medical Center has offered to provide inpatient care in Yellowstone County, for those individuals who would normally be sent to Montana State Hospital. If the Committee is to vote in favor of the campus redesign, I would recommend that they also provide some assurance that, in the future, we will have the possibility of providing a like service in other communities. Perhaps any identified savings from the campus redesign could be used for such services.

My second point is in regard to flexibility in general, and the Managed Care project. For the last year, the entire state has been working on the Managed Care concept put forth by the Department of Medicaid. The discussion has been what to do with the State Hospital in a Managed Care environment. If we stay with the concept that services should be

P.O. Box 219, Billings, MT 59103-0219 1245 North 29th Street Office: (406) 252 5658 — FAX (406) 252 4641

flexible, and community based, how does the redesign model fit into the Managed Care system? If we do redesign and rebuild Warm Springs campus, will it prohibit the State Hospital from being rolled into Managed Care? My preference would be that the vote on this particular issue be delayed until the vote on Managed Care takes place. If Managed Care becomes a reality, there may be other possibilities available besides a single model, single hospital concept.

Sincerely,

Robert M. Ross, M.S.,LPC
Executive Director

RMR:lm

western montana
MENTAL HEALTH CENTER

EXHIBIT 25
DATE 2-14-95
SB 15

Bldg. T-9
Fort Missoula
Missoula, Montana

February 13, 1995

**LEGISLATIVE TESTIMONY**

TO: Members of the Long Range Building Committee

FROM: Paul Meyer, Executive Director

RE: Warm Springs Redesign

I write with the hope that I can share my thoughts with the appropriate legislative committee regarding the plans for redesigning the state hospital at Warm Springs. Anyone that has visited the campus will agree that certain buildings are outmoded and should be replaced. Some of the buildings currently housing patients and treatment programs were designed more than fifty years ago and are unsafe and inefficient. Further, there would undoubtedly be efficiencies achieved through the consolidation of the campus For these reasons the proposals before the legislature is worthy of consideration.

However, the investment of $20 million into the current hospital grounds is probably ill advised at this time. Many questions remain unanswered:

- **How can the hospital continue reducing its population without the development of comprehensive crisis programming in the community?**
- **Where is the parallel plan for support and improvement of the community based services which serve 95% of the persons with a mental illness in the this state?**
- **How can any of us know the effect of the proposed managed care initiative on the size and scope of services needed in the decades to come? How many beds does the state hospital really need under a revamped competitive system?**
- **Does the location at Warm Springs really serve the patient best or might there be other considerations regarding location that should be made?**

In addition to these concerns, the process which developed this plan for redesign is generally perceived to be too heavily influenced by state hospital staff and not reflective of broader mental health concerns. I believe we need more time and more discussion before making decisions which we will all live with for many decades to come. Thank you.

# Mental Health Association of Montana

*An Affiliate of the National Mental Health Association*

State Headquarters • 555 Fuller Avenue • Helena, Montana 59601
(406) 442-4276 • Toll-Free 1-800-823-MHAM • Fax (406) 442-4986




TESTIMONY OF DAVID HEMION
MENTAL HEALTH ASSOCIATION OF MONTANA
HB 15 - MONTANA STATE HOSPITAL RE-CONSTRUCTION
FEBRUARY 14, 1995

EXHIBIT 26
DATE 2-14-95
SB 14

1. THE MENTAL HEALTH ASSOCIATION OF MONTANA HAS LONG ADVOCATED FOR ACCREDITATION BY JCAHO FOR MONTANA STATE HOSPITAL

MHA supported legislation funding for management and facility improvements to meet accreditation. We commend the Mental Health Division of DCHS for the improvements in patient care, treatment programs and quality assurance which have been implemented.

2. MHA CONCURS WITH DCHS ON THE NEED TO REPLACE MSH FACILITIES

Current life & safety code violations create an unsafe environment for treatment and housing of most patients and liability for the State. This will prevent MSH from achieving accreditation and certification for Medicaid eligibility. Facilities are scattered over the campus, creating gross operating inefficiencies.

3. THE RE-DESIGN COMMITTEE AND DCHS WERE CORRECT IN SUGGESTING THAT A NEW FACILITY WAS WARRANTED

Cost of renovating and removing code violations in older buildings is uneconomic for life of investment. Facilities must meet code to allow Montana to receive the HCFA waiver to initiate managed mental health care. There are other waiver questions not related to the hospital's physical plant, making it only one of several issues. The waiver is not the only reason to re-construct MSH and should not be the driving factor.

4. THERE ARE POSSIBILITIES FOR INCREASING TREATMENT IN COMMUNITIES WHICH SHOULD BE FURTHER EXPLORED

The current MSH re-construction plan is to use the existing 56-bed geriatrics unit and build a 110-bed facility, providing a capacity of 166 beds. The Ernst & Young Study indicates the following:

There are a total of 150 licensed mental health beds in private hospitals in Billings, Butte (currently closed), Helena, Great Falls and Missoula. Utilization of these beds averaged only 62 patients daily (41 percent) in

EXHIBIT 20
DATE 2-14-95
SB 15

February 14, 1995

Representative Ernest Bergsagel
Joint Appropriations Long-range
Planning Subcommittee
State Capitol
Helena, Montana 59620

RE: Montana State Hospital Re-Building

Dear Chairman Bergsagel & Members of the Committee:

My name is Yvonne Snell and I am an Advocacy Specialist with the Montana Advocacy Program. My office is located at Montana State Hospital. One of the most rewarding aspects of my job has been to assist consumers with discharge planning.

Many of the consumers at Montana State Hospital have been patients for a long time, and no longer have a support system in the community. Some have never lived independently, and some are considered too ill or too institutionalized to ever live in the community. I would like to tell you about some individuals who seemed unlikely to ever leave Montana State Hospital, yet were discharged and have managed to live successfully in the community.

A. is a lady who had been in Montana State Hospital since 1964. During that time, she had two brief attempts at placement in group homes for persons with developmental disabilities. When I met her she longed to leave the State Hospital and live independently. However, it had been several years since her last attempt at group home placement, and she was losing hope of ever leaving Montana State Hospital.

A. decided she would like to live in Butte. She was able to begin a day treatment program at Silver House with occasional overnight trips to the crisis stabilization center, Gilder House. After a few months of this gradual transition, she was discharged from Montana State Hospital and moved into Butte. A. was assigned an Intensive Case Manager to assist her in learning to live independently. After a good start, A. experienced some difficult times living on her own. She briefly returned to Montana State Hospital, but stayed just a few days and returned to Butte. She had never lived alone, and required some very intensive services from Silver House. The Intensive Case Management services were very flexible and individualized to meet her specific needs. A. has been successful and has told me that she is really happy for the first time in her adult life.

A. is just one of many people I have seen leave Montana State Hospital and succeed in the community because of services available to them. M. is a woman who harmed herself repeatedly and was discharged after many years. She has managed to rebuild her life with the help of Intensive Case Management. D. is a man who was discharged from the Secure Treatment Program to a nursing home. He has blossomed from a uncommunicative man to a happy laughing individual who entertains others with his jokes. J. is a woman who has a diagnosis of mental retardation and no mental illness. She was discharged from Montana State Hospital after many years, and now lives in a group home with more freedom and normalcy than she had at the Hospital.

My purpose in telling you about these individuals is to inform you that people who are thought to be incapable of living in our communities and are committed to Montana State Hospital can live successfully outside of Montana State Hospital if they are provided adequate support and services. I would urge you to consider consumers needs for more community services.

Respectfully Submitted,

Yvonne Snell

EXHIBIT 28
DATE 2-14-95
HB 15

**MONTANA ADVOCACY PROGRAM, Inc.**
P.O. Box 1680
316 North Park, Room 211
Helena, Montana 59624

(406)444-3889
1-800-245-4743
(VOICE - TDD)

February 14, 1995

Representative Ernest Bergsagel
Joint Appropriations Long-Range
Planning Subcommittee
State Capitol
Helena, MT 59620

RE: Montana State Hospital Re-Build

Dear Chairman Bergsagel and Members of the Committee:

For the record my name is Mary Gallagher and I am the Interim Director of the Montana Advocacy Program. We submit the following testimony in opposition to the re-building of the State Hospital at this time and believe such a costly and permanent move should not happen without first evaluating the continuum of mental health services and determining how to best provide those services to Montana consumers. As such, the proposed re-build of the hospital would be a major setback for consumers and community mental health services at this time.

Montana law states that Montana citizens must be afforded the opportunity to be treated in the least restrictive setting appropriate to their needs. As you have heard today, there are numerous patients at the state hospital who could be treated in their home communities if services were available. To truly ensure that consumer needs are met, development of a continuum of community-based services should be the Department's primary emphasis. **Only** if it has been shown that hospitalization needs cannot be met in our communities-with adequate funding and support services-should the Department consider building a new state psychiatric facility. Inpatient care is the most expensive type of mental health care and one that is needed only intermittently by consumers. Supportive mental health services in an individual's community, on the other hand, create, by their very nature, less need to utilize inpatient care.

Many states have completely moved away from providing acute care at their state hospitals because it makes good economic sense and because services can be provided more effectively through contracts in local communities. These states also found that supported living services and intensive case management services have paved the way for less expensive treatment for individuals with long term care needs thus making their dependence on a state hospital less necessary.

An adequate needs assessment has not been done. In fact, the million dollars used by DCHS for planning and architectural designs was mandated to be used for two simple things: 1) For providing a description to the 54th Montana Legislature of the current and projected future use

of the Montana State Hospital campus; and 2) For providing a description of the progress toward and additional steps required for achieving accreditation under JCAHO. See Section 53-21-601 M.C.A.

Only cursory work has been accomplished by DCHS that identifies the needs of consumers. This work was unfortunately accomplished with a pre-determined agenda of rebuilding on the current site. Other factors such as managed care and health care reform promise to bring whole new sets of issues and concerns to this picture. Straight answers on exactly what could be done to make the current use of the hospital safer for patients have been hard to come by. Instead, what this Legislature received was this 18 million dollar proposal.

The cart has definitely been put before the horse on this issue and the State is perched on the brink of making a major move in the wrong direction-away from creating viable long term solutions which could incorporate less costly community services. To accomplish an effective continuum of community-based services, MAP recommends the following:

* do not fund the current proposal to rebuild the hospital;
* implement the legally-mandated perspective for treatment in the least restrictive setting;
* fully analyze the needs of consumers in their home communities or regions and involve all affected parties in the process including consumers, hospitals, advocates and mental health centers;
* fund local and regional projects that make community-based treatment a reality;
* analyze the impact of managed care on funding for inpatient, outpatient, acute and extended care;
* work with the state prison to address the needs of "forensic inmates" at the forensic unit of MSH and work with local general hospitals to address forensic evaluations.
* utilize the accredited unit and several of the buildings at the state hospital that could most easily be brought up to life safety standards so that patients on the extended treatment unit will no longer be put at risk.

We urge you to vote against this appropriation for re-building the hospital at this time.

Sincerely,

Mary Gallagher

Mary Gallagher

Billings Office: 100 North 27th Street, Suite 330, Billings, MT 59101 (406) 256-3889
Warm Springs Office: P.O. Box 177, Warm Springs, MT 59756 (406) 693-7035
Missoula Office: 304 North Higgins, Missoula, MT 59802 (406) 549-8464

# YELLOWSTONE CONSUMER SUPPORT ALLIANCE

BILLINGS CHAPTER OF THE MERIWETHER LEWIS INSTITUTE

Empowering fellow survivors of mental health services by lending a listening ear, a caring heart, and a helping hand; and, by enlightening the community on mental health issues.

Bobby Gene Walton
Chapter President

(406) 252-8153

717 North 19th Street, #309
Billings, MT 59101

TO: Montana State Legislature
Long Range Building Committee
State Capitol Building
Helena, MT 59601

13 February 1995

RE: The Department Of Corrections And Human Services' Plan To Build A New State Mental Hospital At Warm Springs

Dear Legislators:

The Yellowstone Consumer Support Alliance opposes the recommendation of the Montana Department of Corrections and Human Services to build a new State Hospital at Warm Springs, and strongly supports implementation of the State Mental Health Plan. The Montana State Mental Health Plan calls for substantial improvements in community based treatment facilities to maintain community support for clients while in treatment and while in transition back into a community setting, which reduces cost to the State. Therefore, we recommend that improvements in community based services be made first, and then determine what if anything is needed in the way of a State Mental Hospital.

Sincerely,

Bobby Walton

Bobby Walton

EXHIBIT 29
DATE 2-14-95
SB 15

*EXHIBIT # 30*
*DATE: 2/14/95*
*THE ORIGINAL OF THIS PHAMPHLET IS STORED AT THE HIST. SOCIETY AT 225 N. ROBERTS, HELENA MT 59620-1201 PHONE NO: 444-2694*

HOUSE OF REPRESENTATIVES
VISITOR REGISTER

Long Range Planning SUBCOMMITTEE DATE 2/14/95

DEPARTMENT(S) _____ DIVISION _____

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

| NAME | REPRESENTING | |
|---|---|---|
| Cecil L. Keener MD | Montana State Hospital | |
| Dennis J Lawlor | Montana State Hospital | |
| Archie R. McOskal | Montana State Hospital | |
| Keith Wilson | Montana State Hospital | |
| Corning Hill | MSH | |
| Marty Onishuk | Mon AMI | |
| Melissa Case | H.E.L.E | |
| Randy Poulsen | SRS | |
| David Herrion | Mental Health Assoc. | |
| PAUL R. ATH, PhD, MPA. | SPNSR + YOUNG, LLP | |
| Nancy A. Cahill | St. Peters Comm Hosp | |
| Jim Hill | Job Service | |
| Mary Beth Linder | Dept Labor + Industry | |
| Jeff Simon | Helena Community Supported Services | |
| Suzanne Taunt | Family member, MAP | |
| Mary Gallagher | MAP | |
| Shirley Renders | Member Helena AMI | opposed to Bldg Warm Springs |
| Jean McDonald | MHAM | |

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

HOUSE OF REPRESENTATIVES
VISITOR REGISTER

Long Range Planning SUBCOMMITTEE DATE 2-14-95

DEPARTMENT(S) _____ DIVISION _____

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

| NAME | REPRESENTING | |
|---|---|---|
| Nita Jokl | MAP | |
| Yvonne Snell | MAP | |
| Terry Minow | MFT / MFSE | Support Rebuild MSH |
| Winnifred Storlie | FAMILY & CONSUMERS | AMI |
| Dennis Lawler | patient W.S.S.H. | AMI |
| Teresa Hallow | GTCMHC - REGION II | |
| Andrée Larose | Montana Advocacy Program | |
| Margaret A. Murphy | Montana Mental Health and Advisory Com. | planning |
| Kayleen M. Jones | parent advocate, parent of SED child Montana Mental Health Planning | Advis Comm |
| Pat Sharp | MMAP | |
| KATHY STANDARD | MERIWETHER LEWIS INST. | |
| Dan Arden | MH Dr | |
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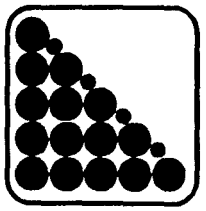
PLEASE LEAVE PREPARED TESTIMONY WITH SECRETARY. WITNESS STATEMENT FORMS ARE AVAILABLE IF YOU CARE TO SUBMIT WRITTEN TESTIMONY.

# LaserJet 4L

HEWLETT PACKARD



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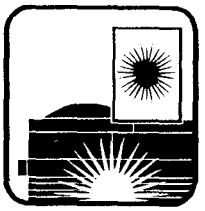
Resolution Enhancement



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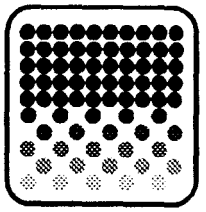

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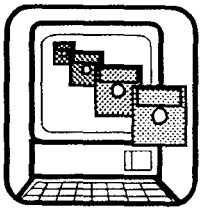

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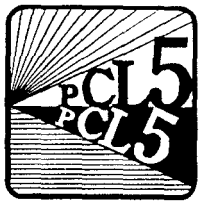


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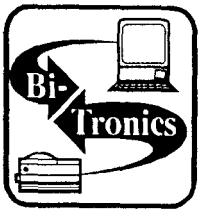
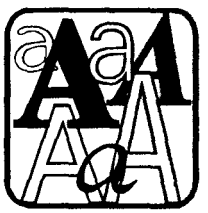



## Bi-Tronics



## 26 Scalable Typefaces

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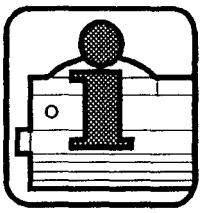
| **Courier Bd** | *Univers Md It* |
| *Courier It* | ***Univers Bd It*** |
| ***Courier Bd It*** | Univers Md Cd |
| Letter Gothic | **Univers Bd Cd** |
| Letter Gothic Bd | *Univers Md Cd It* |
| *Letter Gothic It* | ***Univers Bd Cd It*** |
| CG Times | Antique Olive |
| **CG Times Bd** | **Antique Olive Bd** |
| *CG Times It* | *Antique Olive It* |
| ***CG Times Bd It*** | Albertus Md |
| *Coronet* | **Albertus XBd** |
| Univers Md | Wingdings |



## Printer Information

PRINTER CONFIGURATION:

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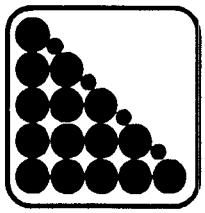
| ORIENTATION: | PORTRAIT |
| LINES OF TEXT: | 60 |
| PAPER SIZE: | LETTER |
| MANUAL FEED: | OFF |
| RET: | MEDIUM |
| DENSITY: | 3 |
| IMAGE ADAPT: | AUTO |
| PAGE PROTECT: | AUTO |
| AUTOCONTINUE: | OFF |
| ECONOMODE: | OFF |
| FONT NUMBER: | 0 |
| FONT SOURCE: | I |
| FONT HEIGHT: | 12.0 |
| FONT PITCH: | 10.0 |
| SYMBOL SET: | ROMAN8 |
| DEFAULT TYPEFACE: | Courier |
| RAM size: | 1024K bytes |
| Power-on Page Count: | 23 |
| Firmware Datecode: | 19921020 |
| Image Adapt Used: | NO |
| Control Errors: | 1 I/O |

# LaserJet 4L

HEWLETT PACKARD

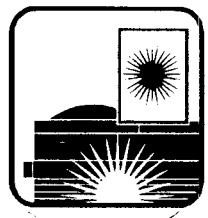


## 300 DPI

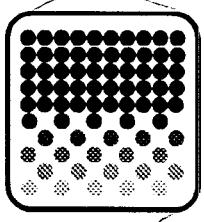
Resolution Enhancement

## 26 Scalable Typefaces

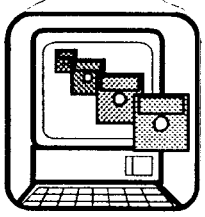
| | |
|---|---|
| Courier | **Univers Bd** |
| **Courier Bd** | *Univers Md It* |
| *Courier It* | ***Univers Bd It*** |
| ***Courier Bd It*** | Univers Md Cd |
| Letter Gothic | **Univers Bd Cd** |
| Letter Gothic Bd | *Univers Md Cd It* |
| *Letter Gothic It* | ***Univers Bd Cd It*** |
| CG Times | Antique Olive |
| **CG Times Bd** | **Antique Olive Bd** |
| *CG Times It* | *Antique Olive It* |
| ***CG Times Bd It*** | Albertus Md |
| *Coronet* | **Albertus XBd** |
| Univers Md | Wingdings |



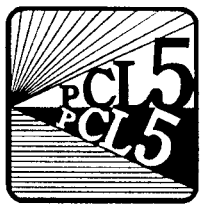
## Memory Enhancement TECHNOLOGY



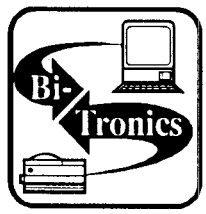
## EconoMode



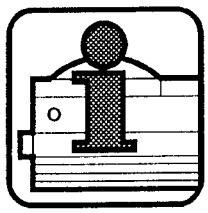
## HP Explorer




## Enhanced PCL 5




## Bi-Tronics



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| PAGE PROTECT: | AUTO |
| AUTOCONTINUE: | OFF |
| ECONOMODE: | OFF |
| FONT NUMBER: | 0 |
| FONT SOURCE: | I |
| FONT HEIGHT: | 12.0 |
| FONT PITCH: | 10.0 |
| SYMBOL SET: | ROMAN8 |
| DEFAULT TYPEFACE: | Courier |
| RAM size: | 1024K bytes |
| Power-on Page Count: | 22 |
| Firmware Datecode: | 19921020 |
| Image Adapt Used: | NO |
| Control Errors: | 1 I/O |