CONSIDERING THE HEALTH AND WELL-BEING OF MONTANANS

A final report on the activities of the
Children, Families, Health, and Human Services Interim Committee
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Legislative Services Division

Legislative Services Division
PO Box 201706
Helena, MT 59620-1706
PHONE: (406) 444-3064
FAX: (406) 444-3036
http://leg.mt.gov/

Children, Families, Health, and Human Services Interim Committee Members 2013-2014 Interim

Before the close of each legislative session, the House and Senate leadership appoint lawmakers to interim committees. Each member of the Children, Families, Health, and Human Services Interim Committee, like the members of most other interim committees, serves one 20-month term. The information below is included to comply with section 2-15-155, MCA.

Senate Members of the Committee

Sen. Dave Wanzenried
Presiding Officer
P.O. Box 2428
Missoula, MT 59806-2428
(406) 546-9442
davew@gmail.com

Sen. Roger Webb
1132 Ginger Ave.
Billings, MT 59105-2062
(406) 861-9322
webb4mt@hotmail.com

Sen. Terry Murphy
893 Boulder Cutoff Rd.
Cardwell, MT 59721-9605
murphter5@yahoo.com

Sen. Jonathan Windy Boy
P.O. Box 269
Box Elder, MT 59521-0269

House Members of the Committee

Rep. Ron Ehli
Vice Presiding Officer
P.O. Box 765
Hamilton, MT 59840-0765
(406) 363-3130
montanamutt@montana.com

Rep. Scott Reichner
78 Redtail Ridge
Bigfork, MT 59911-6283
(406) 837-3929

Rep. Carolyn Pease-Lopez
5723 US Highway 87 E.
Billings, MT 59101-9074
(406) 245-2265
carolynpeaselopez@gmail.com

Rep. Casey Schreiner
2236 6th Ave. N.
Great Falls, MT 59401-1819
(406) 565-0372

Committee Staff

Sue O'Connell, Lead Staff
Alexis Sandru, Staff Attorney
Fong Hom, Secretary

Legislative Services Division

Susan Byorth Fox, Executive Director
Todd Everts, Director, Legal Services
David D. Bohyer, Director, Office of Research and Policy Analysis

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Introduction and Overview

With a broad charge to review matters involving health and human services, the Children, Families, Health, and Human Services Interim Committee used the 2013-2014 interim to delve deeply into topics ranging from mental health services to prescription drug abuse to Medicaid.

The committee examined the spectrum of mental health services in Montana as it undertook the study of state-operated institutions authorized by House Joint Resolution 16. Members also learned about the causes of and responses to prescription drug abuse as part of their Senate Joint Resolution 20 study of ways to reduce abuse, misuse, and diversion of the drugs.

The two studies garnered most of the committee's time and attention and resulted in several legislative proposals, as well as letters to state and federal officials. Bills related to the HJR 16 study focus largely on providing additional mental health treatment options in the community rather than at state institutions. SJR 20-related proposals take various approaches to curbing the prescription painkiller problem.

The committee also invited Montana's Indian tribes to provide comments and recommendations for both of the studies. Recommendations from the Montana-Wyoming Tribal Leaders Council are included as Appendix E.

In addition to carrying out the two studies, the committee:

- monitored issues related to the Montana Medicaid program, with a particular focus on hearing from Medicaid providers about the challenges they face and the topics they believe the 2015 Legislature may confront in funding the Medicaid program;

- conducted the required House Bill 142 review of statutorily required advisory councils and reports related to the Department of Public Health and Human Services (DPHHS);

- reviewed DPHHS activities to fulfill its oversight responsibilities for that agency;

- received regular updates on the number of people registered to grow, manufacture, or use marijuana for debilitating medical conditions and on the legal challenge to the Montana Marijuana Act passed by the 2011 Legislature; and

- monitored a wide range of health and human services topics.

By the end of the interim, the committee had approved 10 bills for introduction in the 2015 legislative session and sent two letters related to its study of state-operated institutions.

This report summarizes the committee's activities and actions related to the HJR 16 and SJR 20 studies and to its monitoring and review duties.

HJR 16 Study: State-Operated Institutions

Recognizing that the line between correctional and treatment facilities has blurred for some individuals, the 2013 Legislature approved an interim study of Montana's state-operated institutions. House Joint Resolution 16 noted that the state facilities for people with mental illness or intellectual disabilities sometimes house people who have been convicted of crimes. At the same time, many inmates sentenced to the state prisons suffer from a mental illness. With a variety of state institutions serving some people with similar characteristics, HJR 16 asked that an interim committee study the institutions to see whether the current system of facilities could:

- provide more effective treatment to individuals with mental illness, intellectual disabilities, and substance abuse disorders; and

- serve individuals in a more cost-effective manner.

Legislators ranked the study fifth out of 17 study resolutions in the post-session poll of interim studies. The Legislative Council in May 2013 assigned the study to the Children, Families, Health, and Human Services Interim Committee.

HJR 16 suggested that the committee examine:

- the populations served by each state facility, including the long-term needs for those populations;

- the services provided at each facility for treatment of mental illness, intellectual disabilities, and chemical dependency;

- the degree to which treatment needs are unmet at each facility and the barriers to providing necessary services;

- the cost of operating each facility, including costs of treatment;

- the ways in which facilities collaborate to provide services; and

- alternative approaches to providing services in order to improve the quality of care and increase access to additional funding sources.

At the outset of the interim, committee members agreed to narrow the broad scope of their study to focus on the needs of people who have been diagnosed with a mental illness and are either committed to or incarcerated in one of the state facilities. Over the following year, members visited four state-run institutions, learned about the challenges of providing services to mentally ill individuals who have been convicted of crimes, heard about the current system of

community mental health services, and weighed the costs and benefits of providing more services either at the state-run facilities or in the community.

As the study proceeded, members decided to focus their efforts on increasing the range of community mental health services as a way to not only treat people closer to their homes but also to ease the pressures on the state facilities. The committee:

- approved six committee bills to provide funding for more community-based efforts;

- sent a letter to Gov. Steve Bullock asking him to include funding in his proposed 2017 biennium budget for five more DPHHS employees to work with intellectually disabled individuals who are in danger of losing their community placements because of a mental health crisis; and

- sent a letter to members of the Montana congressional delegation asking them to support a change in federal law to allow the federal-state Medicaid program to pay for the health care services provided in correctional facilities.

MONTANA'S INSTITUTIONS: A LOOK AT WHAT'S IN PLACE

The Department of Public Health and Human Services operates four facilities that serve people with a mental illness, intellectual disability, or substance abuse disorder. Those facilities are:

- the Montana State Hospital (MSH), which is the primary public institution serving adults with mental illness;

- the Montana Developmental Center (MDC), which serves seriously developmentally disabled adults;

- the Montana Chemical Dependency Center (MCDC), which provides residential treatment services to individuals who have substance abuse disorders; and

- the Montana Mental Health Nursing Care Center, which primarily provides long-term care to individuals with mental illness. It also contains a 25-bed wing that houses prison inmates with chronic medical conditions that require a level of care not available in a correctional facility.

The Department of Corrections operates the Montana State Prison (MSP) at Deer Lodge and the Montana Women's Prison in Billings. Both facilities provide mental health services. MSP has a mental health treatment staff at the prison, while the Women's Prison provides mental health services through a mix of staff and contracted providers.

Some individuals who are convicted of crimes and are also found to have a mental illness or intellectual disability may be ordered to serve their prison sentences at the Montana State Hospital or Montana Developmental Center if placement in those facilities is more appropriate.

The committee began the HJR 16 study with visits to four of the institutions: the Montana State Hospital at Warm Springs, the Montana Developmental Center at Boulder, the Montana Chemical Dependency Center in Butte, and the Montana State Prison. At each location, agency representatives provided an overview of the facility, the services it provides, and the individuals it serves. Members then toured each facility.

Each of the four institutions is described in more detail below.

Montana State Hospital

MSH provides treatment to adults with mental illness, most of whom have been either:

- committed to the hospital through a civil proceeding because they represent a danger to themselves or others; or

- ordered to be evaluated or treated at the hospital because they have been charged with or convicted of a crime.

DPHHS operates the facility on a 380-acre campus at Warm Springs. In the 114-bed main hospital building, patients are placed into one of four units based on the type of treatment they need. One unit is a locked, secure wing that holds individuals involved in the criminal justice system. The campus also has a 60-bed facility for patients with long-term mental health conditions or significant physical limitations and four group homes ranging in size from seven to 12 beds for patients who are able to live more independently.

The hospital had 174 licensed beds in its two main facilities and 27 licensed beds in its transitional group homes in August 2013. It has since added seven more group home beds, for a total of 208 licensed beds. In fiscal year 2013, the average daily census was 168. However, the number of patients fluctuates daily because people are admitted as ordered by a court and discharged as their mental health condition improves.

The hospital serves all Montanans, and admissions data for FY 2013 showed that patients came from 36 of Montana's 56 counties that year. The state's eight most populous counties accounted for 449 of the hospital's 604 admissions, or 74 percent.

The vast majority of patients come to MSH through the following civil proceedings:

- involuntary commitment, in which a court has found that — because of a mental illness — an individual has caused an injury to self or others, poses an imminent threat of injury to self or others, or is substantially unable to provide for the individual's basic needs of food, clothing, shelter, health, or safety;

- emergency detention, in which a county attorney approves a request from a mental health professional to hold the person at MSH until a commitment proceeding is held; or

- court-ordered detention, in which a judge determines probable cause exists to hold a person at the hospital until a commitment hearing is held.

In FY 2013, 563 of the hospital's 604 admissions were made through those civil proceedings.

The hospital also evaluates, treats, and houses "forensic" patients. These individuals come to MSH because they are involved in a criminal proceeding and the hospital is:

- conducting a mental health evaluation to determine a defendant's fitness to proceed with the case or to determine the person's mental state at the time the crime was committed;

- providing mental health treatment so that a defendant will be fit to continue with a criminal proceeding;

- conducting a pre-sentence evaluation for an individual convicted of a crime; or

- housing and treating individuals who have been found:

    - guilty of a crime but having a "mental disease or defect" that prevented them from appreciating the criminality of their conduct or to act in conformance with the law, a status typically described as "guilty but mentally ill" (GBMI); or

    - not guilty because a mental disease or defect prevented them from having the mental state of mind that is an essential element of the crime, a status typically described as "not guilty but mentally ill" (NGBMI).

Forty-one of the hospital's admissions in FY 2013, or about 8 percent, fell into the forensic category. However, forensic patients made up about 37 percent of the hospital's census in August 2013, when 40 GBMI patients and 11 NGBMI patients were at the hospital.

Forensic patients tend to be held at the hospital longer — particularly those who are serving a criminal sentence. Patients who are at MSH under a civil commitment order stay at the facility until their mental health condition allows for a return to the community.

The average length of stay for a court-ordered involuntary commitment was 94 days in FY 2013. That same year, the average length of stay for a GBMI patient was 685 days.

House Bill 2 appropriated $33.2 million for MSH in FY 2014 and $32.6 million in FY 2015, putting the average daily cost of the facility at $572 per person in FY 2014 and $579 in FY 2015.[1] The amount does not include pay raises or retirement adjustments made in other legislation in 2013.

Montana Developmental Center

MDC provides treatment to:

- individuals who meet the statutory definition of "seriously developmentally disabled" and have been determined by a court to be in need of commitment to MDC; and

- individuals who have been convicted of a crime and for whom placement at the Montana State Prison or the Montana Women's Prison is not appropriate.

Buildings on the MDC campus

DPHHS operates the facility on a 52-acre campus on the outskirts of Boulder. The campus contains eight residences for up to 56 clients — five open residences and three buildings within the secure, fenced Assessment and Stabilization Unit (ASU), where residents have more supervision and fewer privileges. The campus also includes additional buildings where educational, habilitation, vocational, medical, and treatment services are provided, including therapy for individuals with mental health disorders.

[1] 2015 Biennium Fiscal Report, *Legislative Fiscal Division*, June 2013, Table 33-C.

All new clients are admitted to the 12-bed ASU, where assessments are conducted in a locked, secure environment. In general, clients move to less restrictive units within the ASU and then to the five nonsecure residences as their treatment progresses.

Individuals are placed at MDC because a judge believes they cannot be safely placed in a community or correctional setting. Most have a mental health or behavior issue that has resulted in a civil commitment proceeding and their removal from a community setting. Some have been convicted of crimes and placed at MDC as an alternative to prison.

Forty-eight individuals were at MDC in early August 2013. Thirty-eight had been committed through a civil proceeding, six were at the facility because of criminal convictions, and two had been committed on an emergency basis. The remaining two were at MDC because their commitment orders had expired but no community placement was available at the time.

Twenty-two of the 48 clients had been diagnosed with a mental health disorder that would be similar to those considered by the state mental health system to be a Severe Disabling Mental Illness (SDMI) — one of the criteria that must be met for individuals to be served in the state-funded mental health system. However, DPHHS officials say most MDC residents have a major mental illness or significant problematic behaviors that require treatment even if the condition does not meet SDMI criteria.

MDC provides a comprehensive biopsychosocial assessment of all individuals committed to the facility. It also provides:

- individual and group therapy when identified in an individual's treatment plan;
- sex offender treatment for residents who have committed sex offenses; and
- medication management for individuals who have been prescribed psychiatric drugs.

HB 2 appropriated $14.1 million in general fund for MDC in FY 2014 and $13.3 million in FY 2015, putting the average daily cost of the facility at $670 per person in FY 2014 and $650 per person in FY 2015.[2] The amount does not include pay raises or retirement adjustments made in other legislation in 2013.

[2] Ibid.

Montana Chemical Dependency Center

MCDC provides inpatient treatment to adults who are dependent on alcohol or drugs and who, in general, have not succeeded in outpatient treatment. The majority of patients enter treatment voluntarily, but some are involuntarily committed to the facility by a court.

MCDC is a 48-bed, nonsecure facility made up of three buildings — a 16-bed unit for men, a 16-bed unit for women, and a 16-bed detoxification unit.

Architectural drawing for one of the new MCDC buildings

Licensed addiction counselors refer individuals for treatment at MCDC. To qualify for treatment, an individual must have not only a chemical dependency but also a co-occurring mental illness or a medical condition requiring a higher level of care than can be provided in the community. Priority is given to women who are pregnant or have dependent children, to intravenous drug users, and to patients who are leaving hospital-based care or community-based detoxification treatment. A waiting list usually exists for MCDC services.

In FY 2013, MCDC logged 634 admissions, with individuals staying an average of 35 days.

Nearly all MCDC patients enter treatment voluntarily, unlike individuals who are committed to MSH or MDC. Although some MCDC patients have an underlying legal issue for which a judge has ordered chemical dependency treatment, the facility does not admit individuals who have been sentenced to the custody of the Department of Corrections. A person who is incarcerated at the time of application for admission must have completed his or her sentence or be on probation or parole before being admitted to MCDC.

A majority of MCDC patients have a co-occurring mental illness and receive mental health services as part of their treatment. The admissions process requires that an addiction counselor submit a biopsychosocial assessment for a person being referred to the center. A mental health disorder may be identified either at this time or during the treatment process.

Mental health services available at MCDC include psychiatric evaluation, individual and group therapy, psychiatric medication management, and lectures on topics related to mental health and recovery. MCDC accepts a patient with a mental illness only if the patient's condition is stable enough to allow the person to participate in and benefit from treatment.

House Bill 2 appropriated $4.9 million in alcohol tax funds to MCDC for each year of the current biennium, putting the average daily cost of the facility at $331 per person.[3] The amount does not include pay raises or retirement adjustments made in other legislation in 2013.

Montana State Prison

MSP houses approximately 1,425 men who have been sentenced for felony offenses or who have been sent to the prison because they have violated the conditions of their probation or parole. The Department of Corrections operates the prison, which is the only facility for male offenders that has an on-call mental health system available to meet inmates' mental health needs around the clock.

The prison houses individuals who are sentenced by a judge, have been removed from a community placement or regional facility at the facility's request, are in need of services not available in a community placement or regional facility, or have been transferred from the Montana State Hospital or the Montana Developmental Center.

A multipurpose building on the Montana State Prison grounds

Located on 36 acres just outside of Deer Lodge, the prison has an intake unit and eight housing units within its secure, fenced perimeter. The units have varying levels of security for different classifications of inmates. One of the housing units contains the prison's 12-cell Mental Health Treatment Unit, for inmates in need of intensive mental health treatment.

All inmates begin their stay at the Martz Diagnostic Intake Unit, where they are typically held for 30 to 90 days for assessments that determine appropriate placement for the remainder of their sentences. Potentially, every inmate at MSP may receive mental health services. The prison's Mental Health Department participates in screening all inmates at intake. This screening narrows down the number of individuals who will be seen regularly by the department and indicates the types of services that inmates will need while incarcerated.

[3] Ibid.

In general, the prison estimates that about 430 individuals receive regular mental health services, or approximately 30 percent of the prison population. All inmates who have been prescribed psychiatric medications are seen by the prison's psychiatrist. In August 2013, 276 inmates were receiving psychiatric medications, or about 20 percent. In July 2013, 93 inmates — or about 6 percent — had been identified as having an SDMI-equivalent diagnosis. The prison also housed 16 GBMI inmates at that time. GBMI inmates receive, at a minimum, a monthly mental health wellness check. Some of the inmates may receive additional services, such as psychiatric appointments, group or individual therapy, or crisis services.

In 2011, the prison attained accreditation from the National Commission on Correctional Health Care. It was re-accredited in July 2014 for another three years after an audit found that the prison met all of the commission's standards and noted no deficiencies.[4] To become and remain accredited, the prison had to demonstrate that it complied with more than 60 health care standards, including standards related to mental health. Each standard lists the processes that a facility must have in place to be considered in compliance with the standard.

For example, to meet the basic mental health services standard, a facility must have a range of services of differing levels and focus. Minimum on-site outpatient services must include identification of inmates with mental health needs, crisis intervention services, management of psychiatric medications, individual and group counseling, and psychosocial and psychoeducational programs. Patients must be seen at least every 90 days, or more often if clinically indicated. Inmates with chronic mental health conditions must have individual treatment plans.

HB 2 appropriated more than $45 million in each year of the current biennium for the prison, nearly all of it from the general fund. The amount does not include pay raises or retirement adjustments made in other legislation in 2013. The Department of Corrections estimates that the average daily cost of housing inmates at MSP was $97.63 in FY 2012.[5]

The table on the following page provides an at-a-glance summary of information related to the capacities, populations, and costs of Montana's state-operated institutions as of August 2013.

[4] "Montana State Prison health services ace national re-accreditation review," *Department of Corrections*, July 29, 2014.

[5] 2013 Biennial Report, *Department of Corrections*, Appendix C-4.

SUMMARY OF FACILITY POPULATIONS AND COSTS
as of August 2013

The information in the table below cannot be read as an apples-to-apples comparison of the facilities because of the differences that exist among the populations served, the ways in which the facilities calculate the number of individuals with a mental health disorder, the allowable maximum commitment periods for the various facilities, and the factors that affect an individual's release from the facility.

	MCDC	MDC	MSH	MMHNCC**	MSP	MWP
Capacity	50*	56	201	100	1,425	196
% of Individuals with Mental Health Disorders	66%	46% to 85%	100%	100%	6.5% to 30%	77%
Number of Forensic Patients	0	6	7%***	0	N/A	N/A
Number of Guilty But Mentally Ill Individuals	0	0	40	0	16	8
Number of Not Guilty But Mentally Ill Individuals	0	0	11	0	0	0
Initial Civil Commitment Period Allowed by Law	40 days	365 days	90 days	40	N/A	N/A
Average Length of Stay: Civil Commitments	35 days****	~1,050 days	94 days	~856 days	N/A	N/A
Average Length of Stay: Forensic Commitments	N/A	~1,230 days	All: 436 days GBMI: 685 days	N/A	N/A	N/A
Mental Health Staffing Levels	3 FTE	5 FTE	33 FTE	1 staff FTE 1 PT contract FTE	19 FTE	3 staff FTE 1.5 PT contract FTE
Average Daily Cost	$331	$670	$572	$330	$97.63	$104.07

* In August 2013, MDC was located in a building with a licensed capacity of 50 beds. It has since moved into a complex of three 16-bed buildings, for a total of 48 beds.
** MMHNCC data does not include the information for the 25-bed Lewistown Infirmary, which houses Montana State Prison inmates with chronic medical conditions.
*** This figure represents the number of forensic admissions in FY 2013, but the number may vary from year to year depending on the number of people who are undergoing court-ordered evaluations or treatment for a criminal case that is pending or completed.
**** Most MCDC residents are not committed but instead enter the facility voluntarily.

Key to Facility Abbreviations

- MCDC = Montana Chemical Dependency Center, Butte
- MDC = Montana Developmental Center, Boulder
- MSH = Montana State Hospital, Warm Springs
- MMHNCC = Montana Mental Health Nursing Care Center, Lewistown
- MSP = Montana State Prison, Deer Lodge
- MWP = Montana Women's Prison, Billings

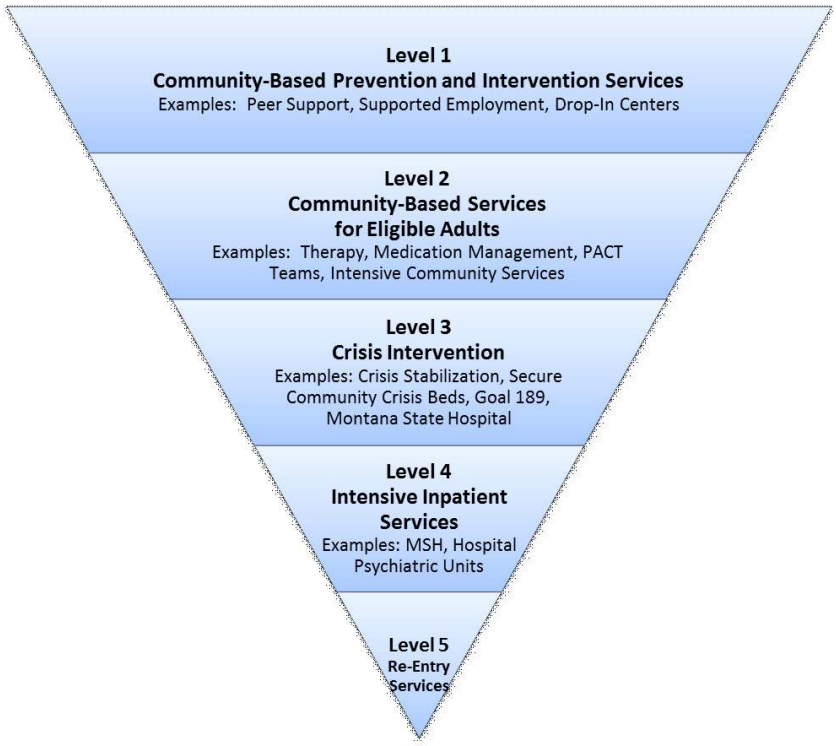
COMMUNITY SERVICES: AN ALTERNATIVE TO INSTITUTIONAL PLACEMENT

After taking a close look at the state institutions and the services they provide, the committee turned its attention to community-based services. As Montana and other states have moved in recent decades to reduce the number of people in state institutions, they have developed alternative services to meet the needs of individuals in the community rather than in a state-run facility.

Reviewing the Continuum of Care

The state provides a continuum of services to individuals with mental illness, intellectual disability, or substance abuse disorders. The services vary depending on the population being served. But the continuum generally begins with outpatient programs offered in the community, progresses through more intensive services offered in more restrictive settings, and concludes with re-entry services for people who have been receiving inpatient treatment, generally on an involuntary basis. Most state-operated facilities serve people who have been either involuntarily committed through a civil proceeding or sentenced through a criminal proceeding. MCDC serves people seeking voluntary admission.

The graphic here illustrates the continuum concept for mental health services, with examples of the types of services available in Montana for different levels of care within the continuum.



Level 5 Examples: Goal 189 Services, Group Homes, Intensive Community-Based Rehabilitation

After visiting the facilities that provide services at the most intensive and restrictive level of care, the committee turned its attention to learning more about other services in the continuum of care. Through panel presentations and briefing papers, members:

- reviewed services that ranged from mental health drop-in services to group homes and secure detention beds where people are held for evaluation or short-term treatment instead of being sent to MSH;

- examined more closely the programs funded in recent legislative sessions to increase the ability to respond to mental health crises in the community and avoid a person's placement at MSH or in a jail;

- heard about a DPHHS program in which employees travel to communities to work directly with intellectually disabled individuals who are at risk of losing a community placement because of a mental health crisis;

- learned about "assisted outpatient treatment" in which a person is committed to treatment in a community rather than an institution, including the Montana laws that allow for that treatment and the practical barriers that make such treatment difficult to carry out in many areas of the state;

- reviewed the history of unsuccessful efforts to establish community-based mental health facilities of 16 or fewer beds; and

- reviewed the potential costs of expanding community-based services.

Some committee members also visited community-based crisis facilities to learn more about the facilities and the services they offer. DPHHS licenses:

- secured crisis stabilization facilities, which represent the most intensive and restrictive level of community-based services. These locked facilities provide short-term, court-ordered or emergency detention as an alternative to placement in a county jail or MSH. Individuals must be in need of crisis intervention services before a petition for involuntary commitment is filed or in need of an emergency or court-ordered detention while an involuntary commitment proceeding is pending.[6]

- inpatient crisis stabilization facilities, which provide 24-hour supervised treatment for individuals who are experiencing a mental health crisis but who are not in need of commitment. The facilities accept individuals who seek admission voluntarily, are

[6] 37.106.2027, Administrative Rules of Montana.

medically stable, and are willing to follow program rules and treatment recommendations. Individuals usually stay five to seven days.[7]

- outpatient crisis response facilities, which provide evaluation, intervention, and referral for people experiencing a crisis because of a serious mental illness or a serious mental illness with a co-occurring substance abuse disorder. This type of facility is targeted at people who may otherwise be taken to jail or treated in a hospital emergency room. The facility is staffed by licensed mental health professionals 24 hours a day, but individuals are not admitted for an overnight stay. In fact, a facility with this type of license may not provide services to an individual for more than 23 hours and 59 minutes.[8]

Western Montana Mental Health Center currently operates secured crisis stabilization facilities in Bozeman, Butte, and Hamilton. Additional facilities are under construction in Helena and Polson. Each of the existing facilities has two beds that may be used for secure detention and a seclusion room where an individual may be held for safety reasons. Meanwhile, the Billings Community Crisis Center is the only facility in Montana licensed as an outpatient crisis response facility.

Needs of the Dually Diagnosed

As the committee was conducting the HJR 16 study, a task force of the Montana Council on Developmental Disabilities was reviewing the needs of and services available to intellecually disabled individuals who also have a mental illness. These individuals are considered to have a dual diagnosis.

The council's Dual Diagnosis Task Force submitted its recommendations to the committee at the June meeting. The group's recommendations are included as Appendix F.

TRIBAL RECOMMENDATIONS

At the request of Sen. Jonathan Windy Boy, the committee notified the Montana-Wyoming Tribal Leaders Council about the HJR 16 study and invited the council to offer ideas for legislative consideration. The council provided the committee with written comments and recommendations, submitted for the June 2014 meeting.

In submitting the recommendations, the council noted that Indians in Montana are disproportionally represented in the prison system. The council cited a 2008 report stating that 20 percent of male inmates and 27 percent of female inmates were Native American, although Indians make up only about 7 percent of Montana’s population.

The council said the high numbers stem from several factors, including adverse childhood

[7] 37.106.1946, Administrative Rules of Montana.

[8] 37.106.1976, Administrative Rules of Montana.

experiences, known as ACEs, and historical and cultural traumas, such as U.S. laws that forced tribes to give up their lands, did not allow Indian children to speak their native languages, and banned native spiritual practices. Combined with subsequent poverty and discrimination, such experiences have led to high rates of crime and violence, as well as chemical dependency and behavioral health problems, the council said.

The council noted that Rep. Carolyn Pease-Lopez sponsored a successful bill in 2009 to require that the Board of Pardons and Parole include a member of a state or federally recognized Montana Indian tribe. Saying that the measure has given a voice to Indian inmates, the council called for other changes to address the high rate of imprisonment among Indians.

The council made a number of recommendations, including:

- strengthen multidimensional and culturally appropriate prevention and education efforts, including requiring consistent cultural education training at every institution at least twice a year, having state boards and agencies support and utilize cultural trainings, and having tribes develop and teach cultural education and effectiveness training;

- increase cultural, educational, and vocational opportunities within state facilities;

- ensure tribal expertise on various state boards, including the Interagency Coordinating Council on State Prevention Programs, the Mental Disabilities Board of Visitors, the Montana Children's Trust Fund, and the Family Support Services Advisory Council;

- develop interventions for at-risk individuals by identifying available resources and coordinating efforts to reach people through screening before their conditions worsen; and

- support aftercare services that include a peer-to-peer approach and that focus on culture, community, family, and the individual.

The full document from the council is included as Appendix E.

NARROWING THE FOCUS

After sifting through the information, committee members decided to focus their efforts on community-based services that could relieve pressure on the Montana State Hospital and the state prisons by:

- expanding crisis and diversion services designed to prevent people from being admitted to MSH or entering the criminal justice system; and

- providing more avenues for people who have either been convicted of crimes or found to be not guilty by reason of mental illness to be released to the community when they have completed treatment and are stable enough to return to the community.

In particular, members decided to increase the amount of support for three programs that were approved by the 2009 Legislature after an interim study that focused on mental health in adult and juvenile corrections. The 2009 Legislature funded a series of bills that focused on creating crisis services and jail diversion programs. Those bills, which are still referred to as "the House Bill 130s," were:

- House Bill 130, which created a grant program that has funded a variety of activities in nine different counties over the past five fiscal years. Counties apply for state funds to match money they are putting into crisis intervention and jail diversion services that meet the needs of their areas. Over the years, the HB 130 grants have provided funds for the Billings Community Crisis Center in Yellowstone County, helped pay for construction of secure detention beds in Ravalli County, provided training in mental health crisis intervention to law enforcement and hospital employees in several counties, and paid for remodeling of hospital facilities in Glasgow, Hamilton, and Helena to allow for secure detention of people in a mental health crisis.

- HB 131, which allowed the state to contract with community providers for secure beds where people in a mental health crisis can be held for evaluation and short-term treatment pending a civil commitment proceeding. Crisis stabilization facilities in Bozeman, Butte, and Hamilton have each set aside two secure detention beds. The facilities are reimbursed by the state when the beds are not occupied. The payments recognize that the facilities have ongoing staffing and maintenance costs so that they can provide care 24 hours a day, seven days a week. When the beds are occupied, the facilities can bill an insurance company, Medicare, Medicaid, or other state programs to cover the costs of care.

- HB 132, which created a short-term diversion process that allows a person facing an involuntary commitment proceeding to undergo up to 14 days of voluntary treatment in the community. If the person's condition stabilizes during that time, the commitment petition must be dismissed. HB 132 as introduced required DPHHS to contract for nine short-term diversion beds around the state. However, that requirement and the associated funding were removed during the 2009 legislative session. As a result, the process for short-term diversion exists, but no state funding has been allocated to pay for the treatment.

The Legislature currently appropriates a total of about $1.25 million a year to support the HB 130 grants and HB 131 reimbursements.

Recognizing that those programs have established a framework for a system of greater community-based services, the committee decided to support legislation to supplement the funding that the programs currently receive. Toward that end, members approved:

- LC 338, to add $2 million to the HB 130 grant program in the next biennium to fund new crisis intervention and jail diversion activities or programs;

- LC 339, to appropriate an additional $600,000 a year to contract for secure detention beds as allowed by HB 131, recognizing that new beds will be available soon in Helena and Polson; and

- LC 347, to appropriate $1 million over the biennium to pay for the short-term diversion allowed by HB 132, providing state funding for that inpatient mental health treatment for the first time.

The committee also recognized the value of a program DPHHS put in place in recent years to prevent the placement of intellectually disabled people in more restrictive settings. So-called "crisis and transition" employees have traveled to communities to work with individuals and community providers to try to maintain the community placement. DPHHS has a staff of five employees who provide this service.

The committee approved LC 337 to appropriate an additional $345,000 a year for five more employees. Members also sent a letter to Gov. Steve Bullock asking him to include funding for the employees in his proposed budget for the next biennium and pledging to support that request during the 2015 legislative session if he does so.

In an effort to address the pressures created by forensic patients, the committee approved two pieces of legislation designed to provide alternative placements for individuals found to be guilty but mentally ill or not guilty because of their mental illness. The committee approved:

- LC 341, to appropriate $3 million to the Department of Corrections to contract for a community corrections facility for guilty but mentally ill individuals who have been released by the Board of Pardons and Parole or for whom the DPHHS director has determined the community facility is the most appropriate placement; and

- LC 342, to appropriate $3 million to DPHHS to operate a transitional mental health group home. This facility would be open to both guilty but mentally ill individuals and those who were found not guilty because of their mental illness.

Finally, the committee sent a letter to the members of the Montana congressional delegation, asking them to support a change to federal laws and regulations that prevent the federal-state Medicaid program from paying for health care services provided in a correctional facility. The committee noted in its letter that Medicaid will only pay for medical services for eligible inmates when those services are provided outside of an institution and for a period of 24 hours or more. Because health care costs, including the costs of mental health care, make up a significant portion of the Department of Corrections budget, allowing Medicaid to pay for more of those costs would ease pressure on the state budget, the committee said.

Reports and proposed legislation related to the committee's HJR 16 study are available at http://leg.mt.gov/css/committees/interim/2013-2014/Children-Family/Committee-Topics/HJR16/hjr-16.asp.

SJR 20 Study: Prescription Drug Abuse

As prescription painkillers have become more widely used in the United States, the associated problems of misuse, abuse, and diversion of the drugs have become more widely known. In recent years, national and state studies have drawn attention to misuse and abuse of the drugs and have shown that prescription drugs cause a high percentage of accidental deaths.

The drugs of most concern involve so-called "opioids," which are synthetic versions of the opium poppy and produce effects similar to opium, including pain relief and sedation. Examples of prescription opioids include morphine, oxycodone, and hydrocodone.

As evidence of prescription drug abuse mounted in the past decade, national, state, and local officials began working to identify and reduce the associated problems while trying to maintain access to the drugs for patients who legitimately need them.

Montana has taken part in those efforts in recent years. In 2009, then-Attorney General Steve Bullock undertook a public awareness and education campaign and created a Prescription Drug Advisory Council that studied the problem in Montana. The advisory group recommended the creation of the Montana Prescription Drug Registry to allow health care providers to review a patient's use of controlled substance prescriptions and make prescribing decisions based on that information.

The 2011 Legislature approved the registry legislation, and the 2013 Legislature continued efforts to reduce prescription drug abuse when it passed Senate Joint Resolution 20.

SJR 20 called for an interim study of "strategies for reducing prescription drug abuse, particularly the use of opioid pain relievers for the treatment of chronic pain caused by conditions other than cancer or the treatment of cancer."

Legislators ranked the study seventh out of 17 study resolutions in the post-session poll of interim studies. In May, the Legislative Council assigned the study to the Children, Families, Health, and Human Services Interim Committee.

ASSESSING THE PROBLEM

The committee began its work on the SJR 20 study by reviewing statistical information, hearing from national experts, and listening to Montanans with an interest in the multifaceted problem of prescription drug abuse.

Looking at the Numbers

Studies abound on the effects of prescription drug abuse, at both the national and state levels. Uniformly, these studies have found that prescription drugs rank among the most abused drugs, that overdose deaths from prescription drugs are a leading cause of accidental death, that many people obtain the drugs from medicine cabinets in their own homes or the homes of

friends or relatives, and that young people view prescription drugs as safer to abuse than illicit street drugs because the drugs are prescribed by health care professionals.

The studies include:

- the 2011 National Survey on Drug Use and Health, which surveyed about 67,500 people 12 years of age or older and reported that:
  - an estimated 6.1 million Americans, or 2.7 percent, had engaged in nonmedical use of prescription drugs in the past year, down from previous years; and
  - 54.2 percent of those individuals received the drugs for free from a friend or relative, with 4.4 percent of them taking the drugs without asking;
- a July 2013 Centers for Disease Control and Prevention report on deaths caused by prescription painkiller overdoses, showing that deaths among women increased by more than 400 percent from 1999 to 2010, although men were still more likely than women to die from such overdoses;
- a DPHHS report concluding that 42 percent of the unintentional poisoning deaths from 2000 to 2011 in Montana were caused by narcotics and hallucinogens, with 91 percent of those deaths including the use of an opioid;[9]
- the 2012 Montana Prevention Needs Assessment of youth in grades 8, 10, and 12, showing that 3.4 percent of respondents had used prescription narcotics in the previous 30 days, down from 4 percent in 2010, and that 9.7 percent had used them at some point in their lives, down from 10.9 percent in 2010; and
- the 2011 Montana Behavioral Risk Factor Surveillance System survey, which found that:
  - 20 percent of adults reported using an opioid medication in the previous 12 months, with 3.8 percent using an opioid that was not prescribed to them; and
  - 73 percent of those who took opioid medications said they had taken the drugs for pain other than prescribed, while 16.2 percent had taken them recreationally.[10]

Hearing from National Experts

Committee members also heard from several national speakers about the extent of the prescription drug abuse problem and the strategies that states are adopting to reduce the misuse, abuse, and diversion of the drugs.

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[9] "Unintentional Poisoning Due to Use and Misuse of Opioid Prescription Medication," Montana Public Health, Volume 8 Issue 2, *Department of Public Health and Human Services*, February 2013.

[10] Ibid.

Through those presentations, the committee learned that:

- opioids, not illegal drugs, have driven the increase in drug overdose deaths in the past decade;

- opioid sales, deaths, and treatment admissions have increased at similar rates in the past decade; and

- for every death attributed to opioid overdose, 15 people were admitted for substance abuse treatment, 26 people were admitted to emergency rooms for opioid use, 115 people abuse or are dependent on opioids, and 733 people are using opioids for nonmedical reasons.

The Centers for Disease Control and Prevention have identified several trends occurring in states as policymakers struggle with balancing the needs of pain patients against measures to prevent abuse of the drugs. State efforts include:

- the use of prescription drug monitoring programs, such as the Montana Prescription Drug Registry;

- programs to review and restrict patient use of the drugs;

- laws and regulations on prescribing or dispensing the drugs; and

- the development of clinical guidelines for managing chronic pain.

Because most states are only now beginning to take steps to curb prescription drug abuse, little data currently exists to evaluate whether one approach is more effective than another. However, committee members heard repeatedly that increasing the use of prescription drug registries can help reduce the abuse of prescription drugs. They also heard about an approach taken in Washington state to reduce the use of opioids in the workers' compensation program y emphasizing the best practices for patients who are receiving prescription painkillers and by establishing a limit on the daily Morphine Equivalent Dose that may be prescribed.

Those restrictions led to a drop in opioid prescribing for workers' compensation patients, as well as to a decrease in opioid-related deaths among work comp claimants.[11] The Washington Legislature subsequently passed legislation in 2010 requiring several health care licensing boards to adopt uniform rules for managing chronic, noncancer pain. Among other things, the guidelines require a prescriber to consult with a pain management specialist about patients who are receiving a 120-milligram Morphine Equivalent Dose or higher on a daily basis.

[11] Testimony of Dr. Gary Franklin, medical director, Washington State Department of Labor and Industries, March 13, 2014.

Montana Stakeholders Weigh In

Committee members also heard presentations from Montana stakeholders who have been studying the extent of the prescription drug abuse problem and working to reduce misuse, abuse, and diversion.

A variety of speakers laid the groundwork for the SJR 20 study during the committee's November 2013 meeting, discussing the benefits and risks associated with opioid pain relievers, the concerns associated with taking strict steps to regulate their use, and the illegal activities that Montana law enforcement officials have seen related to prescription drugs.

Health care providers and representatives of pain patients discussed the benefits and risks of prescription painkillers, focusing on the steps they were taking to prevent abuse and diversion of the drugs. Several physicians outlined their concerns in striking the proper balance between relieving pain for patients with legitimate needs and restricting access to the drugs for those who may be seeking them to use improperly or sell to others. They noted that medical guidelines call for health care practitioners to relieve and manage pain that patients experience, including chronic, long-term pain that isn't caused by cancer.

Although health care representatives acknowledged that practitioners should be careful about prescribing opioid drugs, they also cautioned against legislatively imposed restrictions on prescribing practices. They said that such restrictions could result in unintended consequences that would affect a person's ability to obtain needed medications and could affect the quality of life for chronic pain patients.

Also in November, law enforcement officials discussed the problems they have seen in Montana with abuse and diversion of prescription drugs. Since 2008, the federal Drug Enforcement Administration has created tactical diversion squads made up of DEA agents and state and local law enforcement officials who work together on prescription drug investigations. The majority of federal prosecutions have focused on health care providers.

The Montana Department of Justice also began investigating and prosecuting prescription drug diversion in 2008 with four designated agents. The bureau investigates 200 to 250 prescription drug cases a year, concentrating on street-level sellers rather than medical professionals. Most people selling prescription drugs on the streets have obtained the drugs by fraudulently representing medical symptoms during medical visits or by forging prescriptions.[12]

Committee members learned in January 2014 that state Medicaid and workers' compensation

[12] Testimony of Mark Long, chief, Narcotics Investigation Bureau, Montana Department of Justice, Nov. 15, 2013.

agencies have taken steps to reduce the abuse of prescription drugs by people who are obtaining medical benefits through those programs. For example, the Medicaid program:

- requires review and approval before long-acting opioids are dispensed;

- denies early refills of certain prescription drugs and establishes limits on the number of pills that can be dispensed at one time for some painkillers; and

- educates providers about the benefits of using written agreements on opioid use with patients for whom the provider is providing long-term pain management.

The Montana Department of Labor and Industry has adopted utilization and treatment guidelines for workers' compensation cases. Any medical services or drugs that are outside of the guidelines must be authorized by the department before the work comp recipient may receive them. The guidelines require prior approval for any pain clinic program or for pain medication that is prescribed for six months or longer. The department also cautions against using opioids until other treatment options have been tried and proven to be unsuccessful.

The Montana State Fund, the work comp insurer of last resort, has been having nurses review all new workers' compensation claims since late 2010 to make sure that the providers are following utilization and treatment guidelines. In early 2014, the State Fund began sending letters to patients and their providers when the patients are identified as receiving a high daily Morphine Equivalent Dose of prescription drugs. The letters are designed to alert both the patient and the prescriber to the potential risks posed by the dosage levels and to outline safety considerations for those patients.

In March 2014, the committee received demographic information on prescription drug abuse and overdose deaths and learned more about prevention and treatment efforts in Montana.

DPHHS provided information showing that:

- opioid-related deaths vary across regions of Montana, with northwest Montana averaging the highest death rate over a 12-year period, at 6.5 deaths per 100,000 people from 2000 to 2012. Eastern Montana averaged the lowest death rate, at 2.7 per 100,000 people. However, no geographic difference existed in emergency room and hospitalization rates for unintentional opioid-related poisoning.

- the number of unintentional poisoning deaths caused by narcotics and hallucinogens increased from three in 2000 to more than 60 in 2009;

- the rate of unintentional poisoning deaths consistently has been more than twice as high for Indians as for whites since 2000; and

- in 2007, women made up nearly two-thirds of the people who entered state-funded drug treatment programs and listed prescription drugs as their primary drug of choice. But by

2013, more men than women were listing prescription drugs as their primary drug of choice — 56 percent, compared with 44 percent of women.

DPHHS has received a federal grant of $11 million to undertake prevention efforts over a five-year period, focusing on underage drinking for youth who are 12 to 20 years of age and on prescription drug abuse and misuse by people 12 to 25 years of age. Grant activities will include statewide efforts as well as targeted "environmental prevention" efforts in 16 counties and on all seven Indian reservations. This effort will look at how communities can work together to change perceptions of what behaviors are acceptable and unacceptable for their youth.

In addition, a Department of Transportation work group has been developing prescription drug-related recommendations for the Montana Comprehensive Highway Safety Plan. Its suggestions include public and provider education on the effects of prescription drugs on driving safety, as well as legislative proposals to allow a warrant for collecting blood samples from all DUI suspects and to allow additional types of health care providers to report to the state that a person's physical or mental condition may impair the person's ability to safely operate a motor vehicle.

Montana Medical Association Recommendations

As the committee was conducting the SJR 20 study, the Montana Medical Association (MMA) created a work group of 20 physicians to consider ways to respond to prescription drug abuse. The work group developed recommendations for action and presented them to the committee in March 2014. The recommendations fell into the following areas:

- Education and outreach for physicians, including periodic participation in continuing medical education on the the use of opioids, promotion of tools that health care providers can use to assess for the risk of substance abuse and to reduce the possibility of abuse or diversion, and use of the Montana Prescription Drug Registry after a number of improvements are made to the registry, including development of stable funding sources.

- Education and outreach for patients, including efforts to create more awareness of the addictive nature of opioids, the use of written agreements on the use of controlled substances, and increased substance abuse treatment options in the community.

- Education and outreach for the public to raise awareness about safety concerns related to prescription painkillers, including the use of public service announcements, Web sites, and publications to provide relevant information.

- Collection of data to measure the success of prevention efforts, including data from the registry, hospital data on drug overdoses and emergency room visits related to opioids, DPHHS data on drug overdose deaths and on substance abuse treatment, law enforcement data on arrests related to prescription drug diversion and drug take-back efforts, and information from private insurers, the Veterans' Administration, and the Indian Health Service.

- Reduction in the supply of prescription drugs through cooperation with law enforcement, including increasing the options for safe disposal of unused prescription drugs and changing state law to clarify that health care providers may tell law enforcement officials when they suspect patients are sharing or selling prescription drugs and to provide immunity from suit for providers who share that information.

PRESCRIPTION DRUG MONITORING PROGRAMS: HERE AND ELSEWHERE

Committee members heard about the ways in which prescription drug monitoring programs can be used to review the use of prescription drugs and to identify potential misuse, abuse, and diversion. All states except Missouri have created monitoring programs that allow pharmacists and other health care providers to review prescription drugs that patients are receiving.

Uses of Prescription Drug Monitoring Programs
A prescription drug monitoring program is, in essence, a database that contains information on certain prescription drugs that are dispensed within a state. Pharmacists generally submit the information to the program. The information is then available to health care providers, who can check the database before deciding on treatment options for a patient. Through the database, a provider can see such things as whether the patient has recently obtained similar drugs from other physicians or is taking other prescription narcotics that would result in a high Morphine Equivalent Dose, which would flag potential problems for the patient.

During the interim, speakers discussed other benefits that prescription drug monitoring programs can provide, including:

- notifying health care providers when a patient appears to be receiving an unusually high number of prescription narcotics or receiving prescriptions for the same or similar drugs from multiple providers;

- identifying potentially problematic prescribers;

- allowing states to target drug prevention and treatment efforts by identifying geographic areas with high rates of abuse or addiction; and

- assisting in law enforcement investigations into prescription drug diversion.

Varying Characteristics of Prescription Drug Monitoring Programs
Although nearly all states now have prescription drug monitoring programs, the programs vary in approach. Among other things, committee members learned that states differ in:

- the frequency with which information is reported to the registries. Two states require "real-time" reporting of information to the prescription drug registry, while eight states require daily or twice-weekly reporting, 31 states — including Montana — require weekly reporting, and eight states require less frequent reporting.

- the requirements for use of the registry. Fifteen states require prescribers or dispensers to use the registry in certain instances. The remaining states — including Montana — make use of the registry voluntary.

- the individuals and entities allowed to access registry information. Forty-eight of the 49 states — including Montana — allow law enforcement to review registry data in at least certain circumstances. Two states allow probation and parole officers to review the data, and all states except Nebraska and Pennsylvania let their health care licensing boards access the registry for information related to their licensees.

- the types of drugs reported to their programs. Pennsylvania limits reporting to only Schedule II drugs, while 29 states — including Montana — require reporting of drugs in Schedules II through V. Drugs containing controlled substances are grouped into "schedules" reflecting their relative medical benefits and risks. Schedule II drugs are viewed as having an accepted medical use but also a high potential for abuse and for severe physical or psychological dependence. In contrast, Schedule V drugs are seen as having a low potential for abuse and a limited chance of dependence.

Montana's Prescription Drug Registry

The committee focused much of its attention on the operation of the Montana Prescription Drug Registry, based in part on comments from physicians that the registry is cumbersome and time-consuming to use and does not provide enough information. They suggested that more providers might use the registry if improvements are made to several aspects of the program.

The Montana Prescription Drug Registry began collecting data in 2012, and health care providers were able to start checking the registry data in November 2012. The Montana Board of Pharmacy, which operates the registry, provided information in May 2014 showing that:

- the database contained 4.8 million prescriptions for controlled substances dispensed to more than 620,000 patients;

- 2,296 health care providers were registered to search the registry, representing 24 percent of the Montana health care providers who are eligible to search the registry data; and

- nearly 122,000 data searches had been conducted, including 239 searches conducted for law enforcement subpoenas and 17 searches conducted for professional licensing boards.

Committee members expressed concern about the relatively low number of health care providers using the registry and the timeliness of the information submitted to the registry. However, they decided against taking steps to require use of the registry or to require more frequent reporting of prescription information until pending improvements to the registry are completed.

During the interim, members heard about changes that are being made to the registry, including changes to allow providers in other states to access the registry data and to allow so-called "delegate access," in which registered Montana health care providers may designate staff members who can access the registry on their behalf. Committee members indicated that they wanted to see whether those changes will increase the number of health care providers who check the database before writing prescriptions.

The MMA had opposed requiring prescribers to use the registry before those and other changes are made. The interstate data sharing and delegate access changes were among several changes to the registry that MMA suggested during the study period.

Registry Funding Sources and Options

To date, the registry and the improvements to it have been funded primarily by federal grants. Health care practitioners who prescribe or dispense controlled substances also must pay an annual $15 fee, which is projected to bring in about $94,000 in FY 2015.

The $15 fee will expire on July 1, 2015, unless the 2015 Legislature extends the fee. Committee members discussed the sunset of the fee and the options for raising money for requested improvements as they discussed the registry with the Board of Pharmacy and Montana Interactive, LLC, the vendor that developed and maintains the registry. Stakeholders also offered suggestions on the fee and other funding sources. For example, the MMA suggested a fee of a penny per pill on controlled substances prescriptions as an additional revenue source.

In August 2014, members took a closer look at the current costs of the registry, the costs of enhancements that are currently under way to allow additional medical personnel and providers from other states to access the information, the costs of improvements requested by the MMA, and funding options for the registry when the current $15 fee expires.

That information is summarized in the tables below and on the following page.

Current Operating Costs

Expense	12-Month Cost
Enhancements to Registry	$127,525
General Operating Costs	$67,321
Montana Interactive Hosting/Support	$58,350
Printing and Postage	$24,537
Purchase of National Drug Code File	$9,641
Travel	$8,384
Contracted Trainer	$5,000
Total Expenses Before Fee Offset	**$300,758**

Source: Montana Board of Pharmacy

Potential Costs of MMA-Requested Improvements

Improvement	Low Estimate	High Estimate
Provide Daily/Real-Time Reporting	$7,800	$13,208
Link Patient Profiles to Records	$13,728	$26,520
Enter Comments on Patients	$10,712	$20,904
Integrate Medical Marijuana Information	$21,528	$50,960
Allow Batch Inquiries for Several Patients	$11,232	$25,792
Allow Scheduled Queries	$9,048	$20,488
Additional Reporting Requirements/Options	$121,056	$209,976
Total	**$195,104**	**$367,848**

Potential Revenue Sources

Funding Source	# of People Affected	Revenue
Increase Current $15 Fee to $30	6,266	$187,980
Assess Current $15 Fee on All Individual Licensees	9,427	$141,405
Assess $30 Fee on All Individual Licensees	9,427	$282,810
Assess $15 fee on Wholesalers/Manufacturers	1,184	$17,760
Assess $30 fee on Wholesalers/Manufacturers	1,184	$35,520
Assess a Penny per Pill on Dispensed Prescriptions	Variable	$418,000

The estimated revenue from a penny-per-pill fee assumes that the fee would be assessed only on prescriptions for controlled substances, that about 1.4 million prescriptions for controlled substances are dispensed each year, and that each of the prescriptions is for 30 pills. Actual revenue would likely vary from the estimate.

TRIBAL RECOMMENDATIONS

At the request of Sen. Jonathan Windy Boy, the committee notified the Montana-Wyoming Tribal Leaders Council about the SJR 20 study and invited the council to offer recommendations for legislative consideration. The council provided the committee with written comments and recommendations, submitted for the June 2014 meeting.

The council noted that national studies have shown Indians are more than twice as likely to report abusing prescriptions drugs than are whites. The council said the abuse is often related

to social, demographic, environmental, and geographic disadvantages and noted that efforts in Montana to reduce prescription drug abuse have generally focused on reducing access to the drugs and increasing awareness about their potential for abuse, rather than addressing the root causes of abuse. For the state's Indian population, those root causes include past traumas suffered by tribes and adverse childhood experiences that have affected individuals, the council said.

The council offered suggestions for reducing prescription drug abuse, including:

- promote collaboration with Indian Health Service (IHS) primary care providers and educate the providers on best practices for prescribing opioids;
- include a tribal member on the Board of Pharmacy;
- include an IHS pharmacist and a tribal health delegate on the Prescription Drug Advisory Council;
- provide opportunities for Western-trained professionals to gain cultural understanding and awareness of the ways in which poverty affects people from social, mental health, and behavioral perspectives;
- have Montana Prescription Drug Registry staff provide periodic reports to the council, tribal health departments, and IHS on the status of the registry;
- create a drug diversion help hotline and market it in tribal communities; and
- encourage uniform pain management plans and protocols.

The full document from the council is included as Appendix E.

CONSIDERING THE OPTIONS

In addition to requesting more information on current and potential funding sources for the Montana Prescription Drug Registry, members asked for several pieces of draft legislation as the study progressed. During the study period, they considered bill drafts to:

- require Montana's health care licensing boards to adopt uniform rules on the management of chronic, noncancer pain, similar to the legislation approved in Washington state;
- allow prescriptions for controlled substances to be submitted electronically, as suggested by the MMA and others;
- allow health care providers to share certain health care information with law enforcement officials without being subject to lawsuits, as suggested by the MMA;

- increase the prescription drug registry fee from $15 to $30 and extend the fee for an additional four years; and

- require an adult to pick up controlled substances prescriptions for minors.

Members agreed to introduce the following bills in the 2015 Legislature:

- LC 335, to allow health care providers to share health care information with law enforcement officials when they believe a crime — such as failure to disclose recent narcotic prescriptions received from other providers — may have occurred on the premises or when they believe a person may pose a threat to public safety. The bill contains an immunity provision for providers who share that information.

- LC 336, to allow heath care providers to submit prescriptions for controlled substances using electronic means; and

- LC 340, to extend the prescription drug registry fee until June 30, 2017, and allow the Board of Pharmacy to increase the fee from $15 to up to $30, depending on the costs of operating the registry.

Members decided against introducing the following bill drafts they considered during the study:

- LCCF01, requiring health care licensing boards to adopt uniform pain management rules. Various heath care providers and licensing boards had opposed the draft bill.

- LCCF09, requiring an adult to pick up a controlled substances prescription for a minor in most instances.

Members also discussed the need to collect data to see if measures being taken to combat prescription drug abuse are making an impact. They agreed that data compiled by IMS Health, Inc., a health care analytics firm, should be used as a baseline for measuring future changes in prescription drug prescribing and use patterns.

That data from IMS Health was given to the committee in June 2014. It showed, among other things, that Montana ranked 39th among the 50 states, the District of Columbia, and Puerto Rico in the number of prescriptions per capita for Schedule II controlled substances in 2013. The state had a rate of 0.40 prescriptions per capita for those drugs, compared to a national average of 0.42. Montana had a slightly higher rate of prescriptions for Schedule III substances, at 0.47 prescriptions per capita. However, that was still below the national average of 0.51 prescriptions per capita.

The IMS Health data is included as Appendix G.

Reports and proposed legislation related to the committee's SJR 20 study are available at http://leg.mt.gov/css/committees/interim/2013-2014/Children-Family/Committee-Topics/SJR20/sjr-20.asp.

HB 142 Review of Advisory Councils and Agency Reports

The 2011 Legislature passed House Bill 142, which required interim committees to review advisory councils and agency reports that are established in state law. Each committee reviews the councils and reports related to the state agencies over which it has oversight responsibility. Thus the Children and Families Committee conducts the review for councils and reports related to DPHHS.

DPHHS advisory councils provide guidance on matters that range from aging services to mental health services to telecommunications access issues for disabled individuals.

The agency also is required by law to submit 12 reports to the Legislature. The reports cover topics ranging from suicide prevention to Medicaid to details on the placement of children with mental health needs in out-of-state treatment facilities.

The following councils are established in law:

- Advisory Council on Aging
- Advisory Council on Food Safety
- Board of Public Assistance
- Child Support Enforcement Advisory Board
- Children's System of Care Planning Committee
- Children's Trust Fund Board
- Commission on Provider Rates and Services
- Committee on Telecommunications Access Services
- Community Health Center Advisory Group
- Medicaid Managed Care Advisory Council
- Mental Health Oversight Advisory Council
- Montana 2-1-1 Community Coalition
- Montana Health Coalition
- Montana Suicide Review Team
- Regional Trauma Care Committees
- Service Area Authorities
- Tobacco Prevention Advisory Board
- Trauma Care Committee
- Traumatic Brain Injury Advisory Council

During the 2013-2014 interim, the committee reviewed:

- information summarizing the advisory councils and agency reports;
- recommendations made by DPHHS in the 2011-2012 interim to eliminate five of the councils and seven of the reports;
- recommendations from stakeholders; and
- public comment on the advisory councils and required reports.

Information provided to the committee indicated that several of the councils have been inactive in recent years and that several reports have not been provided to the Legislature. The reasons for the inaction varied for both the councils and the reports. In some instances, the underlying reason for creating a council no longer existed. In others, the department was waiting for advisory council members to provide direction on the council's activities.

The following councils had not met in more than a year and were considered inactive for the purposes of the HB 142 review: Child Support Enforcement Advisory Board, Commission on Provider Rates and Services, Community Health Center Advisory Group, Medicaid Managed Care Advisory Council, Montana 2-1-1 Community Coalition, Regional Trauma Care Committees, and the Tobacco Prevention Advisory Board.

In 2012, DPHHS recommended the repeal of:

- the laws creating the Advisory Council on Food Safety, Child Support Enforcement Advisory Board, Montana 2-1-1 Community Coalition, and Regional Trauma Care Committees;

- the requirements for the Mental Health Oversight Advisory Council and the Children's System of Care Statutory Planning Committee so that DPHHS could create one board to provide public input on both adult and children's mental health matters; and

- seven of the 12 reports required by law so that DPHHS could provide the Legislature with information from those reports in another way.

The 2011-2012 interim committee took no action on the recommendations, suggesting that DPHHS could instead propose legislation to make its recommended changes.

In 2014, DPHHS supported all but two of its earlier recommendations. The agency said it no longer wanted to repeal the Advisory Council on Food Safety. It also no longer supported combining the Mental Health Oversight Advisory Council and the Children's System of Care Statutory Planning Committee.

Committee Decision

At its March 2014 meeting, the committee decided against introducing any HB 142-related legislation. Committee members noted that DPHHS has changed its recommendations in the two years since the last review and that the agency has the ability to propose any changes to the councils or reports if it believes any are no longer necessary.

The report prepared for the committee's HB 142 activities is available online at http://leg.mt.gov/content/Committees/Interim/2013-2014/Children-Family/Meetings/March-2014/hb142-report-march2014.pdf.

SB 423 Monitoring: Montana Marijuana Act

In 2011, the Legislature repealed the Montana Medical Marijuana Act, which was approved by voters in 2004, and replaced it with Senate Bill 423. That bill established new requirements for cultivation, manufacture, and possession of marijuana for use by people with debilitating medical conditions that generally were stricter than those of the Medical Marijuana Act.

SB 423 also required the Children, Families, Health, and Human Services Interim Committee to monitor the new law and to draft legislation if members decided changes to the law were needed. To fulfill this ongoing statutory requirement, the committee received regular reports throughout the 2013-2014 interim on the number of people registered to grow, manufacture, and use marijuana and marijuana-related products. Members also heard periodic updates on the status of a lawsuit filed against SB 423 in May 2011. That lawsuit was still pending at the close of the interim in August 2014.

Registry Statistics

SB 423 put in place more stringent requirements for people to qualify for a card to use marijuana for a debilitating medical condition. It also created new requirements for people who grow or manufacture marijuana for a cardholder and for doctors who certify that a person has a debilitating medical condition and may benefit from the use of marijuana.

When those new requirements went into effect in July 2011, the number of cardholders and providers decreased significantly. The number of Montanans registered to use marijuana has dropped by nearly 72 percent since May 2011, when numbers reached their highest, at 31,522 patients. DPHHS statistics showed 8,956 cardholders registered as of Aug. 5, 2014. The number of patients declined almost every month from May 2011 until June 2013, when 7,043 cardholders were registered. At that time, the number of cardholders began increasing slightly nearly every month.

The majority of patients are still receiving a card for severe chronic pain, as they were before SB 423 was passed. However, they make up a smaller percentage of the total. In May 2011, 73 percent of the patients received a card solely for severe or chronic pain. Additional patients also received cards for chronic pain coupled with nausea, seizures, muscle spasms, or a combination of those conditions. In early August 2014, 66 percent of the patients listed severe chronic pain as a reason for obtaining a card.

The number of providers is down by about 92 percent from May 2011. Providers, formerly known as "caregivers," are allowed to grow marijuana and manufacture marijuana-infused products for cardholders. In May 2011, 4,650 people were registered as caregivers. The number of providers has hovered around 300 since November 2012; 355 providers were registered in August 2014. Nearly two-thirds of the providers had 10 or fewer patients in August 2014, while 13 were growing or manufacturing marijuana for more than 100 cardholders. DPHHS figures, which show the number of patients per provider in groups of 10 patients, indicate that those 13 providers had at least 2,363 patients, or 26 percent of the cardholders.

In August 2014, 207 doctors had provided written certifications for patients, down 43 percent from the 362 doctors who were providing certifications in May 2011. Of those, 189 provided certification for 20 or fewer patients each. Eighteen doctors provided certification for more than 20 patients; 10 of the 18 had more than 100 patients each. Those 10 physicians had provided certifications for at least 8,010 of the 8,956 cardholders registered in August, or 89 percent.

Montana Cannabis Industry Association v. State of Montana

The Montana Cannabis Industry Association filed suit against SB 423 on May 13, 2011, to stop the law from going into effect as scheduled on July 1, 2011. The plaintiffs contended that numerous aspects of the law violated constitutional rights to health, employment, and privacy. On June 30, 2011, District Judge James Reynolds of Helena halted five provisions of the law but allowed the remainder of SB 423 to go into effect until a full trial could be held on the merits of the suit. The provisions that were suspended would have:

- limited providers to having a maximum of three patients;
- prohibited payment for marijuana and marijuana-infused products;
- required DPHHS to provide the Board of Medical Examiners with the names of doctors who provide written certification for more than 25 patients a year;
- prohibited advertising of marijuana and marijuana-infused products; and
- allowed DPHHS and law enforcement to conduct unannounced inspections of locations where providers indicate they are growing or manufacturing marijuana.

The Attorney General's Office appealed two elements of Judge Reynolds' injunction to the Montana Supreme Court — the limit on the number of patients and the prohibition on payment. The state argued that the lower court had incorrectly applied the highest standard of judicial review to those provisions. The Supreme Court ruled in the state's favor in September 2012. The court sent the matter back to Judge Reynolds to be reviewed using the so-called "rational basis" test. Under that standard, a law affecting a constitutional right must be rationally related to a legitimate government interest.

Judge Reynolds continued the injunction and later set a trial date of May 20, 2014. Before the trial began, the Montana Cannabis Industry Association asked for a ruling in its favor on the five provisions that were prevented from going into effect and on the prohibition against the use of marijuana by people on probation or parole. As part of its request, the association dropped its challenge to other portions of SB 423. Meanwhile, the Attorney General's Office filed its own motion, asking Judge Reynolds to rule in the state's favor on the five contested provisions. Judge Reynolds held a hearing on those motions on April 15, 2014. He had not issued a ruling before the committee's final meeting in August.

Reports related to the SB 423 monitoring activities are available at http://leg.mt.gov/css/committees/interim/2013-2014/Children-Family/Committee-Topics/SB423/sb-423.asp.

Other Oversight Activities

The Children and Families Committee is responsible for overseeing the activities of the Department of Public Health and Human Services. The agency provides public health services to all Montanans and assistance to vulnerable Montanans. Its services touch children and the elderly, as well as low-income, disabled, abused, neglected, and mentally ill individuals.

The committee also monitors health and human services matters to identify topics that might need legislative attention. And at its organizational meeting in June 2013, the committee agreed to schedule regular presentations by Medicaid providers as part of its agency monitoring responsibilities.

This section summarizes key activities related to the committee's oversight duties.

DPHHS MONITORING

Over the course of the interim, DPHHS officials reported on various items as requested by the committee or outlined in the committee's work plan for the interim. Through these reports, the committee learned the following information.

- DPHHS is seeking federal approval to expand a waiver that allows the Medicaid program to serve some low-income, mentally ill adults who would otherwise be ineligible for Medicaid. These individuals are currently served by the Mental Health Services Plan (MHSP), a program that is funded solely by the state general fund. Under the Medicaid program, the individuals receive more comprehensive mental health services and also receive physical health care that isn't available under the MHSP. In addition, the federal goverment pays about two-thirds of the health care costs.

  The original waiver allowed 800 individuals with bipolar disorder or schizophrenia to receive Medicaid, and DPHHS received approval in January 2014 to add 1,200 more people with depressive disorder to the waiver. It has since asked to add another 4,000 individuals who have any severe disabling mental illness. Approval of the waiver would bring all MHSP participants with an SDMI diagnosis into the Medicaid program.[13]

- The federal government approved a waiver proposal to allow DPHHS to use federal Title IV-E foster care funds in more flexible ways in an effort to decrease the number of children who are removed from their homes and placed in foster care. Through the five-year waiver, DPHHS will be able to use the federal money for services other than direct foster care payments.

  Sarah Corbally, administrator of the DPHHS Child and Family Services Division, said in

[13] "Section 1115 Basic Medicaid Waiver Amendment," *Department of Public Health and Human Services*, June 30, 2014, Page 4.

January 2014 that DPHHS will focus on the following activities and groups: intensive in-home services for families with children ages 0 to 5 who are being neglected; efforts to re-engage parents of children ages 0 to 12 who have been placed with extended family members in order to reunify the parents with their children or have other family members become legal guardians when reunification isn't possible; and children who are in high-cost institutional placements, to see whether less restrictive placements with extended family members might be available. The state will use any savings from these efforts to increase child abuse and neglect prevention efforts.

- The department has adjusted the number of slots available for long-term care in nursing homes, assisted living facilities, and home-based services under its Home and Community-Based Services Waiver. The changes were made to remain within the budget for the waiver program. Kelly Williams, administrator of the Senior and Long-Term Care Division, said in March 2014 that DPHHS reduced the number of slots for assisted living facilities in FY 2014 while increasing the number of "basic" slots for services that are generally provided in a person's home.

  The change led to a waiting list for some services, with 324 people on the list in February 2014. Of those, 161 had asked for Medicaid funding for assisted living facilities, 146 had sought services related to an in-home placement, and 17 needed intensive care and supported living services.

- DPHHS officials, along with the Departments of Agriculture and Livestock, undertook a study of the state's food laws as directed by House Bill 630. The bill directed the departments to determine whether changes were needed in the laws or related administrative rules to conform with the federal Food Safety Modernization Act. HB 630 also asked the agencies to look at inconsistencies and inefficiencies in Montana's food laws, as well as to determine whether home kitchens could be used to prepare foods for sale while maintaining food safety for the public.

  The departments held public meetings in Bozeman, Billings, and Missoula to learn about areas of concern and confusion concerning Montana's food laws and the enforcement of those laws. The agencies concluded that Montana's "cottage food" law could be expanded by allowing sale of raw agricultural products and some nonhazardous prepared foods.

- The department is updating its Strategic Suicide Prevention Plan to more closely align the objectives for Montana with the 2012 National Strategy for Suicide Prevention. DPHHS Suicide Prevention Coordinator Karl Rosston discussed the objectives with the committee in August 2014 and also presented updated data showing that 231 Montanans committed suicide in 2013. That translates into a rate of 22.8 suicides per 100,000 people, compared with a national rate of 12.7. Firearms were the leading cause of death, used in 63 percent of the Montana suicides.

Rosston discussed the efforts that will be made to increase training in suicide prevention for law enforcement officers, health care providers, schools, and tribes, to create greater awareness of the warning signs of suicide among the general population, and to promote the safe storage of firearms.

MEDICAID MONITORING

To identify Medicaid issues that might come before the 2015 Legislature, members heard from various provider groups during the interim.

At the November 2013 meeting, mental health providers noted that:

- several community-based services — including community crisis services, peer services, and drop-in centers — are allowing people to be served closer to home and at a lower cost, but full funding for many of the programs remains a challenge;

- the increased number of slots in the Medicaid waiver program serving people with mental illness is a move in the right direction but won't meet the full need;

- additional vocational and rehabilitative services are needed to help people with mental illness return to work;

- gaps in services exist for youth who are leaving the children's mental health system and entering the adult system;

- an increasing number of children are being placed in out-of-state psychiatric care because Montana providers can't meet their needs with the services currently in place; and

- crisis diversion for at-risk youth will be an issue for the 2015 Legislature to address.

In January 2014, senior and long-term care providers noted that:

- about 60 percent of nursing home clients are on Medicaid;

- Medicaid reimbursement rates for senior and long-term care services have not kept up with inflation, meaning providers must shift more costs to other payment sources;

- some providers have stopped taking as many Medicaid clients because other clients are able to pay the full costs or have insurance coverage that pays more of the costs than Medicaid does;

- some assisted living facilities have reduced the number of waiver clients they accept because of low Medicaid reimbursement rates;

- providers are concerned about the reduction in the number of assisted living slots in the waiver program; and

- turnover among direct-care workers is high, primarily because of low pay.

In March 2014, developmental disability providers told the committee that:

- they face high staff turnover because pay for direct-care workers is lower than for many other service-industry jobs, particularly in eastern Montana, where businesses are increasing their pay scales because of the Bakken oil development;

- providers are unable to increase direct-care wages because they can't raise their prices to cover the costs and current Medicaid reimbursements are too low to allow pay increases for staff;

- staffing shortages create problems, including safety concerns and an inability to effectively serve clients or to accept new patients; and

- increased administrative requirements over the past several years have increased operating costs without a concurrent increase in the rates paid to providers.

In May 2014, hospital representatives noted that:

- Medicaid has supported hospital-provided services that allow people with physical disabilities or at-risk senior citizens to stay in their home by receiving care or other support services at home rather than in a more restrictive setting;

- bad debt and charity care have made it difficult for some hospitals to sustain their staffing and service levels; and

- expanding the Medicaid program to nonpregnant, nondisabled adults with incomes at or below 138 percent of the federal poverty level, as allowed by the federal Patient Protection and Affordable Care Act, would ease the problems that hospitals experience with bad debt and charity care.

OTHER HEALTH AND HUMAN SERVICES TOPICS

The committee followed health and human services topics that were in the news and that stakeholders raised throughout the interim. Key topics are summarized below.

- **Implementation of the Patient Protection and Affordable Care Act**. A panel of three speakers provided the committee with information in March 2014 about the number of Montanans who are uninsured and how the federal Affordable Care Act could affect those numbers. That law requires individuals to buy health insurance or pay a tax penalty. It also provides subsidies to help people pay for insurance if their incomes are

at or below 400 percent of the federal poverty level.

Economist Gregg Davis summarized the results of a study conducted for State Auditor Monica Lindeen in 2012. The study estimated that 18.1 percent of Montanans were without insurance, compared to 15.4 percent nationally. Adam Schafer, deputy commissioner of insurance and securities, said that about 22,500 Montanans had signed up for insurance through the federal health insurance exchange by the end of February and 86 percent of the enrollees had qualified for federal subsidies to help pay the costs. Christine Kaufmann of the Montana Primary Care Association said that the three Montana groups that received federal funds to help people with the enrollment process held nearly 900 events from fall 2013 through mid-March 2014. Combined, they had provided information to more than 120,000 people on how to find, evaluate, and enroll in an insurance plan.

- **Implementation of Youth Crisis Diversion Grants**. In June 2014, DPHHS and children's mental health providers discussed pilot programs that have focused on youth in crisis who are at risk of being placed in a higher level of care or of coming into contact with the criminal justice system. Services developed by the pilot project have been tailored to meet the needs of each community involved in the pilot. They range from services provided in the home to mobile crisis services to shelter care for children who can't safely remain in their homes but aren't in need of inpatient psychiatric treatment. The Montana Mental Health Trust provided about $841,000 in two-year grants to four projects, while DPHHS made nearly $400,000 in one-year grants to two other projects using federal funds.

  At the request of stakeholders, the committee agreed to introduce LC 334, to appropriate $1.2 million to continue youth crisis diversion pilot projects in the next biennium.

- **Status of the Family Housing Matters Program.** The Center for Children and Families, based in Billings, provided the committee with information in June 2014 about a program it has operated that allows mothers undergoing treatment for chemical dependency to remain with their children while they receive intensive treatment for their addictions. Donna Huston, executive director of the center, said the program has served 81 women and 153 children since obtaining its first grant in 2007 and has prevented the placement of many children in foster care while their mothers are in treatment programs. Two program participants told the committee how the program provided the support they needed to regain their sobriety.

  The program was started with a five-year federal grant from the Administration for Children and Families. The grant was extended for two years in 2012, but the program was slated to close on July 1, 2014, because it had been unable to find revenue from other sources to replace the grant funding.

- **Creation of the Office of Child and Family Ombudsman.** Committee members heard

about the progress made through mid-March 2014 in setting up a new office that will help people who have questions about child abuse and neglect investigations. The 2013 Legislature created the office with passage of HB 76, which was introduced by the 2011-2012 Children and Families Committee based on the committee's study of childhood trauma. The ombudsman position is within the Montana Department of Justice. Dana Toole of the department's Children's Justice Bureau said the ombudsman will have three main duties: teaching people how child abuse and neglect cases are handled by DPHHS and the courts, helping people navigate that system when they have questions, and reviewing the way selected cases were handled. The department has created an online form that people can fill out to ask for the ombudsman's help in looking into a case of suspected child abuse or neglect.

- **Creation of the Montana Healthcare Foundation.** The sale of the nonprofit Blue Cross Blue Shield of Montana and its subsequent conversion to a private insurance company triggered a state law that required certain proceeds from the sale to be distributed to a foundation that will make grants for health care-related purposes. Montana Healthcare Foundation Trustee Mignon Waterman told the committee that the foundation expects to receive up to $150 million in proceeds. It must provide $1 million in grants this year and $7.5 million in grants in following years. Waterman said that trustees are talking with stakeholders to see what activities might have the greatest impact on the health of Montanans. Trustees also hope to adopt an investment strategy that will maintain the principal of the trust so the foundation can make grants indefinitely.

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APPENDICES

APPENDIX A: Summary of Committee Legislation

The committee approved the following 10 bills for introduction in the 2015 Legislature:

- LC 334, to appropriate $1.2 million in general fund to continue mental health crisis diversion pilot projects targeted toward youth;

- LC 335, to allow health care providers to share certain information with law enforcement officials and to be immune from suit when doing so;

- LC 336, to allow transmission of prescriptions for controlled substances by electronic means;

- LC 337, to appropriate $345,000 a year in general fund to hire five crisis and transition technicians to work with intellectually disabled individuals who are in or approaching a mental health crisis that could lead to a more restrictive placement or commitment to the Montana Developmental Center;

- LC 338, to appropriate $2 million in general fund for the biennium to fund additional grants to counties for new or expanded community-based mental health crisis intervention and jail diversion activities;

- LC 339, to appropriate $600,000 a year in general fund for additional secure detention beds for people in need of a mental health evaluation or emergency detention;

- LC 340, to increase and continue for two years the fee for the Montana Prescription Drug Registry;

- LC 341, to appropriate $3 million in general fund for the biennium for the Department of Corrections to contract for a forensic community corrections facility;

- LC 342, to appropriate $3 million in general fund for the biennium for the Department of Public Health and Human Services to operate a transitional mental health group home for individuals who have been found guilty of a crime but mentally ill at the time the crime was committed or not guilty because their mental illness prevented them from having the mental state required to prove criminal intent; and

- LC 347, to appropriate $1 million in general fund for the biennium to pay for voluntary short-term inpatient mental health treatment while a proceeding for involuntary commitment is suspended.

APPENDIX B: Summary of Presentations

Committee members heard from a number of stakeholders while working on their assigned studies and their agency monitoring activities. Following is a list of the topics discussed at each of the meetings and the people who provided information during formal presentations.

HJR 16 STUDY: STATE-OPERATED INSTITUTIONS

Sept. 16-17, 2013

Overview of Montana Chemical Dependency Center Facility and Services
Mary Dalton, Manager, DPHHS Medicaid and Health Services Branch

Overview of Montana Developmental Center Facility and Services
Gene Haire, Administrator, Montana Developmental Center
Polly Peterson, Clinical Director, Montana Developmental Center

Overview of Montana State Hospital Facility and Services
John Glueckert, Administrator, Montana State Hospital
David (Drew) Schoening, Director of Clinical Services, Montana State Hospital

Overview of Montana State Prison Facility and Mental Health Services
Leroy Kirkegard, Warden, Montana State Prison
Jill Buck, Mental Health Director, Montana State Prison
Erin Israel, Mental Health Discharge Planner, Montana State Prison
Todd Boese, Psychiatric Registered Nurse, Montana State Prison
Cathy Redfern, Health Services Administrator, Montana State Prison

Nov. 15, 2013

Site Visit Follow-Up with State Agency Staff
Richard Opper, DPHHS Director
John Glueckert, Administrator, Montana State Hospital
Gene Haire, Administrator, Montana Developmental Center
Jill Buck, Mental Health Director, Montana State Prison

The Continuum of Care
Richard Opper, DPHHS Director
Sydney Blair, Executive Director, Center for Mental Health, Great Falls
Jeff Folsom, A.W.A.R.E. Inc.
Fran Sadowski, Missoula Developmental Services Corp.
Mike Ruppert, CEO, Boyd Andrew Community Services, Helena

Jan. 10, 2014

Use of 16-Bed Facilities for Mental Health Treatment
Lyle Seavy, Ph.D., Director of Psychiatric Services, Billings Clinic
Paul Meyer, Executive Director, Western Montana Mental Health Center
Mary Dalton, Manager, DPHHS Medicaid and Health Services Branch

Assisted Outpatient Treatment

Kristina Ragosta, Director of Advocacy, Treatment Advocacy Center (by phone)
Kim Codding, Clinical Director, Gallatin Mental Health Center
Leo Gallagher, Lewis and Clark County Attorney
Kim Lahiff, Regional Administrator, DOC Adult Probation and Parole
Beth Brenneman, Disability Rights Montana

March 13-14, 2014

Crisis Facilities and Services: A Look at What Exists and What Is Needed

Lyle Seavy, Ph.D., Director of Psychiatric Services, Billings Clinic
Paul Meyer, Executive Director, Western Montana Mental Health Center
Connie Wethern, Executive Director, Milk River, Inc., Glasgow
Deb Matteucci, Chief, DPHHS Mental Health Services Bureau
Rebecca de Camara, Administrator, DPHHS Disability Services Division

May 9, 2014

Psychiatric Services in Eastern Montana: Glendive Medical Center *(by phone)*

Parker Powell, Chief Executive Officer
Barb Markham, Chief Financial Officer
Dr. Bruce Swarny

Strategic Planning for Mental Health

Dan Aune, Mental Health America of Montana
Adrianne Slaughter, Department of Corrections
Rep. Casey Schreiner

June 25, 2014

Recommendations of the Dual Diagnosis Task Force

Deborah Swingley, Montana Council on Developmental Disabilities

Aug. 26, 2014

Perspectives on State and Private Operation of Treatment Facilities

Kelly Speer, Chief, Facilities Program Bureau, Department of Corrections
Dave Armstrong, CEO, Alternatives Inc., Billings
Earl Johnston, Montana State Hospital Resident Council
Josh Gray, Montana State Hospital Resident Council

SJR 20 STUDY: PRESCRIPTION DRUG ABUSE

Nov. 15, 2013

Medical Perspectives on Opioid Use and Abuse

Kaye Norris, Ph.D., Program Director, Montana Pain Initiative
Dr. Camden Kneeland, Kalispell (by phone)
Dr. Megan Littlefield, RiverStone Health, Billings
Dr. Deborah Agnew, Billings Clinic
Dr. Bill Gallea, St. Peter's Hospital, Helena

Montana Prescription Drug Registry

Marcie Bough, Executive Director, Montana Board of Pharmacy
Chad Smith, Montana Pharmacy Association

Law Enforcement Perspectives on Prescription Drug Abuse and Diversion
Alisha Tuss, Drug Enforcement Administration, Billings
Mark Long, Chief, Montana Narcotics Investigation Bureau
Chad Parker, Assistant Attorney General, Prosecution Services Bureau, Montana Department of Justice

Jan. 10, 2014
Prescription Drug Monitoring Programs and Best Practices
Peter Kreiner, Ph.D., PDMP Center of Excellence, Brandeis University (by phone)

State Agency Experiences in Prescription Drug Claims
Dave Campana, R.Ph., Medicaid Pharmacist, Montana Medicaid Program
Dr. Carla Huitt, Medical Director, Workers' Compensation Claims Assistance Bureau, Department of Labor and Industry
Bridget McGregor, Medical Team Director, Montana State Fund

March 13-14, 2014
Opioid Dosing Guidelines in Washington State
Dr. Gary Franklin, Medical Director, Washington State Department of Labor and Industries (by phone)

Prevention and Mitigation: A National Overview
Dr. Leonard Paulozzi, Medical Epidemiologist, Centers for Disease Control and Prevention (by phone)

Prevention and Mitigation: Perspectives from Around the State
Todd Harwell, Chief, DPHHS Chronic Disease Prevention and Health Promotion Bureau
Kevin Howlett, Health Director, Confederated Salish and Kootenai Tribes
Becky Sturdevant, Comprehensive Highway Safety Plan Work Group
Jackie Jandt, Program and Planning Outcome Officer, DPHHS Chemical Dependency Bureau

Montana Medical Association Work Group
Dr. Bill Gallea, St. Peter's Hospital, Helena

Attorney General Settlement of Janssen Drug Case
Jon Bennion, Deputy Attorney General and Legislative Liaison

May 9, 2014
The Oklahoma Approach
Don Vogt, Oklahoma Bureau of Narcotics (by phone)

Montana Prescription Drug Registry History and Update
Marcie Bough, Executive Director, Montana Board of Pharmacy
Becki Kolenberg, Montana Interactive, LLC

Montana Medical Association Work Group
Dr. Michael Brown, Yellowstone Pathology Institute, Billings
Dr. William Gallea, St. Peter's Hospital, Helena
Dr. Deborah Agnew, Billings Clinic
Dr. Megan Littlefield, RiverStone Health, Billings

Tribal Working Group Update
Kevin Howlett, Health Director, Confederated Salish and Kootenai Tribes
Cheryl Belcourt, Acting Director, Montana Wyoming-Tribal Leaders Council

MEDICAID MONITORING

Nov. 15, 2013
Medicaid Mental Health Provider Panel
Sydney Blair, Executive Director, Center for Mental Health, Great Falls
Jani McCall, Yellowstone Boys and Girls Ranch

Jan. 10, 2014
Legislative Finance Committee Medicaid Monitoring
Lois Steinbeck, Legislative Fiscal Division

Medicaid Senior & Long-Term Care Provider Panel
Rose Hughes, Executive Director, Montana Health Care Association
Joel Peden, Montana Centers for Independent Living
Jayne Lux, Community Medical Center, Missoula

March 13-14, 2014
Medicaid Developmental Disability Services Provider Panel
Sherman Weimer, Executive Director, Eastern Montana Industries, Glendive
Brodie Moll, CEO, Mission Mountain Enterprises, Ronan
Wally Melcher, CEO, Helena Industries

May 9, 2014
Medicaid Hospital Provider Panel
Chuck Wright, President/CEO, St. James Healthcare, Butte
Terry Preite, President, Benefis-Spectrum Medical, Great Falls

AGENCY MONITORING

Jan. 10, 2014
Title IV-E Foster Care Demonstration Project
Sarah Corbally, Administrator, DPHHS Child and Family Services Division

March 13-14, 2014
Home and Community-Based Waiver Slots
Kelly Williams, Administrator, DPHHS Senior and Long-Term Care Division

Aug. 26, 2014
Montana Suicide Reduction Plan/Suicide Review Team
Karl Rosston, DPHHS Suicide Prevention Coordinator

OVERSIGHT OF HEALTH AND HUMAN SERVICES MATTERS

March 13-14, 2014
Montana's Uninsured Population
Gregg Davis, Director, Center for Business Information and Economic Research, Flathead Valley Community College (by phone)

The Affordable Care Act in Montana
Adam Schafer, Deputy Commissioner of Securities and Insurance

ACA Outreach and Enrollment Efforts
Christine Kauffmann, Navigator Coordinator, Montana Primary Care Association

Office of the Child and Family Ombudsman
Bryan Lockerby, Administrator, Division of Criminal Investigation, Department of Justice
Dana Toole, DOJ Children's Justice Bureau

June 25, 2014
House Bill 630 Study: Montana Food Laws
Jim Murphy, DPHHS Comunicable Disease Control, Emergency Preparedness and Training Bureau
Gary Hamel, Chief, Meat Inspection Bureau, Department of Livestock

Montana Healthcare Foundation Overview
Mignon Waterman, Member, Foundation Board of Trustees

The Center for Children and Families
Donna Huston, Executive Director, The Center for Children and Families
Jackie Carreno, Family Housing Matters Participant
Keri Brown, Family Housing Matters Participant

Youth Diversion Grants
Sydney Blair, Executive Director, Center for Mental Health, Great Falls
Geoff Birnbaum, Missoula Youth Homes
Zoe Barnard, Chief, DPHHS Children's Mental Health Bureau

Montana Medical Association: Medicaid Expansion Option
Dr. Carter Beck, Missoula

Aug. 26, 2014
Update on Patient-Centered Medical Homes
Adam Schafer, Deputy Commissioner of Securities and Insurance

APPENDIX C: Summary of Staff-Prepared Reports

HJR 16 STUDY: STATE-OPERATED INSTITUTIONS

Institution-Specific Briefing Papers, September 2013

Montana Chemical Dependency Center	*Montana State Hospital*
Montana Developmental Center	*Montana State Prison*
Montana Mental Health Nursing Care Center	*Montana Women's Prison*

Overarching Issues Among State Institutions, September 2013
Summary of Facility Populations and Costs, September 2013
Continuum of Care for Chemical Dependency Services, November 2013
Community Developmental Disability Services, November 2013
HJR 39: An Earlier Look at Community Services for the Dually Diagnosed, November 2013
Recent Developments in Community Mental Health Services, November 2013
Continuum of Mental Health Services, November 2013
Transfers Between MSH and MSP, November 2013
Legislative History: 46-14-312, MCA, November 2013
Montana State Hospital Admissions by Type, January 2014
The Use of Small Mental Health Treatment Facilities, January 2014
Montana Laws Governing Assisted Outpatient Treatment, January 2014
Community Mental Health Facilities in Montana, March 2014
Small Facilities: Considerations and Decision Points, March 2014
Crisis Intervention and Diversion, March 2014
Increasing Crisis Response for Individuals with Developmental Disabilities, May 2014
Expanding Crisis Intervention and Jail Diversion Services, May 2014
Building and Operating a 16-Bed Inpatient Facility, May 2014
Converting Crisis Facilities to Provide Long-Term Treatment, May 2014
Potential Costs and Considerations for Forensic Community Facilities, June 2014
Potential Costs of Short-Term Inpatient Treatment, June 2014
Considerations Related to LCCF10 and LCCF11, August 2014

SJR 20 STUDY: PRESCRIPTION DRUG ABUSE

Roundup of National and State Activity on Opioid Abuse, November 2013
State Approaches to Curbing Prescription Drug Abuse, January 2014
State Prescription Drug Monitoring Practices, January 2014
HIPAA Issues in Prescription Drug Monitoring Programs, January 2014
Development and Funding of the Montana Prescription Drug Registry, May 2014
Disposing of Unused Narcotic Drugs, June 2014
Comparison of Montana and Oklahoma Drug Registry Laws, June 2014
Funding Options for Prescription Drug Monitoring Programs, June 2014
Summary of MPDR Funding Sources, August 2014
LCCF09 Considerations and Decision Points, August 2014

SB 423 MONITORING: MONTANA MARIJUANA ACT

Developments through June 2013, June 2013
Developments through February 2014, March 2014

AGENCY OVERSIGHT

House Bill 142 Review of Statutory Advisory Councils and Reports, March 2014

Copies of staff reports are available on the following pages of the committee's website:

- HJR 16 Study: *http://leg.mt.gov/css/committees/interim/2013-2014/Children-Family/Committee-Topics/HJR16/hjr-16.asp*
- SJR 20 Study: *http://leg.mt.gov/css/committees/interim/2013-2014/Children-Family/Committee-Topics/SJR20/sjr-20.asp*
- SB 423 Reports*: http://leg.mt.gov/css/committees/interim/2013-2014/Children-Family/Committee-Topics/SB423/sb-423.asp*
- HB 142 Report*: http://leg.mt.gov/css/committees/interim/2013-2014/Children-Family/Meetings/March-2014/march-2014.asp*

APPENDIX D

Committee Correspondence Related to HJR 16

Children, Families, Health, and Human Services Interim Committee

63rd Montana Legislature

PO BOX 201706
Helena, MT 59620-1706
(406) 444-3064
FAX (406) 444-3036

SENATE MEMBERS
DAVID WANZENRIED--Chair
TERRY MURPHY
ROGER WEBB
JONATHAN WINDY BOY

HOUSE MEMBERS
RON EHLI--Vice Chair
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SCOTT REICHNER
CASEY SCHREINER

COMMITTEE STAFF
SUE O'CONNELL, Lead Staff
ALEXIS SANDRU, Staff Attorney
FONG HOM, Secretary

July 1, 2014

The Honorable Jon Tester
706 Hart Senate Office Building
Washington, DC 20510

Dear Senator Tester,

The Children, Families, Health, and Human Services Interim Committee has spent the past year studying Montana's mental health system and the mental health services provided in the state's institutions, including the state's prisons.

During the study, committee members have learned about the federal prohibition on using federal Medicaid funds for medical services for inmates while they are in a correctional setting. The Medicaid program will pay for medical services provided to qualifying inmates only when those services are provided outside of an institutional setting and for a period of 24 hours or more.

Health care costs for prison inmates make up a significant portion of the budget for the Montana Department of Corrections. According to the department's 2013 biennial report, the agency spent nearly $13 million on the medical, mental health, and treatment needs of adult and juvenile offenders in institutional settings.

Those costs were covered entirely by state general fund dollars. Had the offenders been eligible for Medicaid, the state would have paid about one-third of that amount, or $4 million, while federal Medicaid funds would have covered the remainder.

Because correctional health care costs create a strain on the Montana state budget, our committee agreed to ask members of the Montana congressional delegation to support a change to federal laws and rules that prevent the use of federal Medicaid dollars for medical care provided to inmates in a public institution.

We hope you'll give favorable consideration to this request.

Sincerely,

Sen. Dave Wanzenried
Presiding Officer

Cl0425 4183soxb.

Children, Families, Health, and Human Services Interim Committee

63rd Montana Legislature

PO BOX 201706
Helena, MT 59620-1706
(406) 444-3064
FAX (406) 444-3036

SENATE MEMBERS
DAVID WANZENRIED--Chair
TERRY MURPHY
ROGER WEBB
JONATHAN WINDY BOY

HOUSE MEMBERS
RON EHLI--Vice Chair
CAROLYN PEASE-LOPEZ
SCOTT REICHNER
CASEY SCHREINER

COMMITTEE STAFF
SUE O'CONNELL, Lead Staff
ALEXIS SANDRU, Staff Attorney
FONG HOM, Secretary

July 1, 2014

Gov. Steve Bullock
P.O. Box 200801
Helena, MT 59620-0801

Dear Gov. Bullock,

The Children, Families, Health, and Human Services Interim Committee recently voted to ask that you include funding in the 2017 Biennium Executive Budget to hire additional employees to work with intellectually disabled individuals who are at risk of a more restrictive placement because they are experiencing a mental health crisis.

The committee has been studying community crisis services as a part of the House Joint Resolution 16 study of state-operated institutions. That resolution sought a study of the institutions that serve individuals with a mental illness, intellectual disability, or chemical dependency to look for more effective treatment options or ways to provide services in a more cost-effective way.

Committee members decided to focus the study efforts on mental health services, including services that can be provided in a community in order to avoid a person's placement in a more restrictive, institutional setting.

During the study, we heard about mobile crisis response provided by the Developmental Services Division to intellectually disabled individuals who are in a community placement and who are in or approaching a mental health crisis. Because of the behavioral problems caused by their mental illnesses, these individuals may be in danger of being placed in the Montana Developmental Center or another more restrictive setting. The division's crisis and transition specialists work with not only the individual, but also the person's family and with the community provider to try to maintain the person's placement in the community.

Our committee applauds this proactive approach to responding to mental health crises. We believe that crisis services such as this are a key to preventing escalating mental health problems and to keeping people in the least restrictive setting possible.

In May, we voted to support the expansion of the division's effort by taking two steps:

- drafting a bill to appropriate $345,000 a year for hiring five additional state employees to provide crisis and transition services; and

- formally asking you to include funding for these employees in the budget that you'll propose to the 2015 Legislature.

The committee gave preliminary approval to the bill draft in June. Although members are prepared to proceed with legislation for the additional employees, we think this idea warrants your endorsement and should be included in the executive budget. If you do make it a part of the budget, the committee stands ready to support the proposal when it comes before the 2015 Legislature.

Thank you for your consideration of this request.

Sincerely,

Sen. Dave Wanzenried
Presiding Officer

c: Dan Villa, Budget Director
Pat Sullivan, Budget Analyst

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APPENDIX E

Montana-Wyoming Tribal Leaders Council Recommendations

Montana & Wyoming Tribal Leaders Council
175 North 27th Street, Suite 1003, Billings, MT 59101 Ph: (406) 252-2550 Fax (406) 254-6355
Website http://www.mtwytlc.org Email: CherylB@mtwytlc.com

24 June 2014

Chair Dave Wanzenreid
Attn: Sue O'Connell
Children & Families Interim Committee
State of Montana
Helena, Mt

Re: Comments and Recommendations for input to Two Studies – HJR 16 and SJR20 – delivered electronically for June 25, 2014 Meeting of the Children & Families Interim Committee

Dear Chairman & Committee Members:

Please provide the statement below with some recommendations that have been assembled along with a sample list of recommended or suggested readings which we have are submitting in response to the two studies that the Committee is conducting on the Prescription Drug Abuse Issue and the treatment of people in the various state run institutions and facilities.

Respectfully,

Cheryl A. Belcourt

Cheryl Belcourt
Executive Director
Tribal Leaders Council

CC: TLC Board Officers
Tribal Chairs, Presidents & Councils
TLC Committee on Health Co-Chairs

State Run Facilities – Effective Treatment of Native Populations at State Institutions & SJR 20

Prepared for the Children, Families, Health and Human Services Interim Committee
Prepared by MT-WY Tribal Leaders Council
June 25, 2014

Background

American Indians are imprisoned, more per capita than any other racial or ethnic group with the exception of African Americans. Two-million inmates are imprisoned in local, state, and federal jails and prisons across the US and of these, 1.6 percent are Native American or Hawaiian Natives.[1] In Montana Native Americans are disproportionately represented in the prison system. According to a 2008 report, 20 percent of men in Montana prisons were Native 27 percent were Native women yet Natives make-up 7 percent of the population. Rates of imprisonment among Natives are 3 to 4 times that of whites in Montana and this is an immediate call to action for state, local, tribal, federal, and private institutions and systems. Action however, must be informed by history- because our current systems, beliefs, and practices are often grounded in the past.

Historical events changed every aspect of American Indian people's lives, the Federal Indian Boarding School Movement[2] and the Dawes Act of 1887[3] are just two examples. These events forced many American Indian people to alter or abandon their land, culture, language, and traditional way of life. Evidence of colonization and Eurocentric practices has been echoed by many, including Ada Pecos Melton, the former director of the AIAN Justice Programs at the US Department of Justice. The former director reported, "..the current system is based on Eurocentric justice and a retributive philosophy that is hierarchal, adversarial, punitive… decision making is limited to a few… punishment is used to appease the victim, to satisfy society's desire for revenge". [4]This is in stark contrast to an indigenous holistic paradigm where everyone involved with a problem or conflict seeks to restore and heal relationships and individuals (restorative justice). In Montana, State Rep. Carolyn Pease-Lopez, D-Billings passed a bill to address institutionalized racism in the current system by placing an American Indian on the parole board- while efforts like this and others have helped give voice to American Indian inmates—more changes are needed to address the long-term systemic determinants of imprisonment among American Indians in Montana.

Colonization and discrimination against American Indians in the US and Montana often result in more harsh punishment and enforcement for American Indians when compared with whites or other groups. This is evidenced by the fact that one out of every 200 Natives are convicted of a felony crime compared with one of every 300 whites.[5] Scott Crichton of the Montana American

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[1] Frank Smith, "Incarceration of Native Americans and Private Prisons",http://www.leanpeprograms.info

[2] Beginning in 1879, AI children were removed from their homes and forced to attend schools that did not allow AI children to speak in their Native language or wear traditional clothing. All AI spiritual practices were banned and children were forced to adopt Christian spiritual practices.

[3] The Dawes Act of 1887 forced AI people to give up their land base and sovereignty in exchange for US citizenship. Within this Act, AI people lost control of their Native lands and sacred sites were destroyed or given to non-Indian people (Gunn, 2011)..

[4] Ada Pecos Melton, "Indigenous Justice Systems and Tribal Society". Tribal Court Clearinghouse: 1, http://www.tribal-institute.org/articles/melton.htm

[5] Jodi Rave (2009). Bismarck Tribune, "Percent of American Indians in Jail is High", http://www.bismarcktribute.com

Civil Liberties Union said in a recent report, "… racism here is real and it is profound, it's demonstrated in the prison system at each stage of the processing from profiling and arrests and public defense to probation."

Determinants of Imprisonment

High rates of imprisonment among American Indians in Montana are the result of multiple factors. Adverse Childhood Experiences (ACE) and historical, cultural, and present-day traumas often result in unhealthy coping strategies where substance abuse, violence, and risk taking lead to imprisonment. [One info link is at http://www.tribalyouthprogram.org/events/webinar-ace-adverse-childhood-experiences-study-and-american-indian-alaska-native-children] Compounding ACE/traumas---poverty, segregation, discrimination, and colonization create the conditions from which high drop-out rates and limited job opportunities emerge. Far too often, we see real human examples that the statistics describe in the attached article "Pipeline to Prison". These conditions also result in a litany of social ills that include high rates of crime, violence, chemical dependency, behavioral health problems and suicide. These conditions are more extreme in rural and isolated reservation communities throughout Montana where job opportunities are limited and school systems fail to provide adequate education or retain students for long-term career successes.

Children of incarcerated parents are more likely to experience hardship. In one national study, children with a parent who has ever been incarcerated are 25 percent more likely to experience material hardship, 32 percent more likely to have parents living separately, and 44 percent more likely to show aggressive behavior. [6] Moreover, of the 1.6 million people in federal facilities, 330,000 were imprisoned for drug offenses. More efforts that end the cycles of Adverse Childhood Experiences – ACE - among current and future generations of American Indian children are needed- this should include systems of care that are culturally informed, 'trauma' informed and ACE informed. These systems and facilities must be thoughtfully designed and implemented across the whole spectrum of state institutions including developing restorative justice models in schools for conflict resolution and behavioral health, culturally informed substance abuse treatment and interventions, training and educational programs for staff and clientele both in ACE and trauma informed care with ongoing monitoring.

These ACE conditions and risk factors coupled with differential policies for arrest and treatment must be examined to achieve justice and health for American Indians in Montana.

Solutions

To address the imprisonment crisis all systems and institutions must work collectively to address the basic needs of people in a culturally effective and informed manner. Abraham Maslow studied among the Blackfeet and wrote about a hierarchy of needs (Maslow's Hierarchy of Needs) where the most basic needs of food, water, sleep must be met (physiological), then security, employment, family, and health (safety), followed by friendship, family (love/belonging), esteem (confidence, respect of others/by others) and finally self-actualization (self-awareness, values clarification, morality, lack of prejudice, problem solving). Many Natives, including those imprisoned in Montana have not been afforded these basic opportunities and therefore, many fail to grow and develop into mature healthy human beings. Indeed, the social, emotional, and spiritual needs of individuals are met by families and communities. When Natives are taken far from their communities, have little connection with or access to a healthy and whole support system (sometimes this is their

[6] "Parents in prison and what its doing to children", http://www.childrends.org

biological family and sometimes it is a spiritual or cultural family) due to multiple barriers (distance, transportation, and treatment)—this continues the downward spiral for many Natives imprisoned in Montana. To remedy this, State systems must recognize these basic human needs and find positive, culturally affirming ways to ensure every individual is afforded every opportunity, through initiatives/interventions, character development/values clarification and educational processes to have their basic needs met. Substance abuse treatment can be more effective when it is culturally meaningful to the individual. Read and consider the approach developed in the attached paper by Joe Gone and Pat CalfLooking (American Indian Culture as Substance Abuse Treatment: Pursuing Evidence for a Local Intervemtion).

The State of Montana and facilities/systems must find ways to address institutional racism and Eurocentric colonizing practices at all-levels. Despite the 1993 passage of the Native American Free Exercise of Religion Act, parity for American Indian inmates in the US and in Montana has been slow to take hold. American Indians are not afforded the same access to healing and spiritual opportunities. For example, in one report a Christian Choir was allowed into a correctional facility without being searched, but a medicine man who came in to counsel inmates was strip-searched in the same facility. Christian inmates have more access to books and resources about their spirituality than American Indians (4 books vs. 1 book) according to one recent report.

The State of Montana must view culture as prevention and protective rather than only an activity or religious beliefway. Culture is foundation for many Native people and positive identity formation is linked to healthy development and serve as protective against violence, substance abuse, and other illicit behaviors. Interventions, educational systems as well as care and treatment programs, curricula and initiatives must promote and affirm the positive identities of American Indian people. Far too often, Indian people exhibit normal reactions to abnormal situations that result in unhealthy and self-destructive methods of coping. Having been denied their own histories, their own cultural stories, in a safe and educational 'neutral' environment like the public schools, many Indian youth experience identity confusion and so their positive 'Indian' identity development is in jeopardy.

State institutions and systems must come to fully understand the terms 'Native' or 'American Indian' and 'Tribe'. There are basic beliefs, traditions, cultural practices, and cultural norms practiced by individual tribes and the State/systems must recognize that individual tribes cannot be grouped into one category, just as traditional practices used by one tribe (e.g. peyote for religious ceremonies) may not be used by another tribe. Current systems and practices fail to support or affirm the identities of American Indian people and their unique cultural beliefs and practices.

Recommendations:

- Prevention & Education efforts should be fully integrated and collaborative amongst Tribal, State and Federal and should be multi-dimensional, holistic, affirming, data informed and strength based.
- Protective Factors Associated with Reducing/Preventing the Risk of Targeted Health Problems should be supported and expanded upon:
    - Embracing of traditional cultural practices, beliefs, norms, values, language, ritual
    - Peer/Community support
    - Commitment by the community

    - Family Ties & Family Wellness
    - Embracing of Spiritual Beliefs
- As a State it is important to convey respect of the worldview and spirituality of Native peoples.
- Mandatory, frequent, ongoing and consistent cultural education training must occur at every institution at least 2x/year to work toward competency and demonstrated application. Goal: Accountability as Cultural bias and Cultural hegemony is discerned and diminished.
- Educate all State employees on how Adverse Childhood Experience (ACE) and historical trauma affect the health status of Native people.
- The cultural education/effectiveness training should be developed and taught by Tribes or Tribal organizations and financed in a manner that doesn't put the burden on the Tribes.
- The cultural trainings should be supported and utilized by State Boards, agencies, and departments frequently with a focus on outcomes and integration.
- Ensure that Tribal expertise has a voice on the following state boards (through representation and education) in order to inform policy and service delivery:
    - Inter-Agency Council for State Prevention Programs
    - Community Health Centers
    - Family Support Services Advisory Council
    - Human Rights
    - Mental Disabilities Board of Visitors
    - Montana Children's Trust Fund
    - Education Commission of the States
    - Board of Public Education
    - Governor's Healthier Montana Taskforce
    - Board of Pardons and Parole
- Quality Review – Policies and Procedures, Standards, Records, Nutrition & Health, Address of Cultural Issues, Gaps, Implementation, Staff Knowledge and Awareness. Delivered by a knowledgeable and authoritative body comprised of Tribal delegates with the capacity to recommend corrective actions. Goal: Improve service effectiveness with a focus on universal virtues and concepts that affirm identity and wellness.
- Develop Interventions for At-Risk Individuals – Identify resources available and coordinate to reach individuals through screening before it gets to worst case scenario.
- Therapeutic Family Care – Strengthen Support Systems for at risk families with the goal to keep families together.
- Dual Diagnosis (Co-occurring) is pervasive – All Treatment should be based on the assumption.
- DPHHS supported "Indian Child & Family Conference" – Goal: To address child, family and community issues that focus on remedies and Tribal – State collaborations.
- Define and incorporate the Tribal definition of family to include grandparents, aunties, uncles, cousins and family friends.

- Increase cultural, educational and vocational opportunities within the state facilities – language, history, credit recovery, distance learning, and GED.
- Increase opportunities and collaborations at Tribal Colleges for workforce development, history and language.
- Human Development Curriculum in Prisons & Pre-Release – Specifically for Native population with a focus on character, values and resiliency.
- Implement & expand the utilization of the OPI Essential Understandings of American Indians in Montana.
- The Institutional Profile should reflect the cultural diversity of the population.
- Define the scope and responsibility of each particular institution. What is the perceived responsibility of the Tribes from a state perspective? Is it accurate?
- Asset or Resource Identification and Mapping of Tribal and State Programs currently providing prevention, treatment, and other important services to Native populations. Define the roles, responsibilities and funding mechanism as part of the asset mapping.
- Work with Tribes to strengthen deferred programs, like Tribal Courts, Peacemakers, Family Counseling and conflict resolution or peacemaking in schools text at: http://www.npr.org/templates/transcript/transcript.php?storyId=194467944 or podcast at: http://www.npr.org/2013/06/22/194467944/schools-try-restorative-justice-to-keep-kids-from-dropping-out .
- Continue and expand upon the recruitment effort for Tribal members to sign up for Affordable Care Act in order to access necessary care.
- Clear guidelines and examples of required evaluations for cultural effectiveness that is tied to accreditation - through certification.
- Utilize and support the peer to peer approach in after-care services with a focus on culture, community, family, and the individual.
- Focus on the idea that recovery is possible and there are many roads to recovery.

Additional Information:

- Melina Angelos Healey, *Montana's Rural Version of the School-to-Prison Pipeline School Discipline and Tragedy on American Indian Reservations*, 75 Mont. L. Rev. 15 (2014) Available at: http://scholarship.law.umt.edu/mlr/vol75/iss1/2
- Contact Tribal Leaders Council for a longer bibliographic reference of materials.
- Paper delivered to Presidents Tribal Nations Conference in December 2013
- For information about the ACE Study – websites and articles abound - http://acestudy.org/ and At CDC - http://www.cdc.gov/violenceprevention/acestudy and in Montana http://helenair.com/news/local/addressing-childhood-trauma-will-take-teamwork-community-leaders-say/article_c4384918-444b-11e3-b564-001a4bcf887a.html
- Example of ACE informed systems of care: http://www.safestartcenter.org/topics/adverse-childhood-experience-ace

- Article on American Indian Culture as Substance Abuse Treatment: Pursuing Evidence for a Local Intervention, Gone & Calflooking, Journal of Psychoactive Drugs, 43 (4), 291-296, 2011
- Effective Evaluation and Child Welfare Concerns:
  https://www.childwelfare.gov/pubs/issue_briefs/tribal_state/index.cfm
  https://www.acf.hhs.gov/sites/default/files/cb/tribal_roadmap.pdf
  http://www.justice.gov/defendingchildhood

Prescription Drug Abuse – How to reduce abuse, misuse and diversion in Native Populations – SJR 20

Prepared for the Children, Families, Health and Human Services Interim Committee
Prepared by MT-WY Tribal Leaders Council
June 25, 2014

SJR 20: Reducing Prescription Drug Abuse Draft Study Plan

Prescription drug abuse is an epidemic and Native communities are disproportionately impacted by prescription drug abuse, more so than any other racial group. [7] The most recent data available show that American Indians are more than two-times more likely to report prescription drug abuse than whites (6.2% vs. 3.0 %). [8] Prescription drug abusers outnumber those using cocaine, hallucinogens, heroin, and inhalants combined. Incidence of fatal overdose from prescription drug abuse among Native communities exceeds the combined rates of other illegal drugs.

Prescription drug abuse is preventable. Similar to other disparities and inequalities, prescription drug abuse among Native people in Montana is often tied to social, demographic, environmental, and geographic disadvantage. In the last several years, Native communities across the country and in Montana participated in 'best or promising strategies' such as take back days, proper drug disposal, outreach and education. Montana created a prescription drug abuse advisory council and recommended a registry for prescription drug orders with controlled substances. Some of these strategies have reduced access to prescription drugs and increased awareness- but none have addressed the root causes for prescription drug abuse. Addressing these 'disadvantages' that lead to prescription drug abuse in Natives throughout Montana requires more than awareness campaigns and advisory councils.

To begin, one must understand the roots of many disadvantages (illicit drug abuse) can be traced back to traumas and histories. Adverse Childhood Experiences (ACE) are often precursors to prescription drug abuse [9] where individuals experience ACE/trauma and use prescription drugs as an unhealthy coping mechanism. The ACE study shows certain experiences (ACEs) are leading causes of poor mental health, early death, poor quality of life, and addiction. For example, one study found that more than 64% of parents with ACE reported illicit drug abuse. [10] Repeatedly, studies show that ACE increases the likelihood that individuals will report illicit drug abuse.

[7] Substance Abuse and Mental Health Services Administration. Results from the 2010 National Survey on Drug Use and Health.

[8] Substance Abuse and Mental Health Services Administration. Results from the 2009 National Survey on Drug Use and Health.

[9] Felitti, M. D., et al. "Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study." *American journal of preventive medicine* 14.4 (1998): 245-258.

[10] Dube, S. R., Felitti, V. J., Dong, M., Chapman, D. P., Giles, W. H., & Anda, R. F. (2003). Childhood abuse, neglect, and household dysfunction and the risk of illicit drug use: the adverse childhood experiences study. *Pediatrics*, *111*(3), 564-572.

Native people have and continue to experience trauma. Traumas resulted in the loss of identity among many Native people and communities. One tribal leader and elder talked about health and Native identity.. " what has sustained us and what can help us collectively improve our health status as a whole must include all things that affirm our respective identities…"[11] Trauma/ACE are some of the root causes of prescription drug abuse among Native people in Montana.

The current approach to prescription drug abuse in Montana, especially among Native people does little to affirm or support healthy identities or recognize the impact of ACE/traumas on Native people and communities. Another tribal leader and elder said, "….. we see that we must first deal with, address, and come to terms with unresolved grief and the resulting anger and depression and not having been allowed the opportunity to grow and fully develop in a safe, healthy, and culturally supportive atmosphere…"[12]

The Indian Health Service conducts reviews and audits, but they lack the resources to address the underlying health issue of the individual. For example, because of the major funding constraints, Contract Health Service will not refer for knee replacements or back surgery because they are not life or limb situations. Too often, the only option for the patient is to use opiates to control their pain level, which is very problematic.

To create a culturally supportive atmosphere where individuals have the opportunity to grow and fully develop in a safe way -State facilities must redesign their approach. Facilities, institutions and systems of care must be ACE informed, trauma aware, culturally effective, and most of all "person centered". Every institution, every state facility needs to learn to accommodate the needs of the person behind the behaviors in constructive and humane ways - not merely punitive and destructive ways.

Recommendations:

- Prevention & Education should be fully integrated and collaborative amongst Tribal, State and Federal and should be multi-dimensional, holistic, affirming, data informed and strength based.
- Protective Factors Associated with Reducing/Preventing the Risk of Targeted Health Problems should be supported and expanded upon:
    - Embracing of traditional cultural practices, beliefs, norms, values, language, ritual
    - Peer/Community support
    - Commitment by the community
    - Family Ties & Family Wellness
    - Embracing of Spiritual Beliefs
- As a State it is important to convey respect of the worldview and spirituality of Native people.
- Mandatory, frequent, ongoing and consistent cultural education training must occur at every institution at least 2x/year to work toward competency and demonstrated application. Goal: Accountability
- Educate State employees on how Adverse Childhood Experience (ACE) and historical trauma affect the health status of Native people.

[11] Belcourt, G. Personal Communication on Culture as a Way of Life. February 10, 2010.
[12] Anonymous. Montana Wyoming Tribal Leaders Council February 1, 2010

- The cultural education/effectiveness training should be developed and taught by Tribes or Tribal organizations and financed in a manner that doesn't put the burden on the Tribes.
- The cultural trainings should be supported and utilized by State Boards, agencies, and departments frequently with a focus on outcomes and integration.
- Ensure that Tribal expertise has a voice on the Board of Pharmacy (through representation and education) in order to inform policy and service delivery.
- Promote collaboration with Indian Health Service primary care providers with a focus on education and training of best practices for prescribing opiates. Education and training should be frequent and ongoing because of high turnover rates within the Indian Health Service.
- Establish a long-term strategy for prescription drug abuse prevention. It takes many years to turn the tide on a problem this big.
- Continue the recruitment effort for Tribal members to sign up for ACA which will help people access the medical care needed to address their core pain issues.
- Attorney General's Office and Tribes partner to ensure the Public Education Campaigns include Native faces, stories and reservation specific information on take back days, etc.
- Drug Take Back days should be frequent and well coordinated within each reservation community and urban Indian health clinic, maybe even extending into Drug Take Back Weeks with lots of education and outreach.
- Work with both Indian Health Service and the Montana Prescription Drug Registry (MPDR) to appoint an IHS pharmacist and Tribal Health delegate to the Prescription Drug Advisory Council
- Staff from the MPDR make periodic update reports to Tribal Leaders Council, Tribal Health and Indian Health Service on the status of the MPDR.
    - Provide update on barriers that may prevent Indian Health Service from using the registry
    - MPDR and Tribes partner for training and resource sharing
- Utilize the Tribal Law & Order Act as a collaborative and strategic planning tool to coordinate among stakeholders and promote a coordinated community response.
- Look at the inter-agency collaboration efforts between the VA and the State; if positive efforts are being made in that realm, could we replicate the approach between the IHS and the State?
- Create a diversion help hotline and market it in Tribal communities.
- Work with State on access to any tribal data on juvenile crime, violence and drug-related.
- Provide opportunity for western trained professionals to gain cultural understandings.
- Provide opportunity for western trained professionals to understand the way chronic poverty affects people socially, mentally and behaviorally.
- Work with Schools (K-12) on prescription drug education, prevention and early detection.
- Promote a broad spectrum of care for those in pain, like chiropractic, acupuncture, physical therapy, massage, sweat lodge, meditation, etc.
- Initiate a dialogue with Tribal Leaders, economic development leaders, and health professionals to talk about solutions to the economic situation on the reservations. Poverty is linked to the prescription drug abuse problem because it drives the diversion of the drugs because to sell opiates is the only income source for some families in poverty.
- Encourage uniform pain management plans and protocols.

APPENDIX F

Dual Diagnosis Task Force Recommendations

Recommendations of the Dual Diagnosis Task Force

June 20, 2014

2714 Billings Avenue
Helena, MT 59601

BACKGROUND

In 2012 the Montana Council on Developmental Disabilities under contract with the Mental Health Settlement Trust performed a series of training opportunities to mental health clinicians, developmental disabilities direct support professionals and law enforcement training officers.

Over a four-week period 576 mental health clinicians and developmental disabilities direct support professionals were provided training on *Understanding People Who have a Dual Diagnosis: Characteristics and Clinical Practices* , and 142 police department training officers received training on *Understanding and Interacting with People with Intellectual Disabilities: A Guide for Law Enforcement.*

Consistently across the state, training attendees requested more information, and more training on working with the population identified as being dually diagnosed (i.e., developmental disability and mental illness).

Based upon this input, the Council established the Dual Diagnosis Task Force in 2013 for the sole purpose of developing a list of recommendation focused
On creating and/or enhancing service delivery for persons identified as dually diagnosed. The Council reached out to a broad array of individuals and entities to come to our table and collectively develop the recommendations.

MEMBERSHIP

The following is the membership list of the Dual Diagnosis Task Force in alphabetical listing.

Kris Bakula, Member - Westmont, DD Provider - Helena
Jean Morgan, Alternate

Martin, Blair, Ph.D., Member – Rural Institute on Community Living – UM Missoula
Meg Traci, Ph.D., Alternate

Tracy Blazo, Member – Residential Support Services, DD Provider – Billings
Jim Uecker, Alternate
Pete Haley, Alternate

Erin Butts, Member – Office of Public Instruction – Helena

Dr. Jody Daley, Member – Center for Mental Health – Missoula/Helena
Natalie McGillen, Alternate

Dr. Katharin Flynn, Member – Montana State Prison/DOC – Deer Lodge
Jill Buck, Alternate

Kandis Franklin, Member – DPHHS Children's Mental Health Bureau/Parent, Helena
Dan Ladd, Alternate

Don Berryman, Member – MT Council on Developmental Disabilities - Butte

Beth Brenneman, Member – Disability Rights MT – Helena

Matt Kuntz, Member – NAIMI MT – Helena

Deb Matteucci, Members – DPHHS AMDD – Helena
Kenny Bell, Alternate

Alicia Pichette, Member – Board of Visitors – Helena

Mike Sadowski, Member – Ravalli Services, Corp DD Provider – Hamilton
Bill Hughes, Alternate

Jeff Sturm, Member – DPHHS Developmental Disabilities Program – Helena
Connie Orr, Alternate

Deborah Swingley, Member – MT Council on Developmental Disabilities

Connie Wethern, Members – Parent - Glasgow

Members were asked to sign a letter of commitment to attend the series of meetings outlined for the work of the Task Force and identify an alternate in the event the member could not attend the meeting. In reaching out to community based providers we sought and secured participation from both Montana Association of Community Disability Services members and non-Montana Association of Community Disability Services members. Deb Matteucci of the Addictive and Mental Disorders Division (AMDD) signed a letter of commitment to participate, but due to scheduling demands, AMDD was represented by Kenny Bell, an AMDD staff from Anaconda.

The Dual Diagnosis Task Force meet over the course of eight months starting in November 2013 running through June 2014.

RECOMMENDATIONS

The Dual Diagnosis Task Force presents the following five recommendations, with rationale in no particular rank order.

Recommendation One
Advocacy and Education to the Public and Legislature

Rationale: Just as the Task Force learned over the course of eight months, there is a great deal of mutual learning to be accomplished between the mental health and developmental disabilities service systems. And simply put, there is not much communication between the staff and administration of either system, nor between the executive branch and the legislature, or the agencies and the public they serve.

The Task Force recommends a standing advisory Council or committee be developed as an information and education conduit to the programs and management of DPHHS, legislative interests and the public. This could be achieved either by creating a new advisory entity or utilizing a subgroup of two existing advisory entities such as the Montana Council on Developmental Disabilities and Mental Health Oversight Committee.

Recommendation Two
Hire a full time State Psychiatrist

Rationale: The population of individuals with co-occurring intellectual/developmental disability and mental illness is increasing in and represents a much greater percentage of those receiving services compared to 5 years ago. Throughout Montana provider agencies struggle with access to qualified mental health professionals. This problem is particularly acute in our many rural communities. A full-time state psychiatrist could provide telehealth psychiatric consultation services to primary care physicians, APRN's, psychiatrists, or others involved in providing health services to this population (services that include prescribing medication).

Recommendation Three
On-going Training Support to Direct Support Professionals

Rationale: Ongoing, integrated education and cross-training is needed for direct support professionals in several service systems. Training of pre-service and practicing professionals in human services, law enforcement, education, employment and other community-based agencies and organizations is essential to the safety and community inclusion of people with dual diagnosis. In any human service field, a policy that ensures individual access to well-trained and cross-trained (i.e., integrated) providers is a foundation for a service system that values all citizens. Consistent with this value, we recommend the following scope of training to establish cross-system understanding and professional capacity in Montana.

Area One: Targeted "awareness" training should include topics such as: definitions of developmental disability, mental health, and dual diagnosis; cross-agency referral sources for crisis, program/services information, and basic information, funding options based on the variances in eligibility criteria; and the scope of mental health outpatient services.

Area Two: Targeted skill-building training, across systems, should include topics such as: first aid and CPR; understanding implications of and working through consistent or conflicting policies and reporting requirements across mental health and developmental disability systems; positive behavior management behavior de-escalation; person-centered planning; and basic client-centered communications strategies.

Families and caregivers of those who are dually-diagnosed should be a primary recipient of the training provided in Area Two. They are often the "first line" of intervention in the crisis escalation cycle. Crisis support professionals and families should have clear criteria to determine when a person in crisis is "well enough" to be under the supervision of family and caregiver support, or when more intensive professional support is required in other words, what are the safe limits of intervention and support for families?

Recommendation Four
Crisis Support

Rationale: **Crisis is not so much an event as it is a complex continuum of events to be addressed proactively and managed, when necessary.**

This Crisis Support recommendation addresses several critical issues and Involves the integration of existing expertise, models and structures. These Sub-recommendations are based on what is working in Montana and in other states. We recognize that there are significant "pockets" of expertise statewide. We recommend incorporating models and methodologies that are already proven to work in Montana and elsewhere.

- Develop regional, professional capacity for persons with mental health issues and developmental disabilities. This is a cross-training/cross-competency concern.

- Develop Crisis and Transition Support Specialists, which may or may not be state employees. These professionals must be trained to use evidence based best practices.

  Ensure that Crisis and Transition Support Specialists collaborate with local expertise in each Region to assist in crisis situations as they arise. This results in stronger local capacity over time; local professional resources can be more readily accessed in each Region. This model results in the development and growth of expertise in each Region and develops resources to assist with

maintaining client stability one the Crisis and Transition Support Specialists leave the Region.

- Develop a flexible (i.e., clear communication among all parties serving the individual – medical, employment, etc.) infrastructure to provide the supports and services already available in the community. This includes funding, reporting and service provision flexibility.

- Provide a safe environment wherein an individual may receive a medical evaluation without being committee to either the Montana Developmental Center or Warm Springs State Hospital. The current crisis homes have limitations regarding length of stay and staff qualification. The current model requires development disabilities services providers to pursue a full institutional commitment when what is needed is simply a comprehensive medical adjustment.

- Develop a Mental Health Crisis Facility located in eastern Montana. Adequate crisis facility resources are not available in eastern Montana.

RECOMMENDATION FIVE

Data Collection and Analysis

Rationale: Valid and reliable data is necessary to make informed and appropriate decisions related to program development, resource allocation and service evaluation. Data that is consistently collected and analyzed will assist in better understanding the needs of Montanans with dual diagnosis, including the needs of their families and the public service system.

Initially the most urgent data need is related to the current services Wait List. Essential questions include a) the cost to reduce or eliminate the wait list? And b) the average time (months, years?) on the wait list.

Additionally, there are service access questions for providers. Montana does not have valid and reliable information regarding its citizens who have difficulty accessing psychiatrists, counselors, crisis facilities or other mental health supports. Understanding these issues at the community/region levels would assist in targeted resource allocation.

MENTAL HEALTH CENTER RECOMMENDATIONS

The Task Force overwhelming endorses and supports the recommendations of the Mental Health Centers which have already been presented to the committee, including:

- Crisis Stabilization
- Involuntary beds
- Involuntary long term stabilization including the population of developmental disabilities

NEXT STEPS

Perhaps the best outcome of the efforts of these last eight months has been getting people who traditionally have not been communicating, effectively to start having a dialogue. Some people shared this could be improved if their "coffee pots were closer together." Whatever the antidotal version may be, communication between the mental health and developmental disabilities systems is crucial.

To this end the Council has endorsed their ongoing support for this group or a reconfiguration of the group to maintain these lines of communication.

I have been with the Council since 1986 and one of the first meetings I attended back in 1986 was on the needs of persons identified with a dual diagnosis. That meeting was held 28 years ago. It's said timing is everything, the Task Force is optimistic that there will be action applied to recommendations, and a system put in place to address the needs of persons who experience both a developmental disability and co-occurring mental health issues.

Deborah Swingley, ED/CEO
Montana Council on Developmental Disabilities

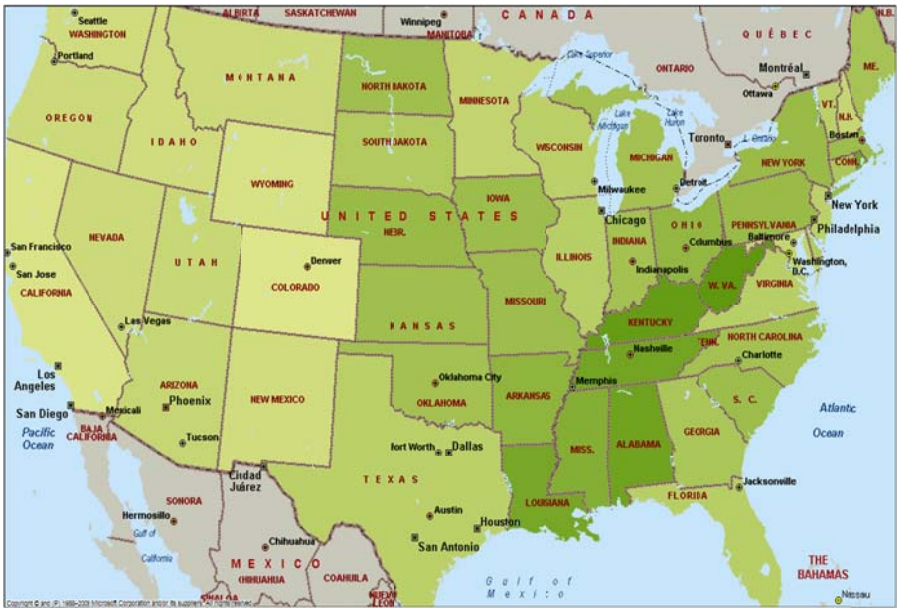
APPENDIX G

Data Related to Controlled Substances Prescriptions

Overall Utilization of Pharmaceuticals by State

A State Comparison: Annual Prescriptions per Capita 2013 All Products					
Rank	State	Rx per Capita	Rank	State	Rx per Capita
1	West Virginia	18.2	27	Delaware	12.0
2	Kentucky	17.3	28	South Dakota	11.7
3	District of Columbia	17.0	29	Florida	11.4
4	Alabama	16.8	30	Virginia	11.4
5	Tennessee	16.7	31	Illinois	11.3
6	Rhode Island	16.6	32	Wisconsin	11.0
7	Louisiana	16.4	33	New Jersey	11.0
8	Mississippi	15.4	34	Vermont	10.7
9	Arkansas	14.6	35	Texas	10.7
10	Ohio	13.9	36	Minnesota	10.6
11	Pennsylvania	13.8	37	Maryland	10.6
12	New York	13.7	38	New Hampshire	10.4
13	Nebraska	13.6	39	Arizona	10.2
14	South Carolina	13.5	40	Utah	9.9
15	Massachusetts	13.5	41	Oregon	9.8
16	Missouri	13.4	42	Nevada	9.8
17	Iowa	13.3	**43**	**Montana**	**9.7**
18	North Dakota	13.3	44	Idaho	9.5
19	Kansas	13.1	45	Washington	9.4
20	North Carolina	13.0	46	Hawaii	9.4
21	Michigan	12.9	47	New Mexico	9.4
22	Oklahoma	12.8	48	Wyoming	8.9
23	Indiana	12.8	49	California	8.6
24	Maine	12.6	50	Colorado	8.3
25	Connecticut	12.4	51	Alaska	6.9
26	Georgia	12.3	52	Puerto Rico	N/A
All states = 11.9 annual prescriptions per capita					

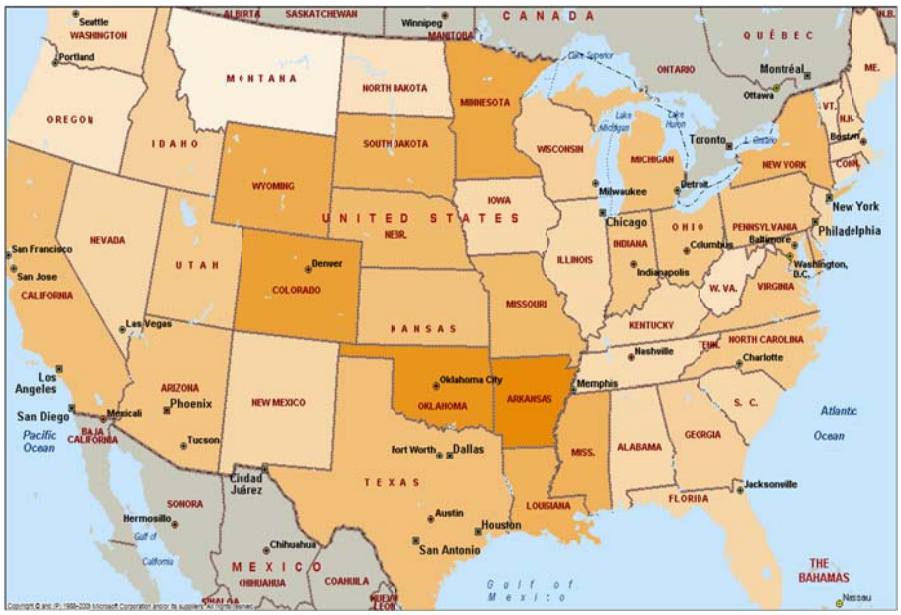
U.S. total prescriptions, all products 2013 = 3,734,451,154
Montana total prescriptions, all products, 2013 = 9,767,961



Sources: IMS Health *Xponent*; US Census Bureau

Growth in Utilization of Pharmaceuticals by State

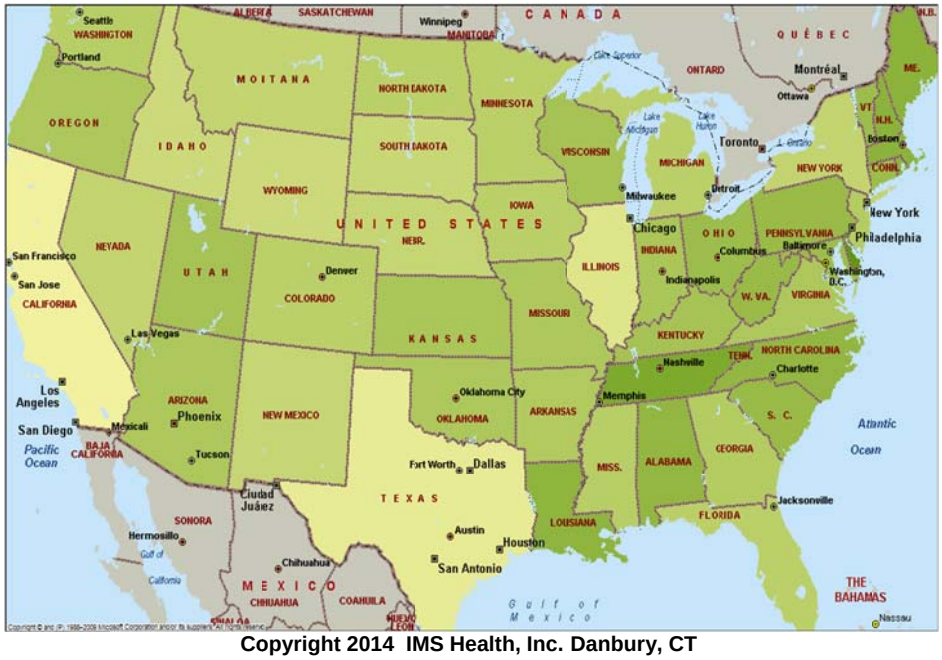
Percent Change in Filled Prescriptions, 2013 vs 2012 All Products					
Rank	State	% Change	Rank	State	% Change
1	Arkansas	7.8%	27	Rhode Island	2.6%
2	Oklahoma	7.1%	28	Idaho	2.5%
3	District of Columbia	6.3%	29	Georgia	2.5%
4	Colorado	6.1%	30	Wisconsin	2.5%
5	Minnesota	5.6%	31	New Mexico	2.2%
6	Wyoming	5.2%	32	New Jersey	2.1%
7	Mississippi	5.0%	33	Florida	2.0%
8	Louisiana	4.8%	34	Nevada	2.0%
9	South Dakota	4.6%	35	Illinois	2.0%
10	New York	4.4%	36	Iowa	2.0%
11	Nebraska	4.2%	37	Kentucky	2.0%
12	Missouri	4.2%	38	Alabama	1.9%
13	Delaware	4.0%	39	South Carolina	1.9%
14	California	3.8%	40	New Hampshire	1.9%
15	Texas	3.7%	41	Tennessee	1.8%
16	Michigan	3.7%	42	Massachusetts	1.7%
17	Kansas	3.6%	43	Washington	1.6%
18	Arizona	3.3%	44	Maine	1.5%
19	Hawaii	3.3%	45	Vermont	1.4%
20	Maryland	3.3%	46	Connecticut	1.4%
21	Ohio	3.3%	47	West Virginia	1.2%
22	Indiana	3.3%	48	North Dakota	1.2%
23	Virginia	3.2%	49	Oregon	0.9%
24	Pennsylvania	3.1%	**50**	**Montana**	**0.1%**
25	Utah	3.1%	51	Alaska	-0.7%
26	North Carolina	3.0%	52	Puerto Rico	N/A
All states = 3.2% annual percentage of change					



C-II Controlled Substance Utilization by State

A State Comparison: Annual Prescriptions per Capita 2013 CII Products					
Rank	State	Rx per Capita	Rank	State	Rx per Capita
1	Delaware	0.81	27	Oregon	0.47
2	Tennessee	0.68	28	Arkansas	0.47
3	District of Columbia	0.63	29	New Jersey	0.45
4	Massachusetts	0.63	30	Georgia	0.45
5	Maine	0.62	31	Mississippi	0.44
6	Rhode Island	0.61	32	Washington	0.44
7	New Hampshire	0.61	33	Michigan	0.42
8	Louisiana	0.61	34	Colorado	0.42
9	North Carolina	0.59	35	Minnesota	0.42
10	Alabama	0.58	36	Iowa	0.42
11	South Carolina	0.57	37	North Dakota	0.41
12	West Virginia	0.57	38	Florida	0.40
13	Pennsylvania	0.56	**39**	**Montana**	**0.40**
14	Ohio	0.56	40	Nevada	0.39
15	Vermont	0.55	41	New York	0.39
16	Maryland	0.55	42	Nebraska	0.38
17	Connecticut	0.54	43	New Mexico	0.37
18	Utah	0.51	44	South Dakota	0.37
19	Wisconsin	0.51	45	Alaska	0.37
20	Kentucky	0.50	46	Idaho	0.36
21	Kansas	0.49	47	Wyoming	0.36
22	Indiana	0.49	48	Illinois	0.28
23	Virginia	0.48	49	Hawaii	0.26
24	Arizona	0.48	50	Texas	0.24
25	Oklahoma	0.48	51	California	0.19
26	Missouri	0.48	52	Puerto Rico	N/A
All states = .42 annual prescriptions per capita					

U.S. total C-II prescriptions 2013 = 132,436,089
Montana total C-II prescriptions 2013 = 399,354



C-II Controlled Substance Growth by State

Percent Change in Filled Prescriptions, 2013 vs 2012 CII Products					
Rank	State	% Change	Rank	State	% Change
1	Wyoming	7.1%	27	Arkansas	1.2%
2	South Dakota	6.1%	28	Wisconsin	0.6%
3	Idaho	5.1%	29	California	0.5%
4	Louisiana	5.0%	30	Indiana	0.4%
5	Mississippi	4.3%	31	Tennessee	0.3%
6	Alaska	4.0%	32	Minnesota	0.3%
7	Illinois	3.9%	33	Maine	0.2%
8	Vermont	3.9%	34	Rhode Island	0.2%
9	Texas	3.7%	35	Washington	0.1%
10	Iowa	3.6%	36	Connecticut	0.0%
11	Alabama	3.3%	37	Colorado	0.0%
12	Michigan	3.0%	38	Georgia	-0.2%
13	Utah	3.0%	39	New Jersey	-0.2%
14	North Carolina	2.8%	40	Ohio	-0.3%
15	Kansas	2.7%	41	Delaware	-0.4%
16	Oklahoma	2.5%	42	District of Columbia	-0.6%
17	Missouri	2.5%	43	Maryland	-1.1%
18	Virginia	2.4%	44	West Virginia	-1.7%
19	North Dakota	2.4%	45	Arizona	-1.9%
20	Hawaii	2.1%	46	Oregon	-2.1%
21	Nebraska	2.0%	**47**	**Montana**	**-2.8%**
22	South Carolina	2.0%	48	Kentucky	-4.5%
23	Massachusetts	1.8%	49	Nevada	-5.4%
24	New Hampshire	1.5%	50	Florida	-6.2%
25	New York	1.5%	51	New Mexico	-6.2%
26	Pennsylvania	1.3%	52	Puerto Rico	N/A
All states = 0.7% annual percentage of change					

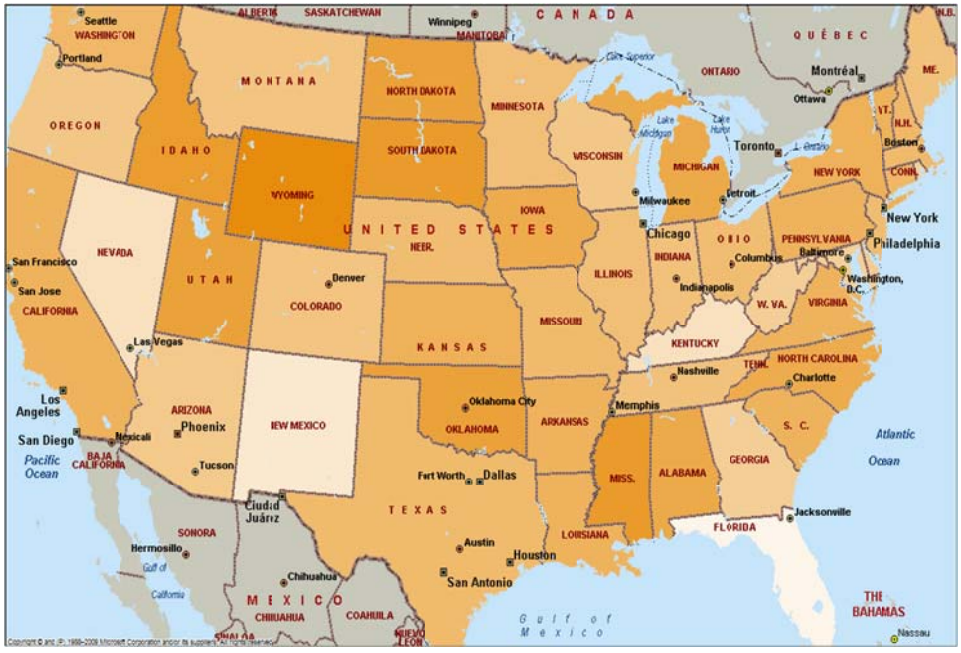
Oxycodone Utilization by State

A State Comparison: Annual Prescriptions per Capita 2013 Oxycodone (All Forms)					
Rank	State	Rx per Capita	Rank	State	Rx per Capita
1	Delaware	0.36	27	New York	0.19
2	District of Columbia	0.32	28	Vermont	0.19
3	Tennessee	0.31	29	Missouri	0.19
4	Massachusetts	0.29	30	Alabama	0.18
5	Pennsylvania	0.29	31	Alaska	0.18
6	Connecticut	0.28	32	Kansas	0.18
7	Maryland	0.27	33	Louisiana	0.17
8	New Hampshire	0.27	34	Florida	0.17
9	Arizona	0.27	35	Minnesota	0.16
10	North Carolina	0.27	**36**	**Montana**	**0.16**
11	Ohio	0.27	37	Wyoming	0.16
12	New Jersey	0.26	38	Arkansas	0.16
13	Rhode Island	0.25	39	Georgia	0.16
14	West Virginia	0.25	40	Indiana	0.15
15	Maine	0.23	41	Mississippi	0.14
16	Oregon	0.23	42	North Dakota	0.14
17	Utah	0.22	43	Nebraska	0.13
18	Colorado	0.22	44	Hawaii	0.13
19	Nevada	0.22	45	Idaho	0.12
20	South Carolina	0.21	46	South Dakota	0.11
21	Kentucky	0.21	47	Michigan	0.10
22	Virginia	0.20	48	Iowa	0.10
23	Washington	0.20	49	California	0.07
24	New Mexico	0.20	50	Illinois	0.05
25	Oklahoma	0.20	51	Texas	0.03
26	Wisconsin	0.19	52	Puerto Rico	N/A
All states = 0.17 annual prescriptions per capita					

U.S. total Oxycodone prescriptions 2013 = 53,773,573
Montana total Oxycodone prescriptions 2013 = 163,516

Growth in Oxycodone Utilization by State

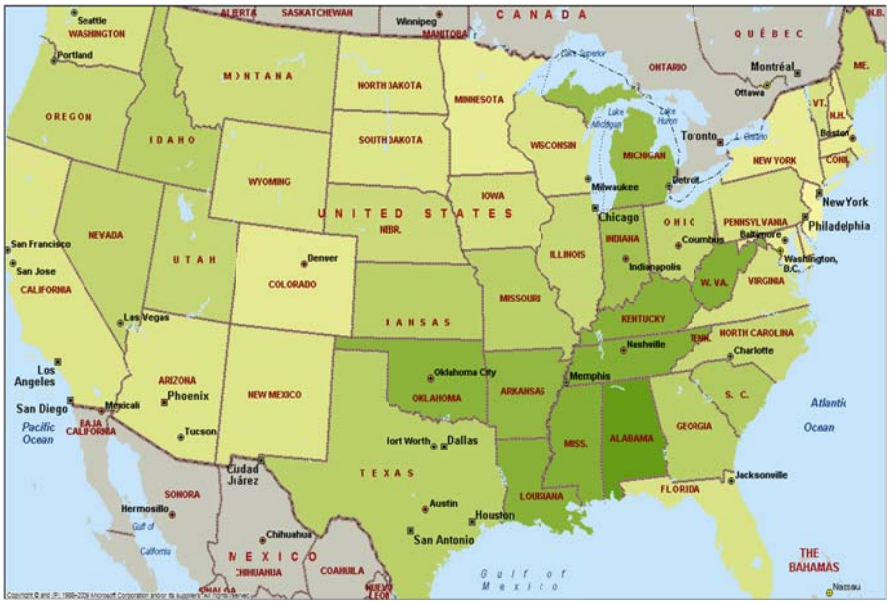
Percent Change in Filled Prescriptions, 2013 vs 2012 Oxycodone (All Forms)					
Rank	State	% Change	Rank	State	% Change
1	Wyoming	5.1%	27	Massachusetts	-3.0%
2	Mississippi	2.7%	28	Missouri	-3.1%
3	South Dakota	2.5%	29	Nebraska	-3.2%
4	Idaho	2.3%	30	New Jersey	-3.3%
5	North Dakota	1.2%	31	Ohio	-3.5%
6	Utah	1.2%	32	District of Columbia	-3.8%
7	Oklahoma	1.1%	33	Minnesota	-4.0%
8	Hawaii	0.9%	34	Illinois	-4.0%
9	Alaska	0.6%	35	Indiana	-4.1%
10	Alabama	0.1%	36	Maine	-4.3%
11	Michigan	-0.2%	37	Tennessee	-4.4%
12	Iowa	-0.3%	38	Colorado	-4.7%
13	North Carolina	-0.6%	**39**	**Montana**	**-4.7%**
14	Kansas	-1.1%	40	Wisconsin	-5.0%
15	New York	-1.5%	41	Oregon	-5.1%
16	Arkansas	-1.5%	42	Arizona	-5.4%
17	Louisiana	-1.6%	43	Delaware	-6.0%
18	Virginia	-1.8%	44	West Virginia	-6.3%
19	California	-1.9%	45	Georgia	-6.5%
20	South Carolina	-1.9%	46	Rhode Island	-6.7%
21	Vermont	-2.1%	47	Maryland	-6.8%
22	Pennsylvania	-2.2%	48	Nevada	-9.7%
23	Connecticut	-2.5%	49	Kentucky	-9.9%
24	Washington	-2.6%	50	New Mexico	-11.1%
25	New Hampshire	-2.7%	51	Florida	-13.5%
26	Texas	-2.8%	52	Puerto Rico	N/A
All states = -3.8% annual percentage of change					



C-III Controlled Substance Utilization by State

A State Comparison: Annual Prescriptions per Capita 2013 CIII Products					
Rank	State	Rx per Capita	Rank	State	Rx per Capita
1	Alabama	1.10	27	Pennsylvania	0.45
2	Tennessee	0.92	28	Virginia	0.43
3	Mississippi	0.91	29	Iowa	0.43
4	West Virginia	0.91	30	Washington	0.42
5	Kentucky	0.89	31	Vermont	0.42
6	Louisiana	0.89	32	Wyoming	0.42
7	Oklahoma	0.88	33	District of Columbia	0.41
8	Arkansas	0.81	34	Florida	0.41
9	Michigan	0.79	35	Wisconsin	0.40
10	Indiana	0.73	36	California	0.39
11	South Carolina	0.65	37	New Mexico	0.39
12	Kansas	0.59	38	South Dakota	0.38
13	Georgia	0.58	39	Arizona	0.38
14	Missouri	0.58	40	North Dakota	0.38
15	Texas	0.57	41	Alaska	0.36
16	Idaho	0.56	42	Colorado	0.35
17	Ohio	0.55	43	Connecticut	0.33
18	Nevada	0.54	44	Massachusetts	0.33
19	North Carolina	0.53	45	Delaware	0.33
20	Utah	0.52	46	New Hampshire	0.32
21	Illinois	0.50	47	Hawaii	0.31
22	Rhode Island	0.50	48	Maryland	0.31
23	Maine	0.50	49	Minnesota	0.31
24	Oregon	0.50	50	New York	0.29
25	Nebraska	0.48	51	New Jersey	0.25
26	**Montana**	**0.47**	52	Puerto Rico	N/A
All states = 0.51 annual prescriptions per capita					

U.S. total C-III prescriptions 2013 = 158,737,323
Montana total C-III prescriptions 2013 = 471,921



C-III Controlled Substance Growth by State

Percent Change in Filled Prescriptions, 2013 vs 2012 CIII Products					
Rank	State	% Change	Rank	State	% Change
1	Vermont	-0.2%	27	Illinois	-3.7%
2	Arkansas	-0.5%	28	Iowa	-3.8%
3	South Dakota	-0.9%	29	New Hampshire	-3.9%
4	North Dakota	-1.0%	30	Georgia	-3.9%
5	Louisiana	-1.2%	31	Ohio	-4.1%
6	Florida	-1.3%	32	Virginia	-4.2%
7	Massachusetts	-1.4%	33	Minnesota	-4.4%
8	Kansas	-1.5%	34	Maine	-4.5%
9	Mississippi	-1.5%	35	Indiana	-4.9%
10	Missouri	-1.8%	36	New Jersey	-4.9%
11	South Carolina	-1.9%	37	Tennessee	-5.0%
12	Alabama	-1.9%	38	Washington	-5.2%
13	Oklahoma	-1.9%	39	California	-5.2%
14	District of Columbia	-2.0%	40	Oregon	-5.5%
15	Utah	-2.3%	41	West Virginia	-5.6%
16	Nebraska	-2.6%	42	Texas	-5.7%
17	Hawaii	-2.6%	43	Connecticut	-6.0%
18	Wyoming	-2.8%	44	Arizona	-6.1%
19	Colorado	-2.8%	**45**	**Montana**	**-6.7%**
20	Alaska	-3.2%	46	Kentucky	-6.8%
21	Delaware	-3.2%	47	Idaho	-6.8%
22	Michigan	-3.2%	48	Nevada	-7.0%
23	North Carolina	-3.3%	49	New Mexico	-7.1%
24	Maryland	-3.3%	50	Rhode Island	-9.3%
25	Wisconsin	-3.3%	51	New York	-12.3%
26	Pennsylvania	-3.3%	52	Puerto Rico	N/A
All states = -4.2% annual percentage of change					

C-IV Controlled Substance Utilization by State

A State Comparison: Annual Prescriptions per Capita 2013 CIV Products					
Rank	State	Rx per Capita	Rank	State	Rx per Capita
1	West Virginia	0.99	27	New Hampshire	0.58
2	Alabama	0.98	28	Nebraska	0.57
3	Tennessee	0.92	29	Iowa	0.56
4	Louisiana	0.87	30	New Jersey	0.55
5	Arkansas	0.87	31	Virginia	0.55
6	Rhode Island	0.81	32	Vermont	0.54
7	South Carolina	0.81	33	Arizona	0.54
8	Oklahoma	0.75	34	Texas	0.52
9	Kentucky	0.75	35	Idaho	0.52
10	Mississippi	0.74	**36**	**Montana**	**0.52**
11	North Carolina	0.70	37	North Dakota	0.51
12	Missouri	0.68	38	Wisconsin	0.49
13	Florida	0.68	39	Illinois	0.49
14	Utah	0.67	40	New York	0.48
15	Connecticut	0.67	41	Colorado	0.48
16	Pennsylvania	0.66	42	Maryland	0.47
17	Massachusetts	0.66	43	Oregon	0.47
18	Michigan	0.65	44	South Dakota	0.46
19	Delaware	0.64	45	New Mexico	0.46
20	Kansas	0.64	46	Wyoming	0.43
21	Georgia	0.63	47	Washington	0.42
22	District of Columbia	0.63	48	California	0.41
23	Indiana	0.62	49	Alaska	0.40
24	Nevada	0.62	50	Minnesota	0.40
25	Maine	0.60	51	Hawaii	0.33
26	Ohio	0.58	52	Puerto Rico	N/A
All states = 0.58 annual prescriptions per capita					

U.S. total C-IV prescriptions 2013 = 183,011,862
Montana total C-IV prescriptions 2013 = 522,490

C-IV Controlled Substance Growth by State

Percent Change in Filled Prescriptions, 2013 vs 2012 CIV Products					
Rank	State	% Change	Rank	State	% Change
1	Arkansas	5.8%	27	Mississippi	-0.9%
2	Maine	4.7%	28	New Hampshire	-1.0%
3	Missouri	4.6%	29	Maryland	-1.0%
4	Wyoming	4.1%	30	Delaware	-1.3%
5	Vermont	3.5%	31	Texas	-1.4%
6	South Dakota	3.2%	32	Alabama	-1.5%
7	Louisiana	2.2%	33	Indiana	-1.6%
8	Colorado	1.9%	34	Connecticut	-1.7%
9	Minnesota	1.9%	35	South Carolina	-1.9%
10	Nebraska	1.8%	36	Georgia	-1.9%
11	Wisconsin	1.5%	37	West Virginia	-1.9%
12	Pennsylvania	1.3%	38	Ohio	-2.0%
13	Iowa	1.2%	39	Alaska	-2.1%
14	Oklahoma	1.1%	40	Rhode Island	-2.3%
15	Massachusetts	1.1%	41	Hawaii	-2.5%
16	North Dakota	1.0%	42	Florida	-2.5%
17	North Carolina	0.8%	43	California	-2.9%
18	District of Columbia	0.4%	**44**	**Montana**	**-3.0%**
19	Illinois	0.3%	45	Tennessee	-3.0%
20	Virginia	0.1%	46	Washington	-3.1%
21	Kansas	0.0%	47	Arizona	-3.5%
22	Utah	-0.1%	48	Oregon	-3.9%
23	New York	-0.4%	49	Nevada	-5.9%
24	Idaho	-0.6%	50	New Mexico	-6.8%
25	New Jersey	-0.7%	51	Kentucky	-8.4%
26	Michigan	-0.9%	52	Puerto Rico	N/A
All states = -1.0% annual percentage of change