Transforming Mental Health Care in Montana

Working Meeting

Whitefish, Montana

August 14 and 15, 2006

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I. INTRODUCTION

This document reflects facilitated discussions that took place with the people listed in the addendum (see p. 11) on August 14 – 15, 2006 in Whitefish, Montana.

It was the consensus of this group that the goals of the 2003 report of the **New Freedom Commission on Mental Health (NFC)** should be used as the framework for mental health system strategic planning.

It is the intent of this group to broaden this discussion in the near future to bring the Children's Mental Health Bureau into this process and to include the complete spectrum of stakeholders throughout the mental health community in Montana.

II. PREMISE

In May 2005, Anna Whiting-Sorrell, Policy Advisor for Governor Schweitzer, convened a series of meetings following the 2005 Legislative session initially involving Bonnie Adee, Mental Health Ombudsman, and Gene Haire, Executive Director of the Mental Disabilities Board of Visitors. (Both the Mental Health Ombudsman and the Mental Disabilities Board of Visitors are administratively attached to the Governor's office.) The initial impetus of these meetings was questions raised by Governor Schweitzer in his vetoes of Senate Bills 46 and 385. The purpose of these meetings was for the Governor's office to develop a deeper understanding of the configuration and functioning of Montana's public mental health system – specifically the part of the system that serves adults with Severe Disabling Mental Illness (SDMI).

Starting in July 2005, these meetings included Joyce DeCunzo, Administrator of the Addictive and Mental Disorders Division (AMDD) and others. Anna Whiting-Sorrell made it clear that these discussions were to focus on issues that are critical for proactive system planning and policy development necessary for Montana to build a high quality, comprehensive, optimally effective public mental health system. As these "Mental Health Connections" meetings continued, themes of system fragmentation and the absence of an overarching conceptual framework for strategic planning emerged. Questions were posed about 'gaps' in the mental health system, about how the various parts of the mental health system are connected, and about interagency coordination between the mental health system and other agencies – particularly the Department of Corrections.[1]

In September 2005, Gene Haire, Joyce DeCunzo, and Pete Surdock (Bureau Chief, Children's Mental Health Bureau) participated in a two-day meeting in Los Angeles - *Transforming State Mental Health Systems Regional Meeting* – sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA), the National Governor's Association Center for Best Practices, and the National Association of State Mental Health Program Directors. The Transformation theme was driven by the five goals of the final report of the **New Freedom Commission on Mental Health** (2003), and SAMHSA's significant commitment to mental health care transformation activities on the federal and state level.

The objectives of this meeting were:

- *to assist State and local policymakers in understanding the importance of mental health transformation in their own States*
- *to launch steps that help to create a State mental health system transformation policy agenda consistent with the New Freedom Initiative and the promise of recovery;*
- *to assist State and local policymakers in identifying, understanding, and forming consensus about mental health system priorities and specific areas of concern in their communities;*
- *to engage State decision-makers in the process of strategic decision-making within the context of consumer and family-driven mental health recovery values.*

Beginning in October 2005 – as a result of the *Transforming State Mental Health Systems Regional Meeting* in Los Angeles - the "Mental Health Connections" meetings began to use the goals of the **New Freedom Commission** report as a guide for further discussion about Montana's mental health system. During the February 2006 meeting, the group began to discuss how **New Freedom Commission** goals could be incorporated into the Department of Public Health and Human Services (DPHHS)/AMDD Executive Planning Process proposals. The "Mental Health Connections" meetings continued about every other month through June 2006, growing to include the Mental Health Services Bureau, the Chemical Dependency Bureau, the Department of Corrections, the Board of Crime Control, and the Budget Office.

In early June 2006, Anna Whiting-Sorrell, Joan Miles (Director of DPHHS), State Senator Dan Weinberg, and Gene Haire discussed the idea of convening a two-day working meeting with "Mental Health Connections" participants and others oriented around the vision for transforming the mental health system in Montana and the need to align Montana's system planning with national initiatives growing out of the work of the **New Freedom Commission**. This meeting was scheduled for August 14-15, 2006 in Whitefish, Montana.

III. PURPOSE

The purpose of the Whitefish meeting was:

> **To refine the vision and to describe a strategic framework for transforming Montana's public mental health system.....in alignment with the principles and recommendations of the <u>New Freedom Commission on Mental Health</u>.**

IV.   DESIRED OUTCOMES

- Adoption of the goals of the **New Freedom Commission on Mental Health** as the guide for mental health system transformation in Montana.
- Provision of assistance to Anna Whiting-Sorrell and the Governor's office for development of policy supporting mental health system transformation in Montana – policy that resonates with all Montanans and that is recognized nationally for excellence and relevance.
- Development of a consistent message with which to engage the Legislature in meaningful discussion about resources and supports necessary for comprehensive, proactive mental health system planning.
- Establishment of a basis for interagency collaboration in recognition of the impact of and the responsibility for addressing mental illness across all branches of Montana government.

V.   WHAT IS MISSING IN MONTANA'S PUBLIC MENTAL HEALTH SYSTEM?

In order to fulfill the meeting's purpose of refining the vision and describing a strategic framework for transforming Montana's public mental health system, and to provide necessary information to Anna Whiting-Sorrell, the work of the group is framed below in terms of "What is missing in Montana's public mental health system?" and is placed within the context of the **New Freedom Commission** report goals:

NFC Goal 1:

Americans Understand that Mental Health Is Essential to Overall Health

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What's Missing?

1.1   Many people with serious mental illnesses go untreated, do not receive treatment early in the disease process prior to reaching crisis, and often do not have immediate access to an appropriate level of care.

- outpatient services for people with serious mental illnesses who qualify for the Mental Health Services Plan (MHSP) are reimbursed at well below the actual cost; inpatient services are not reimbursed at all.
- inadequate service capacity at the community level has resulted in significant wait times for initial evaluation, psychiatrist appointments, and assignment to case managers
- insufficient service capacity at the community level has resulted in unnecessary admission to and unnecessarily lengthy stays at Montana State Hospital for some consumers
- 50-60% of Montana State Hospital admissions enter the public mental health system for the first time at this highest level of the system

- no 10 – 20 year visioning/planning; biennial budgeting process tends to restrict long-range, comprehensive system planning
- the 2006 study conducted by the Western Interstate Commission on Higher Education (WICHE) measuring prevalence of serious mental illnesses in Montana suggests that the mental health system is significantly under funded

1.2   There is no comprehensive anti-stigma campaign in Montana.

1.3   There is no comprehensive suicide prevention campaign in Montana.

- Montana's suicide rate is consistently in the top 3 among all states

1.4   There is no comprehensive, uniform statewide system for crisis/suicide telephone/in-person response to people contemplating suicide.

1.5   The reimbursement methodology for mental health services has contributed to the evolution of a fragmented, compromised collection of services, and does not incentivize outcomes and innovation through the use of Evidence-Based Practices.

1.6   Mental health care and primary health care are not well-coordinated.

NFC Goal 2:

Mental Health Care Is Consumer and Family Driven

What's Missing?
2.1   Plans of Care/Treatment Plans are not consistently individualized, not oriented toward services and supports needed to achieve recovery, not reviewed and updated in a meaningful way, and not coordinated across all programs and agencies.

2.2   Consumers and families are not routinely involved in planning, evaluating, and providing services.

2.3   State programs that address the areas of health care, housing, employment, education, and criminal justice are not properly aligned to meet the needs of people with mental illness.

2.4   Supported Employment is not consistently available to people with mental illnesses.

2.5   Affordable, quality housing with flexible, individualized housing support services is not consistently available.

2.6   Quality mental health services are not consistently available in the criminal justice system for offenders with mental illnesses; consistent

criminal justice diversion and re-entry strategies for non-violent offenders are not in place.

- 12% - 16% of people in Montana's correctional system have serious mental illnesses and have limited access to optimal treatments

Positive Trends

- the creation in mid 2006 of a shared DPHHS/DOC staff position – Behavioral Health Program Facilitator – is intended to improve access to mental health services to people with mental illnesses in the criminal justice system

NFC Goal 3:

Disparities in Mental Health Services Are Eliminated

What's Missing?

3.1 Culturally competent services that address the unique needs of American Indian people with mental illnesses are not defined or consistently available.

The following pieces are often missing:

- standards for culturally competent care
- data to identify points of disparity
- evaluation of services for effectiveness and consumer satisfaction
- collaborative relationships with culturally driven, community-based providers
- benchmarks and performance measures

3.2 The necessary array of mental health services is not available in many of Montana's "frontier" areas.

3.3 People who have serious mental illnesses, but who do not qualify for Medicaid have significantly less access to services.

NFC Goal 4:

Early Mental Health Screening, Assessment, and Referral to Services Are Common Practice

What's Missing?

4.1 There is insufficient incentive for assertive identification of, outreach to, and engagement of people with serious mental illnesses who do not self-initiate service contact.

4.2 Treatment for co-occurring psychiatric and substance use disorders is not integrated. (*Significant AMDD efforts are under way to build an evidence-based approach to the treatment of persons with co-occurring psychiatric and substance use disorders.*)

4.3 Mental Health Problems Are Not Adequately Addressed in Primary Care Settings

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NFC Goal 5:

Excellent Mental Health Care Is Delivered and Research Is Accelerated

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What's Missing?

5.1 Evidence-Based Practices are not uniformly available.

5.2 Reimbursement policies to not provide incentives to support implementation of Evidence-Based Practices (*with the possible exceptions of Dialectical Behavioral Therapy and Assertive Community Treatment*).

5.3 Serious mental health workforce problems exist in Montana.

- shortage of qualified providers, especially in more rural areas
- providers not trained in evidence-based and other innovative practices
- university system does not prepare students for working in the public mental health system with people with serious mental illnesses by teaching evidence-based approaches to practice
- American Indian people are significantly underrepresented in the workforce

Positive Trends

- AMDD has provided leadership toward implementing Evidence-Based Practices: PACT, Dialectical Behavioral Therapy, Integrated Treatment for Co-Occurring Psychiatric and Substance Use Disorders
- There is much discussion and planning (Service Area Authorities, Mental Health Oversight Advisory Council...) for transition toward a system focused on recovery.
- AMDD has funded several new, innovative new services statewide.

NFC Goal 6:

Technology Is Used to Access Mental Health Care and Information

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What's Missing?

6.1 Montana's tele-medicine system is not used to its fullest potential.

6.2 Electronic health records are not used consistently across the mental health system; electronic health records that are in place are not designed to integrate with other electronic systems.

Positive Trends

- Several of the major mental health providers either have implemented or are in the process of moving to electronic health records systems.

VI.   THE FUTURE

The Ideal Mental Health System

The group's multi-level discussions about its vision of the ideal mental health system closely reflected the concepts described in the **New Freedom Commission** report:

A Life in the Community for Everyone.....

- **everyone with a mental illness will recover**
- **mental illness can be prevented or cured**
- **mental illnesses are detected early**
- **everyone with a mental illness has access to effective treatment and supports that are essential for living, working, learning, and participating fully in the community**

Policies, Projects, Programs: How do we achieve the vision?[2]

Overarching conceptual framework:
- *Adopt the New Freedom Commission Report goals as the framework for systemic strategic planning – incorporate into all planning processes and groups (esp. Service Area Authorities); use NFC vision and concepts proactively to drive system planning thinking; develop strategic planning approach that results in a dynamic Transformation Action Plan.*
- Recommend public policy address by Governor.
- Align AMDD approach to the Executive Planning Process and budget proposals with NFC and with the strategic planning approach described above.
- Analyze true costs for a transformed mental health system.
- Work with stakeholders to consider changing the name of Addictive and Mental Disorders Division to more accurately depict the comprehensive nature of the Division's approach to the integration of administration and provision of services to people with co-occurring psychiatric and substance use disorders.
- Explore the concept of shifting from a fee-for-service to a capitated reimbursement system.
- Shift to a system that pays for outcomes, not services.
- Formalize and prioritize implementation of evidence-based practices.
- Develop incentives for implementation of outcome-driven service models.
- Research model programs (Clubhouse, Village, Thresholds, Nord Center) – develop RFP for model program implementation.
- Require evidence in clinical record that shows that treatment plans are individualized and outcome-driven.
- Enhance early identification through training of first responders, schools, medical staff, families, and drug/mental health courts.
- Enhance the continuum of behavioral health services available in the community including within primary healthcare settings.
- Initiate statewide workforce development project:
  - ➢ scholarships
  - ➢ mental health education in classrooms: K12 and college
  - ➢ collaboration with Office of Public Instruction and University system
  - ➢ contracting with Western Interstate Commission for Higher Education for study of mental health workforce issues in Montana
- Develop preferential reimbursement for evidence-based practices.
- Explore increased use of Federally Qualified Health Centers for assessment, treatment, and referral.

ADDENDUM: MEETING PARTICIPANTS

Bonnie Adee ....Mental Health Ombudsman, Governor's Office
Scott Boyles ....Program Administrative Officer, Chemical Dependency
Bureau, Addictive and Mental Disorders Division,
Department of Public Health and Human Services
John Chappuis ....Deputy Director, Department of Public Health and Human
Services
Joyce DeCunzo ....Administrator, Addictive and Mental Disorders Division,
Department of Public Health and Human Services
Gene Haire........................Executive Director, Mental Disabilities Board of Visitors,
Governor's Office
Gary Hamel ....Centralized Services Division Administrator, Department of
Corrections
Suzanne Hopkins ....Consumer
Laura Janes ....Chief, Health Services Bureau, Department of Corrections
Roland Mena ....Executive Director, Montana Board of Crime Control,
Department of Justice
Bob Mullen ....Deputy Administrator, Addictive and Mental Disorders
Division, Department of Public Health and Human Services
Pat Sullivan ....Senior Budget Analysis, Governor's Office
Lou Thompson ....Chief, Mental Health Bureau, Addictive and Mental Disorders
Division, Department of Public Health and Human Services
Dan Weinberg ....Senator, Montana Legislature
Anna Whiting-Sorrell ....Policy Officer, Governor's Office

Meredith Ewer-Speck........Governor's Office (assistant to Anna Whiting-Sorrell)

End Notes:

[1] Participants acknowledged the critical importance of incorporating services administered by the Children's Mental Health Bureau (CMHB) into the discussion; the decision was made to begin this process by focusing on the services for adults administered by the Addictive and Mental Disorders Division – while planning to bring CMHB and children's services stakeholders into this process (see part VI, p. xx).

[2] This list is not prioritized, nor did the Whitefish group intend to imply that it is all-inclusive. It represents this group's conclusions based on the participants' knowledge and experiences and on the facilitated discussions. The group acknowledges and expects that this list will evolve as additional stakeholders come into the process, and as a dynamic strategic planning process is established.