A REPORT ON COMMUNITY-WIDE INTERVENTION IN MENTAL HEALTH CRISIS

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Lynn Myer-Weltzien & Pat Carrick
Mental Health Crisis Intervention Task Force of the
Implementation Team
Beaverhead County Local Advisory Committee on Mental Health
Dillon, MT

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Introduction

A “Summit” entitled “Integrating Physical and Behavioral Health” was held in Dillon, MT in February, 2016. The Summit was sponsored by the Local Advisory Committee on Mental Health/LAC, enabled by a grant from the Montana Healthcare Foundation, and facilitated by the National Council for Behavioral Health. The two-day Summit was attended by over 80 participants representing numerous local and regional agencies as well as many interested individuals. The participants discussed a variety of issues related to mental health and the high rate of suicide in the State of Montana generally and in Beaverhead County specifically. Out of these discussions 4 priority topics were identified: children’s mental health, depression screening, mental health in the criminal justice system, and mental health crisis intervention in the community. In the post-Summit months, the grant Implementation Team/IT of the LAC was able to convene task forces of interested individuals on each of the identified topic areas except mental health crisis intervention. Relevant work has been progressing through the efforts of each of those 3 teams.

In late summer/early fall, 2016, the Implementation Team/IT determined that an appropriate project to address the crisis intervention topic area would be to create a description of current practices and understandings related to mental health crisis in the community in order to identify strengths and weaknesses of those practices and systems. To this end, the IT decided to interview key stake-holders, and to compile these interviews into a descriptive report. The following three interview questions were developed by the IT:

1. What is your understanding of the process that is supposed to occur when a (client/patient/student) experiences a behavioral health (mental/addictive) crisis, and what is your role in that process?
2. From your knowledge of recent situations, could you please describe a typical scenario (i.e. what actually occurs)?
3. Is this an improvement over what was happening 1 year ago? (Your answer may be complex as there may be some aspects that are improved, whereas others are not.)
   - If yes, what specifically is working well and to what or whom do you credit these changes?
   - If no, what specifically, in your opinion, is the most critical obstacle to improvement?

About 14 stakeholders were identified by the IT. Two IT members agreed to conduct the interviews and to compile a report, with the understanding that additional interviewees might be approached as time and opportunity made possible. Between October, 2016 and end-February, 2017, 22 face-to-face interviews were completed by Lynn Myer-Weltzien and Pat Carrick. Nineteen of the interviewees represent 13 different services and agencies within the community. Additionally 3 consumers agreed to be interviewed. One of the 3 consumers declined to be quoted in the final report and that interview is not included, leaving content from 21 interviews referenced in this final report.

Professionals who were interviewed were advised that their responses to the 3 main questions would not be anonymous, and, although each was offered the opportunity to include anonymous comments at the end of their interviews, few did so. In many cases, interviewees were offered transcripts of their interviews for review in order to ensure accuracy. The 2 consumers whose comments are included are recorded anonymously.

Following is a report summarizing the results of this work. We have tried to make our report useful by distilling the content of our interviews into themes. We have been sensitive to the danger of imposing our own agendas onto the data and have high-lighted only those themes that have arisen repeatedly as we listened to subjects from the different settings and as we reviewed and re-reviewed our transcripts again and again.

Finally, the interviewers believe our responsibility in this project has been not only to report what we have heard, but to draw from the data shared with us some suggestions for future actions - acknowledgement of strengths we should support and recommendations for improvements in our community-wide strategies and processes for mental health crisis intervention. To this end, Lynn and Pat were joined by Jenny Given and Carol Kennedy of Barrett Hospital and Healthcare, who have contributed to the process of identifying themes and developing recommendations for the future.

LIMITATIONS

It should be noted from the outset that this document constitutes a REPORT and does not pretend to be a STUDY. Our sample is very much a convenience sample. There are many other stakeholders and interested community members who would undoubtedly bring additional perspective and information to our report including other primary medical care providers, representatives from the local urgent care clinic, private therapists and counselors, parents of school children, officials from our County Jail, law enforcement officers, etc.

Our questions did not specifically address alcohol and substance abuse, and therefore did not elicit specific reference to those issues from our interviewees, although substance abuse is known to be a contributing factor in many, perhaps even most, mental health crisis situations.

Our methods have been informal throughout. While we have tried very deliberately to let the themes and recommendations discussed here arise out of the interviews, they are inevitably influenced by our own professional and personal experiences and opinions.

The reader should also understand that, at the same time that we believe part of our job has been to distill information in a manner that can be hopefully useful to the IT and to the community, what we present, we hope, is the truth of our participants' experience as shared with us. We have tried to render their voices as accurately as possible, even as we recognize that these individual voices do not always reflect the *intended* structure or procedures of the individuals or the system as it currently stands. It is our hope that listening to these voices may help us to see more clearly how things actually *are.* Perhaps a clear vision of the present may help to guide us as we seek improvements for the future.[1]

THEMES

Following are the prominent themes from the interviews conducted over a 4 month period. These themes have been identified by searching key words and phrases from the transcribed records. Some of these themes are directly related to the question statements and vocabulary, while others arose from the responses of our interviewees. There are certainly more areas of interest and concern than we have included in the following discussion. We have tried to

[1] Records of the original interviews are available to members of the Implementation Team upon request.

prioritize those subjects that recurred most often. However, that said, we recognize the inevitability of some measure of subjectivity in any qualitative approach, and members of the IT with interest and time are encouraged to review the source transcripts. The themes addressed in this report:

Process
Roles
Safety
Communication
Transportation
Delays
Lack of Service Availability
Big System Issues
Caring Community

INTERVIEWEES

Parkview Elementary School
Greg Lemelin, school counselor (GL)

Dillon Middle School/DMS
Channon Williams, school counselor (CW)

Dillon Middle School/DMS - Yellowstone Boys & Girls Ranch/YBGR, CSCT Program
Fred Morganthaler, LCSW (FM)

Beaverhead County High School/BCHS - Altacare (YBGR) & **CHC**
Krista Maness, LCPC (KM)

Yellowstone Boys & Girls Ranch/YBGR
Charise Lemelin, School-based Program Director (CL)

University of Montana Western/UMW
Jerry Girard, LCPC, LAC, Director of Student Counseling (JG/UMW)

Women's Resource Center/Community Support Center-WRC/CSC
Melainya Ryan, LCPC (MR)

Parkview Acres, Kindred
Julie Ingram, MSW, SWLC (JI)

Western Montana Mental Health Center/WMMHC
Mary Ann Silve, Case Manager (MAS)

Community Health Center/CHC
Jeanette Prodgers, LCSW (JP)

Community Health Center/CHC
Megan Evans, MD (ME)

Community Health Center/CHC
Dayna Thergesen, PNP (DT)

Ag Workers Health & Services/AWHS
Nieves Gonzales, LCPC (NG)

Barrett Hospital & HealthCare/BHHC Emergency Department
Becky DeBoer, RN (BDB)

Barrett Hospital & HealthCare/BHHC Emergency Department
Greg Moore, MD, Director of Emergency Services (GM)

Barrett Hospital & HealthCare/BHHC Department of Behavioral Health
Jenny Given, LCSW (JG/BHHC)

Beaverhead County Attorney's Office
Jed Fitch, County Attorney (JF)

Beaverhead County Attorney's Office
Mike Gee, Deputy County Attorney (MG)

Dillon City Police
Paul L Craft, Chief of Police, retired (PC)

2 Anonymous Consumers

REPORT

Process

In almost every case, interviewees understand a process for the management of mental health crisis that is generally consistent throughout the community. Mental health crisis may be identified by the individual experiencing the crisis, by family, friends, community members, by associated professionals, or by law enforcement.

> "A student in crisis may self-refer or be referred by faculty, staff, or even by other students." (CW)
> "If any staff determines they have a client in behavioral crisis then they contact . . .the mental health professional to assess for suicide." (MR)
> "Patient may . . . be referred by . . . front desk, social worker, medical provider, dentist or dental staff." (JP)
> "May be brought by friend or roommate . . . by ambulance and/or by law enforcement." (GM)

When a crisis is identified, specific professionals accept the responsibility to provide a safe environment while evaluation including risk review is conducted.

> "Stay with the child until the parent arrives." (GL)
> "The student in crisis is monitored continuously." (CW)
> "Family takes student . . . or, if no family, counselor escorts student to the ER and remains as long as student desires." (JG/WMC)
> "Patient in crisis is seen immediately by PCP and/or by Nurse and/or by Behavioral Health Specialist." (ME)

If the individual in crisis is a student or a minor, in all our school environments, parental contact is attempted immediately (Parkview Elementary, Dillon Middle School, Beaverhead County High School).

If the mental health crisis is found to be beyond the scope and/or resources of the professional conducting the evaluation and/or the setting in which the evaluation is conducted (school, clinic, jail, community), interviewees all understand that referral and transportation to the Barrett Hospital Emergency Department is the correct next step.

> "In the case of a student in acute crisis, especially w/suicidality, the parent is directed to take the student directly to the ED." (CW)
> "If patient is suicidal or homicidal, patient is transferred to ED." (ME)
> "Individual is taken to the BHH ED in an effort to de-escalate the crisis." (MG)

Individuals in crisis encountered indirectly, by telephone, present some unique challenges, but local professionals have developed logical procedures to intervene.

> "If the client is not in the center but on the Hotline instead, I try to get them to agree to meet me at the ER. If they will not agree, then I call 911 and request that a police officer do a well-check." (MR)
> "If I receive the call at home, I urge family members to take the patient to the nearest ED or call 911 if safe transport is not an option." (DT)

Interviewees understand that evaluation in the Emergency Department is conducted by the Medical Provider on duty, and by either or both Barrett Hospital's Behavioral Health Professional and a member of Western Montana Mental Health Center's Crisis Response

Team/CRT. Interviewees verbalize some uncertainty regarding how final disposition of patients in mental health crisis is decided, by whom the decision is made, and what the rationale is for the decision-making.

> "If the ED evaluation does not concur with our estimate of the severity of the crisis, the student may be sent home. This is disappointing because we only refer those students whose crises are more than we feel we can handle." (CW)
> "CRTs do not communicate about discrepancies between their evaluation and that of referring provider, nor do they communicate disposition or plan with referring provider." (ME)

Roles/Safety

Because professional role and safety were found to be entwined concepts in the interview transcripts, these are discussed together.

Local professionals in schools, clinics and ED verbalize clear understanding of their own roles and responsibilities in regard to mental health crisis.

> "Assessment . . . early referral . . . parent contact . . . ensure student safety . . ." (CW, FM, KM)
> "Assess and determine suicide risk . . .determine level of need for help . . . refer appropriately . . .ensure patient safety." (ME)
> "for the patient in crisis, first and foremost, keep the patient safe . . . post-crisis, provide psychiatric care as forced by circumstances" (DT)
> "Perform triage/nursing assessment . . . ensure safety monitoring." (BDB)
> "Perform final assessment, determine and ensure arrangement of appropriate disposition." (GM)
> "Institute correct steps when involuntary commitment is requested." (JF)
> "Marshall the respondent through the emergency detention process." (MG)

Additionally, many acknowledge significant confidence in their ability to deal appropriately with mental health crisis.

> "We have improved steadily in expertise in handling crises." (CW)
> "YBGR in Dillon has made fewer crisis referrals to BHHC ER since the opening of their office in 2014. . . this is because through the local office [we] are able to provide more wrap-around services that better support . . . clients." (CL)
> "A big improvement at Kindred is that that they now have an actual trained social worker doing the social work. This is hugely supportive to the rest of the staff. I am able to do behavioral health assessments, liaison with family and doctors, and monitor psychiatric medications." (JI)
> "Many of the improvements are simply due to my just coming to a better understanding of what is needed to make things happen." (JG/BHHC)

There is a sense of confidence in the expertise of Barrett Hospital's ED services and providers, and there is generally little hesitation about referring patients to the ED, as evidenced by several of the comments above. However, there is uncertainty and even a certain level of mistrust among agencies about exactly what solutions each community agency or category of professional or setting can provide to patients in crisis, and what motivates their services.

> "Dillon area PCP's are not always comfortable with prescribing psychotropic medication to children." (GL)
> "When we send a student to the ED, the rest is out of our hands . . . We only refer those students whose crises are more than we feel we can handle. Usually we are hoping for extra resources for that student - possibly inpatient placement." (CW)

> "CRT's are employed by the WMMHC - their protocol is to use a student's crisis to generate clients and funnel clients into their own services rather than work collaboratively with the student counseling center for follow-up care." (JG/WMC)

Communication

Communication issues surfaced repeatedly as a theme in the interviews. In our study of the transcripts, we identified three areas of concern.

between the Barrett Hospital ED and local referring professionals

Communication with the ED is noted as a problem particularly although not exclusively by professionals within the schools.

> "Lack of communication is the biggest obstacle. . . Since Barrett Hospital began providing its own behavioral health services there were no referrals out and poorer communication with the schools . . . As parents are not always reliable to provide information, the child is often returning to school the next day, and even sometimes the very same day, with staff and teachers left to wonder whether the situation is safe." (GL)
> "Sometimes we do not receive any follow-up information from the ED regarding our student." (CW)
> "Sometimes we do not receive follow-up information regarding our student. . . Sometimes the Barrett Hospital mental health professional follows-up with Altacare staff about the referred patient." (KM)
> ". . . feels strongly that there needs to be more collaboration between the BH ED clinician and the referring clinician so that important information is considered in the assessment . . . her staff's attempts to convey information over the phone fail because the ER staff does not return their phone call prior to the child being sent home. . . " (CL)
> "Communication is sometimes difficult, incomplete or lacking between referring providers and ED." (JP)

However, school-based professionals acknowledge that appropriate releases are not in place and that this may contribute to the problem.

> "Protocol was not allowing for any communication between he and the ER." (GL)
> "We do not have a formal, written release of information in place currently with the ED." (CW)
> "There is no mechanism for call/report back to Altacare counselor from ED provider regarding progress/disposition of student referred to ED - HIPAA constraints." (KM)

between CRTs and local referring professionals

There is pervasive concern about what is perceived locally as a lack of responsiveness and willingness to communicate on the part of members of the Crisis Response Team.

> "there needs to be more collaboration between the . . . CRT clinician and the referring clinician so that important info is considered in the assessment." (CL)
> "He was sent to ER and evaluated by CRT who assessed him without reading all the notes on him." (JI)
> "There is predictably no call from the CRT, nor any method to access or review their assessment. CRTs do not communicate about discrepancies between their evaluation and that of referring provider, nor do they communicate disposition or plan with referring provider." (ME)
> "The CRT/MHP most often does not talk to the doctor, only sometimes accesses the chart, and often simply pastes [our] evaluation notes into their work without doing their own evaluation. Patients who were in need, but involuntary, at the point [we] called the CRT, are seldom evaluated by CRT as requiring crisis care." (JG/BHHC)

"Sometimes there are discrepancies in judgement between decision made for "best care" by local ED provider and CRT." (GM)

between referral facilities and local providers at admission and discharge

Communication between community-based services and facilities to which patients are referred is a mixed bag, and appears to depend on a number of factors that may include the presence of releases, relationships among professionals, relationships between agencies, as well as other unidentified factors.

"We do have a release with Shodair, and usually receive good follow-up information from them." (CW)

"Communication between the in-patient facility and YBGR during the evaluation and with regards to after-care can be improved." (CL)

"After Hays-Morris in-pt care, [the patient] was sent back to the dorms with no discharge planning and no communication with the counseling center or residence life." (JG/WMC)

"The communication between [the] WMMHC office and the WMMHC short-term in-patient facilities such as Hays Morris and Hope House regarding discharge has improved in the past year. Credits the individual staff for making an effort to do so. Case manager receives a pre-release phone call . . . They review the outcome of the psychiatric eval done there and the discharge plans. Receives discharge planning paperwork and follows through with after-care." (MAS)

"After-care is still, overall, poorly designed. The treatment facilities are too often leaving it all up to the client to follow-up with care once back in their own community. . . . when she is proactive there are better outcomes and believes the system must be much more proactive with after-care in general." (MR)

"Now able to get patients into actual treatment much more quickly due to the establishment of good working relationships with St. Patrick's in Missoula, St. Peter's in Helena, and the Eastern Idaho RMEF. After-care is better coordinated via improved communication with the treating facility." (JG/BHHC)

"There is no reliable communication at the time of discharge and there is no follow-up or discharge plan communicated with the County Attorney." (JF)

"More help is needed in developing the after-care once back home. In addition to the BH Providers List available now on the WRC web-site . . . a consultation with a person who would get to know you and help match you to the right counselor could help prevent crisis. In Dillon, you get told you need counseling but are given no help in finding the right services." [He had such a service in Bozeman when choosing a different specialist and it has worked out great.] "Otherwise, you are just stuck going from one to another trying to find the right person and, after a couple of negative experiences, most people give up. Then they face a crisis." (Anonymous Consumer)

between patients and schools/agencies/institutions:

"Would like for . . . [service providers] to understand that a behavioral health crisis is very traumatic as well for the *family member* trying desperately to find help for someone they love. Creating an atmosphere of trust is key." (Anonymous Consumer)

"It is so important for professional staff, from the receptionist to the doctor, to stay tuned in to whether you have processed what was being said before turning to leave or hanging up." (Anonymous Consumer)

"It worked very well to have all the options, and time frames for each, thoroughly explained." (Anonymous Consumer)

"It helps to be given everything in writing because, even as the family member, it is difficult to remember what you were told when so upset." (Anonymous Consumer)

Transportation

Transportation is another area of concern on several levels.

First there are issues with safe, expeditious transport from the presenting site to the Emergency Department. Local schools and clinics do not have their own emergency transport vehicles or drivers. Ideally transport is accomplished by parents (from schools) or by family members(from clinics). However, situations arise in which parents cannot be contacted quickly, patients present unattended and family members cannot be found or are not capable, or patients are so unstable that private transportation is considered risky. Individuals and/or agencies functioning within those institutions may or may not be (but in most cases are not) licensed or insured for use of personal or agency vehicular transport of clients in crisis. Schools or clinics may or may not (but usually do not) have releases allowing them to transport clients in crisis. However, distances are short, activation of the local ambulance service creates delays, is extremely expensive to the individual in crisis, and may not be covered by insurance.

For the patient who is to be admitted to an inpatient facility either voluntarily or involuntarily, there are challenges with transportation from Dillon (usually the ED) to the referral facility. All inpatient facilities are at least 60 miles distant or more. For families with economic or other practical challenges, private vehicular transportation may be prohibitive for a number of reasons, while, again, ambulance transport is expensive and, in almost all cases, probably not insurance-eligible.

In the case of the patient who is involuntarily committed, the County is obligated to provide transportation by County Sheriff personnel and vehicle to the crisis stabilization site with subsequent obligation for transportation to and from up to three face-to-face hearings. Each of these transports is at the expense of the County. Each of these transports removes 1 or more officers (depending on the condition of the patient) and vehicles from the service area for a minimum of 2 to 3 hours and, in many cases, much longer.

> "For the county, the financial burden of transportation [is significant. There is not only the need for transportation to the site for crisis stabilization, but] there are always 2, and sometimes 3, court hearings for the person placed involuntarily at Warm Springs. The law needs to either change to shorten the process or we need to learn to use technology to cut down on the costs to the county of transporting a person between Dillon and Warm Springs. For the patient, often insurance will not view the transportation as necessary and so they are transported in a private car. This can be very risky." (JG/BHHC)

Delays

Voluntary admission.
If a patient is considered by Emergency Department staff to be appropriate for admission to an inpatient facility, if that patient accepts the recommendation for admission, and if the BHHC LCSW is available, then the admission, including transportation, may be arranged by the BHHC LCSW in collaboration with the ED Provider. Even this voluntary process can be laborious, depending on availability of patient bed in an appropriate facility, and often requires hours of the LCSW's time, and many hours of patient detainment in the Emergency Department

Involuntary admission.
However, most concerns focus on delays involved in the system of mental health evaluation by the Crisis Response Team.

If a patient is considered by Emergency Department staff to be appropriate for admission to an inpatient facility, but does *not* accept the recommendation, or if a patient is already a ward of the

corrections system, or is demonstrating dangerous or uncontrolled behaviors, then involuntary commitment must be considered, which can, by Montana State Statute, only be accomplished by a certified Mental Health Provider/MHP. Currently, MHP services are supplied by Crisis Response Team/CRT members employed by the regional mental health services provider, Western Montana Mental Health Center/WMMHC. CRT members are based in Butte and respond to calls from the western region for evaluations. As a result of distances, limited numbers of staff, the possibility of multiple, simultaneous requests for service from different sites (plus other factors of which we are unaware?), CRT response is often delayed hours from the time of request.

> "The CRT system is a big problem. There is often a huge delay in arrival of the CRT." (ME)
> "Huge waits for CRTs - hours or even more than a day - crisis is often past." (BdB)

Such delays entail many difficulties in the ED. If the patient is a danger to self or others, s/he must be temporarily detained in a manner safe for all concerned. If detained in the hospital's "safe room", continuous monitoring must be arranged.

> "If situation demands continuous, 1-on-1 monitoring, there is not always someone available to do so." (BdB)

There are concerns about the anxiety and uncertainty suffered by the patient him-/her-self. The patient may become exhausted and present a very different clinical appearance by the time the CRT member arrives. In such a case, the patient may be evaluated as inappropriate for in-patient admission and released back to the community by the CRT. However, with the underlying mental health issue(s) unresolved, such patients may present again within hours, days or weeks with the same problems still unaddressed.

> "Patients who were in need, but involuntary, at the point [we] called the CRT, are seldom evaluated by CRT as requiring crisis care. Maybe because so much time has passed, they have simply exhausted themselves emotionally and therefore no longer feel immanently suicidal." (JG/BHHC)
> "Sometimes, not infrequently, by the time CRT arrives the individual has exhausted him/her-self, and looks very different. The evaluation is for non-commitment, and then we deal with that same person a day or two days or more down the road with the same crisis again." (JF)

Lack of Service Availability

Inadequate Case Management

Case management services are key to the stability and prevention of mental health crisis for those who are chronically mentally ill. Case management services are also critical to successful resumption and maintenance of community living after mental health crisis occurs.

> ". . . Most WMMHC crisis referrals are new clients who have not yet been assigned to case management. . . case management is part of the solution as this relationship often negates the need for a visit to the ER. [However,] currently each case manager at WMMHC [in Dillon] has [an overload of] 20-22 cases . . . People with mental illness need help getting their basic needs for food and shelter met. It is very difficult to find a place for them to live after being discharged. They tend to end up with a friend 'who is a druggie' or a family member 'that has had it with them' already and so quickly end up again homeless and in a mental health crisis." (MAS)

Availability of Therapy/Counseling Services

Access to appropriate, affordable counseling and therapy is also thought to be an important

element in the maintenance of mental health in the community. On-going support through a community-based counseling relationship may help to facilitate safe, healthy transitions after out-patient or in-patient hospitalization for mental health crisis and can be critical to the prevention of repeated decompensation and crisis. Currently counseling/therapy services are available through BHHC and CHC, but only to the patients established within each of those 2 health systems. While therapy is available on a sliding scale at the CHC, this is not the case at BHHC. Counseling/therapy is available on a full-time basis at WMMHC, but, according to report of WMMHC Director, Mary Morgan, sliding scale is only available on a "case by case basis". Routine determination of sliding scale eligibility does not appear to be transparent and is not widely understood in the community. For children and adolescents, there are counseling services through YBGR and Altacare in the schools to those who qualify. Affordability can be problematic if the child or youth is not on Medicaid. Counseling/therapy services are available through a number of private practices in the community where again, both access and affordability can be prohibitive.

> "The thing most negatively impacting . . . services at this time is the fact that there is currently only one counselor on campus." (JG/UMW)
> "We need more access to . . . trained counselors and therapists capable of working with kids and willing to accept Medicaid."(DT)

Among the counselors and therapists who do practice in the community, there exists no comprehensive, community-wide, local system for counseling or therapy services on an emergency or on-call basis and there has been, so far, no mechanism for payment of such services.

> "When we do not feel in-patient commitment is necessary, but BHHC mental health workers are unavailable, the absence of an on-call, professional therapist or counselor with whom to consult and/or with whom to hook up patient for on-going care the next day is our biggest deficit in services." (GM)

Availability of Local or Regional Psychiatry

At this time there is not a single child psychiatry specialist practicing in Beaverhead County, nor is there any on-site, face-to-face psychiatrist serving adults in Dillon. WMMHC employs a Psychiatric Nurse Practitioner with prescriptive authority who sees WMMHC patients 1 day/week. She does not see children. This provider is relatively new and, unfortunately, does not yet seem to have elicited the confidence of local medical providers. BHHC has a telepsych contract with a psychiatry group in Missoula and is currently offering patients referred by BHHC primary care providers psychiatry services for up to 2 hours/week. Patients with the resources and organization to do so can seek services or be referred regionally or beyond, but even regionally psychiatrists are scarce and can be difficult to access, expensive and entail long waits.

As a result, the burden of treatment for mental illness of any kind - acute or chronic, major or "minor", adult or child - falls directly on the shoulders of local primary care providers. While most accept this responsibility as an unavoidable necessity, and many have developed considerable expertise and experience in psychiatric care, providers also express frustration that psychiatric illness still seems to be treated as a secondary priority in our health system, and that patients often do not and cannot receive the benefit of specialized care.

> "[I have acquired special training that was so helpful and included a year of peer review with a team including a child psychiatrist, but it does NOT make us Child Psychiatrists. If I had a pt with a hot appendix I would not start pretending I know how to do surgery because there isn't a

surgeon around! . . . What angers me is that there are lots of psychiatrists around the country with practices that are treating kids with single diagnoses - depression, anxiety, ADHD - which are problems we are perfectly capable of caring for in primary care, while we in primary care are left treating the severely mentally ill (multiple co-morbid diagnoses, mood disorders, eating disorders, thought disorders, personality disorders, schizophrenia, autism) kids who desperately need the expertise of highly trained psychiatrists." (DT)

Over all, there are few primary care providers in the community who would not welcome at least a collaborative relationship with a trusted psychiatric consultant, and at best, comprehensive, community-based psychiatry services.

"The most critical obstacle to managing critical cases in Dillon is the lack of access to a child psychiatrist." (CL)
"NO child psychiatry/follow-up psychiatric medical care [is available] after discharge." (DT)
"We need psychiatrists who will treat major mental illness and then we need to bolster support in primary care for treatment of patients with routine, single diagnosis" (DT)
"There is a lack of psychiatric prescribing specialists, either MDs or psychiatric nurse practitioners." (ME)
"Beaverhead County desperately needs a local APRN, or other psychiatric staff . . ." (JI)

Inadequate Number of MHPs

A key role in the process of intervention in mental health crisis is the MHP, a Mental Health Provider who is State certified and therefore authorized to commit a patient involuntarily to emergency detention for crisis stabilization and subsequently, when necessary, to in-patient treatment. The responsibility of the MHP is significant, extends to appearances at emergency detention and evidentiary hearings, etc. and can be demanding and time-consuming. Medical Doctors/MDs are, by virtue of their licensure, MHPs, but seldom assume the role. By statute, Clinical Psychologists and Psychiatric Nurse Practitioners are also able to function as MHPs without additional certification. Many others can apply for MHP certification. To our knowledge, there are 2 MHPs in the community at this time (Melinda Newman & Sandra Micken) but, as far as we know, neither is functioning in this role currently. For many years, WMMHC has supplied this service through its CRT program. However, as noted above, this system of service has presented numerous problems including prolonged delays and difficulties with communication.

"Critical need is for more MHP's. The CRT service operated by WMMHC to cover six counties consists of only three positions and one of those positions is now vacant." (MAS)
"We should have a local MHP/Mental Health Practitioner trained and certified to make the call for inpatient care if needed." (ME)
"The lack of a recognized MHP (Mental Health Professional) within the community, licensed by the State to do commitment evals, is a problem that then leads to the necessity to contact the CRTs, with subsequent delays and sometimes discrepancies in judgement between decision made for 'best care' by local ED provider and CRT." GM

Big System Issues

Community members working in mental health generally concur that there are significant inadequacies along the full spectrum of services, and that this hugely obstructs and complicates our ability to adequately and appropriately care for our citizens with mental health needs of all kinds.

Distance and Inadequate Number of In-Patient Crisis Stabilization and Treatment Facilities

We have discussed the impact of these considerations above under delays and transportation at the time of crisis. It should be noted that these factors can have very real impact on potential outcomes and healing, and may contribute to the observed patterns of individual community members with repeated crises, ED evaluations, discharges, and subsequent recurrent presentation in crisis. Several interviewees commented on this problem and on the need for more local, accessible, crisis stabilization facilities.

> "Often there is an inadequate number of pediatric, in-patient, psychiatric beds available for treatment and NO child psychiatry care after discharge." (DT)
> "We lack a safe place to hold people in crisis. While ED has safe room, this is not entirely satisfactory, and may not be continuously monitored." (ME)
> "Biggest obstacle is the geographic space between the UMW campus and treatment services. The outcome is never optimal when services are so far away resulting in there being no personal relationship between the staff there and the staff on campus. (JG/UMW)
> "It would have been so much better to be able to go to the hospital here in Dillon for evaluation. It was hard for my family to understand why I could not be treated here and very hard on them to drive for four hours with me in my critical condition, only to get me to a safe holding place. That was really traumatic and scary for them. I was cooperative but what if I had been more rebellious or confrontational? I think the travel really opens up the situation to a lot more risk." (Anonymous Consumer)
> "At times, there are no beds even for patients willing to go and with the transportation worked out." (JG/BHHC)
> "The system is fuller. It is not performing well because it is overwhelmed. Warm Springs is full. The bolts are looser." (JF)
> "Warm Springs is so full they often kick people out as soon as possible. Group homes are so full that there are long wait times/delays. We need more facilities." (MG)

Costs of Services to System

It is beyond the scope of the current report to itemize or estimate the costs of mental health crisis to the community, the County, the State of Montana, or any larger entity. It is, however, worth noting that there are a number of hidden costs as well as the more obvious fees and payments, to recognize and take into account when we try to consider relative impacts.

> "We are doing an average of 8-10 in-patient placements per month [subjective recall; not based on audit or chart review], mostly voluntary, 2-3 day stays."
> "The County has the costs of transportation of our mentally ill to and from emergency detention, to and from hearings, to and from treatment. This includes the costs of repeatedly removing one or more on-duty law enforcement officers from the community for often hours at a time. Then there is the distraction of the Judge from his/her other cases and duties, the cost to the State of the time and effort of the Public Defenders. The cost to the County of the CA and DCA, who must prosecute ALL cases of involuntary commitment is huge as well as the impingement on other important work of the County Attorney's office. Then when we see our chronically mentally ill community members go through this process repeatedly, all of these costs are multiplied over and over." (JF)
> "From a Law Enforcement perspective, there needs to be some type of system in place that will insure the safety of the patient and Hospital Staff that does not put an additional strain on the Law Enforcement community." (PC)

The County does receive one modest, short-term contract (grant) in effect through 6/30/17, from MT DPHHS, AMDD to address some of these less-than-obvious expenses - "to conduct crisis intervention training, provide mental health services and discharge coordination in the detention center, to develop policy for crisis intervention and jail diversion and to assist with costs in transportation to a Crisis Facility."

There are fees paid to WMMHC through contract by entities within the County - for instance, the costs of in-patient crisis stabilization for uninsured or indigent patients when patients are referred to a WMMHC facility. Both BHHC and Beaverhead County contract with and pay WMMHC for CRT and other "unfunded services". There is a sense of uncertainty about exactly what services should be expected in return for these payments:

> "We are paying a lot of money for what are often not optimal patient outcomes." (JG/BHHC)
> "I entered Hays-Morris on Friday evening being told I would be there about 36 hours. However, on Monday morning I was still there having not seen anyone who was a professional." (Anonymous Consumer)

Funding & Prioritization

Many among our interviewees articulate that problems in mental health service delivery are bigger than our local community and several spoke to this:

> "The state is not putting enough in the budget for community based mental health services in general. . . more money spent in community services would greatly reduce the number of crisis care cases. . . MH Services and Disability Rights MT need to work more together and both advocate for more community service dollars." (MAS)
> "The legislature does not see the underlying costs of untreated mental illness in our communities. . . We need many more beds in State-financed, community-based treatment facilities, at least some of which should be "step-down, lock-down" beds. . . We need the legal authority to mandate treatment at the community level. This would allow us to transition people from Warm Springs to "least restrictive" community settings while still under involuntary commitment with the potential of stabilization and safe, gradual transition to community life. If we had such facilities, we should consider longer mandatory stays - to allow regulation of meds and true therapeutic improvement." (JF)
> "Montana's mental health system stinks!" (Anonymous)

Caring Community

Despite all of the frustrations and difficulties described above, interviewees had many positive comments regarding their local experiences caring for students/patients/clients with mental health problems.

Several interviewees described the perception that the community in general, even students and other youth, as well as their professional colleagues have increased awareness of and sensitivity to the prevalence of mental health problems. There seems to be significant consensus that timely, constructive intervention is of critical importance and that there is shared responsibility for effecting such intervention.

> "When a child is in crisis at Parkview it is usually the teacher who is the 1st responder." (GL)
> "Sometimes students report about a friend about whom they have seen a disturbing comment on Facebook or heard a disturbing comment from another friend." (CW)
> "The faculty and staff try to be preemptive. There is good sensitivity to absences, behavioral patterns, and warning signs contained in students' writing. There is never a child that can slip through." (CW)
> "A sensitivity to the psychological needs of students is supported by the school superintendent, Dr. Johnson." (CW)
> "The vice-principal is very supportive of the Altacare counseling program. There is increased awareness among school faculty and staff (based on observation) of which kids are homeless and therefore may need additional attention/services. The climate of concern has changed - there is a significantly increased sensitivity to the risk posed by mental health crisis." (KM)

> "All the WRC/CSC staff has been trained in how to assess whether a situation is 'situational' or 'behavioral.'" (MR)
> "Patients feel heard, taken seriously." (ME)
> "I think parents and teachers in the community generally do a great job of getting the kids in for care." (DT)
> "In the pre-hospital setting there is increased vigilance, increased awareness, education and recognition among law enforcement personnel. It is the rare ED shift that law enforcement does not bring in at least one patient of concern with depression, suicidality and/or risk of violence. To some degree I attribute this to the efforts of Sheriff Kluesner who, when he was a city officer, was here with a patient almost every night." (GM)
> "The BHH ER doctors and nurses were skilled, kind and compassionate and gave very thorough explanations." (Anonymous consumer)

Although communication in some realms is noted as a problem, there are a number of specific instances in which communication is thought to have improved significantly.

> "Having a provider identify a behavioral health concern and call . . . is a new and good occurrence." (GL)
> "Jenny (at the ER) and I have come to know and appreciate each other's professionalism and so are able to do an authentic 'warm hand-off'. Clients sense level of trust and so feel safe with the process." (MR)
> "The communication between my WMMHC office and the WMMHC short-term in-patient facilities such as Hays Morris and Hope House regarding discharge has improved in the past year. I credit the individual staff for making an effort to do so." (MAS)
> "After-care is better coordinated via improved communication with the treating facility. (This is particularly true of St Pat's, less so of St. Pete's and Idaho, but still non-existent with Hays-Morris.)" (JG/BHHC)
> "Communication has improved between CA/DCA and hospital ED providers. They are very good to work with. Communication has also improved between CA/DCA and law enforcement. We try to have a good foundation with the officers." (MG)

Interviewees providing services understand their own roles clearly, generally feel adequately trained and competent within a given scope of practice. The local process, funneling through the BHHC Emergency Department is widely understood, accepted, appreciated, and followed.

> "I have seen the process evolve for the better over the past several years." (GM)

The "safe room" in the Emergency Department at the new Hospital is recognized and is considered a positive addition to the spectrum of community resources.

> "If overnight hold is considered appropriate, we place patient in "safe room" - can be locked down, everything removed from it, monitored visually, sometimes we bring in a 'sitter' (EMT, admin staff)." (GM)

There is generally mutual respect among professionals and especially noted is a high regard for and confidence in the Barrett Hospital Emergency Team. Repeatedly interviewees commented on their appreciation for the addition of the Behavioral Health Program at BHHC and specifically having the LCSW on staff available to evaluate patients in crisis without the delays of awaiting the CRTs.

> "The BHH piece of the process has improved in that there are more local assessments. I credit this to the obvious fact that BHHC has focused on providing better behavioral health services in the past two years."(CL)

“The reality of BHHC on-site assessments done by local staff area is a huge improvement. This typically now leads to a timely placement and actual treatment.” (MR)
“The addition of licensed clinical social worker(s) . . . to BH complex of services - has been an improvement. Now, when they are available, we do not automatically have to call the CRTs, with all the resultant delays, to accomplish placement.” (JP)
“Addition of MH professionals in ED (about 3 yr ago) has been a positive change, enacted by BHHS. MH professionals do good assessments and know potential placements.” (ME)

RECOMMENDATIONS

There are probably hundreds of activities that could and perhaps should be undertaken to improve services to those in mental health crisis in our communities. We recognize only too acutely that it is not possible to do everything. Additionally, we acknowledge that our Local Advisory Committee on Mental Health is just that - “advisory”. In the end, many of the decisions for prioritization and action must be taken by the professional agencies and organizations delivering direct services. Nonetheless, it is our wish to be in support of any actions that might arise out of this or any other analyses that seek to improve mental health services in our community. In cases where our efforts could be helpful, we hope to be able to engage collaboratively with community partners.

Our recommendations focus first on what we see as immediately arising from our interviews, and what is potentially do-able on a local level. Following those recommendations are comments related to a wider, more “big system” perspective.

Related to **EVERYTHING!**

First and foremost, the Task Force on Crisis Intervention recommends that the LAC retain a **task force on mental health crisis**, choose one or more actions from among the following recommendations and, with or without additional grant funding, undertake the chosen action(s) for the upcoming year.

Communication Between BHHC ED and Local Referring Professionals

1. Create an opportunity for counselors and therapists from the 3 public schools to meet with representatives from BHHC ED to discuss and clarify multiple aspects of the communication questions that arose in the interviews.
(It is our understanding that BHHC has already initiated steps toward such a meeting.)
    - acknowledge previous misunderstandings
    - ensure all voices are heard
    - ensure a shared terminology
    - brain storm timely communication models and mechanisms that can be helpful to schools and do-able for hospital staff
    - realistic assessment of role - services and capacity - the ED is able and appropriate to provide to kids in crisis
        - clarify necessary parameters for in-patient placement
        - discuss availability of referral facilities
        - discuss role of schools in identifying and direct-referring kids who may need it to in-patient treatment centers
    - appropriate releases to facilitate communication
        - BHHC may be able to collaborate with schools on development of a template that would meet the hospital’s regulatory, ethical and clinical requirements and simultaneously address the need of schools for good information allowing them to receive back and follow students after referral to the ED

Communication Between CRTs and Local Referring Professionals

2. Facilitate a discussion between local referring professionals (and/or their institutional representatives) and WMMHC, employer of CRTs, hopefully including the individual CRTs, acknowledging the problem that has been identified and, together, brain-storm possible solutions. Pilot a solution-oriented procedure/routine that closes the communication loop.

Communication Between Referral Facilities and Local Providers at Admission and Discharge

3. Facilitate a discussion with WMMHC (that runs most of the crisis stabilization centers to which local residents get referred) about the problem that has been identified and brain-storm possible solutions. Again, pilot a solution-oriented procedure/routine that addresses the need for improved communication.

Transportation to ED

4. Facilitate a problem-solving discussion among local agencies about safe, responsible transportation of people in mental health crisis within the community (local facilities to ED)

- may need to include law enforcement, community ambulance service, schools, clinics, others?
- process needs to provide safety, timeliness, protection of students/patients ***and*** protection of involved professionals and institutions
- would ambulance transport be possible?
- cost must be considered, addressed
- ideal if process could be developed that is consistent throughout the community
- schools to ED (discussion may be incorporated into meeting on Communication suggested above)
    - liability of individuals using personal vehicles
        - who is liable?
        - is there insurance coverage?
        - are there releases?
        - are there established models within YBGR/Altacare or other organizations that can help to guide development of a consistent plan
- clinics to ED
    - all the same questions
    - how is the hospital clinic handling? policy/procedure already established

Related to **Delays**

5. Encourage trial of CRT/MHP evaluations via internet or tele-net
    - it is our understanding that WMMHC has initiated conversation with BHHC ED on this subject

6. Explore possibility of developing cadre of local MHP(s)
    - first clarify State regulation
        - identify requirements (Jenny has begun)

- vision ideal model for MHP coverage
  - should/could BHHC have MHPs on staff?
- identify all who are currently MHPs in community
  - could we use those who are already here?
- discuss ramifications with WMMHC -
  - ensure that there would be no constraints on admissions by non-WMMHC MHPs
  - may need to create specific contractual waiver w/WMMHC per recent information re: model being used at St. James in Butte
  - change in $$ amount of contract between WMMHC and BHHC if certain services are covered locally?
- who will pay for MHP training and services?
- are there incentives that could be instituted that would encourage some or all of the 30 BHPs in the community to certify as MHPs and share call?
  - waiver of property taxes?
  - respected identity (like Ski Patrol, Volunteer Firemen)?
  - fund-raiser?
- could Beaverhead County & BHHC share responsibility and cost for MHP?
- could we combine role of MHP with that of the proposed "compliance officer"?
- consider applying for grant from MT Healthcare Foundation, SAMHSA, etc. to fund salary as pilot

Communication, **Delays**, and multiple aspects of **Big System Issues**

7. Explore performance of WMMHC as regional mental health services provider to the State of Montana
   - research the agency's duties/obligations according to State of Montana contract or rule
   - identify all agencies/organizations in Beaverhead County that currently hold contracts with WMMHC
     - BHHC and Beaverhead County both acknowledge ongoing contracts. There may be others?
     - encourage these agencies within the County known to have WMMHC contracts to review their contracts individually and collaboratively to clarify and make transparent the services for which they are contracting and the level of service delivery received

Lack of Service Availability and **Big System Issues**

8. Research the proposed Behavioral Health Tech program at UMW - Beth Wharton
   - Explore possibility of community-based mental health advocates or "aides" - WY, AK, NB
   - program for case management training?
   - is there a role for LAC to support such a program?
   - multiple issues related to training, liability, etc
   - are there models that could guide us?

Related to **EVERYTHING (again)!!**

9. Discuss/consider increasing LAC presence and participation on regional and State committees with the express intent of influencing State policy r/t all aspects of Mental Health

- recruitment of psychiatrists
- State-wide telehealth resources
- improved budget for Warm Springs that includes transportation from rural settings (WY model)
- more community-based residential treatment settings

10. Encourage role of LAC in identifying and supporting community strengths. Recognize and celebrate improvements. Acknowledge expertise - both individual and organizational. Publicize positive accomplishments in local services and systems. Promote pilots, trials, new models for service planning and delivery.

Conclusion

We want to thank every one of the individuals who participated in this interview process, both named and anonymous. They all shared valuable time and, with their honest responses to our questions, they have increased our insight and understanding regarding the process of working with our family members, friends and neighbors in mental health crisis. Their comments included in this report and many more included in the original transcripts provide the basis for all of the recommendations offered by the project team.

Assistance with Recommendations was contributed by
Jenny Given & Carol Kennedy of Barrett Hospital and Healthcare and the LAC

Lynn Myer-Weltzien & Pat Carrick
Mental Health Crisis Intervention Task Force of the
Implementation Team, Beaverhead County Local Advisory Committee on Mental Health
Dillon, MT
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