CENTRAL SERVICE AREA AUTHORITY (CSAA) STRATEGIC PLAN

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ACKNOWLEDGEMENTS

TABLE OF CONTENTS

SECTION	Page #:
1.0 EXECUTIVE SUMMARY	**2**
1.1 Mission	**3**
1.2 Objectives	**4**
1.3 Keys to Success	**4**
2.0 ORGANIZATIONAL SUMMARY	**5**
2.1 Legal Entity	**5**
2.2 Organizational History	**5**
2.3 Governance Structure	**6**
3.0 SERVICES	**6**
3.1 Service Description	**7**
3.2 Complementary Resources/Related Entities	**7**
3.3 Printed Materials	**8**
3.4 Fulfillment	**9**
3.5 Technology	**9**
3.6 Future Services	**9**
4.0 MARKET ANALYSIS SUMMARY	**9**
4.1 Services Currently Available	**11**
(a) Statewide Services	**11**
(b) Other Adult Mental Health Services	**12**
(c) Children's Mental Health Services	**14**
(d) Break-down of Available Adult Services, by County	**15**
4.2 Critical Service Needs	**22**
4.3 Potential Obstacles	**24**
5.0 STRATEGY AND IMPLEMENTATION SUMMARY	**28**
6.0 MANAGEMENT SUMMARY	**35**
6.1 Personnel Plan	**36**
7.0 FINANCIAL PLAN	**37**
8.0 GLOSSARY/ACRONYMS	**38**
APPENDICES	
A: MSH Admissions (July 1995 - September 2006)	**39**
B: MSH Discharges (July 1999 - September 2006)	**40**
C: Average MSH Daily Census (July 1995 - August 2006)	**41**
D: Average # of Admissions to MSH (July 1995 – August 2006)	**42**

1.0 EXECUTIVE SUMMARY

Please note that this Strategic Plan is a "snapshot" of sorts, an effort to capture in a particular moment in time a picture of mental health services, issues, and needs in (Central) Montana. The CSAA understands that this picture is, by nature, constantly-evolving, as services are added/dropped, as needs change, or as new information comes to light…

The Central Service Area Authority (*CSAA*), organized in the fall of 2005 as a public benefit/nonprofit corporation, was established by the Montana legislature to collaborate with the Addictive and Mental Disorders Division (AMDD) of the Department of Public Health and Human Services (DPHHS) and Local Advisory Councils (LACs). Through input from consumers, their families, and other interested community stakeholders, the *CSAA* was created to assist in the planning, implementation, and evaluation of the public mental health care system.

The objectives of the *CSAA* are to ensure that care provided to individuals with mental disabilities in (Central) Montana is consumer-driven, family-centered, clinically effective and evidence-based, fiscally responsible, recovery-oriented, locally-informed, culturally-competent, holistic, and well-coordinated. The CSAA feels that these objectives will be best achieved by promoting consumer involvement, consumer buy-in, and broad-based participation in the organization and its agenda, by setting (and meeting) achievable short-term and long-term goals, and by establishing the CSAA's credibility in the eyes of legislators, participants in the public mental health care system, and other important stakeholders.

CSAA members and Board members are mental health consumers (primary or secondary) and other stakeholders interested in improving the public mental health system in Central Montana. Voting members must be at least 16 years of age, must reside in one of the 15 counties which *CSAA* constitute the WSAA region, and must have submitted a membership application. They attend quarterly Summit meetings. The CSAA Board of Directors, of which at least 51% must be consumers of mental health services or their family members, is elected by voting members of the CSAA and meets on a monthly basis. The CSAA receives $15,000 per fiscal year from AMDD to support its activities, and it is currently using these monies to support the LACs in the Central region, to pay a "webmaster" to maintain the CSAA website, and to reimburse members for expenses incurred in attending meetings and in discharging duties assigned by the Board.

In terms of "service" provision, the CSAA focuses on the following: (1) consumer empowerment, (2) planning and oversight, (3) education and advocacy, (4) fund-raising, and (5) coordination of activities with the Eastern and Central SAAs. The CSAA does not provide direct mental health services. Along with the ESAA and WSAA, the CSAA works with the Mental Health Oversight Advisory Council, the Mental Health Ombudsman, the National Alliance for the Mentally Ill, the Montana Mental Health Association, the Montana Advocacy Program, the Mental Disabilities Board of Visitors of the State of Montana, and other entities that conduct legislative activities, provide oversight and input into the public mental health system, and offer education and advocacy regarding mental health issues in (Central) Montana.

The CSAA recognizes that there is a vast need for public mental health care in Central Montana and in the rest of the state. Although many services and programs currently exist in the Central

region, the CSAA has identified as particularly critical the need for the following: presumptive eligibility, emergency assistance, emergency room professional assistance and training, automatic enrollment in the mental health system, discharge medications, increase in the Mental Health Services Plan (MHSP) poverty level, training for law enforcement personnel, peer support services, consumer driven decision-making in recovery planning, enhanced services for 90 days for individuals discharged from the state hospital, higher reimbursement rates for providers, humane transportation of consumers to involuntary services, upgraded crisis bed availability, enhanced PACT services, special needs wrap-around funding for patients discharged from the state hospital, patient assistance in community settings, a state-wide Crisis Help Line, better access to pre-adjudication evaluations, hospital crisis aide reimbursement, higher daily reimbursement to community hospitals, regional assessment and evaluation centers, and transitional services and supports for individuals with mental illness who are released from prison or jail.

The CSAA has also identified numerous obstacles that may interfere with its effectiveness in helping the public mental health system address critical service needs. These include: a lack of political focus/will to improve the mental health system, a lack of organization among people working in and using the public mental health system, compassion fatigue and burnout, funding sources make it difficlt in market compensation, hiring and retention of competent professional staff, difficulty obtaining local intensive mental health supports and resources, criminalization of the mentally ill, a lack of consumer involvement/leadership in quality control of community services, the lack of realistic financing for public mental health services in the community, over-reliance on Medicaid funding, the shrinking federal Medicaid budget, competing priorities, stigma and lack of education regarding mental illness, the strength/influence of AMDD, and potential threats to the survival of the SAAs.

In order to overcome some of these obstacles and to maximize its effectiveness, the CSAA plans to adopt the following strategies: (1) conduct a thorough market analysis to get a clearer picture of the status of mental health services in Western Montana, (2) conduct a thorough needs assessment to identify deficiencies, community needs, and service priorities, (3) present a unified voice by collaborating, coordinating efforts, and combining resources with the Western and Eastern SAAs and other community mental health groups, when appropriate, (4) collaborate with AMDD/DPHHS to develop budget priorities, service priorities, and methods to meet those needs, (5) participate in the legislative process, (6) engage in grant-writing and other fund-raising, (7) promote "best practices," (8) promote consumer involvement, (9) promote insurance parity, (10) participate in AMDD's Request for Proposals (RFP) process by encouraging and supporting consumers and other stakeholders to develop responses to deficiencies in the public mental health system, (11) rate the mental health system, development of recovery models that are evidence-based, and outcome driven fee for service systems.

1.1 Mission

The Central Service Area Authority (CSAA) was established by Montana State statute to collaborate with the Department of Public Health and Human Services (DPHHS) and Local Advisory Councils (LACs) in the planning, implementation, and evaluation of a consumer-driven, recovery-oriented, culturally-competent public mental health care system. Our mission is

to ensure that consumers, their families, and other interested community stakeholders have a strong voice in defining, developing, managing, and monitoring public mental health care delivery in Montana, with a focus on the Central region of the state.

1.2 Objectives

The objectives of the CSAA are in support and correlate to the President's New Freedom Commission on Mental Health: Achieving the Promise – Transforming Mental Health Care in America.:

(a) **Consumer-driven, so that consumers' needs and preferences significantly** influence the services provided, and so that consumers have some choice regarding their services and providers;

(b) **Family-centered**, thereby ensuring that consumers and their families assume greater leadership in the public mental health care system (e.g., have a stronger voice in managing funding for services, treatments, and supports);

(c) **Clinically effective and evidence-based**, in order to enhance accountability, ensure a continuum of care, and promote "best practices";

(d) **Fiscally responsible**, to ensure the most efficient use of resources possible, given the budget constraints for each service region and the state as a whole;

(e) **Recovery-oriented**, i.e., focused on meeting basic needs, enhancing coping skills, facilitating recovery, promoting independence, and building resilience;

(f) **Locally-informed**, i.e., reflective of and responsive to the needs, exigencies, and solutions identified by significant stakeholders from the communities in which it is delivered;

(g) **Culturally-competent**, i.e., sensitive to, respectful of, and competent regarding important dimensions of human experience (e.g., race and ethnicity, gender, sexual orientation, religious affiliation) as they may relate to a consumer's treatment and recovery;

(h) **Holistic**, i.e., addressing all aspects – physical, psychological, emotional, social, and spiritual – of a consumer's treatment and recovery; and

(i) **Well-coordinated**, when necessary or appropriate, with that provided in the Central and Eastern regions of the state.

1.3 Outcome Measures

(a) **Consumer involvement:** Requiring a minimum of 51% consumer involvement on the CSAA Board will help to ensure that the needs and wishes of consumers are truly represented.

(b) **Consumer buy-in:** Putting the needs of consumers first, giving them 51% control, and getting them involved in the leadership of the CSAA will all help consumers to feel that their participation is valued and actually makes a difference.

(c) **Broad-based participation:** Increasing the stakeholder base by 10% a year(consumers, family members, providers, mental health professionals, administrators, and staff) to the CSAA will help to ensure that multiple viewpoints are represented, that checks and balances are built into the development of a responsive system, and that the organization will be more stable.

(d) **Achievable goals:** Setting (and meeting) achievable short-term and long-term goals will help to give the CSAA a sense of purpose and efficacy and make it easier to measure its impact. The three time a year Congress meetings will provide a platform for sharing the outcomes or updates of the goals and setting new attainable goals that can be identified in the bi-annual report to the Montana Legislature.

(e) **Credibility:** Putting consumers first, fostering broad-based participation, and achieving its goals will all help the CSAA to be more responsive to the needs of the individuals it represents and help it to establish credibility in the eyes of legislators, participants in the mental health care system, and other important stakeholders.

2.0 New Freedowm Commission on Mental Health: In a Transformed Mental Health System…

(a) Goal 1 – Americans Understand that Mental Health is Essential to Overall Health.
(b) Goal 2 – Mental Health Care is Consumer and Family Driven.
© Goal 3 – Disparities in Mental Health Services Are Eliminated.
(d) Goal 4 – Early Mental Health Screening, Assessment, and Referral to Services Are Common Practice.
(e) Goal 5 – Exellent Mental Health Care is Delivered and Research is Accelerated.
(f) Goal 6 – Technology is Used to Access Mental health Care and Information.

Measureable Achievements or Actions to Meet the New Freedom Commission Goals

New Freedom Commission Goals	CSAA 2007
Americans Understand that Mental Health is Essential to Overall Health	1. Development of Strategic Plan 2. Participate in NASC (National Anti-Stigma Campaign 3. Develop Leadership/Mentor training for Consumers participating in CSAA 4. Participate in MMHA Mental Health Day at the Capital 5. Advocacy Concensus on Legislative Mental Health Issues
Mental Health Care is Consumer and Family Driven	1. CSAA is 51% consumer membership 2. Mental Health providers recognize and refer consumers to NAMI functions 3. Initiation of WRAP training (Wellness Recovery Action Planning) 4.
Disparities in Mental Health Services Are Eliminated	1. CSAA recognizes and supports National and State parity of mental health and medical/surgical benefits 2. Crisis Stabilization and Crisis Response available across communities in Montana 3.
Early Mental Health Screening, Assessment, and Referral to Services Are Common Practice	1. Adopt Teen Screen Project 2. Adopt SEARCH Institute criteria for healthy communities 3. Adopt Providence Hospital community mental health screening project
Exellent Mental Health Care is Delivered and Research is Accelerated	1. Outcomes for providers are developed and measured 2. CSAA become ASO's 3. CSAA hire an Executive Director 4.
Technology is Used to Access Mental health Care and Information	1. Telemedicine becomes the normative practice in linking high demand services to scarce resources 2. Community LAC's and CSAA have joing annual meeting via MedNet. 3.

2.1 ORGANIZATIONAL SUMMARY

The CSAA was organized in the fall of 2005 as a public benefit/nonprofit corporation under Montana statute. The statute defining Service Area Authorities (SAAs) is MCA §53-21-1001. The purpose of the corporation is to collaborate with the Department of Public Health and Human Services (DPHHS) and to assist in the planning, implementation, and evaluation of public mental health care. The geographic area assigned to the CSAA by DPHHS includes the following 15 counties: Glacier, Toole, Liberty, Hill, Blaine, Pondera, Teton, Chouteau, Lewis and Clark, Cascade, Meagher, Broadwater, Jefferson, Gallatin and Park. (According to 2005 Census estimates, these counties combined comprised 33.0% of the state's population.) The CSAA is one of three (i.e., Western, Eastern, and Central) regional SAAs in Montana which individually focus on a separate region of the state and jointly focus on a limited number of issues of concern to the entire state public mental health system.

2.2 Legal Entity

The Central Service Area Authority, Inc. is a public benefit corporation which is incorporated as an instrumentality of the State of Montana.

2.3 Organizational History

In 1999, the Montana legislature recognized the need for local participation in planning for mental health services, prompting the formation of Local Advisory Councils (LACs). The LACs were the grassroots foundation for the SAAs. In October 2004, the initial CSAA planning …… Mike McLaughlin to complete history.

2.4 Governance Structure

CSAA Membership

CSAA members can be mental health consumers (primary or secondary) or other stakeholders interested in improving the public mental health system in Central Montana. Voting members of the CSAA membership must be at least 16 years of age, must reside in one of the 15 counties which constitute the CSAA region, and must have submitted a membership application attesting to both their age and county of residence.

CSAA Board of Directors

The CSAA Board of Directors (shall comprise of 20 persons) is elected by voting members of the CSAA. The majority (at least 51%) of the CSAA Directors shall be consumers of mental health services or family members of consumers (i.e., primary or secondary consumers). All Directors serves staggered one-to-four-year terms of office. The Directors annually elect a slate of 4 Officers (the Executive Board): President, Vice President, Secretary and Treasurer.

Currently, up to ten (10) directorships are reserved for election directly by up to ten (10) Local Advisory Councils (LACs). (Each LAC may appoint one non-voting alternate to the Board who shall have voting rights when the primary LAC Director is absent.) The CSAA requires that any LAC member voting for an LAC representative Director to the CSAA Board also complete and submit membership forms to the CSAA, thus ensuring that the WSAA Board is elected by its

members. The CSAA has also requested that all LAC representative Directors be either primary or secondary consumers of public mental health services. In addition, up to nine (9) Directors shall be elected from other interested stakeholder groups (e.g., state mental health system, law enforcement, criminal justice system, county commissioners, Western Montana Mental Health Center and The Center for Mental Health, private clinicians, crisis response teams, vocational rehabilitation, housing agencies, substance abuse treatment providers, Native American communities, etc.). The Board of Directors is responsible for voting to fill vacancies for non-LAC seats.

Meetings
The full CSAA membership holds an Annual meeting on the 1st Saturday of April. The CSAA Membership or Board of Directors may host 3 additional quarterly (Congress) meetings. The Board of Directors meets monthly (last Friday of the month) in Helena.

3.0 SERVICES

The CSAA is involved in the following activities and events:

1. Holds monthly Board of Directors meetings;
2. Holds 3 quarterly Congress meetings (and one quarterly Annual meeting);
3. Participates in regularly-scheduled Service Area Authority (SAA) Summit meetings throughout the year;
4. Collaborates actively with the State of Montana AMDD; and
5. Educates legislators and other key stakeholders about pressing mental health issues in Western Montana.

3.1 Service Description

The CSAA provides the following services:

(a) **Consumer empowerment:** (1) Provides forum for consumers, family members and providers of mental health services and all other concerned stakeholders to be heard with regard to mental health issues in Central Montana; and (2) fosters and supports the use of Recovery Models for growth and recovery of individuals with mental illness through placement in leadership roles throughout the CSAA.

(b) **Planning and Collaboration/Managemetn/Directing/Implementing??:** (1) Collaborates with the State of Montana AMDD for purposes of planning and oversight of mental health services in the Central service area, including: (a) provider contracting, (b) quality and outcome management, (c) service planning, (d) utilization management and review, (e) preadmission screening and discharge planning, (f) consumer advocacy and family education and rights protection, (g) infrastructure, (h) information requirements, and (i) procurement requirements; (2) reviews and monitors crisis intervention programs established pursuant to MCA §53-21-139; and (3) submits a biennial review and

evaluation of mental health service needs and services within the Central service area in the beggining of the 2nd year in the interim.

(c) **Education and advocacy:** (1) Provides data and information to AMDD, LACs, and other stakeholders regarding mental health issues in the Central region and statewide; (2) educates legislators regarding mental health issues pertinent to Central Montana; (3) educates the community through dissemination of factual information in order to reduce stigma surrounding mental illness; and (4) participates in advocacy of policy positions that the SAAs develop and support.

(d) **Fund-raising:** Initiates fund-raising activities and seeks out additional revenue through various activities for the purpose of improving mental health services in Central Montana.

(e) **Coordination:** (1) Coordinates with Eastern and Western SAAs in the development of a state-wide mental health agenda; (2) coordinates with the Eastern and Western SAAs in the development of a statewide communication system regarding mental health issues; and (3) considers the policies, plans, and budget developed by the children's system of care planning committee provided for in MCA §52-2-303.

Note: the CSAA does not directly provide mental health services, but may act as an Administrative Service Organization.

3.2 Complementary Resources/Related Entities

Advocacy is shared by CSAA with the following entities who may also conduct legislative activities, provide oversight and input into the public mental health system, and offer education and advocacy regarding mental health issues in Central Montana. The SSAA will need to be clear about its distinct mission in order to provide effective services and to avoid duplication of efforts.

(a) **Mental Health Oversight Advisory Council (MHOAC)**, established in 1999 by MCA §53-21-702, to provide input to the department in the development and management of any public mental health system;

(b) **Mental Health Ombudsman,** defined in MCA §2-15-210, who represents the interests of individuals with regard to the need for public mental health services, including individuals in transition from public to private services;

(c) **National Alliance on Mental Illness (NAMI),** the nation's largest grassroots mental health organization dedicated to improving the lives of persons living with serious mental illness and their families. NAMI provides advocacy, research, support, and education;

(d) **Montana Mental Health Association (MMHA**), a nonprofit association of volunteer citizens concerned with all aspects of mental health and mental illness. MMHA educates

by sponsoring professional conferences and advocacy workshops for consumers, families, professionals and the general public;

(e) **Montana Advocacy Program, Inc. (MAP)**, a federally-funded nonprofit corporation which advocates for the rights of people with mental illness under the authority of the federal Protection and Advocacy for Individuals with Mental Illness Act (PAIMI Act). Montana incorporated the PAIMI Act into state law at MCA §53-21-169; and

(f) **Mental Disabilities Board of Visitors of the State of Montana**, which reviews Montana's public mental health programs and the Montana Developmental Center and assists individuals receiving services from those programs. The Board of Visitors was established in 1975 by MCA §53-21-104 and §2-15-211.

3.3 Printed Materials

(a) **CSAA Strategic Plan:** The goal of this strategic plan is to provide an educational document which outlines the CSAA's mission, objectives, and history, Bylaws and which provides a "blueprint" for its future activities, in order to enhance its effectiveness.

(b) **CSAA Records:** The CSAA keeps all records (e.g., Minutes and Treasurer's Reports) from each Board of Directors and Congress meeting. These records are available to all members and to DPHHS via e-mail or the CSAA website (see section 3.5. "Technology").

(c) **SAA Brochure:** The SAAs will explore the possibility of developing a printed brochure outlining the three SAA regions and their primary objectives and functions. This would facilitate education regarding the SAAs and their mission.

(d) **Mental Health Local Advisory Council Handbook (Revised – January 2006):** Handbook developed by MHOAC (revised and condensed by Daniel Ladd, Regional Planner, Mental Health Bureau, AMDD) to help new LACs to get off the ground.

(e) Community to Community Mental Health Resource Guides: The CSAA encourages the Local Advisory Councils (LAC) to develop Community Mental Health Resource Guides for its citizens.

3.4. Fulfillment

(a) The three SAA Executive Committees will meet at regularly-scheduled Summit meetings throughout the year to discuss, comment upon, and take concerted action on statewide issues, where appropriate;

(b) The three SAA Executive Committees, in consultation with AMDD, will develop mechanisms for effective communication and collaboration;

(c) The CSAA will establish sub-committees, when appropriate, to tackle issues and problems of importance to the fulfillment of its mission; and

(d) The CSAA will educate and disseminate critical information to legislators and other important stakeholders as deemed necessary.

3.5. Technology

To assist in the dissemination of critical information, the CSAA will develop and maintain the following:

(a) **Website:** for the purpose of keeping members informed about the CSAA through the posting of meeting minutes, descriptions of various activities, and information about key mental health issues in Central Montana. (The CSAA hired its own "webmaster," and he developed the website: www.CSAAMT.org.)

(b) **E-mail List:** with current e-mail addresses for all members; and

(c) **(Potential) Newsletter:** for dissemination to CSAA members who do not have easy computer access.

3.6 Future Services

Future services will be those deemed appropriate by the Congress and approved by the Board of Directors.

4.0 MARKET ANALYSIS SUMMARY

Although not broken down by service area, the following statistics provided by AMDD help us to appreciate the magnitude of the problems facing the public mental health system in Montana:

- **Mental Illness:** it is estimated that 1 in 5 Americans suffers from some kind of mental disorder in a given year. In 2003, AMDD provided mental health services to about 1 in 30 Montanans, children and adults.

- **Suicide:** Montana ranks second in the nation in the incidence of suicide.

- **Montana State Hospital:** 795 Montanans were hospitalized at MSH in FY 2004 (199 average daily census).

- **Substance Abuse:** 1 in every 12 Montanans aged 12+ was in need of treatment for a substance abuse disorder in 2001. It is estimated that 50-60% of Montanans who have a mental illness also have a substance abuse disorder. Montana Chemical Dependency Center served 570 Montanans with an average daily census of 50.

- **Medicaid:** 13,417 unduplicated Montanans received Medicaid-supported mental health services in FY2004, with a monthly average of 5,126 Montanans as members.

- **Mental Health Services Plan:** 5,352 Montanans received MHSP-supported mental health services in FY2004 (2,434 monthly average).

In addition, AMDD provided the following statistics, by county, for individuals diagnosed with depression, bipolar disorder, and schizophrenia who were provided public mental health services in the Central Service Area in 2005: (Dennis Cox and Jane Nelson to gather data)

- **Depression:**

County	Frequency	Percent	Cumulative Frequency	Cumulative Percent
BLAINE	36	1.73	36	1.73
BROADWATER	24	1.15	60	2.88
CASCADE	808	38.85	868	41.73
CHOTEAU	21	1.01	889	42.74
GALLATIN	249	11.97	1138	54.71
GLACIER	90	4.33	1228	59.04
HILL	148	7.12	1376	66.15
JEFFERSON	54	2.60	1430	68.75
LEWIS AND CLARK	441	21.20	1871	89.95
LIBERTY	7	0.34	1878	90.29
MEAGHER	7	0.34	1885	90.63
PARK	98	4.71	1983	95.34
PONDERA	33	1.59	2016	96.92
TETON	31	1.49	2047	98.41
TOOLE	33	1.59	2080	100.00

- **Bipolar**

County	Frequency	Percent	Cumulative Frequency	Cumulative Percent
BLAINE	6	1.10	6	1.10
BROADWATER	2	0.37	8	1.47
CASCADE	168	30.88	176	32.35
CHOTEAU	4	0.74	180	33.09
GALLATIN	64	11.76	244	44.85
GLACIER	10	1.84	254	46.69
HILL	29	5.33	283	52.02
JEFFERSON	28	5.15	311	57.17
LEWIS AND CLARK	168	30.88	479	88.05
LIBERTY	1	0.18	480	88.24
MEAGHER	1	0.18	481	88.42
PARK	45	8.27	526	96.69
PONDERA	4	0.74	530	97.43

- **Schizophrenia:**

County	Frequency	Percent	Cumulative Frequency	Cumulative Percent
BLAINE	2	0.63	2	0.63
BROADWATER	3	0.95	5	1.58
CASCADE	125	39.43	130	41.01
CHOTEAU	3	0.95	133	41.96
GALLATIN	41	12.93	174	54.89
GLACIER	12	3.79	186	58.68
HILL	12	3.79	198	62.46
JEFFERSON	15	4.73	213	67.19
LEWIS AND CLARK	66	20.82	279	88.01
LIBERTY	1	0.32	280	88.33
PARK	20	6.31	300	94.64
PONDERA	7	2.21	307	96.85
TETON	6	1.89	313	98.74
TOOLE	4	1.26	317	100.00

These calculated figures do not include all persons/Montanans/Adults in Montana State Hospital (Warm Springs) or Montana State Prison (Deer Lodge), two state-wide facilities located within the Western Service Area Authority region that serve a disproportionately high number of individuals with mental illness. (A September 2006 Justice Department's Bureau of Justice Statistics (BJS) study found that 43% of state prisoners had symptoms of mania, 23% had symptoms of major depression, and 15% had symptoms of psychotic disorder. These numbers were even higher for female inmates: in state prisons, 73% of females (and 55% of males) had mental health problems. Inmates with a mental health problem also had high rates of substance dependence or abuse in the year before their admission.) **In addition, these statistics do not include individuals with private health insurance, individuals with these mental illnesses who did not come to the attention of the public mental health system, or individuals with other significant mental health diagnoses. Thus, these figures significantly under-represent the number of individuals living within the Western service area who are living with mental illness and who need mental health services. (Visit DOC website to gather uptodate information or ask Deb M. to provide)**

4.1 Services Currently Available

(a) Statewide Services:

- **Montana State Hospital:** MSH is the only inpatient stabilization service available to many people living with mental illness in Montana who are uninsured. Although MHS is located in the Western service area, individuals with mental illness are admitted to the hospital from all over the state. (See Appendices A-D for statistics on MSH admissions, discharges, average daily census, and average # of admissions by month, from 1995 – 2006).

  (Personalize to CSAA)
  A "snapshot" of 194 MSH patients taken on 11/6/05 revealed that 46% (N = 90) came from the Western service area, including 11 from Flathead, 27 from Missoula, and 30 from Silver Bow counties. These numbers indicate that the Western region as a whole was over-represented in the hospital population, given that the 13 counties that constitute the Western region represent only 37% of the total population of Montana. These numbers also suggest that particular counties (e.g., Missoula, Powell, and Silver Bow) may be over-represented in the hospital population. It may be beneficial to examine these counties more closely, to try to determine whether their demographics, lack of other inpatient options in these counties, or other factors account for these numbers.

  State officials report that more than half of the people admitted to MSH have neither private insurance nor Medicaid. The cost of managing mental health crises by sending people to MSH is therefore enormous. MSH is budgeted at $26,800,000 for FY 2006 ($27,900,000 for FY 2007). The budget includes all costs associated with operating the hospital, including a bond payment of approximately $1.7 million each year. The bonds were issued back in 1997 to pay for the construction of the "new" hospital. The State Hospital census has increased from an average of 182 patients per day in 1997 to 195 per

day in 2006. Meanwhile, admissions to the Hospital almost doubled, from 327 admissions per year to 721. In response, DPHHS has hired 36 new staff and is asking the Legislature for an additional $1.7 million per year to pay for them. That's $1.7 million that could be used to pay for crisis management in the communities where people live.

- **Crisis Hotlines:** the State of Montana provides funding for a 24-hour/7-day a week telephone crisis hotline available to citizens throughout the state. The hotline also provides information and referral.

  All licensed mental health centers and licensed private practitioners are required to provide a 24 hour/day emergency response to their current active clients. Most ethical providers do, in fact, take this responsibility seriously and make arrangements for after (business) hours coverage. The expectation should be that therapists are available to their clients in a crisis situation because that is where the therapeutic alliance has been established and the individual's therapist is, or should be, the best source for helping the clients resolve an emergency situation.

  WMMHC, CMH and AWARE have a 1-800 telephone hotlines for their respective clients in MT, including CSAA counties. If someone calls in crisis, the hotline (which is staffed and has an on-call therapist) will determine what the issues are, try to assess the seriousness of the emergency call, offer support and assistance, and if the situation warrants immediate attention, will refer the caller to the nearest health care facility (which is generally a hospital emergency room). Depending on the situation, the ER may arrange a face-to-face assessment which can result in an emergency detention and a petition for involuntary commitment.

- **Inpatient Mental Health Treatment:** other than MSH, there is one inpatient psychiatric hospitals in the CSAA region – Benefis of Great Falls provides…..(Marlene to provide description).

  Two Behavioral Health Inpatient Facilities are being developed in the CSAA, one in Helena and the other in Bozeman. The identified initiations of the BHIF's is 2008.

(b) Other Adult Mental Health Services:

- **Program of Assertive Community Treatment (PACT) Information:** there are two current PACT programs in the CSAA region: one in Helena and the other in Great Falls. A third PACT is in development for Park/Gallatin Counties for late Spring 2007. On December 31, 2006, the Helena program had ? patients and the Great Falls program had ? patients. Each of these programs has the capacity to expand to up to 60 clients.

- **Mental Health Professional (MHP) Services Data:** in FY 2005, mobile crisis teams in the CSAA region received a total of ? calls and provided ? face-to-face contacts. Of these contacts, ?% took place in the Bozeman/Livingston area, ?% in the Helena area, and ?% in the Great Falls area.

- **Adult Case Management:** this service component is the primary community-based support available to individuals with serious and disabling mental illness. The program enjoys widespread participation by consumers in all ? counties covered by the CSAA. The program provides a wide array of supports, including: linkage with other health care and mental health services, housing support, income support and assistance in negotiating community services so that individuals can develop a recovery focus in their lives. The Center for Mental Health in Great Falls initiated a Crisis Peer Support Program in 2007 that demonstrated the effectiveness and power of consumer partners in the delivery of services.

- **Medical Services:** a major component in the treatment of major mental illnesses is access to psychiatrists and their medical expertise in prescribing medications and monitoring the patient's progress with symptom management. Recently, (APRN's) Advanced Practice Registered Nurses (APRN) have been utilized for this critical function. Recovery only becomes an option for individuals if they are symptom-free or least symptom-minimized. There is nationally a shortage of community psychiatrists, and Western Montana (particularly the rural communities) experiences that critical shortage.

- **Outpatient Services:** this service is perhaps the most available option for persons experiencing mental health difficulties. Central Montana has a demand for more licensed therapists (Psychiatrists, Psychologists, Licensed Clinical Social Workers, and Licensed Professional Counselors). Licensed master's level clinicians are unavailable in a number of communities in the CSAA area, and psychiatrists and psychologists tend to be available only in major urban centers at a great cost to the centers. This service is almost always office-based and consists of individual or group therapy offered on some regularly scheduled basis (e.g., twice a month for 1 hour per session). Many private therapists have elected to limit or not take state Medicaid clients due to regulatory and funding restrictions, and they have a limited ability to see clients who cannot afford to pay the full cost of care by themselves. Most insurance policies have higher deductibles and/or co-pays for mental health services than regular health services, and other limiting features which often make insurance for mental health services less available than for other medical/health issues.

- **Crisis Facility Data:** there were ? referrals in FY 2006 to the two crisis facilities located in the CSAA region: Hope House, Benefis and Rocky Mtn. Foundation. Of these referrals, ? clients (?%) were admitted to the facilities, and they stayed for a total of ? client days. Hope House accounted for ?% of the admissions and ?% of client days, followed by Benefis (?% of clients, ?% of client days) and Rocky Mtn. Foundation (?% of clients, ?% of client days).

- **Other services:** although AMDD keeps statistics on other adult mental health services provided in the state, it does not break those numbers down by region.

(c) Children's Mental Health Services: (Ask Dennis & Jane to personalize to CSAA)

- **Children's Mental Health Bureau:** in Montana, mental health services for children with serious emotional disturbance (SED) are primarily provided through the Children's Mental Health Bureau under DPHHS. These include Medicaid-supported services such as inpatient psychiatric services, community-based services, community-based outpatient services, and services provided by mental health professionals. The bureau also manages non-Medicaid programs for children with SED under the Children's Mental Health Service Plan, which is limited to low-income youth who are within 150% of the federal poverty guidelines and who are not eligible for Medicaid or the Children's Health Insurance Plan (CHIP). State funding for non-Medicaid and non-CHIP youth is negligible. The State of Montana has relied primarily on Medicaid funded services plus the recent addition of CHIP for non-Medicaid eligible youth. The services covered under CHIP are limited primarily to traditional outpatient coverage. A significant portion of children's mental health services and supports are provided through the schools under the CSCT program, a joint initiative (for Medicaid eligible youth) between local school districts and a local mental health center. The CSCT initiative is the primary vehicle for supporting youth who require extensive support in the classroom and well as assistance with peer and family interactions. CSCT is available primarily to Medicaid eligible youth because that is the only funding source for these programs. In addition, a number of providers offer children's group homes and supported living services to families to help keep children in their own homes. Finally, children with SED may be victims of abuse or neglect and may be served by the Child and Family Services Division and Child Protective Services. An unknown number of children with SED also end up in local juvenile detention facilities and the State facilities for boys and girls.

  The Children's Mental Health Bureau has made a concerted effort to identify, monitor and bring back Montana's high needs children receiving services in other states and to foster development of in-state resources. However, it is challenged by rigid licensing and funding rules, depressed Medicaid payment schedules, and limited professional resources. Consequently, approximately 80%+ of all funding for children's mental health services goes to support out-of-home care for youth in group homes, in-state residential care facilities, or out-of-state residential placements.

  Approximately 25% of Montana's children live in poverty. Another significant percentage lives in the gray area slightly above the federal poverty level. Theoretically, any child eligible for Medicaid should receive all services which are medically necessary to screen, diagnose and treat a child with SED under the Early Periodic Screening Diagnosis and Treatment (EPSDT) provisions of Medicaid. However, Montana has been slow to implement EPSDT, lacks qualified child psychiatrists and other mental health professionals in many areas of the state, and has few or no guidelines for screening children for SED. Moreover, children who are eligible for CHIPS or the Children's Mental Health Plan receive significantly fewer mental health services than children who are Medicaid eligible. Montana has also failed to adequately increase funding for special education in schools, which bear much of the responsibility to provide supports and services necessary to allow a child with SED to progress in the curriculum.

- **Kids Management Authorities (KMAs)** have some similarities to the LACs/SAAs, in that the legislature established them to support a comprehensive and statewide system of mental health care for children, by developing a continuum of care in local communities and providing case planning and coordination for individual youth with SED and their families. Major differences between the two structures are that KMAs are organized by county, have no regional governance structure, and are primarily focused on coordinating individual treatment plans between the various treatment entities, school personnel, custody agencies, and where feasible, the parent of the child being "staffed". There is a very limited role for parents/consumers in the KMA structure other than as parent advocates for their individual case involvement. The SAAs have been mandated by the legislature to work with the KMAs and the children's mental health system.

  Theoretically, there are many more services available in the children's system because EPSDT mandates that all Medicaid-eligible children receive all medically necessary services. However, because Montana has not developed financing incentives to support a broad array of community supports for youth, the only options available to parents are often placement in a group home, limited case management, or limited outpatient services. The fragmentation of multiple service providers, coupled with no clear locus of responsibility at the community level, has impaired the development of a comprehensive children's mental health system. In contrast, mental health is an optional program under Medicaid for adults and can be limited in any number of ways if the limitation applies to all eligible adults. Unfortunately, although the teenage years are often when serious mental illness first appears, the state-defined diagnoses for SED youth often do not translate into eligibility for adult programs with more restricted adult diagnostic definitions for SDMI. Thus, collaboration between the SAAs and KMAs will be critical to smooth and strengthen the precarious transition between the children's mental health system and the adult system.

(d) Breakdown of Available Adult Services, by County, in the Central Service Area:

Please note that this is <u>*not*</u> *an exhaustive list of available services, but rather a listing of those services of which the committee was aware at "press-time"…*

- **Gallatin/Park Counties**

  Crisis Response: Gallatin County, Park County, the Livingston Memorial Hospital and the Bozeman Deaconess Hospital fully funds a 24/7 mobile Crisis Response Team (CRT), supervised by the Western Montana Mental Health Center (WMMHC), to provide full crisis services. These include in-person evaluations and assistance by one of four mental health professionals (MHPs) at emergency rooms, upon police or sheriff request, at the crisis houses, or at a person's home or other community site.

  Crisis Residence: Bozeman is home to Hope House, a 5-bed crisis house which is primarily reserved for residents of Gallatin and Park Counties. The crisis residential program served ? unduplicated individuals in FY 06.

Outpatient Services: Livingston and Bozeman are homes to the WMMHC outpatient mental health treatment center which provides adult case management, psychiatric evaluation, medication management and supports, day treatment services, PACT (proposed to start in late Spring 2007, emergency services, and referral to crisis and services for those in Bozeman. There are satellite offices in Ennis, Three Forks and Belgrade. The adult mental health programs in Gallatin County served 1,588 unduplicated persons in FY 06, while Park County served ? unduplicated persons in FY06. AWARE provided an adult group home until September 2006 and adult case management, although they are drastically downsizing in Bozeman and Livingston.

Inpatient Services: None currently available in Gallatin or Park Counties.

Children's Mental Health Services: in Park and Gallatin Counties:, AWARE has ? therapeutic group homes for children. Youth Dynamic, Inc. provides a shelter care facility for upto 12 boys and girls. AWARE and Yellowstone Boys and Girls offers youth case management services, outpatient services, medical services, and comprehensive school and community treatment (CSCT) to ? separate school sites in Park and Gallatin Counties. Finally, Park and Gallatin Counties are also home to more than 200 private therapists who are providers of outpatient services to youth and their families.

Chemical Dependency Treatment: Southwest Chemical Dependency and Gallatin Alcohol and Drug Services, provides outpatient chemical dependency treatment services to ?individuals in FY 06. In addition, both operate residential recovery programs (a chemical dependency/co-occurring treatment group home with ? beds

Vocational Services: WMMHC has designated one staff person to provide employment related services in Park and Gallatin Counties. Gallatin County fully funded a vocational specialist in July 2006. She/he may set up work assessments sites in the community, provide job search assistance or job coaching, or coordinate supported employment services (extended follow along support). In many ways she serves as a liaison between WMMHC-Gallatin/Park and Vocational Rehabilitation.

Dennis and Jane to help with further descriptors by County

- **Blaine County**

Crisis Response:

Outpatient Services:

Children's Services:

Vocational Services:

Tribal Services:

Chemical Dependency Treatment:

- **Broadwater County**

Crisis Response:

Inpatient Services:

Outpatient Services:

Children's Services:

Vocational Services:

Tribal Services:

Chemical Dependency Treatment:

- **Cascade County**

Crisis Response:

Inpatient Services:

Outpatient Services:

Children's Services:

Vocational Services:

Tribal Services:

Chemical Dependency Treatment:

- **Choteau County**

Crisis Response:

Inpatient Services:

Outpatient Services:

Children's Services:

Vocational Services:

Chemical Dependency Treatment:

Tribal Services:

- **Gallatin County**
  Crisis Response:

  Inpatient Services:

  Outpatient Services:

  Children's Services:

  Vocational Services:

  Tribal Services:

  Chemical Dependency Treatment:

- **Glacier County**

  Crisis Response:

  Inpatient Services:

  Outpatient Services:

  Children's Services:

  Vocational Services:

  Tribal Services:

  Chemical Dependency Treatment:

- **Hill County**

  Crisis Response:

  Inpatient Services:

Outpatient Services:

Children's Services:

Vocational Services:

Tribal Services:

Chemical Dependency Treatment:

- **Jefferson County**
  Crisis Response:

  Inpatient Services:

  Outpatient Services:

  Children's Services:

  Vocational Services:

  Tribal Services:

  Chemical Dependency Treatment:

- **Lewis and Clark County**
  Crisis Response:

  Inpatient Services:

  Outpatient Services:

  Children's Services:

  Vocational Services:

  Tribal Services:

  Chemical Dependency Treatment:

- **Liberty County**
  Crisis Response:

  Inpatient Services:

Outpatient Services:

Children's Services:

Vocational Services:

Tribal Services:

Chemical Dependency Treatment: **Deer Lodge/Powell County**

- **Park**
  Crisis Response:

  Inpatient Services:

  Outpatient Services:

  Children's Services:

  Vocational Services:

  Tribal Services:

  Chemical Dependency Treatment:

- **Pondera**
  Crisis Response:

  Inpatient Services:

  Outpatient Services:

  Children's Services:

  Vocational Services:

  Tribal Services:

  Chemical Dependency Treatment:
- **Teton**

  Toole *Crisis Response:*

  Inpatient Services:

Outpatient Services:

Children's Services:

Vocational Services:

Tribal Services:

Chemical Dependency Treatment:

- **Toole**
  Crisis Response:

  Inpatient Services:

  Outpatient Services:

  Children's Services:

  Vocational Services:

  Tribal Services:

  Chemical Dependency Treatment:

4.2 <u>Essential Service Needs</u>

At the January 2007 CSAA Board of Directors' meeting, the following critical service needs for the region were identified and organized, by priority, in the following order:

(a) **Presumptive eligibility:** for 72 hours at local hospitals, crisis services, and Mental Health Centers;

(b) **Emergency assistance:** statewide 24/7 emergency assistance to local hospitals, including psychiatric consultations by Montana State Hospital (MSH) staff (or mental health centers/private providers) and video conferencing for consultations;

(c) **Emergency room professional assistance and training program**;

(d) **Automatic enrollment in mental health system:** for individuals at imminent risk;

(e) **Discharge medications:** for patients leaving MSH & DOC (i.e., consumers leave the hospital with sufficient medication to last until consultation with a local psychiatrist);

(f) **Increase in the MHSP poverty level:** from 150% to 200% of poverty level, to match the poverty level for co-occurring disorders coverage;

(g) **Training for law enforcement personnel:** to work humanely with individuals in a mental health crisis;

(h) **Peer support services:** such as drop-in centers (e.g., "The Hub" in Billings), NAMI's Peer-to-Peer program, and Montana Mental Health Association's WRAP training;

(i) **Enhanced services for 90 days:** for all MSH (and community hospital) discharges;

(j) **Higher reimbursement rates:** to assist in the recruitment and retention of professional mental health staff;

(k) **Jail Diversion** programming to be initiated in both urban and rural areas.

(l) **Humane transportation:** of consumers with mental illnesses to involuntary services (e.g., MSH, ER's, and MHC crisis services) and to court hearings in a manner that respects dignity;

(m) **Upgraded crisis bed availability:** including secure beds where needed and architecturally reasonable;

(n) **Enhanced PACT services:** such as increased flexibility on eligibility, including when youths with mental illnesses transition to the adult mental health system);

(o) **Special needs wrap-around funding for MSH discharge patients:** e.g., paying rent for a period of time until they can get setup locally;

(p) **Patient assistance in community settings**;

(q) **Crisis Help Line:** to provide statewide, centralized, 24/7 assistance and referral;

(r) **Better access to pre-adjudication evaluations:** in community jails and detention centers, both for forensic purposes (i.e., diversion) and for competency evaluations;

(s) **Hospital crisis aide reimbursement**;

(t) **Higher daily reimbursement to community hospitals**;

(u) **Regional assessment and (inpatient) evaluation centers**; and

(v) **Transitional services and supports for individuals with mental illness who are released from prison or jail:** in order to access community mental health services.

4.3 Assets

(a) AMDD
(b) Providers
© County Governments

(d) Accessibility to local, county and state government
(e) Advocacy Groups
(f) Legislative members

4.4 Obstacles/Threats

The CSAA has identified the following as obstaclesthreats which may interfere with our effectiveness in helping the public mental health system address these essential service needs:

(a) **Lack of political focus and will to improve the mental health system:** It is an unfortunate reality that legislators cut programs for people with little political clout. Few people have less power in our society than mental health consumers, and the stigma surrounding mental illness makes it even less likely that their needs will be discussed and attended to. (This stigma remains strong, despite significant efforts made by NAMI and the Montana Mental Health Association to educate the public.)

(b) **Lack of organization among people working in and using the public mental health system:** The system of care is fragmented, leaving many gaps in the "safety net". There are multiple providers located primarily in urban communities, with the rural parts of the state primarily underserved. Because there are no clear lines of who is responsible for what, many providers "cherry pick" those services that are financially advantageous to their organization. Medicaid eligibility for adults can take up to two years and multiple appeals to achieve, and because Medicaid is the ticket to most services, the individual and his/her family endure countless hardships with multiple hospitalizations and crises before they are recognized as "eligible and in need of services". Although it is widely recognized that early intervention and treatment is the best predictor of treatment success, treatment is often delayed until a major disability has taken hold. By default, the state hospital system has become the front door for treatment access for many people. Most people working in the system are overwhelmed by the sheer inertia of the system, and most people using the system are focused on survival, both physical and financial. It is difficult for these stakeholders to invest the time and energy needed to force system change.

(c) **Compassion fatigue and burnout:** many professionals, consumers, and other stakeholders in the public mental health system have witnessed multiple "reform" efforts and participated on multiple committees, task forces, and advisory boards that have (unfortunately) done little to change the system or address its problems. Understandably, consumers and other stakeholders are increasingly reluctant to get (and stay) involved unless they see results.

(d) **Difficulty hiring and retaining competent professional staff:** even if the public mental health system develops/implements some of the services needed, high turnover in competent professional staff and difficulty in recruiting and retaining such professionals at Medicaid reimbursement rates will likely remain barriers to care. The State of Montana has largely ignored these workforce retention issues by systematically not funding cost-of-living adjustments in an industry that it is responsible for "privatizing".

The salary disparity issues are compounded by State hiring practices: state positions similar to those in the provider agencies are hired at a rate 20-30% higher than that which not-for-profits can offer/sustain. With the exception of the operation of the Montana State Hospital, the public mental health system is a privatized, not-for-profit industry. In addition to base salary concerns, other financial benefit/compensation issues facing the state and not-for-profits are: affordable health insurance, rising worker's compensation rates, high travel expenses for a mobile work force, and lack of retirement programs. The State is sometimes accused of tunnel vision (or no vision) when it comes to ensuring that a viable system is in place when it makes a decision to privatize an industry.

(e) **Difficulty obtaining local, intensive mental health supports and resources:** due to low reimbursement rates and lack of training/interest, most intensive services in Montana are provided at a centralized, remote location rather than through local emergency rooms and community hospitals. This arrangement forces more and more people into MSH, further isolating them from their community supports and families and reducing their chances for recovery.

(f) **Criminalization of the mentally ill:** this phenomenon has been well documented both nationally and in Montana. Advocates and families become almost powerless when a person with mental illness is incarcerated for even low-level crimes. The public defender system is overwhelmed with criminal matters and rarely has the resources or training to work effectively with people with mental illness. Although many law enforcement personnel do not want people with mental illness in their jails, they sometimes find incarceration to be a preferable alternative to making multiple trips to the ER or having officers wait hours for an exam, only to watch helplessly as the individual is released back to the community to foster new complaints to which they must respond. As it becomes more difficult to obtain community services in a timely fashion, jails and prisons are becoming the default system of last resort because they cannot refuse to accept someone. Because of the unavailability of non-Medicaid funding, many criminal justice referrals (who also often do not meet the rigid diagnostic criteria for SDMI adult eligibility) languish in local jails and regional prisons. Even when they have major psychiatric problems, individuals being released from prison have no assurance of any follow-up mental health care upon release. The cycle of recidivist violations with the former inmate returning to prison/jail is the most likely outcome.

(g) **Lack of consumer involvement in quality control of community services:** community providers are not directly accountable to consumers, but rather to funders and licensing/credentialing bodies. If consumers were in charge of doing regular quality-control interviews and follow-up, providers would probably be more responsive. (NAMI is supporting such a policy.)

(h) **Lack of realistic perpetual financing for public mental health services in the community:** a disproportionate and politically-protected amount of funding goes into institutional care, starving community services. Consequently, too many dollars are spent on crisis response, rather than on prevention, skills-building, or recovery.

(i) **Over-reliance on Medicaid Funding:** the public mental health system in Montana (and in most other states) is largely reliant on Medicaid funding for persons living in their home communities with mental illness. In Montana, the ratio of Medicaid funding to non-Medicaid funding is extremely weighted toward Medicaid, especially in the community service sector (~ $34M in FY 2006). The other significant financing comes from state general funds which fund care at Montana State Hospital (~ $20M in FY 2006) and a very small state general fund allocation for the MHSP program (~ $2.3M in FY 2006). In practice, this over-reliance on Medicaid funding means that persons living with mental illness who do not qualify for Medicaid or other health insurance have very limited (if any) treatment options. In addition, their access to care will continue to shrink as providers are forced to implement cost controls to cover their mounting losses resulting from cuts to the Medicaid and MHSP budgets.

(j) **Shrinking Federal Medicaid budget:** "reform" under the current Administration has resulted in cuts to the Medicaid budget. Consequently, even those consumers with Medicaid are eligible to receive fewer mental health services than in the past.

(k) **Competing priorities:** at a time when the nation's economy is in decline, when the budget deficit is growing at a rapid pace, and when other high-visibility priorities (e.g., the war in Iraq, hurricane relief) compete for attention and dollars, it is challenging to keep chronic issues/needs such as mental illness on the radar screen.

(l) **Stigma and lack of education regarding mental illness:** it is difficult to advocate on behalf of individuals with mental illness because there continues to be so much stigma, misinformation, and fear associated with their needs.

(m) **Potential threats to the survival of the SAAs:** in October 2005, the SAAs appeared jointly in front of the legislature to advocate for continued support for SB 499, the Senate bill that established the SAAs. Should the legislature choose to stop supporting this bill, the SAAs would likely lose both their authority and their funding.

(n) **Strength/influence of AMDD:** the WSAA (and other SAAs) were developed specifically to collaborate with AMDD. Therefore, it makes sense to assume that the CSAA's ability to influence the public mental health system will depend, at least in part, on AMDD's ability and willingness to collaborate effectively and to pursue actual system changes, given the current political/financial climate.

Thus far, the SAAs and AMDD have collaborated effectively in a number of ways, including:

(1) Forming and funding of the SAAs, and funneling funding to the LACs. AMDD was very supportive of the SAAs' desire to fund LACs out of SAA grants, and it made the process simple by requiring no AMDD approval and little paperwork.

(2) Getting AMDD to LACs for Listening tour and prioritizing crisis management suggestions created from listening tour 3.

(3) Collaborating on the Executive Planning Process (EPP), including getting 3 out of 4 of the SAAs' top priorities into the EPP and getting 72-hour presumptive eligibility for crisis services expanded to cover Mental Health Centers (MHCs) and other community providers instead of limiting such eligibility to hospitals only.

(4) Collaborating on the RFP process to increase community capacity by including SAA representatives on the team that awarded monies, and by following their recommendations to fund emergency care capacity building as a priority.

(5) Collaborating on data collection for this strategic plan. AMDD was very helpful in providing data, but further collaboration will be needed to encourage AMDD to begin to keep data by SAA region (as opposed to state-wide numbers only).

(6) Having AMDD representatives participate in the SAA process at Board and Summit levels, i.e., attending Board meetings of Dan Ladd, Dennis Cox and Jane Nelson among others, hosting the SAA Summit, and using the Summit meetings to share information with and get feedback from the SAAs.

(7) Having AMDD support increased line-item funding for the SAAs.

There have also been several areas in which the new working relationship between AMDD and the CSAA has not yet produced outcomes that the CSAA has recommended or desired, suggesting the need to improve communication and collaboration. CSAA recognizes that the relationship will continue to develop as the parties continue to work toward common goals. Ongoing areas in which the CSAA would like to improve collaboration include:

(1) Although it is still one of the CSAA's top priorities to increase financial eligibility for MHSP to 200% of poverty level, AMDD was unable to recommend this priority after the executive planning process or through the SJ 41 Subcommittee testimony.

(2) The CSAA would like AMDD to consult with the CSAAs regarding decisions to apply/not apply for significant sources of funding (e.g., the Money Follows the Person federal initiative, SAMHSA funding, other substantial grants) that would help to defray the costs of Olmstead-mandated transitions from mental health institutions to community supports and services.

(3) The CSAA would like AMDD to collaborate intensively with the SAAs re: the AMDD legislative agenda, including additional funding for MSH, DOC and the Mental Health Services Plan.

(4) Due to timing issues (i.e., the SAAs weren't formed before decisions had to be made), AMDD and the SAAs were not able to consult effectively on a Medicaid waiver proposal that essentially leveraged all MHSP general funds to fund non-

mental health expansion of Medicaid coverage, with only a minimal increase in services for people with mental illness. The CSAA would like the opportunity to be more involved in the development of waivers that affect the use of substantial amounts of dollars used for mental health services.

(5) Finally, the CSAA would still like to see improved access to community mental health services (as contrasted to crisis beds or institutional placements). Currently, consumers without Medicaid have extremely limited treatment options in the community, and even those consumers with Medicaid coverage have very little control over their own treatment.

5.0 STRATEGY AND IMPLEMENTATION SUMMARY

The CSAA proposes to adopt the following strategies in order to maximize its effectiveness:

(1) **Conduct a Market Analysis:** survey and develop a clearer picture of the current status of mental health services in Central Montana, including the location and type of services available, and the number and type of consumers in need of those services.

a. The CSAA is currently collecting data regarding the incidence of individuals with mental illness incarcerated in Central Montana, including those housed at Montana State Prison at Deer Lodge.

b. In addition, it would be helpful to understand approximately how many individuals receive mental health treatment services through private payment or insurance, how many individuals receive "mental health" treatment through their primary care providers, and how many individuals are cared for in/by their families without treatment.

c. The CSAA should contact Vocational Rehabilitation services regarding supported employment services offered for people with SDMI. Because employment is such a critical component to individuals in their recovery, all parties need to prioritize this service domain so that individuals can receive necessary supports and treatment while at the same time building their job skills and employment histories.

d. Lastly, CSAA will develop a clearer picture of the number and type of treatment slots (e.g., inpatient beds, crisis treatment slots) available in the Central region.

(2) **Conduct a Needs Assessment:** identify deficiencies, community needs, and service priorities through input from the LACs, CSAA Congress and Board, community providers, and other stakeholders.

a. In December 2005, the CSAA identified four top priorities: (1) improve crisis stabilization in the region, (2) develop peer-to-peer initiatives (e.g., peer-run drop-in centers or supports, training), with Medicaid reimbursement for peer services, (3)

develop, promote, and adequately fund a state policy for the humane transportation of consumers to/from mental health services (including MSH) that respects dignity and does not use law enforcement vehicles, and (4) provide funded access to community-based mental health services regardless of income.

b. In January 2006, the CSAA prioritized the "Crisis Management Initiatives" as proposed by AMDD from its listening tour. These crisis management initiatives are designed to expand on the more general priorities identified above to improve crisis stabilization in the region and to provide funded access to community-based crisis services, regardless of income. Both the WSAA and ESAA adopted the same priorities, and AMDD used the priorities to help establish its budget requests.

c. Throughout the legislative interim, CSAA has provided testimony and priorities to the SJ 41 Legislative Interim Committee on Children, Families and Health and Human Services. The four top issues identified to the SJ 41 committee expand upon the December 2005 priorities. CSAA asked the SJ 41 Committee to consider the following: (a) expand 72-hour presumptive eligibility to anyone who is seeking crisis mental health services through any public avenue, (b) increase financial eligibility for the MHSP to 200% of the federal poverty level to close the gap between eligibility for chemical dependency and co-occurring services and mental health services, (c) provide community-based crisis response for people who are not Medicaid- or MHSP-eligible at the time of crisis without regard to ability to pay, and (d) provide adequate reimbursement to local hospitals for mental health crisis beds for up to 3-4 days to encourage development and maintenance of crisis beds in the community.

d. The CSAA will re-visit priorities regularly, as situations change and develop. At the same time, the WSAA hopes to provide an over-arching vision that is not subject to the vagaries of budgetary and political processes.

e. The CSAA sent out a needs assessment form to the LACs and now needs to collect them. Depending on the response rate, we will analyze the data received or develop a shorter, more user-friendly version to increase participation in the assessment process.

f. The CSAA Board Chairman has been asked to include an update from the LACs in the board meeting agenda.

g. The CSAA Board will develop a needs assessment with the CSAA Congress.

(3) **Present a Unified Voice:** collaborate, coordinate efforts, and combine resources with the Western and Eastern SAAs and other community mental health groups (e.g., NAMI and the MT Mental Health Association), when appropriate.

a. The CSAA website facilitates collaboration with representatives from the Eastern and Western service area regions. Currently, the CSAA has joined the WSAA on the combined website to aggregate information and resources. Both SAAs fund a

webmaster to post and update information in a timely manner and to find useful information for visitors to the website.

b. The three SAAs coordinate their efforts through Summit Meetings at which they collaborate with AMDD, identify issues of common interest, select action steps, identify who will perform the action steps, and set timetables for completion.

c. The three SAAs have jointly adopted priorities for crisis response to assist AMDD to develop its budget requests.

d. The three SAAs will collaborate to present testimony to various legislative committees, jointly write letters to legislators, AMDD, DPHHS, and other policy makers, and provide joint position papers on proposed legislation, when time allows.

e. On an ad hoc basis, the three SAAs will develop position statements (e.g., the CSAA letter from Tom Peluso to AMDD).

f. The three SAAs may develop a Legislative Committee to work together, and the Summit has created a Long-Range Planning Committee.

g. The three SAAs will develop a process through which they can communicate in a more timely manner.

(4) **Collaborate with AMDD/DPHHS:** to develop the Governor's budget priorities, to identify service priorities and develop methods to meet those needs, and to encourage the development of a consumer-run quality control system for mental health services in Central MT.

a. Representatives of AMDD/DPHHS already attend most of the CSAA Board meetings, Summit meetings, and Congress meetings.

b. AMDD/DPHHS has been helpful in sharing data with the CSAA.

c. The CSAA responds to requests for information, prioritization of needs, and consumer perspectives on a variety of issues for AMDD.

d. The CSAA provides input and priorities for the AMDD portion of the Executive Planning Process.

e. The CSAA, in conjunction with the other SAAs, provide guidance and direction to AMDD regarding time-sensitive issues.

f. The CSAA helps AMDD identify and meet with local LACs for its listening tour.

g. MHOAC representation will continue to include three SAAs. The SAA will use representatives to reflect and promote the SAA priorities. SAA will promote direct SAA appointment to MHOAC.

(5) **Participate in the Legislative Process:** educate legislators regarding needs and priorities of consumers in the mental health system, work with appropriate legislative interim and standing committees to educate and inform regarding consumer needs and priorities, draft (where appropriate) mental health-related policies.

a. At its June 2006 Board meeting, the CSAA nominated members for a "Legislative Sub-Committee," the charge of which is to review proposed bills, draft position statements for Board approval, create teams to provide education or comments to legislative committees (so as to include all), and work with consumers to convey effectively their "stories" to illustrate the need for easier access to/more community-based services, among other needs.

b. The CSAA will complete, with extensive input from the LACs, the statutorily required biennial regional report by mid-Fall, to give legislators the "state-of-the-state" update re: what is/isn't working in the public mental health system. These community-level reports will be compelling to legislators who are principally concerned about their constituencies.

c. The CSAA anticipates developing a legislative "action plan" of goals, and then an implementation plan that includes:

   (1) Training the LACs and SAAs on how to communicate with legislators in a timely and effective way;

   (2) Setting up phone and e-mail trees for quick response to legislative requests for information and testimony; and

   (3) Developing packets for LAC and SAA members to use to organize community meetings with their legislators.

d. Once the SAAs have seen what the governor's budget proposal does and doesn't include, and what legislation is being written, they can begin to have discussions at the local and regional levels, and then coordinate the overall SAA response at the Summit level. These discussions will inform the content of the position papers developed by the Legislative Sub-Committee.

e. The CSAA will develop policies and practices to address member presentations in response to public or legislative requests for CSAA positions on various issues. Dan Ladd, Regional Planner for the Mental Health Bureau of AMDD, will present an outline of a system to address public presentation of SAA policies.

(6) **Engage in Grant-Writing and Other Fund-Raising:**

a. The CSAA recently established a "Grants and Fund-Raising" Sub-Committee.

b. The CSAA plans to employ a grant-writer (with or without the other SAAs) to obtain funding for unfunded priorities;

c. The CSAA will coordinate with providers and other stakeholders to develop/identify additional funding sources for needed mental health services.

d. The CSAA will urge AMDD and DPHHS to apply for new federal Medicaid ($1.5 billion in "Money Follows the Person") funding. These monies are being made available over 5 years to states through the Center for Medicare and Medicaid Services (CMS) under the President's New Freedom Initiative and the Deficit Reduction Act of 2005. "Money Follows the Person" funding is targeted to assist states make the transition from institutional care to community-based supports and services and offers incentives of up to 90% federal matching for states to develop services to transition people out of institutions.

e. The Montana Mental Health Association (MMHA) will apply for a grant to provide training for CSAA members in systems change.

(7) **Promote "Best Practices":**

a. The CSAA hopes to encourage and support the use of evidence-based practices (EBPs) (i.e., practices that have been demonstrated to be effective by empirical research) by bringing speakers and experts to Montana (or utilizing "local" experts, such as NAMI representatives) to train providers and other community stakeholders about the practices and their (cost-)effectiveness.

b. The CSAA hopes to educate system stakeholders and legislators about EBPs and emerging best practices which have been demonstrated to be effective (or shown to be promising) in the treatment of adult mental illness, including: assertive community treatment, consumer-run/peer services, crisis services, illness management, integrated treatment for individuals with co-occurring mental illness and substance abuse, newer medications and medication management, psychiatric rehabilitation, psychodeducation for families, psychotherapy, supported employment, and supported housing. (For more information on these practices, see The Campaign for Mental Health Reform website (http://www.mhreform.org/policy/ebs.htm.)

c. The CSAA also hopes to educate system stakeholders and legislators about barriers to the effective implementation of EBPs. A 2004 survey by the National Research Institute of the National Association of State Mental Health Program Directors (NASMHPD) identified the following obstacles in Montana: shortage of an appropriately trained workforce, financing issues, modification of the EBP model to meet local needs, attaining or maintaining fidelity to EBP model standards, and resistance to implementing EBPs from providers. (See their website for more information: http://www.nri-inc.org.) For example, although the Substance Abuse and Mental Health Services Administration (SAMHSA) recommends that EBPs be followed, the the Centers for Medicaid and Medicare Services (CMS) does not

provide adequate reimbursement to support such practices. Thus, additional sources of funding will need to be identified in order to implement EBPs in Montana.

d. The CSAA hopes to educate system stakeholders and legislators about efforts currently being made in Montana to implement EBPs. For example, in May 2004, DPHHS posted a Strategic Plan for Adult Mental Health Services which calls for the state to bring all stakeholders together to develop a comprehensive mental health plan, to include evidence-based practices. The University of Montana has established a Rural Institute to assist rural consumers throughout the country with anything from integrated childcare to supported employment. The Institute has formed the American Indian Disability Technical Assistance Center, which offers culturally competent technical and vocational assistance to Native Americans with and without disabilities. The state has also published its 2006 Block Grant Application, which outlines the goals and strategies of the state with regards to EBPs, among other mental health initiatives. (See http://www.nri-inc.org for more information.

e. The CSAA will continue to receive input from the Montana Mental Health Association (MMHA) regarding its science-to-service message. MMHA was recently awarded an NIMH Outreach Partnership contract to ensure that information on the latest research findings is disseminated to stakeholders in Montana.

f. The CSAA plans to communicate with other rural states to promote practices (e.g., humane transportation of consumers) that have proven effective elsewhere.

g. The CSAA will work to insure cultural competency within its own operations and within the public mental health system (e.g., a subcommittee will be created to research possible cultural competency training options for the CSAA, AMDD, DPHHS, and/or providers within the system). Given that many EBPs have not been proven to be appropriate or effective in all settings and for all racial, ethnic and cultural populations, the CSAA will also work to promote research on the effectiveness of interventions for people of diverse cultural and ethnic backgrounds, with a particular emphasis on Native Americans. These efforts would help to ensure that culturally sensitive and appropriately trained mental health providers are employed to provide services to Native Americans and other cultural minority individuals living in Montana.

(8) **Promote More Consumer Involvement:** create more consumer-run support services and peer counseling services in Western Montana.

a. The CSAA will continue to solicit input from the LACs to identify local needs.

b. The CSAA provides funding to assist the LACs operate.

c. The CSAA board and Congress meetings provide a forum for LACs to share strategies to increase consumer involvement, participate in policy making, identify and share concerns, and share problem-solving strategies and resources.

d. The CSAA supports training in development and leadership as a priority for LACS.

e. The CSAA shares materials and resources with the LACs to further their mission.

f. The CSAA has made a commitment to pay for transportation, hotel, and other costs associated with consumer participation at Board and Summit meetings;

g. The CSAA, through its representatives in the AMDD RFP process, has supported the development of WRAP training, peer-to-peer support services, and peer-run drop-in centers. The CSAA continues to identify peer training and employment as priorities.

(9) **Promote Insurance Parity:** encourage and support efforts to promote insurance parity (i.e., to ensure that mental/behavioral health conditions are covered by health insurance to the same degree that health conditions are).

a. The CSAA will disseminate research findings in support of its position to legislators and other stakeholders. For example, a recent article in the *New England Journal of Medicine* (Goldman et al., "Behavioral Health Insurance Parity for Federal Employees," Vol. 354(13), pp. 1378-1386) concluded that, "When coupled with management of care, implementation of parity in insurance benefits for behavioral health care can improve insurance protection without increasing total costs."

b. The CSAA will research whether comparable studies have been done in the public health/mental health system.

c. The CSAA will educate the legislature about Medicaid limitations with regards to mental illness coverage (e.g., the fact that only certain mental health diagnoses are covered by Medicaid).

(10) **Participate in the AMDD RFP Process:** encourage and support providers or other stakeholders to develop responses to deficiencies in the public mental health system through the AMDD RFP process

a. CSAA Board Members were involved in the 2006 review, approval, and recommendation of projects from the CSAA Region to be considered by AMDD for funding through the RFP process.

b. CSAA representatives participated in identifying and selecting community projects to increase treatment capacity for people with mental illness and to extend the range of options available in crisis response throughout Montana. The Rocky Mtn. Foundation project in Helena to create Crisis Services of a crisis stabilization facility and an MHP team for 24/7 crisis response.

c. The CSAA will continue to work with providers and community groups to prioritize needs and service areas for later development, should additional AMDD RFP's be issued in the future.

(11) **Rate the Mental Health System:** the CSAA will "grade" how the public mental health system has been doing, to keep stakeholders apprised of our progress.

a. The CSAA will issue its biennial review and evaluation of mental health service needs and services within the Central service area, as required by statute.

b. The CSAA will educate legislators and other system stakeholders about mental health "report cards" from the National Mental Health Association and NAMI, and AMDD's response. For example, the most recent report from NAMI rated Montana with an "F" overall for mental health services. AMDD responded by saying that the rating was inappropriate, as it was based on outdated services and did not include all the new work that has been done (e.g., adopting PACT teams).

c. The CSAA will also look at goals and deadlines that have been previously agreed upon with regards to the public mental health system, to help the state of Montana remain accountable.

6.0 MANAGEMENT SUMMARY

The CSAA management team consists of a Board of Directors with at least 51% consumer involvement and officers working closely with representatives of the other SAAs, the LACs, and AMDD. Ultimately, the work of the CSAA will be divided among sub-committees empowered to address particular issues and tasks.

CSAA Relationship with LACs

The CSAA is required by statute to collaborate with the Central region's LACs. The CSAA recognizes that effective interaction between the LACs and the CSAA will be necessary if the CSAA is to be truly responsive to both local and regional needs. The LACs were created by statute, predate the SAA system, and are reflective of early legislative intent to involve consumers in the design and operation of the public mental health system. The SAAs were subsequently created for similar reasons, but SAA collaboration is required (rather than advisory) for the DPHHS and AMDD. Therefore, the LACs and SAAs share common purposes and will benefit from pooling their information and resources. Essentially, the LACs operate as the local "building blocks" for an effective, regional SAA.

The LACs are required to work with the Mental Health Oversight and Advisory Council (MHOAC) through joint meetings, reports, and an interactive recommendation and proposal process (MCA §53-21-702(1)(b)). MHOAC has recommended that a primary focus of the LACs should be advising the SAAs regarding program issues affecting their communities. In addition, MHOAC has recommended that the LACs within an SAA region be represented on the Board of the SAA and work together with the SAA. In response, the CSAA reserved for the LACs 10 of 19 seats on the Board of Directors, thereby ensuring (and institutionalizing) local, informed, and active consumer input into the development of the public mental health system.

CSAA Relationship with MHOAC

MHOAC is formed by the DPHHS to provide input to DPHHS/AMDD in the development and management of the public mental health system (MCA §53-21-702(4)). One half of MHOAC must be primary or secondary consumers of mental health services. All recommendations made by MHOAC must be transmitted by the department to the legislative finance committee, along with an explanation if the department fails to follow the MHOAC recommendations. As a condition for providing a block grant for state mental health services, the federal government requires a state planning council, and MHOAC fulfills this function in Montana. MHOAC is mandated to annually monitor, review, and evaluate the adequacy of both the adult mental health system and the children's mental health system and to report on its findings. Thus, MHOAC fulfills a state function similar to the combined three regional SAAs, and a federal function to ensure State compliance with federal funding requirements.

Like MHOAC, the CSAA is directed to collaborate with DPHHS/AMDD and the LACs to (1) plan, implement, and evaluate the public mental health system, (2) promote consumer and family leadership within the public mental health system, and (3) foster consumer-driven and family-driven systems of care that advance access to a continuum of mental health services and individual choice (MCA §53-21-1013). Until 2003, AMDD oversaw and influenced the structure of both the adult and children's public mental health systems. However, in 2003, the legislature separated the children's mental health system from the adult system and created a new Children's Mental Health Bureau with separate funding. Consequently, the two systems are now developing under separate direction. While the CSAA is directed to take into consideration the policies, plans, and budget developed by the children's mental health system, its primary focus is the functioning of the adult system. Transition planning for youth about to enter the adult mental health care system is essential to provide a seamless transfer and requires collaboration and understanding between the two systems. Nonetheless, MHOAC's mandate is more evenly divided between the two systems than is the CSAA's. Moreover, MHOAC is concerned with the requirements for federal funding, while the SAAs are more focused on collaborating with DPHHS to develop the executive budget for mental health services that will be presented to the legislature. In addition, the MHOAC takes a state-wide perspective, while the CSAA's primary mandate is to evaluate mental health services, identify deficiencies, and recommend improvements within its own (Central) region.

One of the tasks facing the CSAA will be to clarify its relationship with the other SAAs, MHOAC, and the LACs within its region, in order to address overlapping areas of influence and expertise, identify unique responsibilities, and coordinate their efforts.

6.1 Personnel Plan

At first, the work of the CSAA will all be done by the Board of Directors and the CSAA members. A support staff was hired in late Fall 2006 to take meeting notes and facilitate better communication. In the future, it is possible that the CSAA will elect to hire a part-time Executive Director to assist with administrative tasks. The CSAA may also decide to hire part-time consultants with particular expertise (e.g., computer skills, grant-writing) deemed necessary to fulfill the organization's mission.

7.0 FINANCIAL PLAN

The CSAA receives $15,000 per fiscal year as a planning grant from AMDD. The CSAA may decide to leverage these funds by writing grants, requesting donations, etc. According to MCA §53-21-1006, the CSAA may:

(1) Enter into contracts with DPHHS for purposes of planning and oversight of the CSAA if the department certifies that the CSAA is capable of assuming the duty;

(2) Receive and shall administer funding available for the provision of mental health services, including grants from the United States government and other agencies, receipts for established fees rendered, taxes, gifts, donations, and other types of support or income. All funds received by the Board must be used to carry out the purposes of the part;

(3) Reimburse Board members for actual and necessary expenses incurred in attending meetings and in the discharge of Board duties as assigned by the Board.

To date, the bulk of the CSAA's funds have gone to pay the expenses of consumers who have traveled to attend Board, Congress, and Summit meetings. The CSAA Board has also authorized funds to pay a "webmaster" for the development and maintenance of the CSAA website. Lastly, the CSAA has adopted an interim policy to support financially the LACs within the Central region. There are now six (10) LACs within the CSAA region (Great Falls, Choteau, Pondera/Teton County, Helena, Bozeman, Havre, Ft. Belknap and Livingston) that have formalized their structure.

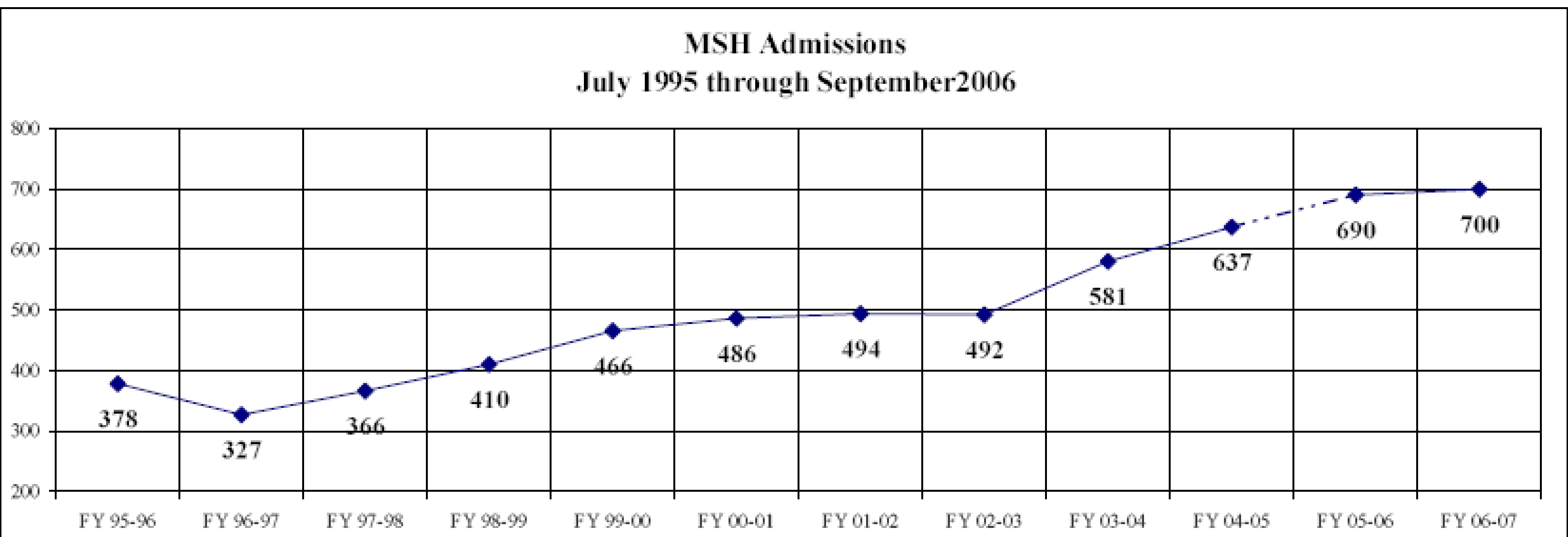
8.0 GLOSSARY/ACRONYMS

AMDD - Addictive & Mental Disorders Division (of DPHHS)
Congress - full WSAA membership
DPHHS - Department of Public Health and Human Services
Executive Board - President, Vice President, Secretary and Treasurer
LAC - Local Advisory Council; a coalition of community members interested in assessing, planning, and strengthening public mental health services in their community
Primary consumer - Individual with a mental disability
Secondary consumer - Family member of a primary consumer
SAA - Service Area Authority (e.g., Western, Eastern, and Central); an entity, as provided for in MCA §53-21-1006, that has incorporated to collaborate with DPHHS for the planning and oversight of mental health services within a service area
SB 499 - Senate Bill that established the SAAs' collaborative relationship with AMDD
Summit - meetings of representatives of the 3 SAAs
CSAA - Central Service Area Authority

WSAA	-Western Service Area Authority
ESAA	-Eastern Service Area Authority

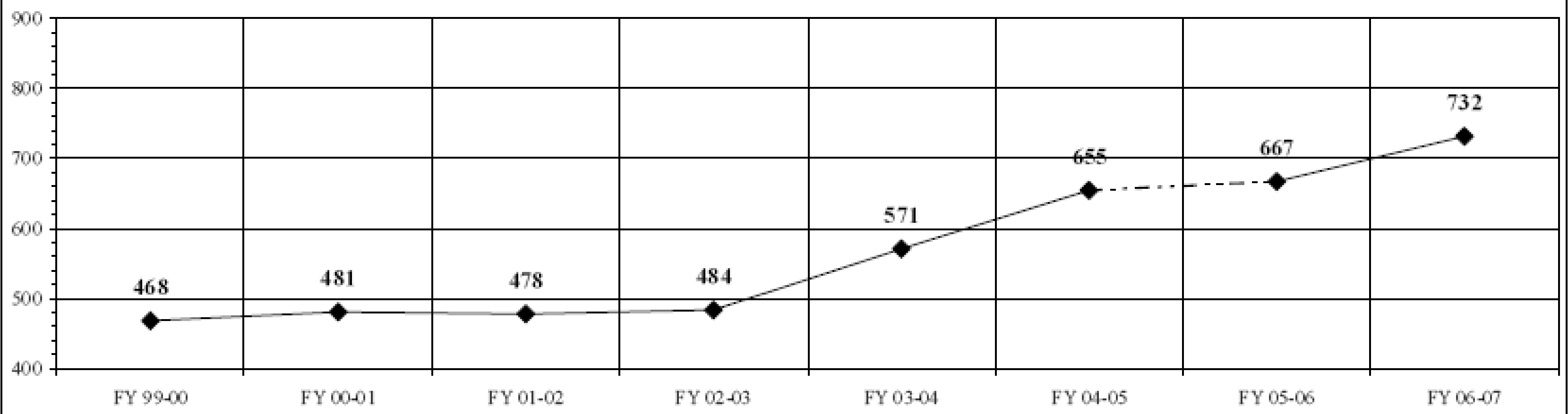
Admissions

	July	August	September	October	November	December	January	February	March	April	May	June	Total for Year
FY 95-96	30	39	43	32	25	33	32	30	31	21	32	30	378
FY 96-97	27	26	30	24	20	19	34	17	35	41	30	24	327
FY 97-98	25	29	31	33	20	25	31	29	30	39	34	40	366
FY 98-99	44	34	33	31	26	31	40	17	34	43	41	36	410
FY 99-00	27	40	34	38	35	23	41	35	56	44	44	49	466
FY 00-01	40	61	46	51	28	35	51	24	34	28	44	44	486
FY 01-02	41	47	35	36	34	40	39	36	46	54	42	44	494
FY 02-03	44	47	36	34	36	53	42	42	36	38	38	46	492
FY 03-04	47	56	51	55	52	38	50	43	44	41	47	57	581
FY 04-05	57	63	43	49	49	62	49	53	59	55	40	58	637
FY 05-06	60	57	51	75	41	65	41	54	61	63	61	61	690
FY 06-07	51	65	59										700
Projection for current year	**612**	**696**	**700**	**729**	**682**	**698**	**669**	**666**	**673**	**682**	**686**	**690**	



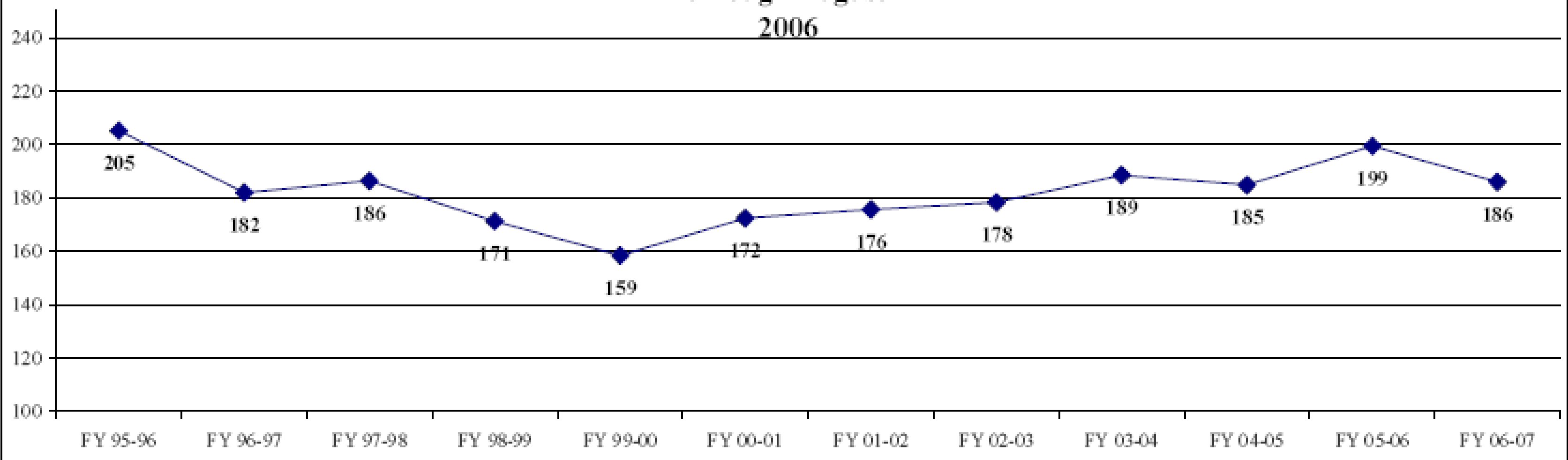
Discharges

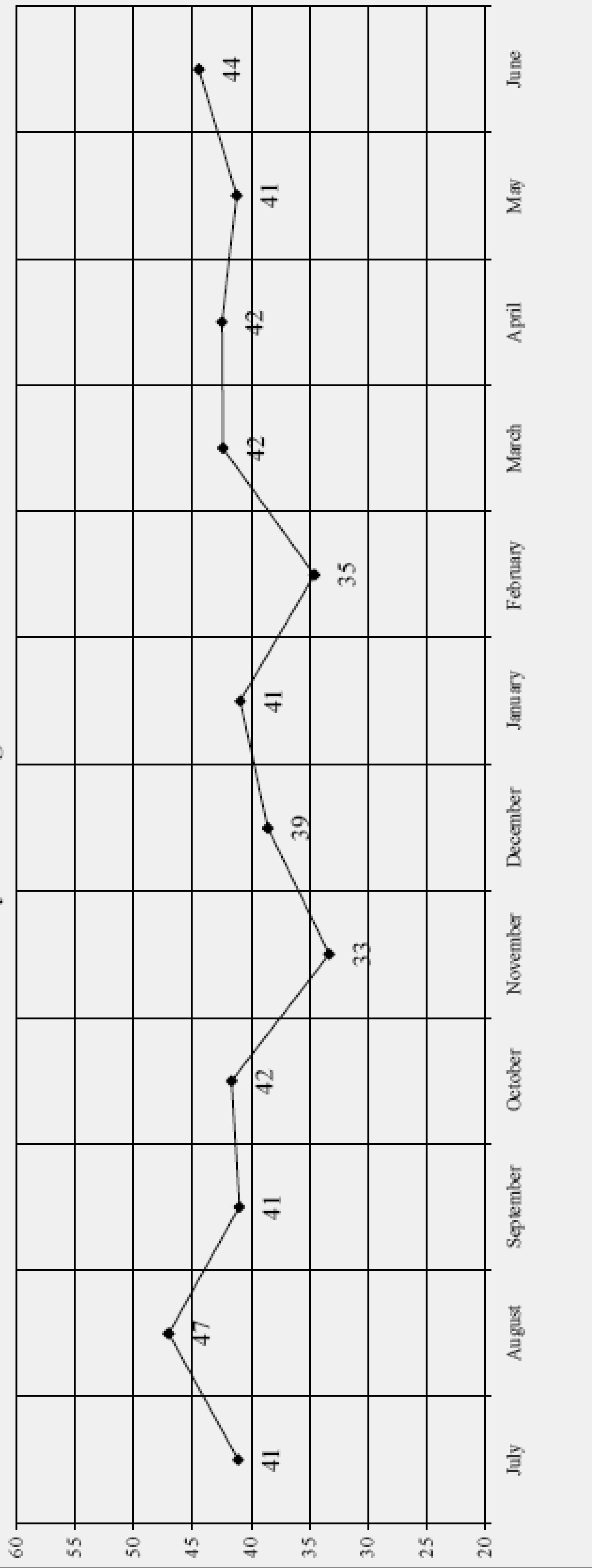
	July	August	September	October	November	December	January	February	March	April	May	June	Total for Year
FY 99-00	29	40	38	21	28	60	36	34	46	55	44	37	468
FY 00-01	34	47	54	45	30	35	43	42	41	35	41	34	481
FY 01-02	38	37	46	36	33	34	46	32	44	48	47	37	478
FY 02-03	43	46	46	35	35	50	38	36	36	44	37	38	484
FY 03-04	51	47	58	46	49	52	38	50	49	45	40	46	571
FY 04-05	69	63	50	52	48	58	47	53	55	54	51	55	655
FY 05-06	48	58	51	68	46	54	55	51	47	56	63	70	667
FY 06-07	53	81	49										732
Projection for current year	**636**	**804**	**732**	**675**	**650**	**650**	**651**	**647**	**637**	**641**	**651**	**667**	



Average Daily Census

	July	August	September	October	November	December	January	February	March	April	May	June	Average for Year
FY 95-96	205	212	200	221	221	210	208	199	200	198	198	191	205
FY 96-97	190	184	182	175	172	169	176	173	172	198	198	196	182
FY 97-98	184	189	192	187	178	178	184	188	187	190	190	190	186
FY 98-99	189	184	178	174	171	163	170	166	151	168	168	173	171
FY 99-00	161	162	155	164	173	158	148	149	155	161	153	163	159
FY 00-01	164	185	180	172	183	177	182	177	165	159	159	166	172
FY 01-02	168	175	176	176	170	170	178	173	176	181	182	184	176
FY 02-03	177	184	179	170	172	167	181	181	185	183	180	181	178
FY 03-04	185	184	192	189	196	188	188	188	185	188	187	193	189
FY 04-05	190	193	186	185	182	182	182	182	191	191	178	177	185
FY 05-06	195	196	192	201	198	201	195	194	199	209	210	202	199
FY 06-07	191	181	186										186




Average # of Admissions by Month of the Year
July 41
August 47
September 41
October 42
November 33
December 39
January 41
February 35
March 42
April 42
May 41
June 44
Average # of Admissions by Month of the Year
July 1995 - August2006
60
55
50
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44
July
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