Mental health care in Montana: A system of mistrust

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The University of Montana

2001
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Mental Health Care in Montana:
A System of Mistrust

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presented in partial fulfillment of the requirements
for the degree of
Master of Arts

The University of Montana

2001

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5-23-01
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Montana's mental health care system has gone through dramatic changes in the past four years. In 1997, the state hired a private company to manage its public mental health program with the idea of saving money and offering more services to more people. The system quickly went awry and was eventually abandoned.

A mistrust between mental health providers and the government, and soaring mental health care costs contributed to many of the problems within the system.

Through a series of articles, this professional project analyzes Montana's mental health system and the problems it faces in the wake of the managed care crisis, with particular emphasis on the lack of communication between the state psychiatric hospital and the regional mental health centers; the lack of funding; the abandonment of the system by many private providers and the struggle to bring them back; the lack of understanding in the Legislature and its demand for cheaper services and more accountability; and the lack of services and funding to Montana's rural communities. The series also examines solutions for improvements.
Acknowledgments

Special thanks to the men and women who shared their stories and struggles with mental illness; to Eric Sells and Mirian Kurinsky for their honesty and patience; to the members of the Missoula chapter of the National Alliance for the Mentally Ill, especially Dorothy Solmonson; to Michael Downs for his insightful suggestions and editing; to Dennis Swibold for seeing through the jargon; and to David Schuldberg.
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Money Matters in Montana's Mental Health System

Eric Sells works with a client who tried to kill himself. The man suffers from depression and, one Sunday, he swallowed 75 Clonopin pills with alcohol. He did not wake up until Wednesday.

"I used to be able to visit this guy three times a week," Sells says. "But now that we're serving more people, I only see him once a week. He's lucky to be alive."

There are two things mental health case managers like Sells find sacred: time and trust. In time they can usually develop trust. But with a mental health system that treats more and more patients, Sells does not have the time.

The mental health system in Montana has undergone dramatic change in the last four years. In 1997, the state Legislature introduced a managed care program to save money and provide more services to more people. But it failed, and the aftermath is full of blame and lingering mistrust.

Before managed care, legislators watched as the mental health budget continued to rise and blamed the psychiatrists and therapists for bilking the system. Psychiatrists and therapists accused politicians of limiting their services and telling them how to treat their patients.

Gene Durand, director of Missoula County Adult Mental Health Services, sums up the mentality that permeates the system. "The Legislature doesn't give us enough money, the Addictive and Mental Disorders Division doesn't know what they're doing, the
providers are only interested in sucking down Medicaid dollars, rather than everybody saying we need to pull together and trust one another.”

The result is more money than ever is spent on a mental health system that does not give patients the care they need.

Thirty years ago, when states began to move more treatment into communities and away from hospitals, Montana established contracts with mental health centers in five regions to provide out-patient services. Today Montana has four mental health centers in Great Falls, Miles City, Missoula and Billings.

The centers treated children and adults with mental illness. The state paid the centers after the services were provided in a system called fee-for-service. Programs included case management, day treatment, therapy, emergency housing and psychiatric services. Not every center offered the same services because not every center could afford to; the quality of care and accountability remained with the individual centers.

But the mentally ill population continued to grow and eventually Montana was no exception to the soaring costs of mental health care. Patients went unserved because mental health centers had the choice of seeing whomever it wished. And the state had little power to make sure mental health providers only billed for services their clients needed.

So the state began to look for other options.

In 1997, Montana hired a private company to manage and improve its mental health system. But services went from bad to worse. As a result:

- poor transitional care from the state psychiatric hospital to communities is leaving patients homeless and without the services they need;
- patients are not getting the best care available because private psychiatrists and therapists will not work with the state;
- lawmakers do not understand the complex mental health system and are forced to vote on issues costing millions of dollars;
• and rural communities cannot provide services or mental health professionals its patients need.

HIGH EXPECTATIONS

The state hired a private managed care company to pay providers once claims were sent in and to make sure the state only paid for the necessary services.

The goal was to modernize a system that was running on three separate budgets. Before 1997:
• the federal Medicaid program provided health care services for the poor;
• the state contracted with the mental health centers to take care of non-Medicaid patients -- the "working poor;"
• and Montana’s Department of Child and Family Services took a piece of the Medicaid budget to treat children.

The idea was to give control of the mental health budget to one entity, thus the state could concentrate on reducing the state psychiatric hospital population while providing more services to the mentally ill in their hometowns. And, of course, save money.

Dan Anderson, administrator of the Addictive and Mental Disorders Division in the Department of Public Health and Human Services, says this approach was expected to create two positive results.

"First, Medicaid was growing at a huge rate and we needed to do something to control that," he says. "Also, we wanted to provide uniform availability of services regardless of where a person lived or what mental health center was in their region."

Under the proposed state managed care system and a new program called the Mental Health Access Plan, non-Medicaid patients could get the services that best suited their illnesses even if the services were not available where they lived.
"We thought that combining the funding sources, giving one entity the power to manage the funds, would essentially allow us to offer more services for the same amount of money because we would be spending the resources more wisely," Anderson says.

Randy Poulsen, former chief of the Mental Health Services Bureau, says the managed care system basically "erased the line between Medicaid and non-Medicaid."

"Non-Medicaid recipients could now go get services from the mental health centers or the private psychiatrist down the street," he says.

And as an added benefit to the state, the company running managed care would take full risk for any cost overruns.

"If they spent more than we gave them, they had to make up the difference," Poulsen says. "If it cost them less, then that's where they made their profit."

So in April 1997, Montana's mental health budget was contracted to CMG, a private managed care company from Virginia, for five years at approximately $75 million a year.

It did not take long for things to go wrong.

"We did not implement the program in the right way," Anderson says. "The plan was solid but there should have been a phasing-in program which would require the company to prove itself at a number of different steps before we turned over all the money."

For example, Anderson says, the state could have implemented management of certain services first, like social workers, then slowly given the company more responsibility. Or, he says, the state could have created dummy claims from around Montana to see how fast the company returned payments to the mental health centers and private providers.

But the state did not. Instead, CMG received all the money and began regulating all the services, and the state began hearing complaints immediately.
"We naively assumed that the one thing a company that does this service should be able to do is take the claims from the providers and pay them," Anderson says. "We underestimated that it is not as easy as it sounds."

Psychiatrists and therapists from across the state complained the process was incredibly slow. They were forced to wait on the phone for hours to get permission to provide treatment and were not getting paid until months later.

Marsha Kirchner, a licensed clinical professional counselor in Missoula, says things got so bad she started sending bills daily with the hope she would see some money.

"I spent hours on the phone trying to get paid," she says. "I'm still owed some money, just not enough to hire a lawyer. And you wonder why therapists stayed away."

It did not take long for private providers to stop taking patients handled by the state managed care system.

Five months after CMG took over, Anderson says, his office realized a big problem was brewing and began "officially and seriously" writing to the managed care company about these concerns.

"They told us that these are just normal start-up problems and that we needed to be more patient," he says.

But things did not get better and in October 1997 the state adopted strict monitoring policies of CMG bolstered by the threat of financial penalties.

For example, Anderson's office wanted the company to return claims quicker and have all the hospitals in Montana under contract by a certain date.

But then the problem took another turn. CMG was bought by another managed care company, Merritt, in the fall of 1997. Then Merritt was bought by Magellan in early 1998.

"To be fair, the claims system started to get better," Anderson says. "We felt Merritt was a bigger company and they were doing a good job with other states. But for
providers, I think the change freaked them out, which basically killed the morale of the
program.”

Things got worse.

In the summer of 1998, the managed care company, now Magellan, told the state
the system was underfunded and the company was losing too much money -- about a
million dollars a month.

“They said to us either we need more money or less responsibility,” Anderson says.
“If we don’t give them money it means we cut services.”

One suggestion from Magellan was to serve fewer patients.

“With the old system we did not have income level cutoffs,” Anderson says.
“Basically we said we’ll give the mental health centers a million dollars and they serve as
many people as they can. But if you’re a person with low income you may have been put
on a waiting list.

“With managed care, we said we’ll only serve those people that make 200 percent
of the poverty level but they will be entitled to any service they need. Now the managed
care company wanted to limit that.”

It was a dilemma. A major reason the state switched to a managed care system
was to make more services available to those who made too much to qualify for Medicaid.
Now, the managed care company was telling them they would have to cut back.

“So the position we were in is that everyone is mad at the contractor and here’s
the contractor saying we want to be relieved of our duties,” Anderson remembers.
“Politically, that was awful. Just awful.”

The state reduced the criteria for services to 150 percent of the poverty level, a
level that still holds. It means a single person making more than $12,885 a year does not
qualify for state assistance under the mental health system.
But by then it was too late. Along with private psychiatrists and therapists, the Legislature lost confidence in the system and decided it would not keep funding it. Before the state could fire Magellan, the company pulled out.

In July 1999, the state managed care system was dead.

MONEY-SAVING MYTH

Anderson says his office still believes the managed care system could have worked. He says that despite all the problems the system was starting to move more people out of the state psychiatric hospital at Warm Springs, which was allowing the state to spend more money on community programs.

In fact, the state hospital’s budget was decreasing along with its daily population. For example, in 1995 the average patient population at Warm Springs was 205. After managed care took over, the hospital’s population decreased in 1997-1998 to 186 patients and in 1998-1999 to 171 patients.

And since the cost per patient at the state hospital runs about $9,500 a month compared to about $6,000 a month at Stephen’s House, a temporary home in Missoula for the mentally ill, it looked like the state would save money.

Yet the numbers are not so cut and dry if the services offered at the hospital are compared to the extra services patients need when they live in a community.

Ed Amberg, hospital administrator at the state psychiatric hospital at Warm Springs, says the money, which breaks down to about $314 a day per patient, includes an array of services.

“For each patient we provide psychiatric treatment, medications, meals, clothing, housing, and physical and dental health care,” he says. “Most of those things aren’t free in the communities.”
Gene Durand, director of the Missoula County Adult Mental Health Services, agrees.

"Besides case management, someone in the community also has to take into account living costs, food stamps, subsidized housing, welfare and intermittent hospital costs," he says. "So in some cases we may approach or even exceed Warm Springs costs."

**QUANTITY OVER QUALITY**

Paul Meyer, executive director for the Western Montana Mental Health Center, says the major problem was not the managed care system; it was the lack of money.

"Everybody recognized the system was underfinanced during managed care," he says. "The department rather stupidly said 'There's enough money in there. It's just that the managed care company isn't managing it well.' That's wrong. There just wasn't enough money."

And the figures since the state assumed responsibility for the mental health system in July 1999 support that theory. Under managed care, the state spent $75 million a year. When the $12 million to $15 million the managed care company says it was supplementing every year is added to that figure, it comes closer to the system's current budget.

The total budget for fiscal year 2001 is $116 million with an increase to $122 million to follow in 2002. The Legislature also provided a supplemental payment of nearly $17 million to keep the system afloat.

And even with increased funding, the state has had to cut services, including case management for children and the number of people in the non-Medicaid program.

Patients have borne the brunt of the money shortfall because case managers like Eric Sells must try to help more clients with less money.
Case managers provide an array of services. Stepping Stones, the case management side of the Western Montana Mental Health Center, has 25 case managers, each serving about 22 clients. Their clients are those with serious mental illness, including schizophrenia and bi-polar disorder; many are either homeless, alcohol or drug dependent or both. Case managers help their clients find everything from psychiatrists and financial benefits to housing. They even help clients shop for groceries. Their goal is to keep their clients in a stable environment.

Eight years ago, when Sells was a full-time case manager, he had 10 clients. Now, working part-time, he handles 12 clients plus he is director of the Program to Assist the Transition from Homelessness, a federal program that provides housing, clothes and food to mentally ill homeless.

"Time is what overcomes people’s mistrust," he says. "But they can’t afford for me to spend that time."

Years ago Sells had a client come out of the state hospital who would only visit with him once a month "for 10 minutes of staring at the floor." Eventually, he gained the client’s trust and they started meeting three times a week for an hour. But it took time.

"Now I can’t do that," Sells says. "I don’t have the time to spend even though the person may need it. We’ve upped the quantity of care but lowered the quality."

Now, in the aftermath of managed care, a main part of Sells’ job is triage. For example, at the Poverello Center, a homeless shelter in Missoula, he worked with a client who was paranoid and aggressive and another client who was anxious and withdrawing.

"One will get into a fight and the other may get raped or beat up," Sells says. "But I need to chose which one I’ll set up in a room for a night. I don’t have the wisdom of Solomon, but I try to make the decision on the one with the greatest risk."

It is unfortunate, he says, but the problem comes down to not enough money.

"The money allocated to our program hasn’t increased in years," he says. "But that doesn’t stop rent prices from going up, salaries to go down not to mention our own
operating and functioning costs. And the mentally ill population has grown and there is no reason to think it will stop growing. We need more help and that means we need more money.”

And he, like many others, wonders where the money will come from.

A RETURN TO FEE-FOR-SERVICE

Regardless of the system’s small budget, Anderson, of the Addictive and Mental Disorders Division in the Department of Public Health and Human Services, says the system, that provides for the needs of about 10,000 people every month, will survive until something better is agreed upon.

“There are clearly more people that could get services,” he says. “But a huge majority of people get the service they want from the provider they want and we pay the bill. I think it’s the old glass is half empty, half full thing.”

However, stabilizing the mental health system does not fix it.

The state is now back to a fee-for-service system, and it again lacks the power to fully regulate what it is paying for, and it cannot provide the services to all who need them. Other than the state hospital and the state nursing home, the government rarely reviews patient care nor does it make sure that patients get only the services they need.

Under fee-for-service, the state pays mental health professionals after the services are delivered. The state reimburses case management at a rate of $224 a month per client. To be paid, a case manager must meet face-to-face with each client once a month plus invest two hours worth of service, such as filing for client benefits with various agencies -- a struggle for case managers when many clients are homeless and difficult to find.

Gene Durand, director of the Missoula County Adult Mental Health Services, says the fee-for-service system, like the managed care system, still fosters the neglect of clients.
For example, Durand says, a case manager may have a client who is homeless and will not keep his appointments. The client does not have a permanent address, is schizophrenic, believes flying saucers are controlling his mind and is often impossible to find. Then the case manager has another client who suffers from major depression and wants help finding a different place to live or getting referred to a therapist. This client is ready and thankful for the case manager’s help.

Case managers have to serve all their clients, but to get paid they have to spend more time finding one client which can lead to the neglect of another client.

“So you’re spending 20 hours a month trying to catch up with one client, while the other is just waiting for help. Which person is going to end up losing services?” Durand asks. “It’s the person with depression because of the amount of time spent finding the person out of reach.”

The problem, Durand says, is case managers deal with a population that rarely has money, transportation, a support system or the desire for help. In essence, clients are often in a “mode of avoidance.”

That is bad for the client. And it is bad for the case manager.

“It’s very difficult to get paid when you have clients missing appointments,” he says.

Sells sees no way out except to put more money in the mental health system. But he also realizes the limitations.

“It’s hard to give the money,” he says. “You can look at a child with down syndrome vs. a dirty homeless person bothering you in front of a store. Who are we more likely to help?

“If the problems with system are not addressed, we’ll just have to deal with it some other way. Whether it’s the police, prisons, emergency rooms or hospitals.”
From Hospital to Home:
Montana’s struggle to provide better transitional mental health care

For the first time, even after all her son’s years of delusions and hallucinations, Gloria feared him.

She knew something was wrong. He was hungry and she told him there were frozen dinners in the freezer. But he accused her of poisoning them. Then he accused her of killing and eating his father.

For nearly two days Adam kept his 81-year-old mother hostage in their home. When the phone would ring, Gloria would run to answer it but Adam would grab the phone away before she could ask for help. Once she tried to escape, sprinting out the front door and screaming for help, but Adam quickly pushed her back inside.

“I felt like I was in a horror movie,” Gloria says, pointing to the bruises on her chin and arms. “I thought, ‘Is this really happening to me?’”

Through Adam’s delusions and hallucinations, Gloria, who asks that her and her son’s names not be revealed because she does not want publicity, finally escaped by convincing her son she needed to see a doctor. She then called Adam’s case manager from the doctor’s office. He was readmitted into the state psychiatric hospital at Warm Springs.

Adam and nearly two million people in the United States suffer from schizophrenia.

A few weeks before keeping his mother hostage, Adam was released for the second time from Warm Springs. With yet another cocktail of medications and time,
Gloria was optimistic that Adam could find some stability. Instead, he fell further into his sickness.

Since 1963, when the Community Mental Health Centers Act was passed by Congress, states have been trying to de-institutionalize mental health systems. The goal was to relieve pressure on the over-populated psychiatric hospitals by providing grants to build and develop community treatment centers. The hope was that patients would get better care in their hometowns.

And Montana was part of the trend. In the 1970s, five mental health centers were created to treat patients in their communities. Now there are four centers in Billings, Great Falls, Missoula and Miles City.

It seemed to work. The only state psychiatric hospital in Montana was built in 1912 and averaged about 800 patients. But by 1941, the patient population at Warm Springs was nearly 2000. Today, the hospital has only 189 beds.

President John Kennedy, who pushed for the 1963 bill, said in a speech that prevention is far more desirable for all concerned because “it is far more economical and it is far more likely to be successful.”

It did not turn out that way in Montana.

A smaller budget, limited facilities and a changing mental health care philosophy put pressure on the state hospital to release patients faster. But the hospital and the mental health centers are not always able or willing to take over a released patient’s care.

Patients like Adam got lost in the shuffle. Patients, who are not ready to leave the hospital or are not given the services they need once released, are often left to fend for themselves. Or, if the patient is lucky enough, the burden falls heavily on the families of the mentally ill person. Gloria found that out the hard way.

“He wasn’t ready to leave the hospital,” she says. “But of course I’m going to take him in when he does.”
Adam is a difficult case. He suffers from schizoaffective disorder, where he has both hallucinations and mood swings. Treating his illness requires juggling several medications and understanding several illnesses and symptoms. Mental health centers do not have all the services needed to treat patients like Adam. As a result, centers often send difficult case to the state psychiatric hospital at Warm Springs.

Ed Amberg, hospital administrator at Warm Springs, says the hospital’s main problem is it has no say on who it treats.

The way the system works now, if a county sends a patient to Warm Springs, the hospital must admit the patient. But when the hospital thinks the patient is ready to be released, the mental health center decides whether to treat that patient. Sometimes, Amberg says, the hospital becomes a dumping ground for the mental health centers’ difficult cases.

Paul Meyer, executive director for the Western Montana Mental Health Center, agrees with Amberg that the state hospital is used by centers to send away difficult cases.

"The state hospital is looked at as a freebee," he says. "Anybody who reaches a tolerance zone with any disruptive patient sends them to Warm Springs."

But the hospital does not always have the space, and if no center accepts a patient, Amberg says, the hospital must decide whether it is safe to release the patient.

"Eventually we reach a point where there is nothing else we can do for a person," he says. "And we have to let them go."

Often patients, if they do not have a family that can provide for them, are put into a homeless shelter.

But the mental health centers need some safeguard against patients just showing up on their doorstep. Several months ago, the Western Montana Mental Health Center created a transitional case manager to screen patients who want to live in the western mental health center region. The transitional case manager makes sure the mental health center’s services match up with the patient needs.
Catherine Price holds that job. She visits Warm Springs every two weeks.

“We’ll get a call from the hospital saying a patient wants to move to Missoula,” she says. “So I go down, talk to the patient and see if we offer the services the person needs.”

If Price determines the mental health center cannot provide the right services, the mental health center can say it does not want the patient.

For example, Price says she had a patient with borderline personality disorder who was cutting himself and had overdosed on drugs. Until the hospital can control him, she says, the mental health center cannot accept him because it doesn’t have the services to help him.

“We’d have to have a case manager with him 24 hours a day,” she says. “And he’d just end up back at the hospital.”

But the hospital’s population increases and its budget does not. Patients have to be released.

“The state has taken money from us to develop services in the community but our population actually went up,” Amberg says.

In fiscal year 1999, the state hospital had a budget of $20 million, spent about $18.5 million and had an average daily population of 172 patients. In fiscal year 2001, the hospital has a budget of $15 million, will spend about $18.3 million and has an average daily population of 175 patients.

“Someone forgot to tell the communities they were supposed to take the patients along with the money,” Amberg says.

For the system to work better the hospital needs more autonomy, he says.

“We need to say when the patient is ready to leave,” he says. “In every other hospital in the world saying that is enough. Well here, someone else has to accept the patient back into the community and some patients even go to court before they’re allowed to leave.”
But what happens when a patient leaves the hospital and there are not services sufficient for his or her needs?

Gloria, her white, curly hair and small frame bouncing with every word, admits she is the primary caretaker for her 47-year-old son.

“I don’t resent it,” she says. “I just felt I wanted to help him in every way possible, and he is in much better condition when I help him. The system regards me as a meddling mother. But I’m the only one he has.”

However, not all psychiatric patients have a family that can support them and keep track of their treatment. Patients often end up back on the streets fighting for their lives rather than against their illness.

For community-based treatment to work, Amberg says, the hospital needs to expand its transitional services to make the patient’s move easier. Ideally, the hospital would have a social worker follow the patient into the community and supervise the patient’s transition to independent living, he says.

That is also true for the mental health centers.

One solution is to develop more transitional group homes for patients released from the hospital. This would give patients a more gradual adjustment to independent living. The state currently has 11 group homes. Only one, Genesis House, is in western Montana.

Maralyn Kailey, director of Genesis House in Stevensville, which is a women’s transitional group home, says if the state is committed to helping the mentally ill function in communities, more group homes are the answer.

“We take women from an institutional setting and offer them a less restrictive setting,” she says. “We’re dealing with fragile, vulnerable people, and it’s safe here.”

Genesis House contracts with the community mental health center at a cost of $55 per day for each patient. The goal is to teach patients basic living skills, like cooking and preparing for a job, in a supervised environment so they can eventually live independently.
And Genesis House has had success, Kailey says.

“We’ve had (clients) get married, succeed in jobs and get back in contact with their families,” Kailey says.

But since 1997, when the state began a managed care system, the Genesis House has not been full because the state will not pay for the patients to stay there.

“We have space for six residents, and we must staff the house 24 hours a day,” Kailey says. “A lot of our clients are pro bono because the state is trying to save money.”

Gloria learned first hand the need for better transitional care. She still believes Adam should not have been released from the hospital, but a supervised transitional home probably would have helped him.

“He should have been in a group home,” she says. “It’s what he needed.”

Gene Durand, director of Missoula County Adult Mental Health Services, says the integration of treatment between the hospital and the community is fundamentally flawed because the state has never defined what level of care it will offer its patients.

“Are we going to direct our system toward positive growth and outcome or are we maintaining people at the level they are in or are we going to institutionalize everybody?” he asks. “It will always be a case of prioritizing.”

Durand says the system fails to give incentives to the hospital to reduce its population.

The hospital, he says, always has to be available for the severely mentally ill. But the politicians tell the mental health centers that the only way to get more money is to reduce the hospital’s population.

The state needs to define how much treatment it will provide the mentally ill, he says, and then the money can be spent in the right areas.

“We’ve focused much too much on the process, or ‘these are the things we have to do,’” he says. “Rather than this is where we want to get, now how do we get there.”
Until then, patients moving back to the community will have to rely on their family or themselves for survival.

Gloria accepted her fate long ago.

"(Adam) can't help that he has an illness," she says. "I didn't consciously think of it as my duty to take care of him. I was just always on the hunt for that magic word, the right psychiatrist, whatever I could do to help him. And I don't resent it at all. I just want to help him in every way possible."

Adam is back in Warm Springs, but eventually he will be released. And despite what he put her through, Gloria has not lost hope. As her thoughts jump from one Adam childhood story to another, she waits, portable phone in hand, for her son to call home.
Mental Health Professionals Find It Hard to Trust the System

Scott Elrod, psychiatrist and medical director for the Western Montana Mental Health Center, sits in his office and remembers the nightmare years.

“At its worst I was seeing 450 patients,” he says. “And it was about a six-week wait before I could see a patient again.”

In 1997, when the state adopted managed care to administer its mental health system, it forced private psychiatrists and therapists to be more accountable for the services they provided to poor patients. Instead of serving patients and then sending the state a bill, private providers were forced to get permission from the managed care company before treating the patient.

This did not go over well with most providers.

In fact, nearly all the psychiatrists in Missoula dropped Medicaid patients, whereas before all but one took Medicaid patients. And statewide, half the mental health providers -- from more than 8,000 to 4,200 -- stopped treating Medicaid patients.

Elrod took the brunt of the patient load because he was the only full-time psychiatrist on staff at the Western Montana Mental Health Center.

The Western Montana Mental Health Center spent two years advertising for a second psychiatrist, but no one was hired until this past March.

“Basically no one in the country wanted my job,” Elrod says.

The rejection of the system by private providers left a significant gap in the number of people treating the mentally ill who could not afford services. Instead of controlling
costs and expanding services to more people, the managed care system gave providers another reason to mistrust the government.

And some patients who needed help the most, did not get it because private providers found it too difficult or expensive.

Elrod calls this the “fat cats don’t hunt” mentality.

“Medicaid patients only pay 40 cents on the dollar,” he says. “Why do it when you can cherry pick for the easier clients?”

William Stratford, a psychiatrist in Missoula, says he stopped taking Medicaid patients because the state was not paying enough “to keep his doors open.”

The state currently pays between $53 and $87 for a one-hour session. Private psychiatrists charge double that rate.

“You can’t go to a trial lawyer in town and say, ‘We’re going to cut your salary in half,’” Stratford says. “With those rates I can’t run this office, pay malpractice or stay alive.”

Janet Allison, a clinical psychologist in Missoula, says low reimbursement was just part of the problem with managed care. She says managed care also wanted too much control over how she treated her patients.

“I had to call someone up across the country, someone who doesn’t know my patient, to get permission to treat them,” she says. “They were asking for confidential information, like detailed histories and diagnostic information, that I did not feel was appropriate.”

Michael Marks, another clinical psychologist in town, agrees. Marks took Medicaid patients before managed care, but stopped during managed care. He has since started seeing Medicaid patients again.

“Basically they were saying, ‘Do it our way or get out of here,’” he says. “And it didn’t matter what we told them. These people just went around and scared everybody.”
It has been a slow process to get providers back in the loop because of this mistrust. Since the end of managed care in 1999, only two Missoula psychiatrists, Michael Silverglat and Noel Hoell, began seeing Medicaid patients again.

Allison does see patients on a pro bono basis through the Access to Therapy program at the Partnership Health Center. The program provides short-term therapy for underinsured and uninsured patients. About 43 therapists in Missoula volunteer their time to the program, seeing clients for five free sessions.

And even that has its problems. Allison says it is difficult to treat the underinsured and uninsured because many of the clients will not show up for appointments she blocks off for them. And, she says, she hesitates to go back to the state system because she does not trust how it was managed.

But should providers have an ethical responsibility to treat people in need?

Silverglat and Hoell say doctors do not have an ethical mandate to see every patient that walks through their doors.

However, they do believe that doctors have a responsibility to their community.

“We make space in our practice for those who cannot pay or are through Medicaid,” Silverglat says.

Silverglat and Hoell tried to work with the state’s managed care but they encountered the same problems: overload of paperwork, slow reimbursement and too much red tape to get permission to treat a client. They faxed information to the managed care company three or four times because they kept being told the documents were lost.

However, Silverglat did say that managed care’s emphasis on cost control is not bad. Part of the blame for the overspending were providers milking the system, whether by performing procedures not needed or ordering extensive and unnecessary lab work.

There are mental health professionals “flagrantly abusing insurance benefits,” Silverglat says. Managed care or a similar system can make those few abusive providers accountable, he says.
Randy Poulsen, former chief of the Mental Health Services Bureau, says the state's goal was not to tell psychiatrists and therapists how to treat their clients but to keep costs down. He says he knows there were, and still are, providers ripping off the system, but he realizes private psychiatrists and therapists are an important piece of state mental health care.

"Our core system will always be the mental health centers," he says. "But we'll always have to rely on the private provider to help out."

But the psychiatrists and therapists are slow in coming back.

In 1999, after the managed care system ended, 5,900 mental health providers were seeing Medicaid patients. Today, about 7,000 providers see Medicaid patients.

Elrod says the perception, when the managed care system took over, was the state pointing its finger at providers and saying, "you are the problem."

"They were calling us thieves," he says. "Publicly and shamelessly saying we need more accountability. That's not exactly imbuing trust."
Educating a Legislature
Mental health advocates strive to make the issues understandable

Bob Keenan admits he does not understand mental illness.

As a state senator from Bigfork, Keenan fell into the mental health issue during the 1999 session when he was put on the Health and Human Services subcommittee as the state was involved in purging itself of the failed managed care system.

"My experience up to that point in mental health was visiting my father in a state lunatic asylum in Massachusetts when I was nine, ten, eleven years old," he says. "After thirty years of being mentally conscious -- but also dormant -- of the issue, I thought maybe there's a reason for me getting involved."

But it was not easy.

"I knew nothing about mental health treatment, the profession, or the layers, and I was just buried with mental health information," Keenan says. "And the problem is the mental health system involves interaction with so many agencies: whether it's schools, county jails, prison, the judicial system. We're dealing with an infinite number of actions as a result of an illness."

Memories of his father, who suffered from depression, give Keenan a passion that has pushed him to the forefront of mental health issues in Montana. And that is a burden he struggles with.

But Keenan and his passion are unusual. Most of the Legislature does not understand mental health care, and they are forced to vote on issues that are confusing and involve millions of dollars. And this lack of understanding feeds into the mistrust between mental health providers and lawmakers.
Rep. Tom Facey, D-Missoula, says a legislator needs to have a real vested interest to get involved with mental health.

“Most legislators don’t understand it because it is too big an issue which makes it more difficult to get new (laws) passed,” he says.

And, he says, it does not help that legislators knowledgeable in mental illness issues face term limits.

“Mental health is a huge elephant to get your hands around and term limits just cause more problems,” Facey says.

And that point rings true with Sen. Mignon Waterman, a Democrat from Helena.

Along with Keenan, Waterman has taken the leadership role in the Legislature on mental health issues since before managed care. Her name appears as the author on most bills concerning mental health, and she is a member of Mental Health Advisory Council, which advocates for mental health legislation. However, her final term ended in April.

Waterman says education is a major solution to getting the system to work and getting more understanding in the Legislature.

Gary Mihelish agrees.

Mihelish, president of the Montana chapter of the National Alliance for the Mentally Ill, has made it his mission -- since his son was diagnosed with a mental illness -- to educate the Legislature on mental illness. For five years he has sent four newsletters a year to every legislator, made hundreds of phone calls and attended countless meetings.

Through his efforts, Mihelish won insurance parity for the severely mentally ill.

“I know the system works if you have a good cause,” he says. “There is so much stigma toward people with mental illness, and unless you’ve lived it you don’t understand. So I try to educate.”

Waterman says the key to educating the Legislature is getting patients and their families involved in the process.
For a long time, she says, mental health providers have taken a maternalistic attitude toward the mentally ill. But now, she says, better treatment allows the mentally ill and their families to become actively involved in recommending the services they need.

Too often, she says, families are told by mental health care professionals, "We know what we're doing so get out of our way."

For example, Waterman says the regional mental health centers' board of directors should include people with mental illness.

"I broached the idea to the centers to change their boards, which are 90 percent made up of county commissioners, and I was told we wouldn't want 'those folks' on the board because we talk about personnel and budgets," she says. "Well, there are plenty of mentally ill people and family members who run small businesses and deal with budgets all the time. That's the old maternalistic viewpoint."

The proof is in the Mental Health Advisory Council where over half the members are people with mental illness or their family members. The council has taken an active role in creating and supporting legislation on mental health issues.

But when the Legislature loses a mental illness advocate like Waterman, it puts a heavy strain on those fighting with her. And Keenan will have to carry most of the load.

Keenan helped establish the Mental Health Advisory Council and became its chairman. Consequently, the Legislature has turned to him more and more for advice and leadership. And it can only help that he is a chair of the Senate Finance Committee and a fiscally conservative Republican in a Republican-dominated Legislature.

"I have a bit of a bully pulpit," he says. "I have credibility because I'm not a bleeding heart liberal Democrat. I'm rock hard as I need to be to keep the budget balanced, yet I've got a passion to take care of people who cannot take care of themselves."

Still, Keenan is one voice in a house of many.
"I need a ton of help," he says. "They got this manic passionate guy to jump in, but I can't do it alone."

But most legislators still have not grasped the issue nor have realized how many areas the mental health system affects if it is ignored.

"I believe if you can spend money on mental health services you have the potential of avoiding a lot of other costs. Not only health care and mental health costs but also welfare costs and prison costs," says Randy Poulsen, former chief of the Mental Health Service Bureau. "The problem is the Legislature is never able to look long term because they always have to look at balancing the budget for this biennium. So we'll never have a system that works just the way we think it should."

The problem, however, runs deeper than a lack of understanding and enters the realm of trust. In the wake of the managed care system debacle, a mistrust between mental health providers and the government emerged.

As Michael Marks, a psychologist in Missoula, says "I'm not going to do anything with the state of Montana."

Dan Anderson, administrator for the Addictive and Mental Disorders Division in the state's Department of Public Health and Human Services, admits that the managed care system set the wrong tone. However, he says, mental health providers did not give the new system a chance.

"I always thought the managed care company and the provider would have a collaborative arrangement," he says. "I just don't think they ever found a respectful relationship."

Gene Durand, director of Missoula County Adult Mental Health Services, says mistrust permeates the system.

"What tends to go on is each side blaming the other side for the problems that exist in the system," he says.
Durand admits it is hard to convince a Legislature that taking the time to develop a relationship with a client is worth the money.

"As a legislator, it becomes extremely difficult to make these kind of financial decisions," he says. "They have to ask themselves, 'Am I going to help these hard working people who lost their business in the fire or am I going to help these people over here where the problem isn't very clear?'"

So what is the solution?

"A shared vision of where we want to go," Durand says.

Easier said than done.

Keenan says the state and the mental health centers must not only share a vision but also the risks, which means everyone involved has to step up and take responsibility.

"We've learned our lesson with managed care," he says. "I don't have tolerance for professional passion. (Mental health) providers should not hide behind the mentally ill to make sure their profession is well reimbursed. And they have to remember they're involved in an advocation and we have limited dollars."

But Keenan is optimistic the system can work.

"We need to straighten out the finances and have everybody focus on an easily attainable, less ambitious system," he says. "We can't fix it, but we can manage it."

There is hope because advocates of mental health issues will not go away.

"Are we going to get enough money? No. Are we going to get enough legislation? No," Mihelish says. "But I always like to say, 'This is a paid job for most of you, and I'll still be here long after this group of legislators are gone.'"

Keenan agrees.

He developed a program for his restaurant that employs people with mental illness. And the awareness and understanding his involvement in mental health issues has given his children, he says, is priceless.
"It has been a nightmare and a dream for me to be able to put my energy into this unsolvable problem," he says. "I don’t think I’ll ever be able to get away from this. It’s made a huge impact on my family and my life."
P.J. Agfner did not understand why she was being handcuffed and shackled and put in the back seat of a police car. She remembers the long drive to Warm Springs; seven hours across the Montana plains. And she remembers the fear.

"I was scared," she says. "It was the most humiliating thing I ever went through."

But Agfner is not a criminal and she was not charged with any crime. She has a mental illness and lives in rural Montana.

Last year's census reported what most people in Montana already knew; the western population grows while the eastern population continues to disappear. The state, in its effort to keep some control over its fledgling mental health system, continues to view the system with a statewide mentality rather than a regional mentality.

But the mental health needs in Kalispell are not the same as in Glasgow. Rural communities, especially in eastern Montana, struggle not only to provide even the most basic services for the mentally ill but also in attracting qualified therapists and psychiatrists to work in such remote regions.

Agfner, 33, suffers from schizoaffective disorder, causing both delusions and dramatic mood changes. When off her medications, she hears voices and sees ghosts. She was in the police car because she was hallucinating and had tried to commit suicide, and the police were taking her to the hospital.

But Agfner lives in Glendive and there are no temporary emergency care centers for the mentally ill in her area. Instead, the county sheriff had to drive her to the state psychiatric hospital at Warm Springs -- a trip of nearly 500 miles.
The mental health system puts sheriff departments in a difficult situation. The county is required to supply the transportation for emergency hospitalizations, but many counties in eastern Montana barely have the staff or the money to do it. In addition, they have little to no education or training in handling the mentally ill, especially when the person may be hearing voices or seeing things that don’t exist.

Sen. Mignon Waterman, a Democrat from Helena and a leader in writing mental health legislation, says law officers need more education. The two hours they get at the law enforcement academy is not enough.

“They can hardly get through what the different illnesses are let alone how to deal with individuals with mental illness,” she says. “We need to have intensive training for law enforcement on how to deal with the mentally ill.”

Sheriff Ronald Rowton of Fergus County, whose department has five deputies for the entire county, never knows when he will have to drive a patient to the state psychiatric hospital.

“When we have these transports they occur within hours,” he says. “We usually average about one every other month, but there have been times when we’ve had three right in a row.”

He says it taxes his small department. When one deputy makes a 10 to 12-hour round trip to Warm Springs, which means two hours of overtime, the expenses add up.

But Rowton says the sheriff department’s responsibility does not end there. Once the patient becomes stabilized, the sheriff has to pick up the patient so they can appear before the county judge. If the patient is committed by the judge to return to the state hospital, the patient must be driven back to Warm Springs.

“We’ve spent $5,000 on one person, driving them back and forth three times,” he says.

And that comes out of an annual budget of $200,000, which includes everything from salaries to running the county jail.
Rowton says a simple solution is creating more emergency care centers.

"So many of the people we deal with have just stopped taking their medications," he says. "If we had some facility closer, it wouldn’t be such a big deal."

Gordon Jackson, director of the Eastern Montana Community Mental Health Center in Miles City, wishes it could be that simple.

"Out here it’s worse than rural," he says. "It’s frontier."

The center handles 17 counties, reaching from Miles City to Sidney to Glasgow, an area roughly the size of Pennsylvania but with a population of only 100,000. Jackson employs no psychiatrists. His therapists travel up to 500 miles a week to see their clients, and the closest hospital with a psychiatric unit is in Billings -- a two to 10-hour drive depending on where the patient lives.

"In rural mental health you deal with everything as best you can," Jackson says. "Everything from mental disorders, chemical abuse, geriatrics and children."

Gordon says his center has seven case managers who must serve both adults and children throughout the region. No matter where a client lives, the center has to be ready to provide support.

"Distance is a struggle," he says. "If we have a crisis in Ekalaka, we’ve got to be there."

Eastern Montana simply does not have the clout needed in Helena to get more resources, Gordon says. If his center had the money, he says, he could hire a psychiatrist and develop more group homes and drop-in centers.

"Helena thinks Montana ends in Billings," he says. "And the squeaky wheel gets the grease."

Agfner understands these problems first hand. She has been to Warm Springs twice since being diagnosed.

When she was released from Warm Springs the first time several years ago, there was still a psychiatrist in Sidney. Every week for several months, Agfner’s case manager
drove her to Sidney, about 50 miles away, to visit the psychiatrist because Agfher did not have a car. After her hour session, she would then have to wait the rest of the day for her case manager to pick her up and bring her back home.

But the Sidney psychiatrist has left and now Agfher relies on her general practitioner to prescribe her medication.

Because there are no psychiatrists, many mentally ill patients in eastern Montana must rely on medical professionals who are not specially trained in psychology or psychiatric medications.

Carleen Gaub, a physician’s assistant in Glendive, says there are days when she feels “out of her league.”

“Out here we are dealing with depression all the time,” she says. “We’re just stuck doing the best we can.”

Gaub says out of 150 patients she sees a week, around 50 are suffering from some form of mental illness. But, she says, diagnosis is often difficult and she is not adequately trained to treat mental illness.

She says she had one client who she thought was depressed. She gave him medications but they did not work.

“So I made a change in his medications, but I was seeing a pattern of high and low (moods),” she recalls. “It turns out he was bi-polar and needed different medications.”

Gaub has been practicing for more than eight years in Glendive, and she says the need for counselors and psychiatrists is urgent.

“I did not realize the extent and depth of (mental illness) here,” she says. “We are in desperate need for counselors.”

And the situation is not much different in rural western Montana.

Jim Sommers, director and therapist for the Western Montana Mental Health Center’s Dillon office, says his problem is not only the need for qualified professionals but the inability to attract qualified professionals to rural regions.
"We’re just a small, agricultural community," he says. “I probably wouldn’t have come here if they didn’t have a college. It’s just difficult to recruit qualified people.”

The state did try to make rural county jobs more attractive by increasing salaries 16 percent. It has not helped.

Sommers says he has a four-person staff running a day treatment program, a drop-in program, out-patient therapy and case management services. Last year, a psychiatrist from Bozeman began traveling to Dillon four times a month, a drastic change from the once-a-month psychiatrist who used to come from Helena. Sommers, himself, has to be both a full-time therapist and manage the office and its budget.

“Basically we can’t respond to every mental health need,” he says. “We could use another case manager.”

Paul Meyer, executive director of the Western Montana Mental Health Center, says a main flaw with the system is that the government has not recognized that the “huge geographic make up of the state creates variabilities in what mental health care systems look like.”

For example, one region may need group homes while another region needs emergency care.

“Montana has a sense that we have to do the same for everyone across the state. Well, it isn’t the same,” he says. “The range of services for people in Missoula is going to be different than in Sidney. You have to figure out the structure for each community and then put a system together.”

Until then, patients like Agfner will have to fend for themselves.
Montana’s mental health system has gone through dramatic and debilitating change over the past fours years. Although the state claims the fee-for-service system is not in a crisis, psychiatrists, therapists, patients and legislators are not happy with it.

But there is cause for optimism.

Mental health providers and the bureaucracy want a regional system with local control. But at this point it is much like getting a pie without the filling: We agree on what it will look like but not how it will taste. Does the state just give the four mental health centers a bundle of money and let them run the system? Or does the state reorganize mental health treatment with new regional centers and an independent governing body?

Last year the Addictive and Mental Disorders Division in the state’s Department of Public Health and Human Services hired Technical Assistance Collaborative Inc., a consulting firm from Massachusetts, to review the mental health system and make recommendations for improvement. The TAC report concluded that the state should develop "five regional authorities with both responsibility and accountability for client care and for managing limited resources for both adults and children."

"It lets the people who know the patients decide on the services," says Don Goeke, clinical supervisor for Stephens House, an adult mental health crisis home in Missoula.
In essence, the state would give each region an annual budget based on population. Each region would be responsible for implementing core services required by the state but then could develop other services needed in that area.

For example, the core requirements would include programs for group counseling, 24-hour crisis services, case management and psychiatric services. Then the regions could use the rest of their annual budget for programs more suited to their patients’ needs; the western region could put more money into homeless services while the eastern region could set up more short-term emergency care units. This would control costs, the theory goes, because money would be directed toward specific programs, and the patients would get the best possible services for their situation.

However, unlike the current system, each region would be responsible for any expenses that go over the annual state allotment, and each region would be required to achieve standards outlined by the state.

The theory is this: Give the money to the people who know best how to use it. But the state also recognizes there might be the need to step in if a region cannot work within its budget.

“One thing we’ve learned from managed care is we have to be ready to step in if something goes wrong,” says Randy Poulsen, former chief for the state’s Mental Health Services Bureau.

This proposed system moves the responsibility of money from a statewide level to a regional level. And regions seem ready for the shift, although officials recognize they will need to prioritize their treatment plans to work within their budgets.

“If you have X amount of money, you want to get your healthiest clients through the system, out on their own feet and then concentrate your resources toward people with high disability levels,” says Paul Meyer, executive director of the Western Montana Mental Health Center. “And how you can do that is by having the money handled at the local level.”
Gene Durand agrees. He is director of Missoula County Adult Mental Health Services and says he has no problem with making regions accountable.

"The money control should be at a more local level," he says. "But the state, the taxpayers and the Legislature absolutely should be able to say, 'Here's how we want the money spent and these are the results we're going to hold you to.' Right now we don't have that."

But handing the money over to the regions does not immediately solve the problem. There is still the question of who will manage the money.

The TAC report says that for any system to work it must take the views of the patients and families to heart. Patients know their needs better than anyone else involved. The report argues that any decision-making or advisory bodies, whether at the state or local level, must have patient representation.

The state is starting to involve patients and their families. For example, the Mental Health Advisory Council represents people from all parts of the system and 10 of its 19 members are patients or family members of patients. The council has made an impact in recommending legislation and educating the Legislature on mental health issues.

Sen. Mignon Waterman, D-Helena, says the state should not jump too quickly into giving the money to the regional centers.

"The centers seem like the logical group to turn into regions," she says. "But until they're willing to put more consumers (patients) on their boards, I'm not ready to let them run the system. They can be a part of it, but we just can't give them money and when they run short give them more."

Each region should have a separate oversight board, Waterman says, with 51 percent membership made up of patients.

"I don't think it should be an exclusive contract with the centers where they are solely deciding what services are needed," she says.
Kathy Bartsch, who suffers from depression and is a member of the board of directors at the Western Montana Mental Health Center, says one danger of a regionalized system is "in-state bus ticket therapy," by which one region sends a difficult patient to another region.

"A problem with regional management is how carefully regions will need to control the funds," she says. "Because if one region screws up treating someone, another region will end up having to pick up the slack."

Meyer points to the Wisconsin system as an example of this problem. In Wisconsin, each county has its own separate mental health center. But this regional system is rife with turf wars.

For example, if a patient gets arrested in one region but lives in another region, which region pays for his treatment?

"The mentally ill are a naturally transient population that hits the major cities like here in Missoula," Meyers says. "When every county or region is its own fiefdom you start getting the smaller regions saying, 'This guy was only here for 12 hours, so send him back.'"

To control the state psychiatric hospital's population as its budget decreases, the system would also have to limit the number of patients a regional center could admit to the hospital.

Meyer and others have suggested that each region, depending on population, gets a certain amount of beds at the state hospital. For example, if one region serves 30 percent of the state's mental health patients, it gets 30 percent of the hospital beds. If the region uses too many beds in a year, it would be responsible for the extra expenses. If the region uses fewer beds than allotted, it could then divert the extra funds to community programs. This would not only keep the state hospital's population from exploding but would give regions fiscal incentives to put every effort into treating their clients in the community.
Ed Amberg, hospital administrator at Warm Springs, says that idea could help stop the “passing the patient” attitude centers now have.

“We would be better managing responsibility at the local level rather than passing it around like we do now,” he says. “I want to see more accountability at the local level because people have a right to live in their community, and we need to help them be as independent as possible.”

Amberg agrees with the regional system and says allotting hospital beds per population is a logical step. But he warns that the hospital will need more autonomy within the system, with a guarantee that the hospital is free to treat the patient as it sees fit and that the hospital gets paid for its services.

“We need to be able to provide services without checking back with the region before doing it,” he says. “We’ve still got to take care of the patient regardless of money disagreements.”

The philosophy behind mental health care, since the Community Mental Health Centers Act of 1963, is to help patients live as independently as possible in their communities. For the regional system to work, it must also provide better transitional services to make a patient’s return from the hospital to the community easier.

The state hopes to create a comfortable transition from institution life to community life with the Program for Assertive Community Treatment, a mobile provider of mental health services that treats patients in their homes and neighborhoods.

The program started in November 1999 with two pilot teams in Helena and Billings. Each program team consists of two therapists, two nurses, a part-time psychiatrist, a vocational-rehabilitation specialist, a chemical dependency counselor and a program assistant. The team treats no more than 60 clients and is available 24 hours a day.

The team monitors medications, provides in-home therapy sessions, teaches clients how to join their community, and even prepares them for job interviews.
“If they need to learn to cook, we’ll teach them to cook,” says Renee Freih, a PACT team member. “But we also consider ourselves a mobile hospital.”

All of PACT’s clients have severe mental illnesses and all have spent some portion of their life in an institution but are stable enough now to live independently. The team meets daily to discuss each patient and provides intense clinical supervision at clients’ homes. The PACT staff also encourage family and friends to become actively involved in the client’s life.

After a year-long pilot program, PACT proved its potential and has been an integral part of the mental health community in Helena ever since.

“I think this is where mental health services are going,” Freih says. “We see people that have spent almost all their life in an institution blossom independently. Traditional case management wouldn’t see that.”

Another program that has had a positive impact on the system is the Mental Health Ombudsman Office. Established in August 1999, the office helps patients solve problems they may have with the mental health system. It also acts as a connection between the “front lines” of mental health and the state government.

Bonnie Adee, the mental health ombudsman, and Brian Garrity, ombudsman program specialist, say their duties continue to expand as they receive more calls asking for help.

Adee has traveled all over the state meeting with mental health professionals and advocates, and creates reports delivered directly to the governor’s office.

Garrity says he has had people call for phone numbers or advice. Once he had an inmate call him who sounded depressed and hopeless.

“So I called the medical staff at the prison and told them this guy might be a potential suicide,” he says. The staff got the inmate into the clinic and probably saved the inmate’s life, Garrity says.
No matter what is done to improve the system, state officials have learned that time is not always a detriment.

"We want to move quickly but we're not going to just dump all of this on a region and say do it," says Poulsen, former chief of the state's Mental Health Services Bureau. "One thing we did learn is to bring these things along. That was our biggest mistake with managed care: We needed to do readiness testing."

For all that is bad with the system, there are still people involved who are fighting to make it work. But to create a system that saves money, keeps those treating the mentally ill happy and helps the patients live as independent a life as they can, a certain amount of trust will have to be included.

"There are no bad guys here," Durand says. "Funding is one piece of it, but trust is the other. In the state of Montana what tends to go on is each side blaming the other side for the problems that exist in the system. We need to presume competence rather than incompetence because that is the big gap in the system."
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