

MONTANA LAW ENFORCEMENT ACADEMY

# MENTAL ILLNESS INTERVENTION

FIELD MANUAL



COVER PHOTO BY SCOTT FELS



MONTANA LAW ENFORCEMENT ACADEMY

# MENTAL ILLNESS INTERVENTION

## FIELD GUIDE



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# INTRODUCTION

The Department of Corrections, Community Corrections Division, the Department of Public Health and Human Services, Addictive and Mental Disorders Division, and the Montana Law Enforcement Academy formed a partnership dedicated to providing the best information to law enforcement officers, detention officers, corrections officers, probation and parole officers, and others involved in responding to or assisting with calls for service involving mental health issues. The partnership has provided training to over 300 officers, and developed this Field Guide to assist officers with their endeavor to interact and effectively assist the person suffering from a mental health issue.

Law enforcement officers respond to calls for service involving mental health issues on a regular basis. Everyone involved in the issue has the expectation that law enforcement officers will be trained to handle each and every situation. There is a need for a comprehensive guide to assist officers in achieving the best possible resolution to each and every situation. The partnership will continue to strive to provide the best information through training and the Field Guide.

Sincerely,

Montana Department of Justice  
Department of Corrections-Community Corrections Division  
Department of Public Health and Human Services-Addictive and Mental Disorders Division  
Montana Law Enforcement Academy

# MENTAL ILLNESS/HEALTH DEFINED

## What is mental illness?

A **medical condition that disrupts** a person’s thinking, feeling, mood, ability to relate to others, and daily functioning.  
A medical condition that **often results in a diminished capacity for coping with the ordinary demands of life.**

## What is mental health?

How a person thinks, feels, and acts when faced with life’s situations. **Mental health** is how people look at themselves, their lives, and the other people in their lives; evaluate their challenges and problems; and explore choices. This includes handling stress, relating to other people, and making decisions.



# LAW ENFORCEMENT RESPONSE

## **IN ROUTE: THE CALL FOR SERVICE**

Dispatchers play an integral role in that they must attempt to obtain as much information as possible about the nature and urgency of the situation.

### **DISPATCHERS MAY BE ABLE TO FIND**

- If there have been past incidents involving the person
- Past incidents involving injury or harm to the individual
- Prior suicide threats
- Reliance on medication
- Failure to take medication
- People who may be able to assist the officer

### **OFFICERS SHOULD REQUEST INFORMATION ON**

- The problem behavior
- The events that may have precipitated the person's behavior, and
- The presence of weapons

### **OFFICERS NEED AS MUCH INFORMATION AS POSSIBLE SO THEY CAN PROPERLY ASSESS AND STABILIZE THE SITUATION.**

## **ARRIVAL**

- Assess the scene and situation
- Upon contact with the person or witnesses, determine if the person presents a danger of death or bodily injury to self or others
- Do not compromise officer safety. There are ways to effectively interact with a person who may have a mental illness without compromising your safety
- Remember the call you were dispatched to is usually a call for help

## **CRISIS INTERVENTION/INTERACTION**

### **OFFICERS SHOULD DO THE FOLLOWING WHEN INTERACTING WITH A PERSON WHO MAY HAVE A MENTAL ILLNESS**

- Remain calm, manage your own emotions
- Be helpful and professional
- Look for medical alert bracelet
- Obtain emergency aid when needed to treat an injury
- Indicate a willingness to understand and help
- Speak simply and briefly

- Move slowly
- Be respectful to the person
- Stay positive
- Be aware of your body language
- Be honest with the person
- Tell the person what you are going to do before doing it

**OFFICERS SHOULD NOT DO THE FOLLOWING**

- Don't move suddenly
- Don't give rapid orders
- Don't shout
- Don't force discussion
- Don't maintain direct eye-contact
- Don't touch the person, unless necessary for safety
- Don't crowd the person or move into their zone of comfort
- Don't express anger, impatience, or irritation
- Don't assume that a person who does not respond cannot hear
- Don't use inflammatory language such as: crazy, psycho, or mental
- Don't challenge delusional or hallucinatory statements
- Don't mislead the person
- Don't try to change the person's beliefs
- Do not threaten the person
- The key to successful management of the encounter is communication

**POST CRISIS INTERACTION, OFFICERS SHOULD CONTINUALLY EVALUATE SEVERAL FACTORS**

- Behavior
- Background
- Support network
- Possible involvement in a crime

**OFFICERS SHOULD EVALUATE THE NATURE OF THE INCIDENT SUCH AS:**

- Reason for law enforcement involvement
- People involved in the incident
- Whether a crime was committed
- Presence of alcohol and/or drugs

**DISPOSITIONS**

- Provide appropriate assistance or counseling
- Counsel, release person on their own, and refer to a mental health

center/advocate/or professional

- Counsel, release to family, friends, or some other support network
- Consult with mental health professional

### **PROTECTIVE CUSTODY**

- If the officer believes the person is in imminent danger of death or bodily harm, or a threat of same to others, take the person into Protective Custody
- A person detained in P.C. must be detained in the least restrictive environment required to protect life and physical safety of the person detained or members of the public
- Least restrictive environment does not include a jail or correctional facility
- The person shall remain in P.C. until evaluated by a professional person, or transported to a medical facility or a mental health facility

### **ARREST**

A person who may have a mental illness may be arrested for a criminal offense when probable cause has been established. When a person arrested is suspected of having a mental illness, the arresting officer should brief the booking officer as to the charges and should advise the booking officer about the suspected mental illness.

#### Arrest, Protective Custody vs Arrest

### **ARREST**

A person who may have a mental illness may be arrested for a criminal offense when probable cause has been established. When a person arrested is suspected of having a mental illness, the arresting officer should brief the booking officer as to the charges and should advise the booking officer about the suspected mental illness.

### **PROTECTIVE CUSTODY vs. ARREST**

If a person is in imminent danger of death or bodily harm, and the person has committed a criminal offense, the officer should take the person into protective custody rather than arrest the person. This situation is based on the type of criminal offense suspected and agency policy.

An officer must evaluate the situation, all facts and circumstances, when making a decision to arrest a person with a suspected mental illness who is in imminent danger to self or others. A jail or correctional facility is not an appropriate place for that person. The decision should be based on the criminal offense and resources available.

## Documentation

A written report should be required on every call for service where the person is suspected of having a mental illness.

- ✓ Documenting the event
- ✓ Statistics
- ✓ Best defense for the officer

The information in a report may be essential in getting the person help. Good reports will benefit the officer, the agency, the family, the mental health professional, and the county attorney.

### **THE WRITTEN REPORT SHOULD INCLUDE ALL INFORMATION**

- ✓ Info from dispatch
- ✓ Type of call for service
- ✓ Info observed upon arrival
- ✓ Info gathered from family, friends, neighbors, witnesses; from anyone who provided you information

### **WRITTEN REPORT**

- ✓ Info observed by the officer
- ✓ Conversation between officer and the person, or the person and others present, exact wording if possible
- ✓ Steps/techniques used to de-escalate the situation

### **WRITTEN REPORT**

- ✓ All signs, symptoms, behaviors, characteristics observed by the officer that made the officer believe the person may have a mental illness
- ✓ Probable cause for an arrest if one is made
- ✓ Elements of the criminal offense

### **WRITTEN REPORT**

- ✓ How the person was transported (patrol vehicle, private vehicle or ambulance)
- ✓ Where the person was transported to
- ✓ Were restraints used?
- ✓ Position of the person during transport

## MAJOR MENTAL ILLNESSES - SIGNS AND SYMPTOMS

### Schizophrenia

The symptoms of schizophrenia fall into three broad categories:

- **Positive symptoms** are unusual thoughts or perceptions, including hallucinations, delusions, thought disorder, and disorders of movement.
- **Negative symptoms** represent a loss or a decrease in the ability to initiate plans, speak, express emotion, or find pleasure in everyday life. These symptoms are harder to recognize as part of the disorder and can be mistaken for laziness or depression.
- **Cognitive symptoms** (or cognitive deficits) are problems with attention, certain types of memory, and the executive functions that allow us to plan and organize. Cognitive deficits can also be difficult to recognize as part of the disorder but are the most disabling in terms of leading a normal life.

Positive symptoms are easy-to-spot behaviors not seen in healthy people and usually involve a loss of contact with reality. They include hallucinations, delusions, thought disorder, and disorders of movement. Positive symptoms can come and go. Sometimes they are severe and at other times hardly noticeable, depending on whether the individual is receiving treatment.

#### *Hallucinations*

A hallucination is something a person sees, hears, smells, or feels that no one else can see, hear, smell, or feel. “Voices” are the most common type of hallucination in schizophrenia. Many people with the disorder hear voices that may comment on their behavior, order them to do things, warn them of impending danger, or talk to each other (usually about the patient). They may hear these voices for a long time before family and friends notice that something is wrong. Other types of hallucinations include seeing people or objects that are not there, smelling odors that no one else detects (although this can also be a symptom of certain brain tumors), and feeling things like invisible fingers touching their bodies when no one is near.

#### *Delusions*

Delusions are false personal beliefs that are not part of the person’s culture and do not change, even when other people present proof that the beliefs are not true or logical. People with schizophrenia can have delusions that are quite bizarre, such as believing that neighbors can control their behavior with magnetic waves, people on television are directing special messages to them,

or radio stations are broadcasting their thoughts aloud to others. They may also have delusions of grandeur and think they are famous historical figures. People with paranoid schizophrenia can believe that others are deliberately cheating, harassing, poisoning, spying upon, or plotting against them or the people they care about. These beliefs are called delusions of persecution.

### ***Thought Disorder***

People with schizophrenia often have unusual thought processes. One dramatic form is disorganized thinking, in which the person has difficulty organizing his or her thoughts or connecting them logically. Speech may be garbled or hard to understand. Another form is “thought blocking,” in which the person stops abruptly in the middle of a thought. When asked why, the person may say that it felt as if the thought had been taken out of his or her head. Finally, the individual might make up unintelligible words, or “neologisms.”

### ***Disorders of Movement***

People with schizophrenia can be clumsy and uncoordinated. They may also exhibit involuntary movements and may grimace or exhibit unusual mannerisms. They may repeat certain motions over and over or, in extreme cases, may become catatonic. Catatonia is a state of immobility and unresponsiveness. It was more common when treatment for schizophrenia was not available. Fortunately, it is now rare.

Negative Symptoms refer to reductions in normal emotional and behavioral states. These include the following:

- flat affect (immobile facial expression, monotonous voice)
- lack of pleasure in everyday life
- diminished ability to initiate and sustain planned activity
- speaking infrequently, even when forced to interact

People with schizophrenia often neglect basic hygiene and need help with everyday activities. Because it is not as obvious that negative symptoms are part of a psychiatric illness, people with schizophrenia are often perceived as lazy and unwilling to better their lives.

Cognitive symptoms are subtle and are often detected only when neuropsychological tests are performed. They include the following:

- poor “executive functioning” (the ability to absorb and interpret information and make decisions based on that information),
- inability to sustain attention, and
- problems with “working memory” (the ability to keep recently learned

information in mind and use it right away)

Cognitive impairments often interfere with the patient’s ability to lead a normal life and earn a living. They can cause great emotional distress.

### Bi-Polar

People with bipolar disorder experience unusually intense emotional states that occur in distinct periods called “mood episodes.” An overly joyful or overexcited state is called a manic episode, and an extremely sad or hopeless state is called a depressive episode. Sometimes, a mood episode includes symptoms of both mania and depression. This is called a mixed state. People with bipolar disorder also may be explosive and irritable during a mood episode.

Extreme changes in energy, activity, sleep, and behavior go along with these changes in mood. It is possible for someone with bipolar disorder to experience a long-lasting period of unstable moods rather than discrete episodes of depression or mania.

A person may be having an episode of bipolar disorder if he or she has a number of manic or depressive symptoms for most of the day, nearly every day, for at least one or two weeks. Sometimes symptoms are so severe that the person cannot function normally at work, school, or home.

*Symptoms of bipolar disorder are described on the next page*

<b>Symptoms of mania or a manic episode include:</b>	<b>Symptoms of depression or a depressive episode include:</b>
<p><b>Mood Changes</b></p> <ul style="list-style-type: none"> <li>• A long period of feeling “high,” or an overly happy or outgoing mood</li> <li>• Extremely irritable mood, agitation, feeling “jumpy” or “wired.”</li> </ul> <p><b>Behavioral Changes</b></p> <ul style="list-style-type: none"> <li>• Talking very fast, jumping from one idea to another, having racing thoughts</li> <li>• Being easily distracted</li> <li>• Increasing goal-directed activities, such as taking on new projects</li> <li>• Being restless</li> <li>• Sleeping little</li> <li>• Having an unrealistic belief in one’s abilities</li> <li>• Behaving impulsively and taking part in a lot of pleasurable, high-risk behaviors, such as spending sprees, impulsive sex, and impulsive business investments.</li> </ul>	<p><b>Mood Changes</b></p> <ul style="list-style-type: none"> <li>• A long period of feeling worried or empty</li> <li>• Loss of interest in activities once enjoyed, including sex.</li> </ul> <p><b>Behavioral Changes</b></p> <ul style="list-style-type: none"> <li>• Feeling tired or “slowed down”</li> <li>• Having problems concentrating, remembering, and making decisions</li> <li>• Being restless or irritable</li> <li>• Changing eating, sleeping, or other habits</li> <li>• Thinking of death or suicide, or attempting suicide.</li> </ul>

In addition to mania and depression, bipolar disorder can cause a range of moods, as shown on this scale:



One side of the scale includes severe depression, moderate depression, and mild low mood. Moderate depression may cause less extreme symptoms, and mild low mood is called dysthymia when it is chronic or long-term. In the middle of the scale is normal or balanced mood.

At the other end of the scale are hypomania and severe mania. Some people with bipolar disorder experience hypomania. During hypo manic episodes, a person may have increased energy and activity levels that are not as severe as typical mania, or he or she may have episodes that last less than a week and do not require emergency care. A person having a hypo manic episode may feel very good, be highly productive, and function well. This person may not feel that anything is wrong even as family and friends recognize the mood swings as possible bipolar disorder. Without proper treatment, however, people with hypomania may develop severe mania or depression.

During a mixed state, symptoms often include agitation, trouble sleeping, major changes in appetite, and suicidal thinking. People in a mixed state may feel very sad or hopeless while feeling extremely energized.

Sometimes, a person with severe episodes of mania or depression has psychotic symptoms too, such as hallucinations or delusions. The psychotic symptoms tend to reflect the person's extreme mood. For example, psychotic symptoms for a person having a manic episode may include believing he or she is famous, has a lot of money, or has special powers. In the same way, a person having a depressive episode may believe he or she is ruined and penniless, or has committed a crime. As a result, people with bipolar disorder who have psychotic symptoms are sometimes wrongly diagnosed as having schizophrenia, another severe mental illness that is linked with hallucinations and delusions.

People with bipolar disorder may also have behavioral problems. They may abuse alcohol or substances, have relationship problems, or perform poorly in school or at work. At first, it's not easy to recognize these problems as signs of a major mental illness.

## Major Depression

There are several forms of depressive disorders. The most common are major depressive disorder and dysthymic disorder.

Major depressive disorder, also called major depression, is characterized by a combination of symptoms that interfere with a person's ability to work, sleep, study, eat, and enjoy once-pleasurable activities. Major depression is disabling and prevents a person from functioning normally. An episode of major depression may occur only once in a person's lifetime, but more often, it recurs throughout a person's life.

Dysthymic disorder, also called dysthymia, is characterized by long-term (two years or longer) but less severe symptoms that may not disable a person but can prevent one from functioning normally or feeling well. People with dysthymia may also experience one or more episodes of major depression during their lifetimes.

Some forms of depressive disorder exhibit slightly different characteristics than those described above, or they may develop under unique circumstances. However, not all scientists agree on how to characterize and define these forms of depression. They include:

- Psychotic depression, which occurs when a severe depressive illness is accompanied by some form of psychosis, such as a break with reality, hallucinations, and delusions.
- Postpartum depression, which is diagnosed if a new mother develops a major depressive episode within one month after delivery. It is estimated that 10 to 15 percent of women experience postpartum depression after giving birth.
- Seasonal affective disorder (SAD), which is characterized by the onset of a depressive illness during the winter months, when there is less natural sunlight. The depression generally lifts during spring and summer. SAD may be effectively treated with light therapy, but nearly half of those with SAD do not respond to light therapy alone. Antidepressant medication and psychotherapy can reduce SAD symptoms, either alone or in combination with light therapy.

# SUICIDE INTERVENTION & PREVENTION

Montana Suicide Prevention Lifeline

1-800-273-TALK

## Be Aware of the Warning Signs

- Someone threatening to hurt or kill themselves, or talking of wanting to hurt or kill themselves.
- Someone looking for ways to kill themselves by seeking access to fire-arms, available pills, or other means.
- Someone talking or writing about death, dying or suicide, when these actions are out of the ordinary for the person.
- Hopelessness
- Rage, uncontrolled anger, seeking revenge
- Acting reckless or engaging in risky activities, seemingly without thinking
- Increased alcohol or drug use.
- Withdrawing from friends, family and society.
- Anxiety, agitation, unable to sleep or sleeping all the time
- Dramatic mood changes.
- No reason for living; no sense of purpose in life
- Feeling trapped – like there’s no way out

## Be Aware of the Facts

- Suicide is preventable
- Most suicidal individuals desperately want to live; they are just unable to see alternatives to their problems
- Most suicidal individuals give definite warnings of their suicidal intentions, but others are either unaware of the significance of these warnings or do not know how to respond to them

## Be Aware of Feelings, Thoughts and Behaviors

Nearly everyone at some time in his or her life thinks about suicide. Most everyone decides to live because they come to realize that the crisis is temporary, but death is not.

On the other hand, people in the midst of a crisis often perceive their dilemma as inescapable and feel an utter loss of control.

**Be Aware, Frequently a Person Cannot...**

- stop the pain
- think clearly
- make decisions
- see any way out
- sleep, eat or work
- get out of the depression
- make the sadness go away
- see the possibility of change
- see themselves as worthwhile
- get someone’s attention
- seem to get control

**Ways to be Helpful to Someone Who is Threatening Suicide**

- Be aware. Learn the warning signs.
- Get involved. Become available. Show interest and support.
- Ask if he/she is thinking about suicide.
- Be direct. Talk openly and freely about suicide.
- Be willing to listen. Allow for expression of feelings. Accept the feelings.
- Be non-judgmental. Don’t debate whether suicide is right or wrong, or feelings are good or bad. Don’t lecture on the value of life.
- Don’t dare the person to do it.
- Don’t give advice by making decisions for someone else to tell them to behave differently
- Don’t act shocked. This creates distance.
- Don’t be sworn to secrecy. Seek support.
- Don’t ask ‘why’. This encourages defensiveness.
- Offer empathy, not sympathy.
- Take action! Remove means! Get help from individuals or agencies specializing in crisis intervention and suicide prevention
- Offer hope that alternatives are available, do not offer glib reassurance; it only proves you don’t understand

**Intervention**

- Ask the question...
- Assist the person with obtaining professional help
- Take care of yourself and your co-workers.
- Watch for warning signs
- Be there if someone needs a little help
- Be committed to provide help



## **DID YOU KNOW?**

**Myth** - No one can stop a suicide, it is inevitable.

**Fact** - If people in a crisis get the help they need, they will probably never be suicidal again.

**Myth** - Confronting a person about suicide will only make them angry and increase the risk of suicide.

**Fact** - Asking someone directly about suicidal intent lowers anxiety, opens up communication and lowers the risk of an impulsive act.

**Myth** - Only experts can prevent suicide.

**Fact** - Suicide prevention is everybody's business, and anyone can help prevent the tragedy of suicide

**Myth** - Suicidal people keep their plans to themselves.

**Fact** - Most suicidal people communicate their intent sometime during the week preceding their attempt.

**Myth** - Those who talk about suicide don't do it.

**Fact** - People who talk about suicide may try, or even complete, an act of self-destruction.

**Myth** - Once a person decides to complete suicide, there is nothing anyone can do to stop them.

**Fact** - Suicide is the most preventable kind of death, and almost any positive action may save a life.

Talking about suicide does not cause someone to be suicidal.

## PSYCHOTROPIC MEDICATIONS

Antipsychotics (used in the treatment of schizophrenia and Mani)	Anti-depressants	Anti-Obsessive Agents
Typical Antipsychotics	Tricyclics	
Haldol (haloperidol)	Anafranil (clomipramine)	Anafranil (clomipramine)
Loxitane (loxapine)	Asendin (amoxapine)	Luvox (fluvoxamine)
Mellaril (thioridazine)	Elavil (amitriptyline)	Paxil (paroxetine)
Moban (molindone)	Norpramin (desipramine)	Prozac (fluoxetine)
Navane (thiothixene)	Pamelor (nortriptyline)	Zoloft (sertraline)
Prolixin (fluphenazine)	Sinequan (doxepin)	
Serentil (mesoridazine)	Surmontil (trimipramine)	<b>Anti-anxiety Agents</b>
Stelazine (trifluoperazine)	Tofranil (imipramine)	Aivan (lorazepam)
Thorazine (chlorpromazine)	Vivactil (protriptyline)	BuSpar (buspirone)
Trilafon (perphenazine)		Centrax (prazepam)
	<b>SSRIs</b>	Inderal (propranolol)
Atypical Antipsychotics	Celexa (citalopram)	Klonopin (clonazepam)
Abilify (aripiprazole)	Lexapro (escitalopram)	Lexapro (escitalopram)
Clozaril (clozapine)	Luvox (fluvoxamine)	Librium (chlordiazepoxide)
Geodon (ziprasidone)	Paxil (paroxetine)	Serax (oxazepam)
Risperdal (risperidone)	Prozac (fluoxetine)	Tenormin (atenolol)
Seroquel (quetiapine)	Zoloft (sertraline)	Tranxene (clorazepate)
Zyprexa (olanzapine)		Valium (diazepam)
	<b>MAOIs</b>	Xanax (alprazolam)
<b>Mood Stabilizers (used in the treatment of bipolar disorder)</b>	Nardil (phenelzine) Parnate (tranylcypromine)	
Depakene (valproic acid)	<b>Others</b>	<b>Stimulants (used in the treatment of ADHD)</b>
Eskalith	Desyrel (trazadone)	Adderall (amphetamine and dextroamphetamine)
Lithobid (lithium)	Effexor (venlafaxine)	Cylert (pemoline)
Lithonate	Remeron (mirtazapine)	Dexedrine (dextroamphetamine)
Lithotabs	Serzone (nefazodone)	Ritalin (methylphenidate)
Lamictal (lamotrigine)	Wellbutrin (bupropion)	
Neurontin (gabapentin)	<b>Anti-Panic Agents</b>	
Tegretol (carbamazepine)	Klonopin (clonazepam)	
Topamax (topiramate)	Paxil (paroxetine)	
	Xanax (alprazolam)	
	Zoloft (sertraline)	

## MAJOR MENTAL ILLNESSES - DEFINITIONS/CAUSE

### MAJOR MENTAL ILLNESSES

#### **Schizophrenia**

Definition – a chronic, severe and disabling brain disorder. It interferes with a person’s ability to think clearly, to distinguish reality from fantasy, to manage emotions, make decisions, and relate to others. Most people contend with the illness chronically or episodically throughout their lives, and are often stigmatized by a lack of public understanding about the disease.

Cause – scientists still do not know the specific cause. It is believed to result from a combination of environmental and genetic factors. Onset usually between 17 and 23.

#### **Bi-polar or manic depression**

Definition – brain disorder that causes unusual shifts in a person’s mood, energy, and ability to function.

Cause – exact cause is not known. Most scientists believe that it is caused by multiple factors that interact with each other to produce a chemical imbalance affecting certain parts of the brain.

#### **Major depression**

Definition – is persistent and interferes with a person’s ability to work, sleep, study, eat, and enjoy once pleasurable activities

Cause – there is no single cause. Psychological, biological, and environmental factors may all contribute to its development.

### ANXIETY DISORDERS

#### **Generalized anxiety disorder**

Definition - a disorder characterized by chronic anxiety, exaggerated worry and tension, even when there is little or nothing to provoke it.

#### **Obsessive-compulsive disorder**

Definition - an anxiety disorder characterized by recurrent, unwanted thoughts (obsessions) and/or repetitive behaviors (compulsions). Repetitive behaviors such as hand washing, counting, checking, or cleaning are often performed with the hope of preventing obsessive thoughts or making them go away. Performing these so-called “rituals,” however, provides only temporary relief, and not performing them markedly increases anxiety.

**Panic disorder**

Definition - an anxiety disorder characterized by unexpected and repeated episodes of intense fear accompanied by physical symptoms that may include chest pain, heart palpitations, and shortness of breath, dizziness, or abdominal distress.

**Post traumatic stress disorder**

Definition - an anxiety disorder that can develop after exposure to a terrifying event or ordeal in which grave physical harm occurred or was threatened. Traumatic events that may trigger PTSD include violent personal assaults, natural or human-caused disasters, accidents, or military combat. The traumatic event is persistently re-experienced in one or more of the following ways; recurrent and intrusive recollections of the event, recurrent distressing dreams of the event, acting or feeling as if the event were recurring (such as hallucinations, flashbacks), intense psychological distress to cues that resemble the event, psychological reactivity on exposure to cues that resemble the event. Persistent avoidance of stimuli associated with the trauma resulting in numbing of responsiveness, as indicated by some or all of the following; efforts to avoid thoughts or feelings associated with the trauma, efforts to avoid activities, places or people that remind the person of the trauma, inability to recall important aspects of the trauma, diminished interest in significant activities, feelings of detachment or estrangement from others, restricted range of affect, sense of foreshortened future. Persistent symptoms of increased arousal, as indicated by some or all of the following; difficulty falling or staying asleep, irritability or outbursts of anger, difficulty concentrating, hypervigilance, exaggerated startle response.

**Social Phobia or Social Anxiety Disorder**

Definition - a disorder characterized by overwhelming anxiety and excessive self-consciousness in everyday social situations. Social phobia can be limited to only one type of situation — such as a fear of speaking in formal or informal situations, or eating or drinking in front of others — or, in its most severe form, may be so broad that a person experiences symptoms almost anytime they are around other people.

**EATING DISORDERS****Anorexia Nervosa**

Definition - characterized by emaciation, a relentless pursuit of thinness and unwillingness to maintain a normal or healthy weight, a distortion of body image and intense fear of gaining weight, a lack of menstruation among girls and women, and extremely disturbed eating behavior. Some people with anorexia lose weight by dieting and exercising excessively; others lose weight by self-induced vomiting, or misusing laxatives, diuretics or enemas. Many people with anorexia see themselves as overweight, even when they are starved or are clearly malnourished. Eating, food

and weight control become obsessions. A person with anorexia typically weighs herself or himself repeatedly, portions food carefully, and eats only very small quantities of only certain foods. Some who have anorexia recover with treatment after only one episode. Others get well but have relapses. Still others have a more chronic form of anorexia, in which their health deteriorates over many years as they battle the illness. According to some studies, people with anorexia are up to ten times more likely to die as a result of their illness compared to those without the disorder. The most common complications that lead to death are cardiac arrest, and electrolyte and fluid imbalances. Suicide also can result. Many people with anorexia also have coexisting psychiatric and physical illnesses, including depression, anxiety, obsessive behavior, substance abuse, cardiovascular and neurological complications, and impaired physical development.

Other symptoms may develop over time, including:

- thinning of the bones (osteopenia or osteoporosis)
- brittle hair and nails
- dry and yellowish skin
- growth of fine hair over body (e.g., lanugo)
- mild anemia, and muscle weakness and loss
- severe constipation
- low blood pressure, slowed breathing and pulse
- drop in internal body temperature, causing a person to feel cold all the time
- lethargy

### **Bulimia Nervosa**

Definition - characterized by recurrent and frequent episodes of eating unusually large amounts of food (e.g., binge-eating), and feeling a lack of control over the eating. This binge-eating is followed by a type of behavior that compensates for the binge, such as purging (e.g., vomiting, excessive use of laxatives or diuretics), fasting and/or excessive exercise. Unlike anorexia, people with bulimia can fall within the normal range for their age and weight. But like people with anorexia, they often fear gaining weight, want desperately to lose weight, and are intensely unhappy with their body size and shape. Usually, bulimic behavior is done secretly, because it is often accompanied by feelings of disgust or shame. The binging and purging cycle usually repeats several times a week. Similar to anorexia, people with bulimia often have coexisting psychological illnesses, such as depression, anxiety and/or substance

abuse problems. Many physical conditions result from the purging aspect of the illness, including electrolyte imbalances, gastrointestinal problems, and oral and tooth-related problems.

Other symptoms include:

- chronically inflamed and sore throat
- swollen glands in the neck and below the jaw
- worn tooth enamel and increasingly sensitive and decaying teeth as a result of exposure to stomach acids
- gastro esophageal reflux disorder
- intestinal distress and irritation from laxative abuse
- kidney problems from diuretic abuse
- severe dehydration from purging of fluids

### **Binge Eating Disorder**

Definition - characterized by recurrent binge-eating episodes during which a person feels a loss of control over his or her eating. Unlike bulimia, binge-eating episodes are not followed by purging, excessive exercise or fasting. As a result, people with binge-eating disorder often are overweight or obese. They also experience guilt, shame and/or distress about the binge-eating, which can lead to more binge-eating. Obese people with binge-eating disorder often have coexisting psychological illnesses including anxiety, depression, and personality disorders. In addition, links between obesity and cardiovascular disease and hypertension are well documented.

## **PERSONALITY DISORDERS**

Personality disorders are defined as an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture.

1. cognition (ways of perceiving and interpreting self, other people and events)
2. affectivity (the range, intensity, lability, and appropriateness of emotional response)
3. interpersonal functioning
4. impulse control

This pattern leads to distress or impairment in social, occupational, or other important areas of functioning. The pattern is of long duration.

Personality disorders are categorized into three groups;

**CLUSTER I**

**Paranoid Personality Disorder**

- A pervasive distrust and suspiciousness of others
- Suspects others are exploiting, harming, or deceiving him or her
- Is preoccupied with unjustified doubts about loyalty or trustworthiness
- Fearful that information will be used maliciously against him or her
- Believes attacks are being made on his or her character.

**Schizoid Personality Disorder**

- A pattern of detachment from social relationships and a restricted range of expression of emotions in interpersonal settings
- Does not enjoy or seek out close relationships and is generally isolated, is not involved in many activities, detached

**Schizotypal Personality Disorder**

- A pattern of social and interpersonal deficits
- Delusional
- Odd thinking and speech, vague and meaningless
- Suspiciousness or paranoid
- Behavior or appearance that is odd, eccentric or peculiar

**CLUSTER II**

**Antisocial Personality Disorder**

- There is a pattern of disregard for and violation of the rights of others
- Failure to conform to social norms with respect to lawful behaviors as indicated by repeatedly performing acts that are grounds for arrest
- Deceitfulness, as indicated by repeated lying, use of aliases, or conning others for personal profit or pleasure
- Impulsivity or failure to plan ahead
- Irritability and aggressiveness, as indicated by repeated physical fights or assaults
- Reckless disregard for safety of self or others

- Consistent irresponsibility, as indicated by repeated failure to sustain consistent work behavior or honor financial obligations
- Lack of remorse, as indicated by being indifferent to or rationalizing having hurt, mistreated, or stolen from another

**Borderline Personality Disorder**

- A pattern of problems in interpersonal relationships, self-image and affects
- Efforts to avoid real or imagined abandonment
- Unstable and intense interpersonal relationships alternating between extremes of idealization and devaluation
- Impulsivity
- Recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior
- Affective instability (intense episodic sadness, irritability, or anxiety usually lasting a few hours and only rarely more than a few days)
- Chronic feelings of emptiness
- Inappropriate, intense anger or difficulty controlling anger (frequent displays of temper, constant anger, recurrent physical fights)

**Histrionic Personality Disorder**

- A pattern of excessive emotionality and attention seeking center of attention
- Shallow expression of emotions
- Has a style of speech that is excessively impressionistic and lacking in detail
- Shows self-dramatization, theatricality, and exaggerated expression of emotion
- Is suggestible, easily influenced by others or circumstances

**Narcissistic Personality Disorder**

- A pattern of grandiosity, need for admiration, and lack of empathy
- Has a grandiose sense of self-importance
- Is preoccupied with fantasies of success, power, brilliance, beauty, or ideal love
- Has a sense of entitlement
- Is interpersonally exploitative
- Lacks empathy – is unwilling to recognize or identify with the feelings and needs of others

### **CLUSTER III**

#### **Avoidant Personality Disorder**

- A pattern of social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation
- Avoids
- Is unwilling to get involved with people
- Views self as socially inept, personally unappealing, or inferior to others

#### **Dependent Personality Disorder**

- A pervasive and excessive need to be taken care of that leads to submissive and clinging behavior and fears of separation
- Has difficulty making everyday decisions
- Has difficulty expressing disagreement with others
- Goes to excessive lengths to obtain nurturance and support from others
- Feels uncomfortable or helpless when alone because of exaggerated fears of being unable to care for himself or herself
- Urgently seeks another relationship as a source of care and support when a close relationship ends

### **AUTISM SPECTRUM DISORDER**

Autism Spectrum Disorders (ASD), also known as Pervasive Developmental Disorders (PDDs), cause severe and pervasive impairment in thinking, feeling, language, and the ability to relate to others. These disorders are usually first diagnosed in early childhood and range from a severe form, called autistic disorder, through pervasive development disorder not otherwise specified (PDD-NOS), to a much milder form, Asperger syndrome. They also include two rare disorders, Rett syndrome and childhood disintegrative disorder.

Signs & Symptoms - Parents are usually the first to notice unusual behaviors in their child. In some cases, the baby seemed “different” from birth, unresponsive to people or focusing intently on one item for long periods of time. The first signs of an autism spectrum disorder can also appear in children who had been developing normally. When an affectionate, babbling toddler suddenly becomes silent, withdrawn, self-abusive, or indifferent to social overtures, something is wrong.

## MONTANA LAWS

**53-21-102. Definitions.** As used in this part, the following definitions apply:

(1) “Abuse” means any willful, negligent, or reckless mental, physical, sexual, or verbal mistreatment or maltreatment or misappropriation of personal property of any person receiving treatment in a mental health facility that insults the psychosocial, physical, or sexual integrity of any person receiving treatment in a mental health facility.

(2) “Behavioral health inpatient facility” means a facility or a distinct part of a facility of 16 beds or less licensed by the department that is capable of providing secure, inpatient psychiatric services, including services to persons with mental illness and co-occurring chemical dependency.

(3) “Board” or “mental disabilities board of visitors” means the mental disabilities board of visitors created by 2-15-211.

(4) “Commitment” means an order by a court requiring an individual to receive treatment for a mental disorder.

(5) “Court” means any district court of the state of Montana.

(6) “Department” means the department of public health and human services provided for in 2-15-2201.

(7) ***“Emergency situation” means a situation in which any person is in imminent danger of death or bodily harm from the activity of a person who appears to be suffering from a mental disorder and appears to require commitment.***

(8) “Friend of respondent” means any person willing and able to assist a person suffering from a mental disorder and requiring commitment or a person alleged to be suffering from a mental disorder and requiring commitment in dealing with legal proceedings, including consultation with legal counsel and others. The friend of respondent may be the next of kin, the person’s conservator or legal guardian, if any, representatives of a charitable or religious organization, or any other person appointed by the court to perform the functions of a friend of respondent set out in this part. Only one person may at any one time be the friend of respondent within the meaning of this part. In appointing a friend of respondent, the court shall consider the preference of the respondent. The court may at any time, for good cause, change its designation of the friend of respondent.

(9) (a) “Mental disorder” means any organic, mental, or emotional impairment that has substantial adverse effects on an individual’s cognitive or volitional functions.

(b) The term does not include:

- (i) addiction to drugs or alcohol;
- (ii) drug or alcohol intoxication;
- (iii) mental retardation; or
- (iv) epilepsy.

(c) A mental disorder may co-occur with addiction or chemical dependency.

(10) “Mental health facility” or “facility” means the state hospital, the Mon-

tana mental health nursing care center, or a hospital, a behavioral health inpatient facility, a mental health center, a residential treatment facility, or a residential treatment center licensed or certified by the department that provides treatment to children or adults with a mental disorder. A correctional institution or facility or jail is not a mental health facility within the meaning of this part.

(11) “Mental health professional” means:

- (a) a certified professional person;
- (b) a physician licensed under Title 37, chapter 3;
- (c) a professional counselor licensed under Title 37, chapter 23;
- (d) a psychologist licensed under Title 37, chapter 17;
- (e) a social worker licensed under Title 37, chapter 22; or
- (f) an advanced practice registered nurse, as provided for in 37-8-202, with a clinical specialty in psychiatric mental health nursing.

(12) (a) “Neglect” means failure to provide for the biological and psychosocial needs of any person receiving treatment in a mental health facility, failure to report abuse, or failure to exercise supervisory responsibilities to protect patients from abuse and neglect.

(b) The term includes but is not limited to:

- (i) deprivation of food, shelter, appropriate clothing, nursing care, or other services;
- (ii) failure to follow a prescribed plan of care and treatment; or
- (iii) failure to respond to a person in an emergency situation by indifference, carelessness, or intention.

(13) “Next of kin” includes but is not limited to the spouse, parents, adult children, and adult brothers and sisters of a person.

(14) “Patient” means a person committed by the court for treatment for any period of time or who is voluntarily admitted for treatment for any period of time.

(15) “Peace officer” means any sheriff, deputy sheriff, marshal, police officer, or other peace officer.

(16) “Professional person” means:

- (a) a medical doctor;
- (b) an advanced practice registered nurse, as provided for in 37-8-202, with a clinical specialty in psychiatric mental health nursing;
- (c) a licensed psychologist; or
- (d) a person who has been certified, as provided for in 53-21-106, by the department.

(17) “Reasonable medical certainty” means reasonable certainty as judged by the standards of a professional person.

(18) “Respondent” means a person alleged in a petition filed pursuant to this part to be suffering from a mental disorder and requiring commitment.

(19) “State hospital” means the Montana state hospital.

**History:** Ap. p. 38-1302 by Sec. 2, Ch. 466, L. 1975; amd. Sec. 9, Ch. 37, L. 1977; amd. Sec. 2, Ch. 546, L. 1977; Sec. 38-1302, R.C.M. 1947; (15)En. 38-106.1 by Sec. 3, Ch. 120, L. 1974; Sec. 38-106.1, R.C.M. 1947; R.C.M. 1947, 38-106.1, 38-1302; amd. Sec. 1, Ch. 547, L. 1979; amd. Sec. 18, Ch. 361, L. 1983; amd. Sec. 1, Ch. 578, L. 1983; amd. Sec. 1, Ch. 376, L. 1987; amd. Sec. 1, Ch. 262, L. 1991; amd. Sec. 1, Ch. 312, L. 1993; amd. Sec. 486, Ch. 546, L. 1995; amd. Sec. 15, Ch. 490, L. 1997; amd. Sec. 2, Ch. 310, L. 2001; amd. Sec. 6, Ch. 342, L. 2001; amd. Sec. 2, Ch. 344, L. 2001; amd. Sec. 3, Ch. 513, L. 2003; amd. Sec. 1, Ch. 81, L. 2005; amd. Sec. 1, Ch. 71, L. 2007; amd. Sec. 1, Ch. 116, L. 2007.

**53-21-120. Detention to be in least restrictive environment -- preference for mental health facility -- court relief -- prehearing detention of mentally ill person prohibited.**

(1) A person detained pursuant to this part must be detained in the least restrictive environment required to protect the life and physical safety of the person detained or members of the public; in this respect, prevention of significant injury to property may be considered.

(2) Whenever possible, a person detained pursuant to this part must be detained in a mental health facility and in the county of residence. If the person detained demands a jury trial and the trial cannot be held within 7 days, subject to the provisions in 53-21-193, the individual may be sent to the state hospital or a behavioral health inpatient facility until the time of trial if arrangements can be made to return the person to trial. The trial must be held within 30 days. The county of residence shall pay the cost of travel and professional services associated with the trial. A person may not be detained in any hospital or other medical facility that is not a mental health facility unless the hospital or facility has agreed in writing to admit the person.

(3) A person may not be detained pursuant to this part in a jail or other correctional facility.

(4) A person detained prior to involuntary commitment may apply to the court for immediate relief with respect to the need for detention or the adequacy of the facility being utilized to detain.

**History:** En. 38-1304 by Sec. 4, Ch. 466, L. 1975; amd. Sec. 4, Ch. 546, L. 1977; R.C.M. 1947, 38-1304(5); amd. Sec. 7, Ch. 547, L. 1979; amd. Sec. 5, Ch. 376, L. 1987; amd. Sec. 1, Ch. 360, L. 1989; amd. Sec. 1, Ch. 636, L. 1991; amd. Sec. 4, Ch. 513, L. 2003.

**53-21-129. Emergency situation -- petition -- detention.**

(1) *When an emergency situation exists, a peace officer may take any person who appears to have a mental disorder and to present an imminent danger of*

*death or bodily harm to the person or to others into custody only for sufficient time to contact a professional person for emergency evaluation. If possible, a professional person should be called prior to taking the person into custody.*

(2) If the professional person agrees that the person detained is a danger to the person or to others because of a mental disorder and that an emergency situation exists, then the person may be detained and treated until the next regular business day. At that time, the professional person shall release the detained person or file findings with the county attorney who, if the county attorney determines probable cause to exist, shall file the petition provided for in 53-21-121 through 53-21-126 in the county of the respondent’s residence. In either case, the professional person shall file a report with the court explaining the professional person’s actions.

(3) The county attorney of a county may make arrangements with a federal, state, regional, or private mental facility or with a mental health facility in a county for the detention of persons held pursuant to this section. If an arrangement has been made with a facility that does not, at the time of the emergency, have a bed available to detain the person at that facility, the person may be transported to the state hospital or to a behavioral health inpatient facility, subject to 53-21-193 and subsection (4) of this section, for detention and treatment as provided in this part. This determination must be made on an individual basis in each case, and the professional person at the local facility shall certify to the county attorney that the facility does not have adequate room at that time.

(4) Before a person may be transferred to the state hospital or to a behavioral health inpatient facility under this section, the state hospital or the behavioral health inpatient facility must be notified prior to transfer and shall state whether a bed is available for the person. If the professional person determines that a behavioral health inpatient facility is the appropriate facility for the emergency detention and a bed is available, the county attorney shall direct the person to the appropriate facility to which the person must be transported for emergency detention.

History: En. 38-1307 by Sec. 7, Ch. 466, L. 1975; amd. Sec. 7, Ch. 546, L. 1977; R.C.M. 1947, 38-1307; amd. Sec. 1, Ch. 560, L. 1983; amd. Sec. 25, Ch. 490, L. 1997; amd. Sec. 7, Ch. 513, L. 2003; amd. Sec. 2, Ch. 116, L. 2007.

**53-21-138. Diversion of certain persons suffering from mental disorders from detention center.**

(1) The sheriff or administrator of a detention center in each county shall require screening of inmates to identify persons accused of minor misdemeanor offenses who appear to be suffering from mental disorders and who may require commitment, as defined in 53-21-102.

(2) If as a result of screening and observation it is believed that an inmate is suffering from a mental disorder and may require commitment, the sheriff or administrator of the detention center shall:

(a) request services from a crisis intervention program established by the department, as provided for in 53-21-139;

(b) refer the inmate to the nearest qualified mental health care provider as arranged by the county; or

(c) subject to 53-21-193 and subsection (3) of this section, transfer the inmate to a private mental health facility, a behavioral health inpatient facility, or a hospital equipped to provide treatment and care of persons who are suffering from a mental disorder and who require commitment.

(3) The facility must be notified, and the facility shall state that a bed is available and agree to accept transfer of the patient based on admission criteria before a person may be transferred under this section.

(4) As used in this section, the term “minor misdemeanor offense” includes but is not limited to a nonserious misdemeanor, such as criminal trespass to property, loitering, disorderly conduct, and disturbing the public peace.

(5) A person intoxicated by drugs or alcohol who is accused of a minor misdemeanor offense may be detained in a jail until the level of intoxication is reduced to the point that screening for a mental disorder and the need for commitment can be performed.

History: En. Sec. 3, Ch. 636, L. 1991; amd. Sec. 2, Ch. 312, L. 1993; amd. Sec. 488, Ch. 546, L. 1995; amd. Sec. 28, Ch. 490, L. 1997; amd. Sec. 4, Ch. 247, L. 1999; amd. Sec. 8, Ch. 513, L. 2003; amd. Sec. 4, Ch. 561, L. 2003; amd. Sec. 14, Ch. 602, L. 2003.

# RESOURCES

## SUICIDE PREVENTION & INTERVENTION

MT Suicide Prevention Lifeline **1-800-273-TALK (1-800-273-8255)**

**TTY: 1-800-799-4TTY (4889).**

- Helpline Mental Health Center, Billings (406) 252-5658
- The Community Crisis Center, Billings, 704 N 30th, MT 59102, (406) 259-8800
- Voices of Hope, Great Falls, North Central and North East Montana, (406) 268-1330
- The Help Center, Bozeman, South Central and South East Montana, (406) 586-3333
- District XI Human Resource Council, Missoula, South West Montana, (406)728-3710
- United Way of NW Montana, North West Montana, (406) 752-7266
- Center for Mental Health, Helena, (406) 443-5353
- Gilder House Crisis Line, Butte, (406) 723-7995

**MT Warm Line 1-877-688-3377**

Mon – Fri: 5:30 – 9:30 PM

Saturday: 1:00 – 5:00 PM

Do you need someone understanding to talk to? The Warm Line is staffed by mental health consumers, *ready to listen.*

## STATE FACILITIES

**MT State Hospital**, Warm Springs: (406) 693-7000

**MT Chemical Dependency Center**, Butte: (406) 496-5400

Butte, MT

**MT Mental Health Nursing Care Center**, Lewistown: (406) 538-7451

## MENTAL HEALTH CENTERS

### CENTER FOR MENTAL HEALTH (CMH)—CENTRAL MONTANA COMMUNITY MENTAL HEALTH SERVICES

**Administration—Great Falls (CMH)**

621 1st Ave S—Great Falls, MT

**771-8648**

**Conrad Center for Mental Health (CMH)**

514 S Front St—Conrad, MT 59425

**278-3205**

**Boulder Center for Mental Health (CMH)**

106 N Main—PO Box 420—Boulder, MT 59632

**(406) 225-9114**

**(406) 225-3379 Fax**

**Cut Bank Center for Mental Health (CMH)**

Courthouse Annex—1210 E Main—Cut Bank, MT 59427

**873-5538**

**873-3348 Fax**

**Browning: Blackfeet Adult Day Treatment (CMH)**

Quarters #56, Government Square—PO Box 2009—Browning  
MT 58417

**338-5566**

**Great Falls (CMH)**

**Center For Mental Health** (outpatient)

915 1st Ave S—Great Falls, MT 59401

**771-8648**

**Chinook Center For Mental Health (CMH)**

301 Indiana—PO Box 939—Chinook, MT 59523

**357-3364**

**357-2934—FAX**

**New Directions (outpatient)**

621 1st Ave S—Great Falls, MT 59401

**761-2104**

**Choteau Center for Mental Health (CMH)**

19 3<sup>rd</sup> Street NE—Choteau, MT 59422

**466-5681**

**Passages**

704 5th Ave N—Great Falls, MT 59401

**727-7586**

**Langel House (residential)**  
1109 2nd Ave N—Great Falls, MT 59401  
**452-3354**

**Gateway (residential)**  
1118 1st Ave N—Great Falls, MT 59401  
**453-2906**

**PACT**  
513 1st Ave S—Great Falls, MT 59401  
**727-4315**

**Havre (CMH)**  
**Center For Mental Health**  
312 3rd St.—PO Box 1658—Havre, MT 59501  
**265-6771**  
**265-6771 Fax**

**Havre Adult Day Treatment**

**Center for Mental Health**  
900 N Jackson—Helena, MT 59601  
**443-7151**  
**443-3420 Fax**  
**1-888-442-5353 Emergency**

**Helena (CMH)**  
**Care House** (crisis residential)

**Hanniford House--residential**  
925 N Hannaford St—Helena, MT 59601  
**449-5650**

**PACT**  
24 E 16th—Helena, MT 59601  
**495-8545**

**Shelby Center for Mental Health (CMH)**  
301 1st Street—Shelby, MT 59501  
**434-5285**  
**434-5240—FAX**

**Townsend Center for Mental Health**  
417 Broadway—Townsend, MT 59644  
**266-3327**

**SOUTH CENTRAL MONTANA COMMUNITY MENTAL HEALTH SERVICES  
(SCMCMHC)**

**Administration--Billings (SCMCMHC)**  
1245 N 29th Street—PO Box 219—Billings, MT  
59103-0219  
**252-5658**  
**252-4641 Fax**

**Billings (SCMCMHC)**  
**Mental Health Center**  
1245 N 29th St—Billings, MT—59103  
**252-5658**

**The Hub (outpatient)**  
515 N 27th St—Billings, MT 59102-3238  
**248-2925**

**Mental Health Center—Group Home #2**  
1212 Ave C—Billings, MT 59102  
**248-2925**

**Mental Health Center—Group Home #3**  
920 Parkhill Dr—Billings, MT 59102  
**252-5658**

**Rainbow House**  
925 N 18th St—Billings, MT 59101  
**252-7851**

**Hardin Mental Health Center**  
809 N Custer Ave—Hardin, MT 59034-1300  
**665-1049**

**Lewistown Mental Health Center (outpatient)**  
212 Wendell Ave—Lewistown, MT 59457-0044  
**538-7483**

**Red Lodge Mental Health Center (outpatient)**  
5 E 9th St—Red Lodge, MT 59068  
**446-2500**

**Roundup Mental Health Center (outpatient)**  
26 Main St—Roundup, MT 59072-2828  
**323-1142**

**Scobey Clinical Office (outpatient)**  
105 5th Ave E—Scobey, MT 59263  
**487-2296**

**Sidney Clinical Office**  
221 5th St SW—Sidney, MT 59270-4901  
**433-4635**

### EASTERN MONTANA COMMUNITY MENTAL HEALTH SERVICES

Administration—Miles City (EMCMHC)

2508 Wilson St—Miles City, MT 59301-5000  
234-0234

Baker Clinical Office (EMCMHC) (outpatient)

205 S 4th St NW-- Baker, MT 59313  
**234-1687**

Big Timber Mental Health Center Office (EMCMHC)

515 Hooper St—Big Timber, MT 59011  
**932-5924**

Broadus Clinical Office (EMCMHC)

507 N Lincoln—Broadus, MT 59317  
**436-2651**

Colstrip Clinical Office (EMCMHC) (outpatient)

415 Willow—Colstrip, MT 59323  
**748-2800**

Forsyth Clinical Office (EMCMHC) (outpatient)

1093 Main St—Forsyth, MT 59327  
**346-7654**

Glasgow Clinical Office (EMCMHC) (outpatient)

1009 6th Ave N—Glasgow, MT 59230-1626  
**228-9349**

Glendive Clinical Office (EMCMHC)

204 N Kendrick Ave—Glendive, MT 59330  
**377-6075**

Jordan: Garfield County Medical Center (EMCMHC)

322 Leavitt Ave—Jordan, MT 59337  
**234-1687**

Malta: Phillips County Hospital (EMCMHC) (outpatient)

311 S 8th Ave E—Malta, MT 59538-0929  
**654-1599**

Plentywood: Sheridan County Courthouse (EMCMHC)

Plentywood, MT 59254  
**765-2550**

Miles City: Clark Street Inn (EMCMHC) (residential)

2607 Main St—Miles City, MT 59301-3901  
**234-1856**

Terry: Prairie County Clinic (EMCMHC)

409 Bowen—Terry, MT 59349  
**635-5863**

Wibaux Clinical (EMCMHC) (outpatient)

115 S Wibaux—Wibaux, MT 59353  
**377-6075**

Wolf Point Clinical Office (EMCMHC) (outpatient)

124 Custer St Public Service Bldg—Wolf Point, MT 59201  
**653-1872**

### WESTERN MONTANA COMMUNITY MENTAL HEALTH CENTER (WCMHC)

Administration--Missoula (WCMHC)

T-9 Fort Missoula—Missoula, MT 59801  
**728-6870**  
**728-6817 Emergency**  
**543-4536 Fax**

Ofc Hours: M-Th 8-5; F 8-4

Anaconda: Western Montana Mental Health Center

(WCMHC) (out patient, case management)

307 E Park, Suite 211—Anaconda, MT 59711  
**563-3413**  
**563-3414 Fax**

Bozeman (WCMHC)

Gallatin Mental Health Center

301 N Willson Ave—Bozeman, MT 59715  
**585-1103**

Hope House (crisis residential)

316 N Tracy—Bozeman, MT 59715  
**585-1130**

Butte (WCMHC)

106 W Broadway St—Butte, MT 59701  
**723-4033**  
**723-7117 Fax**

Butte Children's Services

2400 Continental Drive—Butte, MT 59701  
**782-0046**  
**782-3174 Fax**

Director of Children's Service (782-4401)

Crossroads (children's day treatment)

106 W Broadway St—Butte, MT 59701  
**496-2150**

**Gilder House** (crisis residential)

2460 Kossuth—Butte, MT 59701  
**723-7104**  
**723-4857 Fax**

**Our House** (residential)

2 East Copper—Butte, MT 59701  
**782-9470**

**Silver House Adult Outpatient**

106 W Broadway St—Butte, MT 59701  
**723-5489**  
**782-4020 Fax**  
**723-3319 Client Phone**

**Columbus Mental Health Center (WCMCHC)**

410 E Pike Ave—Columbus, MT 59019  
**322-4514**

**Deer Lodge: Western Montana Mental Health Center  
Addiction Services (WCMCHC)**

304 Milwaukee Ave Ste 27—Deer Lodge, MT  
59722-1085  
**846-3442**

**Dillon: Beaverhead County Mental Health Center  
(WCMCHC) (outpatient)**

234 East Reader—Dillon, MT 59725  
**683-2200**  
**683-4168 Fax**

**Hamilton (WCMCHC)**

Riverfront Counseling and Support Center  
**1205 W Main—PPO Box 1300—Hamilton,  
MT 59840**  
**532-9101**  
**363-4498 Fax**  
**363-1217 Day Treatment**

**Kalispell: (WCMCHC)**

**Western Montana Mental Health Center** (adult services)  
410 Windward Way—Kalispell, MT 59901-2680  
**257-1336**

**Lamplighter House** (day treatment)

410 Windward Way—Kalispell, MT 59901-2680  
**257-1336**  
**257-1353 Fax**

**Lone Pine Lodge** (adult residential)

1300 Eighth St W—Kalispell, MT 59901  
**257-8161**

**Outreach Case Management**

410 Windward Way—Kalispell, MT 59901-2680  
**257-5666**

**Safe House** (residential crisis)

410 Windward Way—Kalispell, MT 59901-2680  
**751-8366**  
**257-1353 Fax**

**Sinopah House** (youth residential)

909 Fifth Ave E—Kalispell, MT 59901  
**257-5194**  
**257-3194**

**Stillwater Therapeutic Services**

418 Windward Way—Kalispell, MT 59901-2680  
**752-6100**  
**752-6262 Emergency Services**  
**755-3720 Fax**

**Libby (WCMCHC)**

402 Montana Ave—Libby, MT 59923  
**532-9100**  
**293-3862 Fax**

**Livingston/Park County Mental Health Center (outpatient)**

232 S Main St—Livingston, MT 59047-3017  
**222-3332**

**Missoula: WCMCHC**

**Carole Graham House** (residential)

1330 S 4th St W—Missoula, MT 59804-2439  
**549-8309**

**Child and Family Services Network** (Outpatient)

1305 Wyoming St—Missoula, MT 59801-1725  
**532-9770**  
**721-5786 Fax**

**Dakota Place**

1273 Dakota St, Missoula MT 59801  
**542-1411**  
**543-2631 Fax**

**River House** (adult day treatment, outpatient, and emergency services)

1315 Wyoming St—Missoula, MT 59801-1725  
**532-9700**  
**532-9710 Emergency Services**  
**721-5786 Fax**

**Share House** (Western MT Addiction Services, Inc: co-occurring residential)  
1335 Wyoming St—Missoula, MT 59801-1725  
**532-9830**

**Stephens House**  
1315 Wyoming St—Missoula, MT 59801-1725  
**542-1411**

**Stepping Stones** (adult intensive case management)  
113 W Front, Suite 105—Missoula, MT 59802  
**532-9700**  
**532-9710 Emergency**  
**542-1675 Fax**

**Turning Point** (Western MT Addiction Services, Inc: co-occurring outpatient)  
1345 Wyoming St—Missoula, MT 59601-1725  
**532-9800**

**Teen Recovery Center** (youth residential)  
1467 Hayes Dr—Missoula, MT 59808  
**721-5379**

**Plains—see Thompson Falls**

**Polson Mental Health Center**  
1105 First St E—Polson, MT 59860  
**883-3556**

**AWARE Mental Health Center**  
205 E. Park Ave. Anaconda, MT 59711  
Tel: (406) 563.8117  
Toll free: 800.432.6145  
Fax: (406) 563.5956  
E-mail: info@aware-inc.org

**Services offered in various areas across the state;**

- Therapeutic Family Care
- Youth Case Management
- Comprehensive School and Community-based Treatment Services
- Galen Therapeutic Program
- Transitional Living Services
- Therapeutic Foster Care
- Residential Programs for Youth
- Community Based Psychiatric Rehabilitation and Support Services
- Outpatient Clinical Services
- AWARE Psychiatric Services

**Ronan (WCMHC)**  
8 Second Ave SW—Ronan, MT 59864  
**532-9170**  
**676-8503 Fax**

**Stevensville: Genesis House (WCMHC) (transitional living)**  
116 N College St—Stevensville, MT 59870  
**777-3751**

**Superior: Mineral County Mental Health Center (WCMHC) (outpatient)**  
305 W Main—PO Box 745—Superior, MT 59872  
**532-9150**  
**822-3077 Fax**  
**822-4807 CCM**

**Thompson Falls (Plains Outpatient Office) (WCMHC) (outpatient)**  
704 Maiden Lane—PO Box 562—Thompson Falls, MT 59873  
**532-9190**  
**827-4491 Fax**  
**826-5529 McGowan Mall**

## **VETERANS RESOURCES**

### **Crisis Services:**

National Number: 1-800-273-TALK (press 1 for veterans)

In Montana: (406) 447-7356

M-F 8 AM to 4:30 PM

After hours: Dial (406) 442-6410

Behavioral Health: 1-877-468-8387

Scheduling Appointments: 1-877-468-8387 (1-877-4MT-VETS)

### **Fort Harrison: VAMC Homeless Veteran Programs Coordinator**

Gerry Kuhl - (406) 447-7309 Ext. 2929

- Grant and Per Diem Liaison - Megal Phillips - (406) 447-7309 (Cruse House, Helena/Valor House, Missoula)
- HUD/VASH - Mark Annas - (406) 447-7192 VA Supportive Sect. 8 Housing (Helena, Missoula, Billings)

### **Recovery Coordinator \_ Pamela Mann - (406) 446-7361**

Liaison to the following recovery-oriented programs:

- Vet to Vet Support Group
- Mental Health Intensive Case Management
- Compensated Work Therapy
- Veteran Advisory Council

## **MENTAL HEALTH ADVOCACY**

### **NAMI Montana**

616 Helena Ave., Suite 218

Helena, MT 59601

(406) 443-7871

info@namimt.org

### **MHA-MT**

Mental Health America of Montana

P.O. Box 88, Bozeman, MT 59771

Toll free: 877-927-MMHA (406) 587-7774

Fax: (406) 587-7794

www.montanamentalhealth.org

## COMMUNITY MENTAL HEALTH DROP IN CENTERS

### Gallatin County Drop In Center

Scott M. Malloy, Director  
Gallatin Mental Health Center  
300 North Wilson, Suite 3005  
Bozeman, MT 59715  
(406) 522.7357  
smalloy@wmmhc.org

### Billings, The HUB

Joseph W. Chalupa  
HUB Team Lead  
515 North 27th Street  
Billings, MT 59101  
(406) 248-4803 Ext. 100  
jchalupa@scmrhc.org

### Livingston CMHC- Livingston Drop In Center

John Beck, Office Director of Western Montana Mental  
Health Center - Livingston  
232 S Main St.  
Livingston, MT 59047  
(406) 222-3332  
jbeck@wmmhc.org

### Miles City, EMMHC, Drop In Center

Jeanne Vetch, B.S.  
P.O. box 1530  
Miles City, Mt 59301  
(406) 234-0234  
jvetch@msn.com

### Montana Mental Health Association, state wide “Warm Line”

Jana Lehman, Program Director  
205 Haggerty Lane, Suite 170  
Bozeman, Montana 59715  
(406) 587.7774  
**1-877-688-3377**  
jana@montanamentalhealth.org  
www.montanamentalhealth.org

### Helena Drop In center

Elaine Bruce, Rocky Mountain Development Council  
Kristi Carroll, Program Manager  
Our Place Drop-in Center  
Rocky Mountain Development Council  
(406) 442-1374, Ext. 107  
kcarroll@rmdc.net

### Missoula Drop-In Salcido Center

Tessa Johnson, MSW tessaj@montana.com  
Program Director  
The Salcido Center  
308 W. Pine St.  
PO Box 7644  
Missoula, MT 59807  
(406) 541-7811

### Billings, Community Crisis Center

704 N. 30th , Billings MT 59101  
(406) 259-8800  
**Open 24/7**

## “CRISIS RESPONSE TEAMS” AVAILABLE IN SOME AREAS

CRT Team, Lewis & Clark County.

- Contact Center for Mental Health for information. (406) 443-7151
- Emergency 1-800-442-5353

CRT Team available in Missoula, Flathead and Silver Bow Counties.

- Contact WMMHC for information. (406) 728-6870
- Emergency (406) 543-4536



