

Office of Research & Policy Analysis

**Diverting the Mentally Ill from the  
Justice System and Providing Involuntary  
Commitment Alternatives**

**A Report to the 61st Legislature  
From the  
Law and Justice Interim Committee**

*Prepared by Sheri Heffelfinger, Research Analyst  
Montana Legislative Services Division*

**January 2009**

**Published By**

Montana Legislative Services Division  
P.O. Box 201706  
Helena, MT 59620-1706  
<http://leg.mt.gov>  
(406) 444-3064 FAX: (406) 444-3036



**Legislative  
Services  
Division**



## LAW AND JUSTICE INTERIM COMMITTEE

### Committee Members

#### Senators

Dan McGee (R- Laurel)  
*Presiding Officer*

Larry Jent (D - Bozeman)

Carol Juneau (D - Browning)

Jesse Laslovich (D - Anaconda)

Gary Perry (R - Manhattan)

Jim Shockley (R - Victor)

#### Representatives

Shannon Augare (D - Browning)  
*Vice-Presiding Officer*

Bob Ebinger (D - Livingston)

Edward Hilbert (R - Glendive)

Krayton Kerns (R - Laurel)

Deb Kottel (D - Great Falls)

Ron Stoker (R - Darby)

#### Staff

Sheri Heffelfinger, Research Analyst  
Valencia Lane, Staff Attorney  
David Niss, Staff Attorney  
Dawn Field, Secretary

#### Published By

Montana Legislative Services Division  
P.O. Box 201706  
Helena, MT 59620-1706  
<http://leg.mt.gov>  
(406) 444-3064 FAX: (406) 444-3036



# TABLE OF CONTENTS

<b>Executive Summary</b> .....	1
Assigned studies .....	1
Four main recommendations .....	1
Other recommendations .....	2
Special notes .....	4
<b>Part I - HJR 26 and HJR 50: Studies of Mental Health Treatment in the Justice System and Involuntary Precommitment</b>	
<b>Process and Costs</b> .....	5
Study priorities .....	5
Key activities .....	5
Recommended legislation .....	6
Is there overlap in purpose and funding? .....	6
HB 130 (LC0307) - Grant Program for Local Crisis Intervention Services .....	9
Problem .....	9
Research highlights .....	9
Bill summary .....	12
Policy goals .....	13
Recommendations of the Children, Families, Health and Human Services Interim Committee (CFHHS) .....	14
Endnotes .....	15
HB 60 (LC0329) - Jail Suicide Prevention Pilot Project .....	17
Problem .....	17
Research highlights .....	18
Bill summary .....	20
Policy goals .....	21
Recommendations of the Children, Families, Health and Human Services Interim Committee (CFHHS) .....	22
Endnotes .....	23
HB 131 (LC0516) - State Contracting For Regional Crisis And Emergency Detention Beds .....	25
Problem .....	25
Research highlights .....	26
Bill summary .....	28
Policy goals .....	29
Endnotes .....	30
HB 132 (LC0517) - Diversion from Involuntary Commitment to Short-term Treatment .....	31
Problem .....	31
Research highlights .....	32
Bill summary .....	33
Policy goals .....	35
Endnotes .....	36

<b>Part II - SJR 6 and HJR 26: Studies of the Juvenile Justice System and Mental Health Treatment for Justice-Involved Youth</b>	
Study priorities	37
Problem	38
Research highlights	39
Actions, recommendations, outcomes	42
Endnotes	45
<b>Part III - SJR 24: Study of Prison Population Growth and Diversion to Treatment</b>	
Study priority	47
Key activities	47
Research highlights	47
Actions, recommendations, outcomes	50
Endnotes	51
<b>Part IV - In Summary</b>	53
Recommendations	53
Goals	53
Funding	54
<b>Appendices</b>	
Appendix A Study Resolutions	A-1
Appendix B Committee Bills: HB 130, HB 60, HB 131, HB 132	B-1
Appendix C Memorandum on Psychiatric Residential Treatment Facility for Youth	C-1

## EXECUTIVE SUMMARY

### ***Assigned studies***

The Legislative Council assigned the following joint study resolutions passed by Montana's 60th Legislature to the Law and Justice Interim Committee (LJIC) for the 2007-2008 interim:

- SJR 6 - study of the juvenile justice system;
- SJR 24 - study of prison population growth and alternatives for diverting drug offenders to treatment;
- HJR 26 - study of mental health treatment and diversion alternatives for justice-involved adults and youth; and
- HJR 50 - study of involuntary precommitment process and costs.

Copies of these study resolutions are provided at Appendix A.

### ***Four main recommendations***

The Law and Justice Interim Committee (LJIC) recommends to the 61st Legislature the enactment of four bills to divert mentally ill individuals from the criminal justice system and from involuntary commitment at the Montana State Hospital (MSH) and to assist counties with costs for crisis intervention, jail suicide prevention screening, and precommitment costs:

- HB 130 (LC0307) - establishing a grant program for county crisis intervention and jail diversion programs. The preliminary cost estimate is \$615,937 from the state general fund in each year of the biennium.

---

*The LJIC recommends the enactment of four bills to divert mentally ill individuals from the criminal justice system and from involuntary commitment at the Montana State Hospital (MSH) and to assist counties with costs for crisis intervention, jail suicide prevention screening, and precommitment costs.*

---

- HB 60 (LC0329) - establishing a pilot project for a statewide jail suicide prevention program. The preliminary cost estimate is \$264,000 for FY2010 and \$189,000 from the state general fund for FY2011.
- HB 131 (LC0516) - requiring that DPHHS contract for up to three secure psychiatric treatment beds in each of four mental health regions. The preliminary cost estimate is \$410,625 from the state general fund in each year of the biennium.
- HB 132 (LC0517) - allowing an involuntary commitment hearing to be suspended if the respondent agrees to

be diverted to a 14-day short-term inpatient treatment program and requiring that DPHHS contract for up to three short-term inpatient treatment beds in each of four mental health regions. The preliminary cost estimate is \$1.7 million from the general fund in each year of the biennium.

An explanation of the issues identified in the study process and highlights of the research findings are provided in Part I of this report.

The introduced versions of each of these bills are provided at Appendix B.

### ***Other recommendations***

Other recommendations relevant to the assigned studies, but not highlighted in this report, are as follows:



- SB 35 (LC0589) - requiring that when an inmate is being transferred to prison, all mental and physical health information in the possession of a jurisdiction be forwarded to the prison at the time the prisoner is transferred.\*
- SB 91 (LC0198) - requiring that a youth be represented by an attorney at a probable cause detention hearing unless that right is waived after consultation with an attorney.

In addition to conducting its study assignments, the LJIC is responsible for on-going oversight and monitoring of matters related to the Department of Corrections, the Department of Justice, and the Judicial Branch. In the course of exercising these general duties, other issues arose. To address these, the LJIC recommends enactment of the following other bills:

- SB 50 (LC0364) - revising salaries for supreme court justices and district court judges.\*\*
- SB 125 (LC0199) - adding Judicial District 22 to the list of judicial districts represented on the judicial nomination commission.
- SB 10 (LC0299) - striking obsolete language concerning federal funding to research the impact of drug courts.

---

\* For more information, see LJIC meeting materials and minutes for June 26, 2008, and David Niss, *No. 6 - Legislation and Administrative Issues Concerning Transfer of Mental Health Information Between MSP and Counties*, legal memorandum dated June 13, 2008.

\*\* This issue was brought by Senator Shockley to the LJIC at its April 10-11, 2008, meeting. A National Center for State Courts survey showing Montana's judicial salaries rank 51st among the 50 states and the District of Columbia, and other related materials are available online at the committee website, [www.leg.mt.us](http://www.leg.mt.us), following the links to the LJIC 2007-2008 website and meeting materials for April 10-11, 2008.

### ***Special notes***

#### Reference material

The LJIC's minutes, exhibits, staff reports, and other meeting materials, including audio files for meetings held in Helena, are available online at [www.leg.mt.gov](http://www.leg.mt.gov) by following the links for interim committees, the Law and Justice Interim Committee, and the 2007-2008 interim.

#### Terminology note

Throughout this report the term "jail" is used but means any local detention center whether it is operated by a city, county, or regional cooperative.

#### Organization and abbreviations

Part I includes separate sections on each of the four primary bills being recommended by the LJIC. Endnotes are provided at the end of each section. Because these sections may be extracted and used separately, some of the research findings are intentionally repeated.

## **PART I - HJR 26 AND HJR 50 STUDIES OF MENTAL HEALTH TREATMENT IN THE JUSTICE SYSTEM AND INVOLUNTARY PRECOMMITMENT PROCESS AND COSTS**

### ***Study priorities***

- The HJR 26 study tasks were to examine mental health treatment in the adult and juvenile justice systems and options for diverting people from incarceration to treatment. The youth portion of the study is summarized under Part II along with the SJR 6 study of the juvenile justice system.
- The HJR 50 study tasks were to examine the precommitment process and costs for involuntary commitment to the Montana State Hospital, to identify ways to streamline the system and allow for more timely resolution of involuntary commitment proceedings, and to improve the ability of counties to predict and budget for costs.

### ***Key activities***

- The study plan was designed using the National GAINS Center's sequential intercept model as a blueprint for study activities.<sup>1</sup> The Law and Justice Interim Committee (LJIC) conducted panel discussions on each intercept in the model.
- The LJIC examined constitutionally-required standards for mental health treatment of inmates.
- For the HJR 50 study of involuntary precommitment costs, the LJIC gathered research, held panel discussions, and surveyed all 56 of Montana's counties.

### **Recommended legislation**

As noted in the Executive Summary, the following bills are the LJIC's core recommendations and each are discussed in separate sections within this part:

- HB 130 (LC0307) - establishing a grant program for local crisis intervention programs *(to be carried by Rep. Stoker)*;
- HB 60 (LC0329) - establishing a pilot program for jail suicide prevention screening *(to be carried by Rep. Ebinger)*
- HB 131 (LC0516) - requiring state contracting for regional emergency detention beds *(to be carried by Rep. Stoker)*; and
- HB 132 (LC0517) - providing for diversion from involuntary commitment to short-term treatment *(to be carried by Rep. Stoker)*.

### **Is there overlap in purpose and funding?**

As illustrated in the following diagram, these bills work together to address: (1) initial contact with law enforcement, crisis intervention, jail diversion, and jail suicide prevention; (2) emergency detention and treatment beds; (3) short-term inpatient treatment beds as an alternative to involuntary commitment. Questions about seeming overlaps in purpose and funding may arise. It is not the intent that passage of all of these bills will fund the same services twice. It is the intent that the funding be used to seamlessly connect each piece to the other.

# HOW THE FOUR KEY BILLS WORK TOGETHER

## Initial Response

## Emergency Detention

## Treatment



Now: No state funding for:  
 - crisis training for law enforcement  
 - mental health professional crisis response teams



Now: Patrol car therapy  
 - transport to MSH  
 - involuntary commitment proceeding initiated



Now: Involuntary commitment hearing, commitment determination  
 - court delays  
 - increased treatment costs for counties



Needed: Crisis centers for initial screening  
 - collaborations like Billings Crisis Center and Billings Clinic offer local solutions, funding needed



LC0516 = LOCAL ALTERNATIVE regional beds for emergency detention and evaluation  
 - reduces admissions to MSH  
 - reduces county transportation costs



Now: Commitment is to MSH for up to 90 days  
 - involuntary  
 - stigma of commitment



Now: Jail diversion required by state law, but no state funding provided  
 High jail suicide rates



HB 132 (LC0517) SHORT-TERM TREATMENT:  
 - provided locally/regionally  
 - no commitment hearing  
 - voluntary agreement  
 - no stigma  
 - reduces MSH admissions  
 - reduces county precommitment costs

### **HB 130 (LC0307) - Grant Program** **(Rep. Stoker)**

- DPHHS to administer
- reimburse up to 50% of local costs for eligible expenses, such as CIT training, crisis response teams, jail diversion, if DPHHS determines these to be eligible expenses
- Includes incentive to participate in LC0329 program, and precommitment cost insurance
- Cost: \$615,937 annually (preliminary est.)

### **HB 60 (LC0329) - Jail Suicide Prevention** **(Rep. Ebinger)**

- pilot project
- DPHHS to contract with mental health provider
- inmates screened via telephone or video
- jail risk management protocols triggered
- follow-up services if needed
- Cost: \$264,00 in FY2010; \$189,000 in FY2011

### **HB 131 (LC0516) - Contracting for regional beds** **(Rep. Stoker)**

- DPHHS to contract for beds
- up to 3 beds in each mental health region
- for emergency detention and evaluation
- contract can allow local flexibility
- Cost: \$410,625 annually (prelim. est.)
- supports LC0307 and LC0329 jail diversion and crisis intervention programs by providing a place to go other than jail or the MSH

### **HB 132 (LC0517) - Diversion to short-term treatment** **(Rep. Stoker)**

- Process streamlined*
- court hearing on involuntary commitment suspended if attorneys and respondent agree to short-term treatment
  - 14 days, can be released earlier
  - hearing held if treatment refused, longer treatment needed, attorney requests
- Contracting for local beds*
- DPHHS to contract for up to 3 bed each region - Cost: \$1.7 million annually (prelim. est.)



---

**HB 130 (LC0307) -  
GRANT PROGRAM FOR  
LOCAL CRISIS INTERVENTION SERVICES**

---

***Problem***

As national studies and Montana's own newspaper headlines attest, people with mental illness are falling through the cracks of the public mental health system and landing in the criminal justice system at an alarming rate, straining local resources, consuming law enforcement time, crowding detention centers and prisons, and clogging court processes.<sup>2</sup> The lack of local crisis intervention programs often results in a "criminalization" of mental illness (i.e., charging a person with a minor crime so they can be detained in jail even though the underlying problem is mental illness) or "patrol car therapy" (i.e., transporting the person in hand cuffs to the Montana State Hospital (MSH)). But, admission to the MSH requires the initiation of involuntary commitment proceedings and that makes the county ultimately responsible for all precommitment costs for detention, evaluation, and treatment if the individual, private insurance, or a public assistance program, such as Medicaid, does not cover the costs.<sup>3</sup>

***Research highlights***

Initial response - need for training and treatment alternatives

- When a person presents an imminent danger of bodily harm to themselves or others because of a mental disorder, state law recognizes that an emergency situation exists and authorizes the person to be held in emergency detention, such as a hospital bed in a psychiatric unit, for evaluation and treatment.<sup>4</sup>

---

*People with mental illness are falling through the cracks of the public mental health system and landing in the criminal justice system at an alarming rate.*

---

- Recognizing that a mental disorder may be involved can be a challenge for law enforcement. However, Crisis Intervention Team (CIT) training for local law enforcement and establishing working relationships with on-call mental health professionals (i.e., crisis teams) is a nationally recognized, proven strategy that helps law enforcement de-escalate potentially dangerous situations and divert people to treatment rather than holding them in jail on a minor charge, such as disorderly conduct.<sup>5</sup> Law enforcement officers from around Montana have participated in CIT training and several communities have established crisis response teams, but there is no statewide approach or state funding for these efforts.<sup>6</sup>
- Local law enforcement officers told the LJIC, that their biggest frustration is the lack of treatment alternatives and local crisis beds to which a mentally ill person picked up by law enforcement can be taken.<sup>7</sup>

#### Need for jail screening and diversion programs

- The increasing number of mentally ill inmates presents a significant treatment challenge for local detention and state corrections officials who told the LJIC that they are the largest mental health treatment providers in the counties and state.<sup>8</sup> According to the U.S. Bureau of Justice Statistics, about half of all prison and jail inmates have mental health problems\*, and about three-fourths the inmates with mental health problems also have a substance abuse disorder.<sup>9</sup> An American Psychiatric Association study concluded that about 20% of all prison and jail inmates need psychiatric care, and about 5% are actively psychotic.<sup>10</sup>

---

\* A "mental health problem" was defined as having a recent (i.e., within the last 12 months) clinical diagnosis or treatment for symptoms of a disorder specified in the Diagnostic and Statistical Manual of Mental Disorders, fourth edition, commonly called the DSM-IV.



- Montana state law requires detention centers to screen inmates for mental illness and develop jail diversion programs so mentally ill inmates may be transferred to appropriate treatment alternatives, but the requirement is not state-funded.<sup>11</sup>

Local collaborations offer solutions

- Yellowstone County has developed a jail screening and diversion program, including crisis intervention services, through collaboration with private mental health service providers. County commissioners, sheriffs, detention officers, and private providers told the LJIC that this type of collaboration could serve as a model for other communities if state resources were made available to help. Yellowstone County's services include:
  - ▶ the Hub, which is a walk-in center for the homeless and mentally ill with services provided by the VA, Community Mental Health, and the Indian Health Service;
  - ▶ the Community Crisis Center, a collaborative between St. Vincent's Health Care, Billings Clinic, the City/County Health Department, and Community Mental Health, provides out-patient screening, stabilization, and referral services for people in crisis because of a mental health and addiction problem; and
  - ▶ the Billings Clinic psychiatric center, consisting of 44 beds. Yellowstone County contracts with the Billings Clinic for a mental health counselor to work in the Yellowstone County Detention Center about 5 hours a day. The Clinic also offers secure beds for emergency detention.
- These collaborative efforts, especially the Community Crisis Center, have been credited with reducing jail, emergency room, and MSH admissions.<sup>12</sup>

### Precommitment costs

- Montana's state law provides that emergency detention beyond one business day requires that the county attorney file an involuntary commitment petition. Once a petition is filed, the county is the payer of last resort (which many stakeholders told the LJIC means the payer of *only* resort because most of the respondents are not insured and do not qualify for Medicaid) for all detention, evaluation, and treatment costs until the final disposition of the case.<sup>13</sup> Some stakeholders are concerned that county attorneys decide not to file commitment petitions solely because of the costs; thus, the mental illness goes untreated, problems escalate, and the person may ultimately end up in jail or prison.<sup>14</sup>
- Prior to a commitment petition being filed and whenever a county attorney decides to not file a commitment petition, private providers are on the hook for the unrecoverable costs. These costs can be significant. St. Patrick Hospital in Missoula testified that the hospital's charity care for mental health treatment alone amounted to more than \$2.8 million in FY07.<sup>15</sup>

### **Bill summary**

The following summary outlines the main components of HB 130 (LC0307) to provide a grant program for local crisis intervention and jail diversion programs:

- To the extent funding is appropriated by the legislature, DPHHS would offer grants to eligible counties for up to 50% of their prior fiscal year expenditures made for eligible jail diversion and crisis intervention programs. The DPHHS formula for determining the amount of the grants would reward counties who reduced their admissions to the MSH for emergency detention.

- DPHHS would determine, by rule, what expenses would be eligible for reimbursement through the grant. The bill specifies that premiums for a precommitment insurance pool must be considered an eligible expense.
  
- To be eligible for a grant, a county must:
  - ▶ apply for it;
  - ▶ have a strategic plan approved by DPHHS;
  - ▶ participate in a county insurance pool for precommitment costs, if such a pool has been established for counties;
  - ▶ participate in a state-contracted jail suicide prevention program, if one has been established and is available to the county (see the next section summarizing LJIC's recommendation for HB 60 (LC0329)); and
  - ▶ collect and report performance data to the DPHHS.
  
- The bill appropriates \$615,937 from the state general fund in each year of the biennium (based on preliminary estimates by DPHHS, which are subject to change).
  
- The target date for full implementation is July 1, 2010, and a progress report would be made to the LJIC.

***Policy goals***

HB 130 (LC0307) was drafted to accomplish the following policy goals, which were articulated during various committee meetings and in meetings and interviews between staff and stakeholders, including state administrators, county commissioners, county attorneys, public defenders, consumer advocates, and consumer family members:

- to help local governments implement current statutes concerning crisis intervention and jail diversion for the mentally ill;

- to give counties an incentive to collaborate with the state, others communities, and private mental health service providers, to develop local and regional solutions; and
- to reduce reliance on MSH as the default crisis intervention service.

***Recommendations of the Children, Families, Health and Human Services Interim Committee (CFHHS)***

- In 2007, the Montana legislature appropriated \$200,000 for a contracted, state-wide study of mental health services. The final report and study recommendations<sup>16</sup> were presented to the CFHHS after the LJIC had concluded its business for the interim.
- The contracted mental health study identified local crisis services as a priority need in Montana and the CFHHS voted unanimously to recommend the following amendments to LC0307, now HB 130:

---

*In 2007, the Montana legislature appropriated \$200,000 for a contracted, state-wide study of mental health services. The contracted mental health study identified local crisis services as a priority need in Montana.*

---

- ▶ include specific language to ensure that county expenditures for CIT training for law enforcement would be considered an eligible expense;
- ▶ make the grant program available to "collaboratives," such as the Billings Community Crisis Center, rather than to a county alone; and
- ▶ use the grant to match county precommitment costs, but only if the county is an active financial participant in the collaborative.<sup>17</sup>

ENDNOTES FOR SECTION ON HB 130 (LC0307)

1. See sequential intercept chart available online at [http://gainscenter.samhsa.gov/pdfs/integrating/GAINS\\_Sequential\\_Intercept.pdf](http://gainscenter.samhsa.gov/pdfs/integrating/GAINS_Sequential_Intercept.pdf). GAINS stands for Gather, Assess, Interpret, Network, and Stimulate change.
2. See Council of State Governments, *Criminal Justice / Mental Health Consensus Project*. New York: Council of State Governments, June 2002, available online at [http://consensusproject.org/the\\_report/](http://consensusproject.org/the_report/). See also Zachary Franz, "Care for mentally ill can overwhelm jail, emergency services", *Great Falls Tribune*, September 2, 2008; Jennifer McKee, "Mentally ill crowd state jails: Also clog courts, prisons", *The Montana Standard*, October 2, 2007; Perry Backus, "Sheriff: Mentally ill strain Ravalli resources", *Missoulian*, January 1, 2007; and Ed Kemmick, "The default psychiatric center", *Billings Gazette*, March 2, 2008.
3. Law and Justice Interim Committee (LJIC), *Minutes*, Montana Legislative Services Division, October 1, 2007.
4. Section 53-21-129, Montana Code Annotated (MCA).
5. Jennifer Teller, Mark Munetz, Karen Gil, Christian Ritter, "Crisis Intervention Team Training for Police Officers Responding to Mental Disturbance Calls", *Psychiatric Services*, February 2006, Vol. 57, No. 2. See also, Melissa Reuland, *A Guide to Implementing Police-Based Diversion Programs for People with Mental Illness*, TAPA Center for Jail Diversion, U.S. Department of Health and Human Services, January 2004, also available online at [http://gainscenter.samhsa.gov/pdfs/jail\\_diversion/PERF.pdf](http://gainscenter.samhsa.gov/pdfs/jail_diversion/PERF.pdf)
6. Becky Shay, "Emergency responders to get training in helping mentally ill", *Billings Gazette*, March 22, 2007. See also, LJIC, *Minutes*, Montana Legislative Services Division, October 1, 2007.
7. LJIC, *Minutes*, Montana Legislative Services Division, October 1, 2007.
8. Ibid.
9. Bureau of Justice Statistics, *Mental Health Problems of Prison and Jail Inmates*, U.S. Department of Justice, Special Report NCJ 213600, September 2006.
10. DPHHS, *Montana Strategic Suicide Prevention Plan*, pp. 33-34. Updated as of Summer 2008.
11. Section 53-21-138, MCA.
12. LJIC, *Minutes*, Montana Legislative Services Division, April 10, 2008. Testimony from Bill Kennedy, Yellowstone County Commissioner.
13. Section 53-21-132, MCA.
14. LJIC, *Minutes*, Montana Legislative Services Division, November 9, 2007. Panel on HJR 50 - precommitment process and costs.

15. Ibid.

16. DMA Health Strategies, *Report to the State of Montana: Legislative Mental Health Study*, November 18, 2008. Available online through [www.leg.mt.gov](http://www.leg.mt.gov), follow links to the Children, Families, Health, and Human Services Interim Committee website for the 2007-2008 interim.

17. Children, Families, Health and Human Services Interim Committee, *Minutes*, Montana Legislative Services Division, October 14, 2008.

---

**HB 60 (LC0329) -  
JAIL SUICIDE PREVENTION PILOT  
PROJECT**

---

***Problem***

In 2005, Ravalli County residents were demanding answers from the county sheriff for a series of three suicides in two months by inmates at the detention center. Outraged family members alleged the jail's staff failed to implement proper suicide prevention protocols even though the men were known to be suicidal.<sup>1</sup>

In May 2007, Tia Henriksen, 23, and mother of a toddler, hung herself from an air vent inside her jail cell at the Cascade County Detention Center. The vent had allegedly been used at least once previously for the same suicidal purpose. The family recently filed a lawsuit against the county for negligence and for not having appropriate suicide prevention procedures in place.<sup>2</sup>

On November 5, 2007, after being booked into the Custer County Detention Center for a probation violation stemming from a felony Driving Under the Influence conviction and threatening suicide, Linda Wilson was allegedly left unobserved in an unsecured cell. She hung herself with a telephone cord. In April 2008, her husband and daughter filed a civil lawsuit for wrongful death.<sup>3</sup>

---

*Between 2003 and 2007, 18 Montana citizens committed suicide while incarcerated, 14 were in county jails—a rate 5 times higher than the national average.*

---

Between 2003 and 2007, 18 Montana citizens committed suicide while incarcerated, 14 were in county jails.<sup>4</sup> This rate is 5 times higher than the national average, based on statistics for the number of suicides per 100,000 inmates.<sup>5</sup> The death of someone while in county custody is not only a personal and family tragedy, it

is a traumatic experience for detention staff and can lead to costly lawsuits against the county for a wrongful death. The national suicide rate in jails with less than 100 beds is ten times higher than in larger jails<sup>6</sup> because smaller jails often lack access to mental health professionals, suicide-restraint cells, and the level of staffing needed for constant observation.<sup>7</sup>

### **Research highlights**

- There are six minimum requirements that a state prison or local jail must meet as a matter of constitutional law under the Eighth Amendment to the U.S. Constitution, which prohibits cruel and unusual punishments:
  - (1) a systematic program for screening inmates to identify those who require mental health treatment for a serious mental disorder;
  - (2) treatment must entail more than segregation and close supervision of inmates suffering from serious mental disorders;
  - (3) treatment must involve participation by trained mental health professionals, employed in sufficient numbers to identify and treat, on an individual basis, treatable inmates suffering from serious mental disorders;
  - (4) maintenance of accurate, complete, and confidential mental health records;
  - (5) appropriate supervision and evaluation concerning the use of behavior-altering drugs; and
  - (6) a basic program of identification, treatment, and supervision of prisoners with suicidal tendencies.<sup>8</sup>



- As previously noted, according to the U.S. Bureau of Justice Statistics, about half of all prison and jail inmates have mental health problems,\* and about three-fourths of these inmates have a co-occurring substance abuse disorder.<sup>9</sup> An American Psychiatric Association study concluded that about 20% of all prison and jail inmates need psychiatric care, and about 5% are actively psychotic.<sup>10</sup>
  
- Mental health professionals agree that suicide risk does not directly coincide with mental illness and that, in fact, those most at risk of suicide are usually not mentally ill. Suicide risk is highest immediately after a person is booked into jail, immediately following a hearing, or immediately following sentencing.<sup>11</sup>
  
- In response to a series of publicized jail suicides in Kentucky, the 2004 Kentucky Legislature enacted and funded a jail suicide screening and prevention program that reduced Kentucky's jail suicide rate by 80%.  

---
  
- The Kentucky program is now recognized as a national model. The model program provides:
  - ▶ standardized screening instruments;
  - ▶ a telephonic triage system with mental health professionals;
  - ▶ standardized suicide risk management protocols; and
  - ▶ follow-up measures.<sup>12</sup>

---

*Mental health professionals agree that suicide risk does not directly coincide with mental illness and that, in fact, those most at risk of suicide are usually not mentally ill.*

---

\* A "mental health problem" was defined as having a recent (i.e., within the last 12 months) clinical diagnosis of or recent treatment for symptoms of a disorder specified in the Diagnostic and Statistical Manual of Mental Disorders, fourth edition, commonly called the DSM-IV.

### **Bill summary**

The LJIC's bill recommendation, LC0329 (now HB 60), creates a two-year pilot program that would establish a mental health triage system based on the Kentucky model for a sample of small, medium, and large population counties. The main components of the bill are outlined below.

- Requires DPHHS to contract with a mental health provider, such as a community mental health center, for the creation of a jail suicide prevention program consisting of:
  - (a) a screening form with questions to be answered by the detention staff and possibly by the arresting officer;
  - (b) a 24-hour, seven days per week, electronic communications link between the detention staff and a mental health professional, perhaps at a community mental health center;
  - (c) a computer-assisted, guided interview with the detention staff and perhaps the prisoner, after which the mental health professional would advise the detention staff that the detainee's potential for suicide is "critical", "high", "moderate", or "low";
  - (d) the use of jail management protocols to care for the detainee or prisoner according to the individual's potential for suicide; and
  - (e) follow -up counseling in the jail of any individual whose risk for suicide is "critical" or "high", in order to reduce that risk to a lower level.
  
- Requires that every inmate in a participating county jail be screened for suicide potential using the triage system to be created by contract.

- Requires that the DPHHS adopt administrative rules to create the pilot program.
- Requires data collection and a report to the LJIC on the operations and findings of the pilot program.
- Appropriates from the state general fund \$264,000 for FY2010 and \$189,000 for FY2011, based on preliminary estimates that are subject to change during the session.

Although the LJIC initially voted not to add to the bill a grant program to help counties cover costs, such as for video monitors and additional detention center staff, the bill sponsor, Rep. Ebinger, supported the grant program. Because the LJIC gave bill sponsors implicit authority to act on the LJIC's behalf in finishing the drafting and introducing the committee bills<sup>13</sup> and acting with the support of other committee members, including the chairman, Rep. Ebinger instructed that the bill draft be revised to include the grant program.

***Policy goals***

HB 60 (LC0329) was drafted to accomplish the following policy goals for the counties that would be involved in the pilot project:

- to help counties meet their constitutional obligation to provide mental health care, including suicide prevention, for inmates of county detention centers;
- to take advantage of Montana's existing telecommunications capabilities and connect mental health service providers in larger population centers with detention centers in rural areas where there are provider shortages; and
- to standardize suicide screening instruments and prevention protocols based on best practices.

**Recommendations of the Children, Families, Health and Human Services Interim Committee (CFHHS)**

- As previously noted, during the 2007 session, the Montana legislature appropriated \$200,000 for a contracted, state-wide study mental health services. The final report and study recommendations<sup>14</sup> were presented to the CFHHS after the LJIC had concluded its business for the interim.
  
- The contracted mental health study identified jail screening for mental disorders as a need in Montana and the CFHHS voted unanimously to recommend that LC0329 (now HB 60) be amended to include screening and followup protocols for mental disorders, not only for suicide risk.<sup>15</sup>

ENDNOTES FOR SECTION ON HB 60 (LC0329)

1. Timothy Mitchell, "Inmate suicide epidemic: Sheriff Chris Hoffman addresses concerns over three inmate deaths in two months", *Ravalli Republic*, May 24, 2005.
2. Zachary Franz, "County sued over prison suicide", *Great Falls Tribune*, December 18, 2008.
3. David Niss, *No. 1 - Custer County Jail Suicide Case Study and Analysis*, a Montana Legislative Services Division legal memorandum to the Law and Justice Interim Committee (LJIC), dated June 13, 2008, also available online through [www.leg.mt.gov](http://www.leg.mt.gov), follow the links to the LJIC website for the 2007-2008 interim, June 26, 2008, meeting materials.
4. DPHHS, *Montana Strategic Suicide Prevention Plan*, pp. 33-34. Updated as of Summer 2008.
5. This is based on a Montana jail inmate population of 1,521, which was reported by DMA Health Strategies in its *Report to the State of Montana: Legislative Mental Health Study*, November 18, 2008, pg. 107. This report is available online through [www.leg.mt.gov](http://www.leg.mt.gov), follow the links to the Children, Families, Health, and Human Services Interim Committee for the 2007-2008 interim.
6. *Ibid.*
7. Suicide Prevention Center, "What Corrections Professionals Can Do to Prevent Suicide", October 2007.
8. For a thorough discussion of the relevant constitutional law, case studies, and policy implications discussed by the LJIC, see David Niss, *Constitutional and Federal Law Requirements for Mental Health Care for Convicted Offenders, Jailed Persons, and Detainees in Montana*, a legal memorandum to the LJIC dated September 14, 2007, also available online through [www.leg.mt.gov](http://www.leg.mt.gov), follow the links to the LJIC website for the 2007-2008 interim. See also, Cohen, *The Mentally Disordered Inmate and the Law*, Civic Research institute, 1998. See also, LJIC, *Minutes*, Montana Legislative Services Division, October 1, 2007. See also, LJIC, *Minutes*, Montana Legislative Services Division, June 26, 2008, including Exhibit 19, David Niss, *No. 4 - Kentucky Jail Mental Health Crisis Network, Issues and Options*, a legal memorandum to the LJIC, dated June 13, 2008, also available online through [www.leg.mt.gov](http://www.leg.mt.gov), follow the links to the LJIC website for the 2007-2008 interim.
9. Bureau of Justice Statistics, *Mental Health Problems of Prison and Jail Inmates*, U.S. Department of Justice, Special Report NCJ 213600, September 2006.
10. DPHHS, *Montana Strategic Suicide Prevention Plan*, pp. 33-34. Updated as of Summer 2008.
11. Subcommittee on Jail Standards and Suicide Prevention, LJIC, *Minutes*, Montana Legislative Services Division, July 17, 2008.
12. David Niss, *No. 4 - Kentucky Jail Mental Health Crisis Network, Issues and Options*, dated June 13, 2008, a legal memorandum to the LJIC dated June 13, 2008. See also LJIC, *Minutes*, Montana Legislative Services Division, June 26, 2008.

Law and Justice Interim Committee Report to the 61st Montana Legislature  
Diverting the Mentally Ill from the Justice System and Alternatives to Involuntary Commitment

13. LJIC, *Minutes*, Montana Legislative Services Division, September 15, 2008.
14. DMA Health Strategies, *Report to the State of Montana: Legislative Mental Health Study*, November 18, 2008. Available online through [www.leg.mt.gov](http://www.leg.mt.gov).
15. Children, Families, Health and Human Services Interim Committee, *Minutes*, Montana Legislative Services Division, October 14, 2008.

---

**HB 131 (LC0516) -  
STATE CONTRACTING FOR REGIONAL CRISIS AND  
EMERGENCY DETENTION BEDS**

---

***Problem***

When a person presents an imminent danger of bodily harm to themselves or others because of a mental disorder, state law recognizes that an emergency situation exists and authorizes law enforcement to step in.<sup>1</sup> State law also provides that a mental health professional may keep the person for evaluation and treatment on an involuntary basis for no longer than 24 hours or until the next business day.<sup>2</sup> For that period of time, if the person is unable to pay or uninsured and is not eligible for public assistance, such as Medicaid, the hospital cannot recover the costs and the costs become part of the hospital's "charity care". Hospitals told the Law and Justice Interim Committee (LJIC) that their costs were increasing and were an unfair burden on private providers.<sup>3</sup>

In many Montana communities, there are very few crisis intervention or emergency detention beds available, so law enforcement and mental health professionals often rely on transporting the person, sometimes hundreds of miles, in handcuffs, to the Montana State Hospital (MSH) in Warm Springs.<sup>4</sup> This not only increases admissions to the MSH, but also results in significant costs to counties for transportation.

---

*When a person presents an imminent danger of bodily harm to themselves or others because of a mental disorder, state law recognizes that an emergency situation exists and authorizes law enforcement to step in.*

---

### **Research highlights**

- In FY2007, there were 427 admissions to the MSH for emergency and court-ordered evaluations and, of those, 266 resulted in involuntary commitments, which translates to 63% percent of MSH admissions being for emergency and court-ordered detention pending a commitment hearing, and 38% of these not resulting in a commitment.<sup>5</sup>
- The MSH's average daily population has been consistently above its licensed capacity of 189, which strains MSH resources.<sup>6</sup>
- County costs for transportation to the MSH are significant. Lewis and Clark County Sheriff Cheryl Liedle told the LJIC that her deputies transported 111 people to the MSH between January and October 2007. Sheriff Leidle estimated the annual cost for transportation alone to be between \$30,000 and \$40,000, equivalent to a full-time position.<sup>7</sup>
- Of the 36 counties that responded to a survey on precommitment costs, 18 said they relied solely on the MSH for emergency detention; others relied on the MSH as well as local hospitals with psychiatric units.<sup>8</sup> Only four community hospitals in Montana have psychiatric units; they are in Kalispell, Great Falls, Missoula, and Billings.
- Respondents to the survey said they would rather use local or regional beds if they were available and could be offered at an affordable daily rate that at least offset their transportation costs.<sup>9</sup>
- Hospital rates reported in the survey ranged from \$900 to almost \$1,500 per day. Rates at MSH average about \$450 to \$500 per day. The average length of stay for emergency detention (whether at the MSH or at a community hospital) was about 3 to 5 days,<sup>10</sup> but the LJIC was informed on several occasions the length of state can be



twice or three times as long because the legal process gets bogged down.

- As previously noted, community hospitals told the LJIC that they are being asked to shoulder an inordinate share of the burden for initial crisis intervention services. St. Patrick Hospital in Missoula testified that their charity care for mental health treatment alone amounted to more than \$2.8 million in FY07.<sup>11</sup>

*Only four community hospitals in Montana have psychiatric units; they are in Kalispell, Great Falls, Missoula, and Billings.*
  
- The need to provide secure treatment (i.e., keep a person involuntarily) presents licensure and liability issues for mental health service providers. The Western Montana Mental Health (WMMH), which provides mental health services throughout the western mental health service area, is developing crisis beds in Butte and Bozeman, but whether they will be able to provide the level of care necessary for an emergency or court-ordered detention equivalent to what is now provided at the MSH or a local hospital's psychiatric unit remains to be worked out.<sup>12</sup>
  
- In Helena, the Center for Mental Health has established the Montana House, which offers a voluntary day treatment "safe house" for people in crisis, but it cannot offer inpatient treatment or emergency detention services.<sup>13</sup>
  
- Montana is challenged by a shortage of mental health professionals who can provide the psychiatric services needed for emergency detention and evaluation. Interested persons and primary stakeholders agreed that regional facilities would be the most economical way to share costs and provider services if such facilities could be licensed accordingly and if state funding were available to help.<sup>14</sup>

---

*Montana is challenged by a shortage of mental health professionals who can provide the psychiatric services needed for emergency detention and evaluation.*

---

- Notably, Yellowstone County developed partnerships with local providers (i.e., the Hub, the Billings Clinic, and the Community Crisis Center). As a result, fewer commitment petitions were filed and the county significantly reduced its precommitment costs, which were more than \$300,000 in FY2004, but which were less than \$65,000 by FY2007.<sup>15</sup>

### **Bill summary**

The main components of HB 131 (LC0516), the LJIC's recommendation that the state contract for regional emergency detention beds, are:

- Provides that to the extent funding is appropriated by the legislature, the DPHHS would contract for up to three beds in each of the four mental health service areas for:
  - ▶ inpatient crisis intervention treatment to cover the time period from initial intake at a hospital to the filing of an involuntary commitment petition or, if a commitment petition is not filed, to cover the first 24 hours or until the next business day when the person must be released; and
  - ▶ emergency or court-ordered detention after the filing of a commitment petition has been filed and pending a court determination on the petition.
- Provides that the costs for initial inpatient crisis intervention services, the state will be ultimately responsible to pay any unrecoverable

costs;\* though after a petition is filed, the costs will still become precommitment costs under current law and the county will remain ultimately responsible for the costs.<sup>16</sup>

- Requires the collection and reporting of data to DPHHS and that the DPHHS adopt rules to administer the program.
- Appropriates \$410,625 from state general fund money in each year of the biennium, based on preliminary estimates that could change during the session.
- Allows phased implementation, with contracting in at least one region by July 1, 2010, and full implementation in all four regions by July 1, 2011.

### ***Policy goals***

HB 131 (LC0516) was drafted to accomplish the following policy goals, which were articulated during various committee meetings and in meetings and interviews between staff and stakeholders, including state administrators, county commissioners, county attorneys, public defenders, consumer advocates, and consumer family members:

- to provide for emergency detention in mental health facilities closer to home than the MSH;
- to reduce MSH admissions for emergency detention; and
- to provide state funding to assist counties with precommitment costs.

---

\* Because current law prohibits a person from being held involuntarily for longer than 24 hours or the next business day without the filing of an involuntary commitment petition, the costs being covered by the state until LC0516 would be for inpatient treatment during the initial 24 hours or over the weekend or holiday (until the next business day) when the person would have to be released if a petition has not been filed.

ENDNOTES FOR SECTION ON HB 131 (LC0516)

1. "Emergency situation" is defined in section 53-21-102, Montana Code Annotated (MCA), as "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."
2. Section 53-21-129, MCA.
3. Law and Justice Interim Committee (LJIC) *Minutes*, Montana Legislative Services Division, November 9, 2007. HJR 50 panel discussion.
4. LJIC, *Minutes*, Montana Legislative Services Division, October 1, 2007. Intercept 1 - panel discussion with Lewis and Clark County Sheriff Cheryl Leidle, Sweetgrass County Sheriff Dan Tronrud, and Addictive and Mental Disorders Division Administrator Joyce DeCunzo. Audio time 01:28:39.
5. Sheri S. Heffelfinger, *HJR 50 Survey Results: Involuntary Commitment Process and Costs*, April 10, 2008. See Tables 4 and 5 for data provided by the MSH. See also LJIC, *Minutes*, April 10, 2008.
6. Lois Steinbeck, *Montana State Hospital Update June 2008*, Montana Legislative Fiscal Division, prepared for the Legislative Finance Committee, June 4, 2008.
7. LJIC, *Minutes*, October 1, 2007. Intercept 1 - panel discussion with Lewis and Clark County Sheriff Cheryl Leidle, Sweetgrass County Sheriff Dan Tronrud, and Addictive and Mental Disorders Division Administrator Joyce DeCunzo. Audio time 01:28:39.
8. Sheri S. Heffelfinger, *HJR 50 Survey Results: Involuntary Commitment Process and Costs*, April 10, 2008. See also LJIC, *Minutes*, Montana Legislative Services Division, April 10, 2008.
9. Ibid. Written comments provided as an attachment.
10. Ibid. See also LJIC, *Minutes*, Montana Legislative Services Division, April 10, 2008.
11. Ibid.
12. Ibid. Testimony of Paul Meyer, Executive Director, Western Montana Mental Health (WMMH). Audio time: 04:45:05. Also, public comment by Patty Kent, Housing and Development Director WMMH. Audio time: 06:42:54.
13. Ibid. Public comment by Patti Jacques of Helena. Audio time: 06:48:08.
14. LJIC, *Minutes*, Montana Legislative Services Division, April 10, 2008, and June 26, 2008.
15. Sheri S. Heffelfinger, *HJR 50 Survey Results: Involuntary Commitment Process and Costs*, April 10, 2008. See Table 9. See also, LJIC, *Minutes*, Montana Legislative Services Division, April 10, 2008.
16. Section 53-21-132, MCA.

---

## **HB 132 (LC0517) - DIVERSION FROM INVOLUNTARY COMMITMENT TO SHORT-TERM TREATMENT**

---

### ***Problem***

County commissioners, mental health professionals, attorneys, judges, and mental health advocates share frustrations with the current involuntary commitment process and costs. These frustrations are summarized below.

- Mental health professionals are frustrated by the clash between medical standards concerning treatment needs and the legal standard for involuntary commitment.
- Attorneys are frustrated by the adversarial legal process that requires an all-or-nothing commitment determination by the court (i.e., either a commitment to the Montana State Hospital (MSH) for up to 90 days or no treatment at all).
- For judges, commitment hearings are time consuming and represent a significant caseload and workload.
- County commissioners are frustrated by high and unpredictable costs that begin when a commitment petition is filed and continue to be incurred while the legal process plays out.
- Mental health advocates are frustrated by the lack of community-based mental health services, which results in calls to law enforcement and over-reliance on involuntary commitment to the MSH.<sup>1</sup>

### **Research highlights**

- For a mental health professional to hold a patient in secure treatment for more than one business day, state law requires that the county attorney file an involuntary commitment petition.<sup>2</sup>
- When an involuntary commitment petition is filed, the county becomes ultimately responsible for all precommitment, evaluation, and treatment costs. County precommitment costs were found to be significant, extremely unpredictable, and especially problematic for smaller counties. In Hill County, precommitment costs were reported to be more than \$40,000 in FY 2005, but were only \$750 the next year.<sup>3</sup>

---

*When an involuntary commitment petition is filed, the county becomes ultimately responsible for all precommitment, evaluation, and treatment costs.*

---

- Between FY 2004 and FY 2007, some of the highest precommitment costs reported in the HJR 50 survey were:
  - ▶ \$402,537 in Missoula County for FY 2005;
  - ▶ \$317,282 in Yellowstone County for FY 2004;
  - ▶ \$178,148 in Ravalli County in FY 2007;
  - ▶ \$108,700 in Cascade County in FY 2005;
  - ▶ \$67,1214 in Lewis and Clark County for FY 2005; and
  - ▶ \$62,265 in Gallatin County for FY 2004.<sup>4</sup>
- In FY 2007, there were 427 admissions to the MSH for emergency or court-ordered evaluations pending a commitment hearing. Of those, 266 resulted in involuntary commitments. As noted in the summary for HB 131 (LC0516), the committee bill on emergency detention, 63% of MSH admissions were for emergency and court-ordered

detention pending a commitment hearing, and 38% of the cases did not result in a commitment.<sup>5</sup>

- The MSH's average daily population has consistently been above its licensed capacity of 189, which strains MSH resources.<sup>6</sup>
- According to the MSH Administrator, Ed Amberg, many people committed to the MSH can be and are released prior to the 90-day commitment period and voluntary treatment is more successful than involuntary treatment.<sup>7</sup>
- Oregon law allows a person to be diverted from involuntary commitment to an alternative 14-day intensive inpatient treatment program, if the respondent's attorney agrees and a short-term treatment bed is available.<sup>8</sup>
- County commissioners, county attorneys, public defenders, state agency officials, mental health professionals, and mental health advocates, and interested persons supported a short-term diversion alternative to involuntary commitment at the MSH similar to what is provided for in Oregon.<sup>9</sup>

### ***Bill summary***

The main provisions in HB 132 (LC0517) to allow a person to be diverted from involuntary commitment to short-term inpatient treatment are:

- Establishes a 14-day inpatient treatment program as an alternative to involuntary commitment.
- Requires the court to inform the respondent of the diversion alternative and provides that the professional person appointed by the court to conduct an evaluation must make a determination and recommendation about whether the respondent should be diverted to short-term inpatient treatment.

- Provides that if a diversion determination is made, the court shall suspend the commitment hearing unless the county attorney or the respondent's attorney objects within 24 hours.
- Provides that the payment responsibility for the treatment costs will be billed as is currently done for precommitment costs (to the individual, private insurance, or a public assistance program) except that the state, not the county, will ultimately be the payer of last resort.
- Allows a treatment provider to release a respondent earlier than 14 days; but specifies that a commitment hearing must be held if:
  - ▶ the treatment provider wants to keep the respondent longer than 14 days;
  - ▶ the respondent refuses treatment;
  - ▶ the respondent's attorney requests the release prior to the end of the 14-day treatment period; or
  - ▶ the county attorney objects to an early release.
- Specifies that short-term treatment patients must receive a full medical and mental health examination within 24 hours of admission; provides for the patient's treatment rights, for treatment and discharge planning, and for safety requirements.
- Requires DPHHS to contract for up to three short-term inpatient treatment beds within each of the four mental health service areas and requires data collection and reporting. Gives DPHHS rulemaking authority for the program.
- Appropriates \$1.7 million from the state general fund in each year of the biennium, based on preliminary estimates provided by DPHHS, which are subject to change.



***Policy goals***

HB 132 (LC0517) was drafted to accomplish the following policy goals, which were articulated during various committee meetings and in meetings and interviews between staff and stakeholders, including state administrators, county commissioners, county attorneys, public defenders, consumer advocates, and consumer family members :

- to offer an alternative to an adversarial, all-or-nothing commitment process;
- to shorten the precommitment process and reduce county costs;
- to allow a respondent to avoid the stigma of an involuntary commitment to the MSH;
- to reduce the workload for county attorneys, public defenders, and judges; and
- to reduce the number of admissions to the MSH.

ENDNOTES FOR SECTION ON HB 132 (LC0517)

1. LJIC, *Minutes*, Montana Legislative Services Division, November 9, 2007, testimony of HJR 50 panelists, Bill Kennedy, Yellowstone County Commissioner, Merle Raph, Toole County Attorney and President of the Montana County Attorney Association (MCAA), Brett D. Lenneweber, Park County Attorney, the Honorable Kurt Krueger, District Judge in the 2nd Judicial District (Silver Bow County), Ed Amberg, Administrator, MSH, Joan Daly, Billings Clinic, Merry Hutton, St. Patrick Hospital, Linda Bradford, St. Patrick Hospital, and John Honsky, RN, Missoula and researcher of commitment proceedings in the 4th Judicial District. See also, LJIC, *Minutes*, Montana Legislative Services Division, April 10, 2008, testimony of HJR 50 panel and associated public comment by Bill Kennedy, Yellowstone County Commissioner; Merle Raph, Toole County Attorney and President of the MCAA,; Leo Galleggar, Lewis and Clark County Attorney; Kevin Gillan, Yellowstone Deputy County Attorney; Erin Olson, Kelly Harrison, and Dr. Laura Wendland, Office of State Public Defender; Ed Amberg, MSH Administrator; Anita Roessman, Disability Rights Montana; Mitzi Anderson, member of the National Alliance for the Mentally Ill - Montana Chapter. See also, LJIC *Minutes*, Montana Legislative Services Division, June 26, 2008, HJR 50 discussion.
2. Section 53-21-132, MCA.
3. Sheri S. Heffelfinger, *HJR 50 Survey Results: Involuntary Commitment Process and Costs*, Montana Legislative Services Division, April 10, 2008. See Table 9.
4. *Ibid.*
5. *Ibid.* Tables 4 and 5. Data provided by the MSH.
6. Lois Steinbeck, *Montana State Hospital Update June 2008*, Montana Legislative Fiscal Division, prepared for the Legislative Finance Committee, June 4, 2008.
7. LJIC, *Minutes*, Montana Legislative Services Division April 10, 2008. Testimony by Ed Amberg, Administrator, MSH.
8. Section 426.237, Oregon Revised Statutes. See also information provided by Anita Roessman, Disability Rights Montana summarized in LJIC, *Minutes*, Montana Legislative Services Division, April 10, 2008. Exhibit #15. See also, Sheri Heffelfinger, *Presentation Outline: Precommitment Process and Costs (HJR 50) - Progress Report, Summary of Montana Statutes, Comparison with Oregon Diversion Program, Staff Analysis So Far*, LJIC, *Minutes*, Montana Legislative Services Division, June 26, 2008, Audio time: 03:38:10.
9. LJIC, *Minutes*, Montana Legislative Services Division, June 26, 2008.

## **PART II - SJR 6 AND HJR 26 STUDIES OF THE JUVENILE JUSTICE SYSTEM AND MENTAL HEALTH TREATMENT FOR JUSTICE-INVOLVED YOUTH**

### ***Study priorities***

#### Focus on mental health

- The Law and Justice Interim Committee (LJIC) adopted a study plan that combined the study tasks under SJR 6 with the HJR 26 study tasks that focused on mental health treatment in the juvenile justice system.

#### Residential treatment

- After considering a range of issues for justice-involved youth, including several panel discussions about community mental health services, the court system, detention and incarceration, and re-entry, the LJIC identified residential psychiatric treatment needs for justice-involved youth as the most pressing need. In designating this as a top priority, committee members acknowledged that preventing mentally ill youth from ever entering the justice system was the preferred solution. Nonetheless, members also acknowledged the fact that mentally ill youth do enter the justice system and that some of these youth will require residential psychiatric treatment. Because the LJIC's jurisdiction does not include family services and early intervention programs, but relates to needs once the youth is in the juvenile justice system, priority was given to residential treatment needs for justice-involved youth.<sup>1</sup>

---

<p><i>After considering a range of issues for justice-involved youth, including several panel discussions about community mental health services, the court system, detention and incarceration, and re-entry, the LJIC identified residential psychiatric treatment needs for justice-involved youth as the most pressing need.</i></p>	<p><b>Problem</b></p> <p><u>Unmet inpatient residential treatment needs</u></p> <p>When a youth is suffering from a mental disorder that is not recognized or treated, the youth may engage in dangerous and disruptive behaviors, such as using alcohol or drugs, attempting suicide, cutting or other self-mutilation, or verbal or physical aggression against classmates, parents, or other authority figures. Such behaviors often result in the youth being "ticketed" for an offense and entering the juvenile justice system, where, unless the mental disorder is identified and treated, the youth's behavior pushes the youth deeper into the juvenile justice system and towards incarceration.<sup>2</sup></p>
--	---

---

The number of youth with a mental disorder who end up in the juvenile justice system is staggering. According to several national studies, between 65% to 70% of all justice-involved youth suffer from a diagnosable mental disorder; and in 25% of these cases, functional impairment is significant.<sup>3</sup> About 50% of the youth who suffer from a mental disorder also have a co-occurring substance abuse problem.<sup>4</sup>

Inappropriate use of juvenile detention

Testimony to the LJIC indicated that youth court judges may have no other alternative but to place a youth in detention for a mental health evaluation. Although current law allows a judge to place a youth in an assessment center for a multi-disciplinary assessment of education, chemical dependency, mental health, and other service needs,<sup>5</sup> the state of Montana has not funded these and there are no dedicated state emergency detention and treatment beds for youth.

### Disproportionate minority contact

Another problem is that American Indian youth are over-represented in the youth justice system, particularly with regard to incarceration in either detention or a correctional facility. American Indians make up about 7% of the total population in Montana. Yet, in 2007, Montana's youth courts handled 6,692 different youth, of which 846 (12.6%) were American Indian. American Indian youth were ticketed for 15.6% of all juvenile offenses,<sup>6</sup> and 39% percent of Montana's incarcerated youth are American Indians.<sup>7</sup>

### **Research highlights**

#### Inpatient residential treatment alternatives

- A youth court may order a mental health evaluation for a youth at any time during the youth court process.<sup>8</sup> If a youth is found to have a mental disorder, the youth may not be placed in a youth correctional facility. If a youth is found to have a mental disorder after being placed in a youth correctional facility, the Department of Corrections (DOC) must move the youth to a mental health facility, which includes a residential treatment facility if necessary.<sup>9</sup>
  
- Although state law allows a youth court judge to directly commit a youth found to have a mental disorder to a mental health facility,<sup>10</sup> Montana does not have a state-administered residential psychiatric treatment facility, state law prohibits a youth from being treated at the Montana State Hospital (MSH), except when the youth is being processed as an adult,<sup>11</sup> and private treatment providers often decline to accept youth with difficult behavior problems, especially justice-involved youth.

---

*Montana has three in-state private residential treatment facilities that serve Montana youth: Shodair in Helena, Yellowstone Boys and Girls Ranch (YBGR) in Billings, and Acadia in Butte.*

---

- Montana has three in-state private residential treatment facilities that serve Montana youth: Shodair in Helena, Yellowstone Boys and Girls Ranch (YBGR) in Billings, and Acadia in Butte. As private providers, they may decline to accept a youth either because they do not have a bed available or the youth is too disruptive and difficult.
  - ▶ Of the 106 youth in the YBGR residential treatment program, which emphasizes a behavioral treatment model, only 10 of the youth are from Montana.<sup>12</sup>
  - ▶ About 85% of the youth in Acadia's 69-bed residential treatment center in Butte are Montana youth. As a medical model facility, Acadia's program is focused on stabilizing a youth and returning the youth to the community as soon as possible.<sup>13</sup>
  - ▶ Shodair is also a medical model facility, has 68 residential treatment beds and 28 acute care beds, and employs five child/adolescent psychiatrists, which is the highest concentration of child/adolescent psychiatrists in the state. Shodair rarely treats out-of-state youth.<sup>14</sup>
  
- Between July 1, 2007, and April 4, 2008:
  - ▶ only five justice-involved youth with serious mental disorders were placed with in-state private providers for treatment and all were eventually sent out-of-state.<sup>15</sup>
  - ▶ a total of 25 justice-involved youth were placed in out-of-state residential treatment facilities because they could not be placed in state: 15 were placed by DOC and 10 were placed by juvenile probation. Three youth in DOC youth correctional facilities could not be placed at all and remain in the correctional facilities.<sup>16</sup>

- As of February 2008, a total of 161 youth in the public mental health system were placed out-of-state for residential psychiatric treatment. These youth were not involved in the justice system and may not exhibit the more difficult behavioral problems that justice-involved youth may have, but may have some of the same mental health treatment needs as the justice-involved youth.<sup>17</sup>
- The estimated state general fund cost of placing an average of 18 justice-involved youth in out-of-state residential treatment facilities is more than \$2 million annually.<sup>18</sup>
- The estimated cost of operating a 20-bed in-state youth residential treatment facility with 35 full-time staff is about \$1.9 million, not including construction or building renovation costs.<sup>19</sup>

#### Juvenile detention and disproportionate minority contact

- Current law sets the criteria that must be met before a youth may be placed in detention. However, it also allows a judge to place a youth in detention based on any "additional criteria" set by the youth court.<sup>20</sup> The Montana Board of Crime Control's (MBCC) Youth Justice Council recommended legislation to eliminate this "loophole", but did not officially request the legislation as an agency bill.<sup>21</sup>
- Work by the MBCC led to stakeholders in the Great Falls, Missoula, and Havre areas agreeing to participate in the Juvenile Detention Alternatives Initiative (JDAI) offered by the Annie E. Casey Foundation. Under JDAI, stakeholders (including judicial, law enforcement, tribal, detention, and school officials) collaborate in a three-year effort to collect data and implement changes to reduce inappropriate detention, develop detention alternatives, and reduce disproportionate minority contact and confinement.<sup>22</sup>
- Current law allows a youth to waive the right to attorney representation during a probable cause detention hearing without

first consulting an attorney.<sup>23</sup> Judges, attorneys, and probation officers agreed that youth should be represented by an attorney at these hearings.<sup>24</sup>

### ***Actions, recommendations, outcomes***

#### Residential treatment facility not pursued

- The LJIC considered whether Montana should build an in-state youth residential treatment facility. However, the LJIC chose not to move forward with the idea for the following reasons:
  - (a) some members and advocates had lingering concerns about the unintended consequences of establishing a state or state-contracted facility (i.e., the "if you build it they will fill it" mantra reflecting concern that the facility would be used inappropriately and cost more than anticipated);
  - (b) there were questions about whether one facility could meet the treatment needs of youth with varied, diverse diagnoses and that were now in different facilities out-of-state;
  - (c) there were questions about whether the facility would be Medicaid eligible; and
  - (d) representatives of Shodair, YBGR, and Acadia assured the LJIC they were committed to collaborating with the state to assess individual cases and possibly serve more justice-involved youth in-state.<sup>25</sup>
- On September 27, 2008, DOC and DPHHS issued a request for information to gauge private provider interest in establishing a 24-hour psychiatric residential treatment facility to treat youth with mental illness or behavioral health issues. The department announced on November 21, 2008, that after review of the information received,



they would not be moving forward on the idea, but that the information would be filed for possible future consideration. A memorandum summarizing this decision and the rationale for it is provided at Appendix C.<sup>26</sup>

Bill draft to clarify current law needed further work, not pursued

- The LJIC considered a bill draft to:
  - (a) clarify the statutes prohibiting the placement of a youth with a mental disorder in a correctional facility;
  - (b) create a definition of "disabling condition" under the Youth Court Act that would cover developmental disabilities, brain injuries, and mental disorders rather than rely on the involuntary commitment statutes to define mental disorder, which current law provides and which does not include developmental disabilities or brain injuries; and
  - (c) require a youth court judge to order a full mental health evaluation for a youth prior to ordering placement of a youth in a correctional facility, if such an evaluation has not already been done.<sup>27</sup>
  
- The bill draft needed further work on the disabling condition definition and to resolve concerns about how mental health evaluations would be conducted, by whom, and whether to mandate them.
  
- The LJIC chose not to recommend the draft bill as a committee bill, but acknowledged that DOC requested a similar bill (LC0311), which could be drafted and forwarded as an agency bill to address some of the issues the committee draft tried to address.<sup>28</sup> However, DOC announced on December 17, 2008, that it would not move forward the requested bill.<sup>29</sup>

Juvenile detention, hearing recommendation

- The LJIC expressed interest in continuing to monitor the progress of JDAI activities in Montana.<sup>30</sup>
  
- The LJIC voted to recommend to the 61st Legislature, LC0198 (now SB 91), a bill requiring that a youth be represented by an attorney at a probable cause detention hearing, unless the youth waives that right after the youth has consulted with an attorney.<sup>31</sup>

## ENDNOTES FOR PART II ON SJR 6 AND HJR 26 STUDIES

1. Juvenile Justice Working Group, Law and Justice Interim Committee (LJIC), *Minutes*, Montana Legislative Services Division, January 11, 2008.
2. LJIC, *Minutes*, Montana Legislative Services Division, November 30, 2007, panel discussions.
3. Kathleen R. Skowrya and Joseph Coccozza, *A Blue Print for Change: Improving the System Response to Youth with Mental Health Needs Involved with the Juvenile Justice System*, Research and Program Brief, National Center for Mental Health and Juvenile Justice, June 2006.
4. National Mental Health Association, *Mental Health Treatment for Youth in the Juvenile Justice System: A Compendium of Promising Practices*, 2004.
5. Sections 41-5-1203(2)(a) and 41-5-1512(1)(p), MCA.
6. LJIC, *Minutes*, Montana Legislative Services Division, January 10, 2008. Testimony by Bob Peake, District and Youth Court Services Bureau Chief, Judicial Branch. Audio time: 03:31:52.
7. *Ibid.* Exhibit 11 from Steve Gibson, *OJJDP DMC Reduction Best Practices Database*.
8. Section 41-5-1503(1), Montana Code Annotated (MCA).
9. Section 41-5-1504, MCA..
10. Section 41-5-1512, MCA.
11. Section 53-21-506, MCA.
12. LJIC, *Minutes*, Montana Legislative Services Division, June 27, 2008. Testimony from Jani McCall, Vice President, Government Relations, Yellowstone Boys and Girls Ranch, Billings.
13. *Ibid.* Testimony from Jim McVeigh, Director of Business Development, Acadia of Montana.
14. *Ibid.* Testimony from Jack Casey, Administrator, Shodair Children's Hospital, Helena.
15. LJIC, *Minutes*, Montana Legislative Services Division, April 10, 2008, Exhibit 4. Handout from Steve Gibson, Youth Services Division Administrator, Department of Corrections (DOC).
16. *Ibid.*
17. *Ibid.* Exhibit 6. Handout from Mary Dalton, Health Resources Division Administrator, Department of Public Health and Human Services (DPHHS).

18. Ibid.

19. LJIC, *Minutes*, Montana Legislative Services Division, June 27, 2008, Exhibit 29. Testimony by Steve Gibson, Youth Services Administrator, DOC.

20. Section 41-5-341(2)(f), MCA.

21. Juvenile Justice Working Group, LJIC, *Minutes*, Montana Legislative Services Division, January 11, 2008, Audio time: 00:03:34.

22. Ibid. Exhibits 1 and 2. Expert testimony, including testimony from Bart Lubow, Director of Programs for High Risk Youth, Annie E. Casey Foundation, and working group questions and discussion about juvenile detention. Audio time: 00:03:34.

23. Sections 41-5-332 and 41-5-333, MCA.

24. Juvenile Justice Working Group, LJIC, *Minutes*, Montana Legislative Services Division, February 29, 2008, Audio time starting: 01:00:45

25. LJIC, *Minutes*, Montana Legislative Services Division, June 27, 2008. See discussion and Exhibit 28 provided by Jack Casey of Shodair.

26. Deb Matteucci, Summary of Decision re: Psychiatric Residential Treatment Facility for Youth, memorandum dated December 1, 2008.

27. Ibid. Exhibit 26 and testimony by Mary Dalton, Health Resources Division Administrator, DPHHS.

28. LJIC, *Minutes*, Montana Legislative Services Division, September 15, 2008. Audio time: 04:17:20.

29. Mike Ferriter, email copied to Sheri Heffelfinger, December 17, 2008.

30. Juvenile Justice Working Group, LJIC, *Minutes*, Montana Legislative Services Division, January 11, 2008, and February 28, 2008. See recommendations adopted by the full LJIC, *Minutes*, Montana Legislative Services Division, February 29, 2008.

31. Juvenile Justice Working Group, LJIC, *Minutes*, Legislative Services Division, February 28, 2008. See recommendations adopted by the full LJIC, *Minutes*, February 29.

## **PART III - SJR 24**

### **STUDY OF PRISON POPULATION GROWTH AND DIVERSION TO TREATMENT**

#### ***Study priority***

In conducting the SJR 24 study, the Law and Justice Interim Committee (LJIC) focused on drug offenders and whether Montana's law should be changed to divert nonviolent drug offenders to treatment as an alternative to incarceration.

#### ***Key activities***

The LJIC's key study activities were as follows:

- Review of the Department of Corrections (DOC) prison population reports and growth projections.
- Examination of drug offender sentencing data and correctional treatment alternatives.
- Examination of California's Proposition 96, which reformed drug offender sentencing and treatment alternatives in California, including a presentation by Mr. Daniel Abrahamson<sup>1</sup> and Ms. Tamar Todd,<sup>2</sup> Drug Policy Institute.

#### ***Research highlights***

##### Prison population growth

- Of about 13,000 offenders in Montana's state adult corrections system, more than 80% are in community placements.<sup>3</sup>

- As of the first quarter of FY2008, the male prison population had been reduced by 4% and the female prison population had been reduced by 25%, mostly due to more community placements, diversion to treatment programs, and the use of the sanctions and assessment centers.<sup>4</sup>
- DOC projected a 3.4% annual growth rate in the male prison population, which would result in the Montana State Prison exceeding its current capacity by 132 inmates by FY2011.<sup>5</sup>
- DOC projected a 6.9% annual growth rate in the female prison population, which would result in the Montana Woman's Prison exceeding its capacity by 9 inmates by FY2011.<sup>6</sup>

#### Drug offenses and sentencing data

- Drug possession is the most common offense for which male and female offenders under DOC supervision have been convicted. Felony driving under the influence is the 3rd most common offense among men and the 6th most common offense among women. The sale of drugs ranks 5th most common offense among both men and women.<sup>7</sup>
- About 26% of the all offenses committed are drug offenses, with 58% of these offenses involving only drug possession and/or use (not including drug manufacture, distribution, possession with intent to sell, or fraudulently obtaining drugs).<sup>8</sup>
- Montana's current law allows judges to impose alternative sentences for drug offenses so that felony drug offenders can be enrolled in DOC treatment programs rather than imprisoned.<sup>9</sup>
- Based on 5 years of sentencing data, 95% of those convicted of felony drug possession or use received suspended, deferred, or alternative sentencing, while 5% (119 individuals) were sentenced to

prison. Of those sentenced to prison, all but 6 had a record of prior drug offenses or other criminal offenses.<sup>10</sup>

- Between July 1, 2002, to July 1, 2006, of the offenders convicted for drug possession and/or use and who were sentenced to the DOC for placement, about 26% were placed in a treatment program.<sup>11</sup>
- DOC's residential chemical dependency treatment programs are:

<b>Name</b>	<b>Location</b>	<b>Capacity</b>	<b>Program</b>	<b>Duration</b>
WATCh West	Warm Springs	108 beds	DUI (males)	180 days
WATCh East	Glendive	42 beds	DUI (females/males)	180 days
Connections West	Warm Springs	52 beds	Alcohol & Drug (males)	60 days
Connections East	Butte	42 beds	Alcohol & Drug (males)	60 days
Passages	Billings	40 beds	Alcohol & Drug (females)	60 days
Elkhorn Center	Boulder	40 beds	Meth (females)	270 days
Nexus Center	Lewistown	80 beds	Meth (males)	270 days

*Source: Department of Corrections.*

- For FY 2008, DOC's expenditures for treatment programs were just over \$15 million, with almost \$14 million spent on contracted programs.<sup>12</sup> DOC's total general fund appropriation for FY2008 was just over \$157 million,<sup>13</sup> which means that about 9.5% of DOC's budget for FY 2008 was spent on treatment.
- The total average population in DOC chemical dependency programs is about 930 offenders, with 51% of them in state-run (rather than contract provider) facilities. As of a February 2008 report to the LJIC, the total waiting list for these programs was 699 offenders.<sup>14</sup>

***Actions, recommendations, outcomes***

- The LJIC did not develop recommendations for legislative action under SJR 26.
- A comprehensive report from DOC providing further data on drug offenders is available from the Montana Legislative Services Division.<sup>15</sup>



## ENDNOTES FOR SUMMARY OF SJR 24 STUDY

1. Law and Justice Interim Committee (LJIC), *Minutes*, Montana Legislative Services Division, November 9, 2007.
2. Adult Justice Working Group, LJIC, *Minutes*, Montana Legislative Services Division, February 29, 2007.
3. LJIC, *Minutes*, Montana Legislative Services Division, November 9, 2007. See Exhibits 5 and 6 and testimony and report by Gary Hamel, Health Planning and Information Services Division Administrator, Department of Corrections (DOC).
4. Ibid.
5. LJIC, *Minutes*, Montana Legislative Services Division, November 9, 2007. Report by DOC.
6. Ibid.
7. DOC, *Biennial Report*, State of Montana, 2007.
8. Adult Justice Working Group, LJIC, *Minutes*, Montana Legislative Services Division, February 28, 2008, Exhibit 9. DOC report on drug offender data.
9. Section 45-9-202, MCA.
10. Sheri Heffelfinger, *SJR 24 Drug Offender Sentencing Data Analysis*, Montana Legislative Services Division, November 2007, for the Law and Justice Interim Committee. Raw data provided by DOC.
11. Adult Justice Working Group, LJIC, *Minutes*, Montana Legislative Services Division, February 28, 2008, Exhibit 9. DOC report on drug offender data.
12. Ibid. Exhibit 9, DOC report, p.1.
13. Montana Legislative Fiscal Division, *Profile of Department of Corrections*, October 2008.
14. Ibid. Exhibit 9, DOC report, p.1.
15. Adult Justice Working Group, LJIC, *Minutes*, Montana Legislative Services Division, February 28, 2008, Exhibit 9. DOC report on drug offender data.



## **PART IV - IN SUMMARY**

### ***Recommendations***

The LJIC recommends to the 61st Legislature for the 2009 Session the following bills:

- HB 130 (LC0307) - a grant program for community-based crisis intervention and jail diversion;
- HB 60 (LC0329) - a pilot project for a statewide jail suicide prevention program;
- HB 131 (LC0516) - state contracting for regional emergency detention beds; and
- HB 132 (LC0517) - diversion from involuntary commitment at the MSH to short-term inpatient treatment.

### ***Goals***

The overall goals of these for bills are to support community-based mental health services that will:

- reduce the number of mentally ill individuals held in local detention centers and ultimately prison;
- reduce county precommitment costs;
- reduce county admissions to the MSH for emergency detention; and
- reduce the number of mentally ill individuals committed to the MSH.

**Funding**

The bills rely on appropriations from the state general fund in the following amounts, which are based on the very preliminary estimates provided by DPHHS, so are subject to change during the 2009 Session:

	<u>FY2010</u>	<u>FY2011</u>
▶ HB 130 (LC0307)	\$615,937	\$615,937
▶ HB 60 (LC0329)	\$264,000	\$189,000
▶ HB 131 (LC0516)	\$410,625	\$410,625
▶ HB 132 (LC0517)	\$1.7 million	\$1.7 million

# **APPENDIX A**

## **Study Resolutions**

- SJR 6:** study of the juvenile justice system
- SJR 24:** study of prison population growth and diversion to treatment for drug offenders
- HJR 26:** study of mental health treatment and diversion alternatives in the adult and juvenile justice systems
- HJR 50:** study of involuntary precommitment process and costs



1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28  
29  
30

SENATE JOINT RESOLUTION NO. 6

INTRODUCED BY SCHMIDT

A JOINT RESOLUTION OF THE SENATE AND THE HOUSE OF REPRESENTATIVES OF THE STATE OF MONTANA REQUESTING A STUDY OF THE JUVENILE JUSTICE SYSTEM IN ORDER TO IDENTIFY ANY GAPS IN THE LAW OR RESOURCES OR BETWEEN THE EXISTING AGENCIES WITH VARIOUS RESPONSIBILITIES WITHIN THE SYSTEM.

WHEREAS, our state should work to balance youth accountability for delinquent behavior with the best and most appropriate services to help youth contribute to our state and our society; and

WHEREAS, our state should coordinate youth services in order to provide the best services in the most fiscally responsible manner in order to enhance rehabilitation and restore the communities affected by juvenile offenders; and

WHEREAS, a comprehensive study of juvenile justice programs and data is necessary to determine the most objective and fair treatment of youth; and

WHEREAS, the Montana Constitution provides that the rights of persons under 18 years of age include but are not limited to all the fundamental rights unless specifically precluded by laws that enhance their protection; and

WHEREAS, a review of the juvenile justice system is needed because of its complexities that involve many entities in government and because of the effects on the youth, families, and communities in Montana.

NOW, THEREFORE, BE IT RESOLVED BY THE SENATE AND THE HOUSE OF REPRESENTATIVES OF THE STATE OF MONTANA:

That the Legislative Council be requested to designate an appropriate interim committee, pursuant to section 5-5-217, MCA, or direct sufficient staff resources to study the various entities of the Montana system of juvenile justice, its governing statutes, and its resources.

BE IT FURTHER RESOLVED, that the committee prioritize areas for study based on the review and the areas of need brought to its attention by the public and the stakeholders and determine those that could be effectively addressed during the interim.

BE IT FURTHER RESOLVED, that the committee:



1 (1) identify gaps or overlap and consistency in services by examining the roles of the specific entities  
2 involved, including juvenile probation, juvenile parole, detention centers, secure care, foster care, schools, and  
3 mental health professionals in state, local, and tribal governments;

4 (2) determine what statutory changes to the Montana Youth Court Act or other laws may be required to  
5 facilitate a more seamless delivery of services among and between the various agencies that are involved with  
6 youth in the juvenile justice system;

7 (3) identify the existence and quality of any tools used for assessment, evaluation, and treatment of youth  
8 and the extent to which the tools need to be developed or updated to reflect research-based best practices and  
9 to measure outcomes;

10 (4) identify any inconsistencies statewide in the handling of graduated sanctions and probation violations;

11 (5) research how to improve the transition of the population of youth that is between 18 and 24 years  
12 of age to the adult correctional system; and

13 (6) analyze existing data to determine areas of greatest success in prevention of and early intervention  
14 in juvenile delinquency and related areas that need improvement.

15 BE IT FURTHER RESOLVED, that the committee develop methods, such as public hearings, panel  
16 discussions, or working groups, to solicit concerns and information from the public and representatives from the  
17 Office of Court Administrator, juvenile probation, juvenile detention, the Department of Corrections, juvenile  
18 parole, the Board of Crime Control, the Youth Justice Council, school districts, tribal and local governments,  
19 County Attorneys, the public defender system, law enforcement, the mental health profession, addictive and  
20 mental disorders and child and family services in the Department of Public Health and Human Services, and  
21 youth and parents either currently involved or previously involved in aspects of the juvenile justice system relevant  
22 to this study.

23 BE IT FURTHER RESOLVED, that if the study is assigned to staff, any findings or conclusions be  
24 presented to and reviewed by an appropriate committee designated by the Legislative Council.

25 BE IT FURTHER RESOLVED, that all aspects of the study, including presentation and review  
26 requirements, be concluded prior to September 15, 2008.

27 BE IT FURTHER RESOLVED, that the final results of the study, including any findings, conclusions,  
28 comments, or recommendations of the appropriate committee, be reported to the 61st Legislature.

29 - END -



## 1 SENATE JOINT RESOLUTION NO. 24

2 INTRODUCED BY LASLOVICH

3 BY REQUEST OF THE SENATE JUDICIARY STANDING COMMITTEE

4  
5 A JOINT RESOLUTION OF THE SENATE AND THE HOUSE OF REPRESENTATIVES OF THE STATE OF  
6 MONTANA REQUESTING AN INTERIM STUDY TO ASSESS PRISON POPULATION GROWTH AND  
7 NONPRISON TREATMENT ALTERNATIVES FOR CERTAIN NONVIOLENT OFFENDERS.

8  
9 WHEREAS, Montana experienced a growth of 920% in its incarceration rate from 1970 to 2003, the  
10 largest rate of growth in incarceration of any state for that period; and

11 WHEREAS, Montana's adult correctional population grew by an estimated 10.2% in 2005, the second  
12 highest increase nationally, and 5.7% faster than the national average; and

13 WHEREAS, the Executive Budget for the 2009 biennium proposes a spending increase of 38% for the  
14 Montana Department of Corrections; and

15 WHEREAS, the 60th Legislature may be the first Legislature in Montana history to appropriate more  
16 general fund dollars to corrections than to higher education; and

17 WHEREAS, a recent report of the University of Montana School of Social Work found that 92.4% of  
18 offenders assigned to prerelease facilities have been diagnosed with chemical dependency or substance abuse  
19 issues, mental illness, or both; and

20 WHEREAS, treatment is an effective and necessary tool for the successful rehabilitation of offenders with  
21 drug and alcohol addictions; and

22 WHEREAS, other states have found treatment for certain convicted nonviolent offenders with substance  
23 abuse addictions to be a cost-effective alternative to secure care, while reducing prison population overcrowding  
24 and providing an overall cost savings to the taxpayers.

25  
26 NOW, THEREFORE, BE IT RESOLVED BY THE SENATE AND THE HOUSE OF REPRESENTATIVES OF THE  
27 STATE OF MONTANA:

28 That the Legislative Council be requested to designate an appropriate interim committee, pursuant to  
29 5-5-217, MCA, to study secure care diversion alternatives for certain nonviolent offenders ~~convicted of a first or~~  
30 ~~second offense of simple drug possession.~~

1 BE IT FURTHER RESOLVED, that the committee make recommendations to the criminal justice and  
2 corrections systems and the judiciary to alleviate Montana's prison population growth.

3 BE IT FURTHER RESOLVED, that the study:

4 (1) examine the impacts of diversion and treatment alternatives for certain nonviolent offenders on  
5 Montana's current and future corrections population;

6 (2) estimate the overall effects to the state budget provided by nonsecure care treatment alternatives  
7 for certain nonviolent offenders;

8 (3) propose revisions to laws related to secure care placement guidelines and treatment availability; and

9 (4) work collaboratively with the Corrections Advisory Council established by Executive Order No.  
10 20-2005;

11 BE IT FURTHER RESOLVED, that all aspects of the study, including presentation and review  
12 requirements, be concluded prior to September 15, 2008.

13 BE IT FURTHER RESOLVED, that the final results of the study, including any findings, conclusions,  
14 comments, or recommendations of the appropriate committee, be reported to the 61st Montana Legislature, to  
15 each tribal government located on the seven Montana reservations and to the Little Shell Chippewa tribe, and  
16 to the Governor.

17 - END -

## 1 HOUSE JOINT RESOLUTION NO. 26

2 INTRODUCED BY CALLAHAN, RASER, HINER, RICE, WEINBERG, W. JONES, PARKER, MCGEE,  
 3 GRINDE, STOKER, WARD, GALLUS, WILLIAMS, JOPEK, BIXBY, GROESBECK, HENDRICK, CAMPBELL,  
 4 BERGREN

5  
 6 A JOINT RESOLUTION OF THE SENATE AND THE HOUSE OF REPRESENTATIVES OF THE STATE OF  
 7 MONTANA REQUESTING THAT AN INTERIM COMMITTEE OR STAFF STUDY AND DEVELOP AN  
 8 IMPLEMENTATION PLAN FOR MENTAL HEALTH CARE FOR ADULTS AND YOUTH IN THE CRIMINAL AND  
 9 JUVENILE JUSTICE SYSTEMS.

10  
 11 WHEREAS, criminal justice research data revealed that ~~the rate of current severe mental disorder was~~  
 12 ~~6.4% for male detainees entering jail and 12.2% for female detainees~~ MORE THAN HALF OF JAIL INMATES AND STATE  
 13 PRISONERS HAVE MENTAL HEALTH PROBLEMS, BASED ON SYMPTOMS WITHIN THE PAST 12 MONTHS, which is significantly  
 14 more prevalent than in the general population; and

15 WHEREAS, ~~the vast majority~~ A NUMBER of youth in the juvenile justice system; ~~approximately 70%;~~ suffer  
 16 from mental ~~disorders,~~ with ~~25%~~ HEALTH PROBLEMS, SOME experiencing disorders so severe that their ability to  
 17 function is significantly impaired; and for some youth, contact with the juvenile justice system is often their first  
 18 and only chance to get help; and

19 WHEREAS, appropriate and early intervention and treatment of adults and youth with mental disorders  
 20 may divert them from costly incarceration and future crime and assist them to become productive members of  
 21 society; and

22 WHEREAS, community treatment options for adult and juvenile offenders may require supervision,  
 23 housing, and employment supports toward a recovery-based life, and a study of the issue of mental health care  
 24 for adult and juvenile offenders is needed to determine ways to improve the criminal and juvenile justice systems;;

25 AND

26 WHEREAS, THE LAW AND JUSTICE INTERIM COMMITTEE OF THE MONTANA LEGISLATURE STUDIED THE  
 27 "DISPROPORTIONATE MINORITY CONTACT IN THE MONTANA CRIMINAL JUSTICE SYSTEM" AND FOUND THAT A SIGNIFICANT  
 28 NUMBER OF INDIVIDUALS IN THE CORRECTIONS SYSTEM HAVE MENTAL HEALTH ISSUES; AND

29 WHEREAS, AT LEAST ONE PREVIOUS INTERIM STUDY OF THE MONTANA LEGISLATURE ADDRESSED THE MENTAL  
 30 HEALTH OF INDIVIDUALS IN THE JUVENILE JUSTICE SYSTEM BUT DID NOT STUDY THE CRIMINAL JUSTICE SYSTEM AS A

1 WHOLE; AND

2 WHEREAS, THERE IS A NEED FOR A COMPREHENSIVE INTERIM STUDY THAT WOULD INCLUDE A REVIEW OF ALL  
3 PREVIOUS STUDIES AND LAWS RELATED TO MENTAL HEALTH ISSUES IN THE CRIMINAL AND JUVENILE JUSTICE SYSTEM  
4 SYSTEMS FOR THE PURPOSES OF DEVELOPMENT OF A PLAN TO IMPLEMENT PRIORITIES TO DEAL WITH THOSE ISSUES.

5

6 NOW, THEREFORE, BE IT RESOLVED BY THE SENATE AND THE HOUSE OF REPRESENTATIVES OF THE  
7 STATE OF MONTANA:

8 That the Legislative Council be requested to designate an appropriate interim committee, pursuant to  
9 section 5-5-217, MCA, or direct sufficient staff resources to address mental health care in the criminal and  
10 juvenile justice systems.

11 BE IT FURTHER RESOLVED, that the goal be to study and develop an implementation plan to provide  
12 mental health care in the criminal and juvenile justice systems that includes:

13 (1) mental health care of youth who are adjudicated as delinquent;

14 (2) mental health care of convicted adult defendants;

15 (3) addressing options for supervising adjudicated youth and convicted adults in the community,  
16 including mental health probation options;

17 (4) developing a continuum of care encompassing community placements and inpatient treatment  
18 options and addressing the interplay between community placements and treatment options; and

19 (5) the availability and use of mental health treatment prior to adjudication of juvenile or conviction of  
20 adult defendants.

21 BE IT FURTHER RESOLVED, that if the study is assigned to staff, any findings or conclusions be  
22 presented to and reviewed by an appropriate committee designated by the Legislative Council.

23 BE IT FURTHER RESOLVED, that all aspects of the study, including presentation and review  
24 requirements, be concluded prior to September 15, 2008.

25 BE IT FURTHER RESOLVED, that the final results of the study, including any findings, conclusions,  
26 comments, or recommendations of the appropriate committee, be reported to the 61st Legislature.

27 - END -

## 1 HOUSE JOINT RESOLUTION NO. 50

2 INTRODUCED BY BECKER, STAHL, ARNTZEN, GRINDE

3

4 A JOINT RESOLUTION OF THE SENATE AND THE HOUSE OF REPRESENTATIVES OF THE STATE OF  
5 MONTANA REQUESTING THAT AN APPROPRIATE INTERIM COMMITTEE STUDY MONTANA'S  
6 PSYCHIATRIC PRECOMMITMENT EXAMINATION, DETENTION, AND TREATMENT PROCESS AND COSTS.

7

8 WHEREAS, section 53-21-132, MCA, requires Montana counties to serve as the payor of last resort for  
9 the psychiatric precommitment examination, detention, and treatment costs incurred when a court order has been  
10 sought to commit a seriously mentally ill person to the Montana State Hospital; and

11 WHEREAS, psychiatric precommitment evaluations for which counties have been billed have ranged in  
12 duration from 3 days to more than 45 days; and

13 WHEREAS, the lack of time limits on psychiatric precommitment evaluations not only creates uncertainty  
14 for a person subject to commitment proceedings, but also may delay the person's placement in the most  
15 appropriate treatment setting; and

16 WHEREAS, the lack of time limits on psychiatric precommitment evaluations also creates financial  
17 uncertainty for Montana's counties, resulting in unanticipated costs.

18

19 NOW, THEREFORE, BE IT RESOLVED BY THE SENATE AND THE HOUSE OF REPRESENTATIVES OF THE  
20 STATE OF MONTANA:

21 That the Legislative Council be requested to designate an appropriate interim committee, pursuant to  
22 section 5-5-217, MCA, or direct sufficient staff resources to:

23 (1) study the ways in which the psychiatric precommitment examination, detention, and treatment  
24 provisions of state law have been used across the state, including the number of days that individuals are in  
25 precommitment evaluation status in each county;

26 (2) determine the amount of money that Montana's county governments have paid for psychiatric  
27 precommitment examination, detention, and treatment, including the trends in those costs over time; and

28 (3) review the number of people committed to the Montana State Hospital pursuant to the provisions of  
29 Title 53, chapter 21, part 1, MCA, including the number of people committed from each Montana county.

30 BE IT FURTHER RESOLVED, that the study involve discussions with county officials, mental health

1 providers, District Judges, County Attorneys, the Office of State Public Defender, the Department of Public Health  
2 and Human Services, and mental health advocates to provide needed information on ways to streamline the  
3 system for both mental health consumers and county governments.

4 BE IT FURTHER RESOLVED, that the committee identify alternatives to the current psychiatric  
5 precommitment examination, detention, and treatment process that would:

6 (1) allow timely resolution of commitment proceedings to ensure that a person who is subject to a  
7 commitment proceeding is placed in the most appropriate treatment setting as quickly as possible; and

8 (2) improve a county government's ability to predict and budget for the costs of psychiatric  
9 precommitment evaluations.

10 BE IT FURTHER RESOLVED, that if the study is assigned to staff, any findings or conclusions be  
11 presented to and reviewed by an appropriate committee designated by the Legislative Council.

12 BE IT FURTHER RESOLVED, that all aspects of the study, including presentation and review  
13 requirements, be concluded prior to September 15, 2008.

14 BE IT FURTHER RESOLVED, that the final results of the study, including any findings, conclusions,  
15 comments, or recommendations of the appropriate committee, be reported to the 61st Legislature.

16 - END -

# APPENDIX B

## Committee Bills Discussed in this Report

- HB 130 (LC0307) - establishing a grant program for county crisis intervention and jail diversion programs.
- HB 60 (LC0329) - establishing a pilot project for a statewide jail suicide prevention program.
- HB 131 (LC0516) - requiring that DPHHS contract for up to three secure psychiatric treatment beds in each of four mental health regions.
- HB 132 (LC0517) - allowing an involuntary commitment hearing to be suspended if the respondent agrees to be diverted to a 14-day short-term inpatient treatment program and requiring that DPHHS contract for up to three short-term inpatient treatment beds in each of four mental health regions.





1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28  
29  
30

HOUSE BILL NO. 130  
INTRODUCED BY R. STOKER  
BY REQUEST OF THE LAW AND JUSTICE INTERIM COMMITTEE

A BILL FOR AN ACT ENTITLED: "AN ACT PROVIDING FOR STATE MATCHING FUNDS TO BE GRANTED TO COUNTIES FOR CRISIS INTERVENTION, JAIL DIVERSION, AND INVOLUNTARY PRECOMMITMENT COSTS FOR THE MENTALLY ILL; REQUIRING RULEMAKING; PROVIDING AN APPROPRIATION; PROVIDING IMPLEMENTATION INSTRUCTIONS; REQUIRING A REPORT; AND PROVIDING AN EFFECTIVE DATE."

WHEREAS, the 2007 Legislature passed House Joint Resolution No. 26, requesting an interim legislative study to examine diversion of mentally ill adults from the justice system, and House Joint Resolution No. 50, requesting a study to examine county precommitment costs related to involuntary commitment proceedings; and

WHEREAS, these studies were assigned to the Law and Justice Interim Committee; and

WHEREAS, after 14 months of testimony and examination of data and information from all stakeholders, the Law and Justice Interim Committee identified crisis intervention and jail diversion to be the most critical need and the most effective way to divert mentally ill individuals from the criminal justice system and recommends this bill as part of a package of bills to address this need; and

WHEREAS, the lack of local crisis intervention and jail diversion alternatives means counties must rely on the Montana State Hospital for emergency and court-ordered detention and evaluation, which increases county costs, strains the Montana State Hospital, and diverts resources from community-based services; and

WHEREAS, sections 53-21-138 and 53-21-139, MCA, originally enacted by the 1991 Legislature, provide a solid statutory framework for diversion of mentally ill adults from the justice system but do not provide state funding; and

WHEREAS, state matching funds granted to counties based on certain criteria are an appropriate way to share costs and provide incentives for local resources to be spent on community-based treatment capacity rather than on jail capacity or on transportation to and capacity in the Montana State Hospital; and

WHEREAS, crisis intervention team training and collaboration between local law enforcement officers, mental health professionals, and private corporations can offer creative solutions that should be encouraged and sustained; and

1 WHEREAS, counties should be encouraged to participate in a county self-insurance pool to help pay for  
2 unpredictable and sometimes financially catastrophic precommitment costs.

3

4 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

5

6 **NEW SECTION. Section 1. State matching fund grants for county crisis intervention, jail**  
7 **diversion, and precommitment costs.** (1) As soon as possible after July 1 of each year, from funds  
8 appropriated by the legislature for the purposes of this section, the department shall grant to each eligible county  
9 state matching funds for eligible county expenditures made in the previous fiscal year for jail diversion and crisis  
10 intervention services to implement 53-21-138 and 53-21-139 and for insurance coverage against catastrophic  
11 precommitment costs, if a county insurance pool is established pursuant to 2-9-211. The grant amount may not  
12 exceed 50% of the county's eligible expenditures and must be prorated based on available funding. The  
13 department shall develop a mechanism to provide higher grant amounts to counties that reduce their admissions  
14 to the state hospital for emergency and court-ordered detention and evaluation.

15 (2) In order to be eligible for the state matching funds, a county shall, in the time and manner prescribed  
16 by the department:

17 (a) apply for the funds;

18 (b) develop and submit to the department a county jail diversion and crisis intervention services strategic  
19 plan pursuant to 53-21-138 and 53-21-139, including a plan for community-based or regional emergency and  
20 court-ordered detention and examination services;

21 (c) participate in a statewide or regional county insurance plan for precommitment costs under  
22 53-21-132, if a statewide or regional insurance plan has been established, as authorized under 2-9-211;

23 (d) participate in a statewide or regional jail suicide prevention program, if one has been established by  
24 the department for the state or for the region in which the county is situated;

25 and

26 (e) collect and report data and information on county jail diversion and crisis intervention services in the  
27 form and manner prescribed by the department to support program evaluation and measure progress on  
28 performance goals.

29 (3) The department shall adopt rules to implement the provisions of this section and to specify eligible  
30 expenses.

1 (4) Insurance premiums paid by counties pursuant to subsection (2)(c) must be considered an eligible  
2 expense under this section.

3  
4 **NEW SECTION. Section 2. Appropriation.** (1) There is appropriated from the general fund to the  
5 department of public health and human services:

6 (a) for fiscal year 2010, \$615,937; and

7 (b) for fiscal year 2011, \$615,937.

8 (2) The money appropriated in this section may be used only for the purposes of [section 1].

9  
10 **NEW SECTION. Section 3. Implementation -- report.** (1) Implementation of the grant program  
11 established in [section 1] may be conducted in phases. However, it is the legislature's intent that the grant  
12 program be fully implemented by no later than July 1, 2010.

13 (2) As soon as possible after July 1, 2010, the department shall report to the law and justice interim  
14 committee established in 5-5-226 on the implementation status of [section 1].

15  
16 **NEW SECTION. Section 4. Codification instruction -- instructions to code commissioner.** (1)  
17 [Section 1] is intended to be codified as an integral part of Title 53, chapter 21, and the provisions of Title 53,  
18 chapter 21, apply to [section 1].

19 (2) Sections 53-21-138 and 53-21-139 are intended to be renumbered and codified with [section 1] as  
20 an integral new part of Title 53, chapter 21.

21

22 **NEW SECTION. Section 5. Effective date.** [This act] is effective July 1, 2009.

23

- END -

## 1 HOUSE BILL NO. 60

2 INTRODUCED BY B. EBINGER

3 BY REQUEST OF THE LAW AND JUSTICE INTERIM COMMITTEE  
4

5 A BILL FOR AN ACT ENTITLED: "AN ACT REQUIRING THE DEPARTMENT OF PUBLIC HEALTH AND  
6 HUMAN SERVICES TO CONTRACT FOR THE CREATION AND OPERATION OF A PILOT PROGRAM FOR  
7 THE REDUCTION OF RISK OF INMATE SUICIDES IN CERTAIN DETENTION FACILITIES; PROVIDING FOR  
8 THE CONTENT OF THE PROGRAM AND THE DUTIES OF THE DEPARTMENT; REQUIRING RULEMAKING;  
9 PROVIDING AN APPROPRIATION; AND PROVIDING EFFECTIVE DATES AND A TERMINATION DATE."

10  
11 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:  
12

13 NEW SECTION. **Section 1. Short title.** [Sections 1 through 7] may be cited as the "Linda Wilson  
14 Memorial Jail Suicide Prevention Act of 2009".  
15

16 NEW SECTION. **Section 2. Legislative finding and intent.** An examination of inmate suicides  
17 occurring in detention centers in Montana has demonstrated to the legislature that while the number of yearly  
18 suicides in those facilities is no more than an average of 3.6 per year, the rate of those suicides compared to  
19 other states, when compared on the basis of the number of inmates in detention centers, warrants the creation  
20 of a pilot program designed to reduce the risk of suicides in those centers. The intent of the legislature in enacting  
21 [sections 1 through 7] is to create a time-limited pilot project based upon the Kentucky jail mental health crisis  
22 network established pursuant to Kentucky Revised Statutes 210.365. It is the intent of the legislature that the pilot  
23 program be conducted in detention centers representing a mixture of both small and large detention centers, by  
24 inmate population, in order to demonstrate the viability of a permanent program to reduce the risk of inmate  
25 suicide within detention centers in all counties of the state. It is also the intent of the legislature that in creating  
26 and operating the pilot program, the department shall consider the creation and operation of the Kentucky jail  
27 mental health crisis network for guidance.  
28

29 NEW SECTION. **Section 3. Definitions.** As used in [sections 1 through 7], the following definitions  
30 apply:

1 (1) "Department" means the department of public health and human services established in 2-15-2201.

2 (2) "Detention center" means a detention center, as defined in 7-32-2120, that is operated by a local  
3 government.

4 (3) "Inmate" means a person who is confined in a detention center.

5 (4) "Management protocol" means a rule providing the best management practices in the subject areas  
6 of housing, supervision, clothing, property, and food for an inmate at risk of suicide.

7 (5) "Mental health professional" has the meaning provided in 53-21-102.

8 (6) "Rule" has the meaning provided in 2-4-102.

9 (7) "Screening instrument" means a written or electronic series of questions designed to determine the  
10 degree of likelihood or risk that an inmate may commit suicide.

11

12 **NEW SECTION. Section 4. Pilot program for reduction of inmate suicide risk in certain detention**  
13 **centers -- design and content -- inmate screening required.** (1) The department shall contract to create a  
14 program for the reduction of likelihood or risk that an inmate in any of the detention centers within the state may  
15 commit suicide. The program must include the use of:

16 (a) one or more screening instruments for which the department's goal should be uniformity in all  
17 instruments for all detention centers and for other individuals who may be required to complete or respond to the  
18 questions in the screening instrument;

19 (b) an interview of one or more detention officers in a detention center in which the inmate is located or  
20 an interview of the inmate, or both, by electronic means or otherwise, by a mental health professional;

21 (c) a determination by the mental health professional participating in the program of the degree of  
22 likelihood or risk that an inmate may attempt to commit suicide;

23 (d) management protocols to be used by the detention facility as indicated by the degree of likelihood  
24 or risk of inmate suicide determined by the mental health professional and as provided in this section and by the  
25 rules of the department; and

26 (e) appropriate followup counseling or treatment by a mental health professional for an inmate  
27 determined to be at risk for suicide as provided in this section in order to reduce that risk.

28 (2) Each inmate, upon admittance to a detention facility represented in the program provided for in this  
29 section and at such other times as determined by the rules of the department, must be screened for a degree of  
30 likelihood or risk that the inmate may attempt to commit suicide. Screening, management, and followup

1 counseling or treatment of an inmate must occur as provided for in subsection (1). An inmate in a detention center  
2 included in the program who cannot be safely housed in the detention center by the use of management  
3 protocols, counseling, treatment, or any combination of those procedures and who must be treated for a serious  
4 mental illness in order to reduce the inmate's risk of suicide may not be treated in a detention center.

5  
6 **NEW SECTION. Section 5. Contracting or consultation and department rulemaking.** (1) In  
7 developing the program provided for in [sections 1 through 7], the department, an entity that the department  
8 contracts with, or either of them may contract or consult with operators of any similar program in the country.

9 (2) The department shall adopt rules to implement [sections 1 through 7]. In creating and maintaining  
10 the program provided for in [sections 1 through 7] and in adopting management protocols and other rules to  
11 implement [sections 1 through 7], the department shall consult with the suicide prevention officer appointed  
12 pursuant to 53-21-1101, the Montana sheriffs and peace officers association, the mental health ombudsman  
13 appointed pursuant to 2-15-210, and the mental health oversight advisory council appointed pursuant to  
14 53-21-702 and may consult with other appropriate groups and individuals.

15 (3) The program administered by the department must include a grant program that pays those expenses  
16 incurred by a detention center participating in the program that are determined by the department to be  
17 appropriately payable. If an insufficient number of detention centers apply to participate in the pilot program, the  
18 department shall by rule designate the detention centers that are required to participate.

19  
20 **NEW SECTION. Section 6. Data collection.** The department shall, as part of the program provided  
21 in [sections 1 through 7], collect data concerning inmates at risk of suicide in detention centers included in the  
22 program and the treatment of inmates in those detention centers. County sheriffs and detention center personnel  
23 shall cooperate with the department in providing data to the department.

24  
25 **NEW SECTION. Section 7. Report to committee required.** Before January 1, 2011, the department  
26 shall provide to the law and justice interim committee, provided for in 5-5-226, a report on the program provided  
27 for in [section 1 through 7]. The report must include:

28 (1) an assessment by the department of the degree of success of the program and a recommendation  
29 by the department as to whether that program should be continued as a pilot program, be made permanent, or  
30 be allowed to terminate;

1 (2) an assessment of:

2 (a) the collateral impacts of the program, such as whether the program places unacceptable pressure  
3 on other parts of the state or local mental health treatment system;

4 (b) whether the program causes or should require additional diversions to community crisis centers; and

5 (c) whether the program causes or should require additional transportation operations to the Montana  
6 state hospital; and

7 (3) any draft legislation that the department considers necessary to implement any recommendation of  
8 the department.

9

10 **NEW SECTION. Section 8. Appropriation.** There is appropriated from the general fund to the  
11 department of public health and human services the following amounts in the fiscal years indicated for the  
12 purposes of [sections 1 through 7]:

13 Fiscal Year 2010: \$264,000

14 Fiscal Year 2011: \$189,000

15

16 **NEW SECTION. Section 9. Effective dates.** (1) Except as provided in subsections (2) and (3), [this  
17 act] is effective October 1, 2009.

18 (2) [Sections 5(1) and 8 and this section] are effective on passage and approval.

19 (3) [Section 4(1)] is effective July 1, 2009.

20

21 **NEW SECTION. Section 10. Termination.** [This act] terminates July 1, 2011.

22

- END -

HOUSE BILL NO. 131

INTRODUCED BY R. STOKER

BY REQUEST OF THE LAW AND JUSTICE INTERIM COMMITTEE

A BILL FOR AN ACT ENTITLED: "AN ACT REQUIRING THE DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES TO CONTRACT FOR DEDICATED CRISIS BEDS AND EMERGENCY AND COURT-ORDERED DETENTION BEDS FOR THE MENTALLY ILL; REQUIRING RULEMAKING; PROVIDING AN APPROPRIATION; PROVIDING TARGET IMPLEMENTATION DATES; REQUIRING A REPORT; AND PROVIDING AN EFFECTIVE DATE."

WHEREAS, the 2007 Legislature passed House Joint Resolution No. 26, requesting an interim legislative study to examine diversion of mentally ill adults from the justice system, and House Joint Resolution No. 50, requesting an interim legislative study to examine county precommitment costs related to involuntary commitment proceedings; and

WHEREAS, these studies were assigned to the Law and Justice Interim Committee; and

WHEREAS, this bill is one in a package of bills recommended by the Law and Justice Interim Committee to address diversion of mentally ill adults from the justice system to appropriate treatment; and

WHEREAS, the Law and Justice Interim Committee found that one of the biggest challenges to diverting mentally ill individuals from the justice system is a lack of community-based mental health treatment beds; and

WHEREAS, 63% of admissions to the Montana State Hospital, whose daily census routinely exceeds its licensed capacity of 189, are for emergency and court-ordered detention and evaluation; and

WHEREAS, 38% of emergency and court-ordered admissions to the Montana State Hospital do not result in commitments; and

WHEREAS, it is preferable for these psychiatric services to be provided locally and without fiscal pressure driving treatment decisions or decisions about whether to file an involuntary commitment petition; and

WHEREAS, the costs for local hospitals to provide psychiatric treatment services is very high and counties help pay some of these costs only after an involuntary commitment petition has been filed and only in an amount that would have been paid by a public assistance program; and

WHEREAS, these high unrecoverable costs can deter hospitals from providing community-based psychiatric treatment beds; and





1 WHEREAS, current involuntary commitment laws and funding mechanisms create tensions between  
2 mental health professionals concerned about the medical necessity for treatment, hospitals concerned that county  
3 funding is available only after an involuntary commitment petition is filed, county attorneys concerned that medical  
4 necessity is not necessarily legal sufficiency for an involuntary commitment petition, and county commissioners  
5 concerned about county costs after a commitment petition is filed; and

6 WHEREAS, some mental health facilities may be able to provide inpatient psychiatric services at lower  
7 cost by providing services in a nonhospital mental health facility or through a telepsychiatry linkage with a  
8 psychiatric unit at a community hospital or with the Montana State Hospital; and

9 WHEREAS, by contracting with private providers for dedicated local or regional psychiatric treatment  
10 beds at rates that would help subsidize county funding and reduce the risks to private providers, the state can  
11 become a partner in fostering creative local solutions that reduce emergency admissions to the Montana State  
12 Hospital.

13  
14 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

15  
16 **NEW SECTION. Section 1. Department to contract for detention beds -- rulemaking.** (1) To the  
17 extent funding is appropriated for the purposes of this section, for each service area, as defined in 53-21-1001,  
18 the department shall contract with a mental health facility for up to three dedicated psychiatric treatment beds that  
19 may be used for:

20 (a) inpatient crisis intervention services needed prior to an involuntary commitment petition being filed;

21 and

22 (b) emergency detention under 53-21-129 and court-ordered detention under 53-21-124 after an  
23 involuntary commitment petition has been filed but before final disposition.

24 (2) Each contract must provide that for payment of costs for detention, evaluation, and treatment  
25 pursuant to subsection (1), the facility shall bill for payment of costs in the order of priority provided for under  
26 53-21-132(2)(a).

27 (3) Each contract must require the collection and reporting of fiscal and program data in the time and  
28 manner prescribed by the department to support program evaluation and measure progress on performance  
29 objectives. The department shall establish baseline data on emergency and court-ordered detention admissions  
30 to the state hospital from each county and analyze the effect of contracting under this section on state hospital

1 admissions.

2 (4) The department shall adopt rules to implement this section.

3

4 **NEW SECTION. Section 2. Appropriation.** (1) There is appropriated from the general fund to the  
5 department of public health and human services:

6 (a) for fiscal year 2010, \$410,625; and

7 (b) for fiscal year 2011, \$410,625.

8 (2) The money appropriated in this section may be used only for the purposes of [section 1].

9

10 **NEW SECTION. Section 3. Implementation -- report.** (1) The provisions of [section 1] may be  
11 implemented in phases. However, it is the legislature's intent that contracted beds be operational in at least one  
12 service area by no later than July 1, 2010, and that full implementation be completed by no later than July 1,  
13 2011.

14 (2) As soon as possible after July 1, 2010, the department shall report to the law and justice interim  
15 committee established in 5-5-226 on the implementation status of contracting under [section 1].

16

17 **NEW SECTION. Section 4. Codification instruction.** [Section 1] is intended to be codified as an  
18 integral part of Title 53, chapter 21, and the provisions of Title 53, chapter 21, apply to [section 1].

19

20 **NEW SECTION. Section 5. Effective date.** [This act] is effective July 1, 2009.

21

- END -

## 1 HOUSE BILL NO. 132

2 INTRODUCED BY R. STOKER

3 BY REQUEST OF THE LAW AND JUSTICE INTERIM COMMITTEE  
4

5 A BILL FOR AN ACT ENTITLED: "AN ACT PROVIDING THAT A RESPONDENT IN AN INVOLUNTARY  
6 COMMITMENT CASE MAY AGREE TO SHORT-TERM INPATIENT TREATMENT IN LIEU OF FACING A  
7 COMMITMENT HEARING; AMENDING COURT PROCESS AND PROFESSIONAL EXAMINATION  
8 PROVISIONS; REVISING PAYMENT RESPONSIBILITIES FOR PRECOMMITMENT COSTS AND PROVIDING  
9 NEW STATE FUNDING RESPONSIBILITIES; SPECIFYING SHORT-TERM INPATIENT TREATMENT  
10 PARAMETERS AND PATIENT RIGHTS; REQUIRING THE DEPARTMENT OF PUBLIC HEALTH AND HUMAN  
11 SERVICES TO CONTRACT FOR SHORT-TERM INPATIENT TREATMENT BEDS; REQUIRING RULEMAKING;  
12 PROVIDING AN APPROPRIATION; PROVIDING FOR IMPLEMENTATION AND A REPORT; AMENDING  
13 SECTIONS 53-21-102, 53-21-113, 53-21-122, 53-21-123, 53-21-132, 53-21-162, AND 53-21-1001, MCA; AND  
14 PROVIDING AN EFFECTIVE DATE."

15  
16 WHEREAS, the 2007 Legislature passed House Joint Resolution No. 26, requesting an interim legislative  
17 study to examine diversion of mentally ill adults from the justice system, and House Joint Resolution No. 50,  
18 requesting an interim legislative study to examine county precommitment costs related to involuntary commitment  
19 proceedings; and

20 WHEREAS, these studies were assigned to the Law and Justice Interim Committee; and

21 WHEREAS, this bill is one in a package of bills recommended by the Law and Justice Interim Committee  
22 to address diversion of mentally ill adults from the justice system to appropriate treatment; and

23 WHEREAS, the Law and Justice Interim Committee found that mental health professionals, county  
24 attorneys, public defenders, and advocates for the mentally ill have a common interest in a viable alternative to  
25 a frustrating, all-or-nothing, adversarial precommitment process that can result in a mentally ill person receiving  
26 no access to inpatient treatment unless involuntarily committed;

27 WHEREAS, under section 426.237 of Oregon's Revised Statutes, Oregon provides a voluntary 14-day  
28 diversion alternative to involuntary commitment; and

29 WHEREAS, voluntary inpatient treatment is preferable to and more effective than involuntary commitment  
30 and many respondents facing involuntary commitment could be effectively treated in a 14-day inpatient treatment

1 setting and would have a strong incentive to agree to the treatment; and

2 WHEREAS, the daily census at the Montana state hospital is consistently over its licensed capacity of  
3 189 beds;

4 WHEREAS, the Law and Justice Interim Committee found that because the state is responsible for costs  
5 when a person is involuntarily committed, the state should be responsible for the cost of a short-term inpatient  
6 treatment alternative aimed at reducing involuntary commitments to the state hospital; and

7 WHEREAS, state contracting for short-term inpatient treatment beds would provide dedicated beds for  
8 treatment closer to home and help relieve county costs for transportation to the state hospital.

9

10 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

11

12 **Section 1.** Section 53-21-102, MCA, is amended to read:

13 **"53-21-102. Definitions.** As used in this ~~part~~ chapter, the following definitions apply:

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

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

21 (3) "Board" or "mental disabilities board of visitors" means the mental disabilities board of visitors created  
22 by 2-15-211.

23 (4) "Commitment" means an order by a court requiring an individual to receive treatment for a mental  
24 disorder.

25 (5) "Court" means any district court of the state of Montana.

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

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

30 (8) "Friend of respondent" means any person willing and able to assist a person suffering from a mental

1 disorder and requiring commitment or a person alleged to be suffering from a mental disorder and requiring  
2 commitment in dealing with legal proceedings, including consultation with legal counsel and others. The friend  
3 of respondent may be the next of kin, the person's conservator or legal guardian, if any, representatives of a  
4 charitable or religious organization, or any other person appointed by the court to perform the functions of a friend  
5 of respondent set out in this part. Only one person may at any one time be the friend of respondent within the  
6 meaning of this part. In appointing a friend of respondent, the court shall consider the preference of the  
7 respondent. The court may at any time, for good cause, change its designation of the friend of respondent.

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

10 (b) The term does not include:

11 (i) addiction to drugs or alcohol;

12 (ii) drug or alcohol intoxication;

13 (iii) mental retardation; or

14 (iv) epilepsy.

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

16 (10) "Mental health facility" or "facility" means the state hospital, the Montana mental health nursing care  
17 center, or a hospital, a behavioral health inpatient facility, a mental health center, a residential treatment facility,  
18 or a residential treatment center licensed or certified by the department that provides treatment to children or  
19 adults with a mental disorder. A correctional institution or facility or jail is not a mental health facility within the  
20 meaning of this part.

21 (11) "Mental health professional" means:

22 (a) a certified professional person;

23 (b) a physician licensed under Title 37, chapter 3;

24 (c) a professional counselor licensed under Title 37, chapter 23;

25 (d) a psychologist licensed under Title 37, chapter 17;

26 (e) a social worker licensed under Title 37, chapter 22; or

27 (f) an advanced practice registered nurse, as provided for in 37-8-202, with a clinical specialty in  
28 psychiatric mental health nursing.

29 (12) (a) "Neglect" means failure to provide for the biological and psychosocial needs of any person  
30 receiving treatment in a mental health facility, failure to report abuse, or failure to exercise supervisory

1 responsibilities to protect patients from abuse and neglect.

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

3 (i) deprivation of food, shelter, appropriate clothing, nursing care, or other services;

4 (ii) failure to follow a prescribed plan of care and treatment; or

5 (iii) failure to respond to a person in an emergency situation by indifference, carelessness, or intention.

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

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

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

11 (16) "Professional person" means:

12 (a) a medical doctor;

13 (b) an advanced practice registered nurse, as provided for in 37-8-202, with a clinical specialty in  
14 psychiatric mental health nursing;

15 (c) a licensed psychologist; or

16 (d) a person who has been certified, as provided for in 53-21-106, by the department.

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

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

21 (19) "State hospital" means the Montana state hospital."  
22

23 **Section 2.** Section 53-21-113, MCA, is amended to read:

24 **"53-21-113. Costs of committing a patient already voluntarily admitted -- transportation costs for**  
25 **voluntary admission.** (1) ~~The~~ Except as provided in [section 9], the cost of involuntarily committing a patient who  
26 is voluntarily admitted to a mental health facility at the time the involuntary proceedings are commenced must be  
27 paid by the county of the patient's residence at the time of admission.

28 (2) ~~The~~ Except as provided in [section 9], the costs of transportation to a mental health facility under  
29 53-21-111 and 53-21-112 must be provided by the local office of public assistance located in the county of the  
30 patient's residence. However, if protective proceedings under Title 72, chapter 5, have been or are initiated with

1 respect to the person, the local office of public assistance may seek reimbursement. If no one else is available  
2 to transport the person, the sheriff shall transport the person."

3

4 **Section 3.** Section 53-21-122, MCA, is amended to read:

5 **"53-21-122. Petition for commitment – filing of – initial hearing on.** (1) The petition must be filed with  
6 the clerk of court, who shall immediately notify the judge.

7 (2) The judge shall consider the petition. If the judge finds no probable cause, the petition must be  
8 dismissed. If the judge finds probable cause and the respondent does not have private counsel present, the judge  
9 may order the office of state public defender, provided for in 47-1-201, to immediately assign counsel for the  
10 respondent, and the respondent must be brought before the court with the respondent's counsel. The respondent  
11 must be advised of the respondent's constitutional rights, the respondent's rights under this part, and the  
12 substantive effect of the petition. The respondent must also be advised that the professional person appointed  
13 to conduct the examination under 53-21-123 will include in the professional person's report a recommendation  
14 about whether the respondent should be diverted from involuntary commitment to short-term inpatient treatment  
15 provided for in [sections 7 through 10]. The respondent may at this appearance object to the finding of probable  
16 cause for filing the petition. The judge shall appoint a professional person and a friend of respondent and set a  
17 date and time for the hearing on the petition that may not be on the same day as the initial appearance and that  
18 may not exceed 5 days, including weekends and holidays, unless the fifth day falls upon a weekend or holiday  
19 and unless additional time is requested on behalf of the respondent. The desires of the respondent must be taken  
20 into consideration in the appointment of the friend of respondent.

21 (3) If a judge is not available in the county in person, the clerk shall notify a resident judge by telephone  
22 and shall read the petition to the judge. The judge may do all things necessary through the clerk of court by  
23 telephone as if the judge were personally present, including ordering the office of state public defender, provided  
24 for in 47-1-201, to immediately provide assigned counsel. The judge, through the clerk of court, may also order  
25 that the respondent be brought before a justice of the peace with the respondent's counsel to be advised of the  
26 respondent's constitutional rights, the respondent's rights under this part, and the contents of the order, as well  
27 as to furnish the respondent with a copy of the order. The respondent must also be advised that the professional  
28 person appointed to conduct the examination under 53-21-123 will include in the professional person's report a  
29 recommendation about whether the respondent should be diverted from involuntary commitment to short-term  
30 inpatient treatment provided for in [sections 7 through 10]. The justice of the peace shall ascertain the desires

1 of the respondent with respect to the assignment of counsel or the hiring of private counsel, pursuant to  
 2 53-21-116 and 53-21-117, and this information must be immediately communicated to the resident judge."

3

4 **Section 4.** Section 53-21-123, MCA, is amended to read:

5 **"53-21-123. Examination of respondent following initial hearing -- recommendation of**  
 6 **professional person.** (1) Following the initial hearing, whether before a judge or justice of the peace, the  
 7 respondent must be examined by the professional person without unreasonable delay. The examination may not  
 8 exceed a period of 4 hours. The professional person shall immediately notify the county attorney of the findings  
 9 in person or by phone and shall make a written report of the examination to the court, with copies to the  
 10 respondent's attorney and the county attorney.

11 (2) (a) The professional person shall include in the report a recommendation about whether the  
 12 respondent should be diverted from involuntary commitment to short-term inpatient treatment provided for under  
 13 [sections 7 through 10].

14 (b) If the professional person recommends commitment, the professional person's written report must  
 15 contain a statement of the professional person's recommendations to the court for disposition under 53-21-127.

16 ~~(2)(3)~~ The following action must be taken based on the professional person's findings:

17 (a) If the professional person recommends dismissal, the professional person shall additionally notify  
 18 counsel and the respondent must be released and the petition dismissed. However, the county attorney may,  
 19 upon good cause shown, request the court to order an additional, but no more than one, examination by a  
 20 different professional person for a period of no more than 4 hours.

21 (b) If the professional person recommends diversion from involuntary commitment to short-term inpatient  
 22 treatment, the court shall suspend the commitment hearing unless the county attorney or the respondent's  
 23 attorney objects within 24 hours of receiving notice of the professional person's recommendation.

24 (c) If the court finds that commitment proceedings should continue, the hearing must be held as  
 25 scheduled.

26 ~~(3)(4)~~ The court may not order further evaluation pending the hearing unless sound medical reasons  
 27 require additional time for a complete evaluation. The reasons must be set forth in the order, along with the  
 28 amount of additional time needed."

29

30 **Section 5.** Section 53-21-132, MCA, is amended to read:



1           **"53-21-132. Cost of examination and commitment.** (1) The cost of psychiatric precommitment  
 2 examination, detention, treatment, and taking a person who is suffering from a mental disorder and who requires  
 3 commitment to a mental health facility must be paid pursuant to subsection (2)(a). The sheriff must be allowed  
 4 the actual expenses incurred in taking a committed person to the facility, as provided by 7-32-2144.

5           (2) (a) ~~The Except as provided in [section 9], the~~ costs of precommitment psychiatric detention,  
 6 precommitment psychiatric examination, and precommitment psychiatric treatment of the respondent and any  
 7 cost associated with testimony during an involuntary commitment proceeding by a professional person acting  
 8 pursuant to 53-21-123 must be billed to the following entities in the listed order of priority:

9           (i) the respondent, the parent or guardian of a respondent who is a minor, or the respondent's private  
 10 insurance carrier, if any;

11           (ii) a public assistance program, such as medicaid, for a qualifying respondent; or

12           (iii) the county of residence of the respondent in an amount not to exceed the amount paid for the service  
 13 by a public assistance program.

14           (b) The county of residence is not required to pay costs of treatment and custody of the respondent after  
 15 the respondent is admitted to a mental health facility for short-term inpatient treatment pursuant to [sections 7  
 16 through 10] or committed pursuant to this part. Precommitment costs related to the use of two-way electronic  
 17 audio-video communication in the county of commitment must be paid by the county in which the person resides  
 18 at the time that the person is committed. The costs of the use of two-way electronic audio-video communication  
 19 from the state hospital for a patient who is under a voluntary or involuntary commitment to the state hospital must  
 20 be paid by the state. The fact that a person is examined, hospitalized, or receives medical, psychological, or other  
 21 mental health treatment pursuant to this part does not relieve a third party from a contractual obligation to pay  
 22 for the cost of the examination, hospitalization, or treatment.

23           (3) The adult respondent or the parent or guardian of a minor shall pay the cost of treatment and custody  
 24 ordered pursuant to 53-21-127, except to the extent that the adult or minor is eligible for public mental health  
 25 program funds.

26           (4) A community service provider that is a private, nonpublic provider may not be required to treat or treat  
 27 without compensation a person who has been committed."  
 28

29           **Section 6.** Section 53-21-162, MCA, is amended to read:

30           **"53-21-162. Establishment of patient treatment plan -- patient's rights.** (1) Each patient admitted

1 as an inpatient to a mental health facility must have a comprehensive physical and mental examination and  
2 review of behavioral status within 48 hours after admission to the mental health facility, except as provided in  
3 [section 8].

4 (2) Each patient must have an individualized treatment plan. This plan must be developed by appropriate  
5 professional persons, including a psychiatrist, and must be implemented no later than 10 days after the patient's  
6 admission, except as provided in [section 8]. Each individualized treatment plan must contain:

- 7 (a) a statement of the nature of the specific problems and specific needs of the patient;  
8 (b) a statement of the least restrictive treatment conditions necessary to achieve the purposes of  
9 hospitalization;  
10 (c) a description of treatment goals, with a projected timetable for their attainment;  
11 (d) a statement and rationale for the plan of treatment for achieving these goals;  
12 (e) a specification of staff responsibility for attaining each treatment goal;  
13 (f) criteria for release to less restrictive treatment conditions; and  
14 (g) a notation of any therapeutic tasks and labor to be performed by the patient.

15 (3) Overall development, implementation, and supervision of the treatment plan must be assigned to an  
16 appropriate professional person.

17 (4) The inpatient mental health facility shall periodically reevaluate the patient and revise the  
18 individualized treatment plan based on changes in the patient's condition. At a minimum, the treatment plan must  
19 be reviewed:

- 20 (a) at the time of any transfer within the facility;  
21 (b) at the time of discharge;  
22 (c) upon any major change in the patient's condition;  
23 (d) at the conclusion of the initial estimated length of stay and subsequent estimated lengths of stay;  
24 (e) no less than every 90 days; and  
25 (f) at each of the times specified in subsections (4)(a) through (4)(e), by a treatment team that includes  
26 at least one professional person who is not primarily responsible for the patient's treatment plan.

27 (5) A patient has the right:

- 28 (a) to ongoing participation, in a manner appropriate to the patient's capabilities, in the planning of mental  
29 health services to be provided and in the revision of the plan;  
30 (b) to a reasonable explanation of the following, in terms and language appropriate to the patient's

1 condition and ability to understand:

2 (i) the patient's general mental condition and, if given a physical examination, the patient's physical  
3 condition;

4 (ii) the objectives of treatment;

5 (iii) the nature and significant possible adverse effects of recommended treatments;

6 (iv) the reasons why a particular treatment is considered appropriate;

7 (v) the reasons why access to certain visitors may not be appropriate; and

8 (vi) any appropriate and available alternative treatments, services, or providers of mental health services;

9 and

10 (c) not to receive treatment established pursuant to the treatment plan in the absence of the patient's  
11 informed, voluntary, and written consent to the treatment, except treatment:

12 (i) during an emergency situation if the treatment is pursuant to or documented contemporaneously by  
13 the written order of a responsible mental health professional; or

14 (ii) permitted under the applicable law in the case of a person committed to a facility by a court.

15 (6) In the case of a patient who lacks the capacity to exercise the right to consent to treatment described  
16 in subsection (5)(c), the right must be exercised on behalf of the patient by a guardian appointed pursuant to the  
17 provisions of Title 72, chapter 5.

18 (7) The department shall develop procedures for initiating limited guardianship proceedings in the case  
19 of a patient who appears to lack the capacity to exercise the right to consent described in subsection (5)(c)."

20

21 **NEW SECTION. Section 7. Short-term inpatient treatment -- process -- placement -- length --**  
22 **conditions for proceeding with commitment hearing.** (1) When a commitment hearing has been suspended  
23 pursuant to 53-21-123(3)(b) so that the respondent may be diverted to short-term inpatient treatment, the  
24 professional person who conducted the examination shall refer the respondent to the department for appropriate  
25 placement in a mental health facility with available short-term treatment beds.

26 (2) Short-term inpatient treatment may not exceed 14 days, except pending a commitment hearing  
27 scheduled pursuant to subsection (5).

28 (3) Subject to the provisions of this section, a respondent may be released before completing 14 days  
29 of treatment if the professional person responsible for the respondent's treatment plan determines that the  
30 respondent no longer requires inpatient treatment. However, the county attorney and the respondent's attorney

1 must be notified at least 24 hours before a respondent is released.

2 (4) When a respondent is released, the professional person shall notify the court and the court shall  
3 dismiss the commitment petition.

4 (5) The court must be notified and shall proceed with a commitment hearing within 5 business days of  
5 receiving notice of any of the following circumstances:

6 (a) the professional person responsible for the respondent's treatment plan determines that the  
7 respondent should not be released after 14 days of treatment because, in the professional person's judgment,  
8 an emergency situation would exist if the respondent were released;

9 (b) the respondent refuses treatment;

10 (c) the respondent's attorney requests the respondent's release before the 14-day treatment period is  
11 completed; or

12 (d) the county attorney objects to the respondent's release within 24 hours of being notified of the  
13 respondent's pending release as required in subsection (3).

14

15 **NEW SECTION. Section 8. Treatment and discharge plan -- safety -- rights.** (1) For each respondent  
16 admitted as an inpatient to a mental health facility for short-term inpatient treatment pursuant to [sections 7  
17 through 10], the provisions of 53-21-162 and 53-21-180 apply, except as follows:

18 (a) the comprehensive physical and mental examination and review of behavioral status must be  
19 completed within 24 hours of admission;

20 (b) the individualized treatment plan must be implemented no later than 3 days after the admission; and

21 (c) a discharge plan must be developed prior to discharge.

22 (2) Short-term inpatient treatment must be provided in a manner that considers the safety of the  
23 respondent, other patients, staff, and the general public.

24 (3) A respondent in a mental health facility for short-term inpatient treatment is entitled to all of the rights  
25 and protections provided in part 1 of this chapter.

26

27 **NEW SECTION. Section 9. Contracting -- data collection and analysis -- payment of costs.** (1) The  
28 department shall contract with a mental health facility in each service area, as defined in 53-21-1001, for up to  
29 three beds dedicated to short-term inpatient treatment under [sections 7 through 10].

30 (2) A contract for short-term inpatient treatment beds must require the contractor to collect and report

1 fiscal and program data in the time and manner prescribed by the department to support program evaluation and  
 2 measure progress on performance goals. The department shall establish baseline data on commitments to the  
 3 state hospital from each county and analyze what effect diversion to short-term inpatient treatment has on state  
 4 hospital commitments.

5 (3) Except as provided in subsection (4), short-term inpatient treatment costs are not a precommitment  
 6 cost under 53-21-132 and must be paid by the department and billed to the following entities in the following order  
 7 of priority:

8 (a) the respondent or the respondent's private insurance carrier, if any; or

9 (b) a public assistance program, such as medicaid, for a qualifying respondent.

10 (4) Costs to transport a respondent to a mental health facility for short-term inpatient treatment are a  
 11 precommitment cost under 53-21-132.

12

13 **NEW SECTION.** **Section 10. Rulemaking.** The department shall adopt rules to implement the  
 14 provisions of [sections 7 through 10].

15

16 **Section 11.** Section 53-21-1001, MCA, is amended to read:

17 **"53-21-1001. Definitions.** As used in this part, the following definitions apply:

18 (1) "Community mental health center" means a licensed mental health center that provides  
 19 comprehensive public mental health services in a multicounty region under contract with the department,  
 20 counties, or one or more service area authorities.

21 ~~(2) "Department" means the department of public health and human services as provided for in~~  
 22 ~~2-15-2201.~~

23 ~~(3)~~(2) "Licensed mental health center" means an entity licensed by the department of public health and  
 24 human services to provide mental health services and has the same meaning as mental health center as defined  
 25 in 50-5-101.

26 ~~(4)~~(3) "Service area" means a region of the state as defined by the department by rule within which  
 27 mental health services are administered.

28 ~~(5)~~(4) "Service area authority" means an entity, as provided for in 53-21-1006, that has incorporated to  
 29 collaborate with the department for the planning and oversight of mental health services within a service area."

30

1           **NEW SECTION. Section 12. Appropriation.** (1) There are appropriated from the general fund to the  
2 department of public health and human services the following amounts:

3           (a) for fiscal year 2010, \$1.7 million;

4           (b) for fiscal year 2011, \$1.7 million.

5           (2) The money appropriated in this section may be used only for the purposes of [section 9].  
6

7           **NEW SECTION. Section 13. Implementation -- report.** (1) Contracting under [section 9] may be  
8 implemented in phases. However, it is the legislature's intent that contracted beds in at least one service area  
9 be operational by no later than July 1, 2010, and that full implementation be completed by no later than July 1,  
10 2012.

11           (2) As soon as possible after July 1, 2010, the department shall report to the law and justice interim  
12 committee established in 5-5-226 on the implementation status of contracting under [section 9].  
13

14           **NEW SECTION. Section 14. Codification instruction.** [Sections 7 through 10] are intended to be  
15 codified as an integral part of Title 53, chapter 21, and the provisions of Title 53, chapter 21, apply to [sections  
16 7 through 10].  
17

18           **NEW SECTION. Section 15. Effective date.** [This act] is effective July 1, 2009.  
19

- END -

# **APPENDIX C**

**Memorandum on Psychiatric Residential Treatment Facility for Youth**





**TO:** Anna Whiting Sorrell, Director DPHHS  
Mike Ferriter, Director Dept of Corrections  
**FROM:** Deb Matteucci, Behavioral Health Program Facilitator  
**DATE:** December 1, 2008  
**RE:** Summary of Decision re: Psychiatric Residential Treatment Facility for Youth

On December 10, 2007 the Department of Corrections and the Office of the Court Administrator hosted a statewide met net meeting focused on the placement and program challenges for youth with serious mental illness/emotional disturbance and who required secure placements due to contact with law enforcement and court proceedings. The meeting participants were asked to consider these two questions:

1. *How does Montana want to address the challenges of youth in the juvenile justice system that present a serious mental illness, may pose a public safety risk that requires a secure residential setting, and may be low intellectual functioning?*
2. *Is it acceptable to continue placing youth out-of-state at our current level?*

At that meeting, numerous participants from across the state discussed issues, concerns and challenges. Some were stated by a number of participants and are noted here for your reference:

- √ **POPULATION:** "There is a need for a facility to serve both adjudicated youth and youth outside the juvenile justice system. The facility must be in a location where other services are available."
- √ **PUBLIC VS. PRIVATE:** "Private institutions have a right of refusal and have refused to accept youth who are deemed to be so unmanageable or in need of security that private providers will not take on the risk. A public institution, no matter how difficult the child, must play a role."
- √ **OUT OF STATE:** "Placing youth out of state is very expensive and does not allow for appropriate monitoring." "Sending youth out of state is not conducive to treatment and results in youth being taken away from their families."
- √ **CRIMINALIZATION OF M/I** "Often, the reason for the offense is because of mental illness and when placed in detention, it just continues to criminalize."
- √ **COMMUNITY SERVICES NEEDED:** "It is essential youth with dual diagnoses be eligible for treatment in an in-state center. Key programs do not know when people are sent to an out-of-state facility, resulting in a small window of time to provide services. An in-state program would enable key programs to plan services." "There is a need for a long-term, community-based component. Youth return to the community, but there is no follow-up with what needs to be done in the community in some cases."

Following this meeting, the DOC, DPHHS and Office of Court Administrator (Youth Court) met to discuss possible options to address the issue. Also during this time the Law & Justice Interim Committee designated a Juvenile Justice work group to study this issue and others impacting youthful offenders.

It was determined that the agencies needed more information from potential service providers, to better identify youth in need of this type of placement, and possible funding streams to pay for services. (e.g. would these beds be eligible for Medicaid payment?)

In July 2008, a Memorandum of Understanding was drafted for consideration of the three agencies. This MOU would outline the responsibilities of each related to the issuing of a Request for Information to potential providers. The Office of Court Administrator chose not to participate in the MOU, but an agreement was signed between DPHHS & DOC on September 15, 2008 to issue a Request for Information.

The Request for Information was released on September 27<sup>th</sup> and three providers responded. The responses included suggestions about partnering with neighboring states, questions about infrastructure improvement costs, estimated costs per day of care, and other requested information. Following receipt of the responses, DPHHS and DOC staff met to review and consider the proposals, and to determine if a Request for Proposals should be issued to move the project forward. This meeting was held on October 17<sup>th</sup>, and the Office of Court Administrator was invited and did participate.

DPHHS determined that it would be cost prohibitive for them to move forward. To enter into contract via RFP would require DPHHS to guarantee beds with general fund dollars, whether the bed was filled or empty. They would be unable to use Medicaid funds to secure these beds. (Three youth can be treated using Medicaid as a source of funding for every one youth that is reimbursed with general fund.) Some of the youth currently out of state also have specialized treatment needs that probably cannot not be appropriately met by a single provider. In addition, DPHHS felt that preliminary discussions with in-state providers had been promising. They plan to continue to work with OCA, DOC and these in-state providers to develop further treatment options. At the time of the meeting, the department did not feel that they had sufficient demand for the beds to guarantee 8 – 10 beds yearly.

The OCA determined that they could not join DOC and DPHHS in an RFP because they cannot guarantee payment for bed days. The OCA does not have authority to commit the funds allocated to 22 individual judicial districts for this purpose. In addition, as of October 2008 they only had five juveniles placed in Residential Treatment Facilities. They plan to continue to work with existing in-state facilities to meet most of their needs.

DOC determined that without the partnership of one of more agencies, it would be cost prohibitive for them to pursue the RFP alone. The feasibility of funding this type of program would only be possible with 20 – 30 beds, and DOC did not need that number of beds alone. There would also be an increased risk for youth to be pushed deeper into the criminal justice system if the only available secure instate beds were offered through Corrections.

A formal notice from OCA was sent to DOC stating that they would not move forward. Former Director Miles met with Director Ferriter on November 10, 2008 and also stated that DPHHS would not be a partner. Based on the information outlined in this memo, a decision was made to not proceed with an RFP.

**Cc:**

Mary Dalton  
Bonnie Adee  
Steve Gibson  
Rhonda Schaffer

Lois Menzies  
Bob Peake  
Sheri Heffelfinger  
Brent Doig