Minutes
Subcommittee on Mental Health
Thursday, September 6, 2007
9:30 a.m. to 4:30 p.m.
Idaho State School and Hospital, Nampa/Supreme Court Building, Basement Conference Room
451 W. State Street, Boise, Idaho

The meeting was called to order at 9:30 a.m. by Cochairman Representative Sharon Block. Other committee members present included Cochairman Senator Joe Stegner, Senator Tim Corder, Senator Patti Anne Lodge, Representative Fred Wood and Representative Margaret Henbest. Staff members present were Eric Milstead, Amy Castro and Toni Hobbs.

Others present for the morning session in Nampa were Dick Armstrong, Dick Schultz and Kathleen Allyn, Department of Health and Welfare; Nels Sather, State Hospital South, Toni Lawson, Idaho Hospital Association; Susan Broetje, Idaho State School and Hospital.

People present at the afternoon meeting in Boise included Kathleen Allyn, Todd Hurt, Scott Tiffany, Bill Talbott, Dick Schultz and Dick Armstrong, Department of Health and Welfare; Kathie Garrett, Partners of Crisis in Idaho; Larry Calicutt, Juvenile Corrections; Dr. Bill Hazle, Amy Holly-Priest and Lyn Darrington, Business Psychology Associates; Robert Luce and Ralph Blount, Attorney General's Office; Courtney Lester, Idaho Federation of Families; Teresa Wolf, Nez Perce County; Toni Lawson and Steve Millard, Idaho Hospital Association; Woody Richards, Chuck Christiansen and Richard Bangert, Intermountain Hospital; Jim Baugh, Comprehensive Advocacy Inc.; Doug Call and Carine Call, National Alliance on Mental Illness; Gary Payne, Idaho Psychology Association; Tony Poinelli, Idaho Association of Counties; Kelly Buckland, State Independent Living Council; Molly Steckel, Idaho Medical Association/Idaho Psychology Association and Dr. Linda Hatzenbuehler, Designated Examiner.

Before the group toured the Idaho State School and Hospital facility, **Ms. Kathleen Allyn, Administrator, Division of Behavioral Health, Department of Health and Welfare,** was introduced to continue discussion of plans for a secure mental health facility in Idaho.

She explained that by law, the Department of Health and Welfare must receive into custody and provide care to people involuntarily committed to it by the courts. She said while most people committed to the Department are harmless, there are a few who are accused of violent crimes and are dangerous to others, but need to be restored to competency to stand trial. There are also some who have committed no crime but who present a substantial risk of violent physical harm to others because of mental illness.

Ms. Allyn stated that at any given time, the Department has about 25 very dangerous adult

clients committed to it for treatment. Based on clinical judgment, all of these clients should be in a secure setting that will prevent them from escaping from the facility and going into the community.

Ms. Allyn reiterated that the Department of Health and Welfare has no secure facility to take care of these dangerous clients. The law provides a mechanism for transferring custody of dangerous clients to the Department of Correction (DOC), but the 12 bed psychiatric unit at DOC is almost always full and so DOC is often unable to take the Department of Health and Welfare's client.

As a result, many of these clients are located at State Hospital South which has an open campus and no fences, some are in community hospitals, some are being treated in jail, which is arguably against the law and two are at the DOC secure facility. She commented that so far, the Department of Health and Welfare has managed to avoid a tragic accident or a lawsuit but the number of dangerous clients in their custody continues to grow.

Ms. Allyn said that even though the new 300 bed facility being developed by DOC and the Department of Health and Welfare should address this problem, that facility is not expected to be in operation for at least four years. In the meantime, there is a need for an interim secure psychiatric facility to house these clients. One possible solution being looked at is modification of existing buildings at the Idaho State School and Hospital. There are several buildings that have floor plans that lend themselves to being modified to make them secure psychiatric facilities.

Ms. Allyn explained that the Division of Behavioral Health has contracted with WICHE to look at these buildings and assess the feasibility and costs of modifying one or more into secure facilities. The initial estimate of this cost is about $6.6 million or $185 per square foot for two buildings that would provide 40 beds and include perimeter fencing. The Department is expecting the final report from WICHE in October.

In response to questions, **Ms. Allyn** said that the buildings being considered are the newest buildings on the campus and that there are currently people housed in them.

Senator Stegner clarified that this facility is being modified to provide the approximately 25 annual beds needed by the Department of Health and Welfare for the involuntary commitments. **Ms. Allyn** said that is the need of her Department but there are additional clients of the Idaho State School and Hospital that could also be housed there. **Senator Stegner** asked whether the ultimate goal is to remodel all three buildings bringing the total number of beds up to 60 to account for future growth needs and to make it so that people already housed there could stay. **Ms. Allyn** said that was correct. **Senator Stegner** commented that this will still involve a significant relocation for clients that would not be able to stay into another portion of the state system.

He asked whether the resulting facility will be considered a hospital. **Ms. Allyn** said it could be a forensic hospital eventually. In her opinion, it will not be a hospital to begin with. It would be built to hospital specifications. The decision has not been made as to whether the buildings will become hospitals.

Ms. Allyn went on to say that the hope for the 300 bed facility being developed with the DOC is that it will also be located on Idaho State School and Hospital property. The site has ample room for the facility and is located in an area with a population base to support staffing. They are looking at the possibility of sharing professional and clinical staff as well as services such as laundry, food preparation and maintenance.

Over time, she said there could be development of a psychiatric complex that would include the severe psychiatric treatment center with separate units for criminal and civil patients, a general psychiatric hospital to serve southwest Idaho, transitional units that help patients learn to live in the community and crisis intervention housing to prevent more expensive hospitalization. **Ms. Allyn** said that the operation of such a complex would enable the DOC and Department of Health and Welfare to work more closely in helping inmates make the transition to return to the community and get enrolled in community-based services thus helping to reduce recidivism.

The thought is once the DOC facility is complete, this interim facility can be reassessed and may be converted to other needed uses such as crisis stabilization, transitional services or psychiatric hospital beds. In response to a question from **Senator Stegner, Ms. Allyn** said this could also develop into a state hospital facility for western Idaho. **Senator Stegner** noted that even though it is not the charge of the committee to look at utilization of the site for the next 50 years, it makes it easier for them to commit money to an interim four year project knowing that money will be utilized long-term. In his opinion, such a site should become a state hospital for utilization by people in this area eliminating the need to move people from this area to Blackfoot or Orofino.

Representative Henbest said that in looking at the number of dangerous and aggressive clients which is 56 already housed at ISSH and the 25 that could or would be housed there after renovation, the numbers add up to over 60, she asked for more explanation. **Ms. Broetje** categorized the dangerous and aggressive and said that number comes from the health information management system. She said many of the clients that are categorized as dangerous and aggressive have stabilized by the time they reach the ISSH. She explained that even though the 56 were classified as dangerous and aggressive when they were brought in, that number is actually significantly lower. **Representative Henbest** asked whether it would be appropriate to house these clients in the same area as the 25 from the Department of Health and Welfare. **Ms. Allyn** stated that the clients from ISSH that are being considered are dually diagnosed. She said that other states do this. She added that this can also be done on a smaller scale.

Mr. Dick Schultz, Department of Health and Welfare and Ms. Broetje, ISSH were introduced to discuss how existing clients of ISSH will be affected by this. **Mr. Schultz**

commented that in his opinion the current size of the population at ISSH makes it difficult for them to manage the facility. There are more behavioral issues due to this. The current standard is moving toward smaller groups in smaller housing units. The proposal is for the older buildings on campus to be demolished and to construct new facilities that are 8 beds each in four-plexes resulting in 48 beds total. It was noted that these four-plexes very much resemble homes and homelike settings are much more conducive to treatment for many of these people. He did note that there is a difference between this number and the 95 persons that are currently on campus and that there will be some challenge in moving some of those people to locations off campus. He said there is a plan to do that regardless of whether the above plan happens. The plan is to try to build capacity of community providers to be able to deal with this population. He said the more clients of the dual diagnosis population that can be placed in community settings with well trained providers having ISSH as a backup, the better it will be for everyone.

Mr. Schultz went on to explain that ISSH is licensed as an intermediate care facility for the mentally retarded. With that license there is a significant financial benefit for Idaho because Medicaid pays 70/30 for the population. The cost per day is $780 or $284,000 per year per client while the cost for private care is about $84,000. Losing that license will cause a loss of that 70/30 Medicaid payment. He said that with the proposed changes they are looking at licensing each of the new buildings separately to avoid the entire campus being at risk of losing the intermediate care license.

Representative Wood asked what the cost and timeline of this demolition and reconstruction would be. **Mr. Schultz** said that cost is estimated at $8 million or $161 per square foot construction costs with $2 million for the demolition. He said depending on appropriation, if they start in July, this is estimated to be completed in two years. The total price tag for the demolition and removal of asbestos, construction, remodel, fencing and landscaping is $16 million, not including operational costs.

Mr. Schultz noted, in response to **Senator Stegner's** question about the role of this in the future, that it depends on whether the DOC facility is located on the ISSH grounds. If that happens and it is designed to only serve DOC clients, ISSH and the Department of Health and Welfare will need this other facility for their clients.

Senator Stegner said he would like to have more information and more explanation of the population that is housed at ISSH. He commented that at one time the facility housed the largest population of developmentally disabled sexual predators in the state. In his opinion, this is probably not the best place to be housing this population and said he would like to know how many of the 102 people housed there fit into this category and whether that is the population that will be moved to the new buildings. He said he would like more discussion about who these people are and how we plan to accommodate them and their families in the future at a later date. **Ms. Allyn** agreed and noted that there will be family members that have great concern about any changes made.

The discussion was ended at this time and the subcommittee embarked on a tour of the ISSH facilities.

The meeting was reconvened in Boise at 2:00 p.m.

The meeting was called back to order by **Cochairman Representative Block. Senator Stegner** noted that this afternoon's meeting will include testimony from various people involved in mental health care regarding suggestions that were included in the Model Commitment Law and what that might mean to Idaho. Two specific items for discussion include changing and easing the in-patient commitment process and possibly combining it with outpatient commitment and the development of a psychiatric treatment board that would take over the process for commitment hearings. In his opinion, those two issues are the most pertinent but noted that the subcommittee is interested in any information presenter's want to give.

Mr. Larry Calicutt, Department of Juvenile Corrections, stated that the Model Commitment Law will not impose any new obligations on the Department. He pointed out that the words "danger to himself or others" do allow for the immediate treatment or observation upon initiation of a law enforcement officer or physician, psychologist, psychiatrist or other person designed to do so by the state. He noted that as a former police officer, he observed many times in responding to these individuals that they are taken to the hospital, examined by a DE and then end up being taken right back to the environment where the concern began. He said it was very frustrating.

Mr. Calicutt said the involuntary treatment portion of the Model Commitment Law is also more inclusive. It simply states that a person in need of psychiatric care should be admitted into treatment whenever possible. Someone stated that the real impact of the Model Commitment Law is that it allows for earlier intervention. **Mr. Calicutt** said that is obviously something that juvenile corrections is interested in. He said earlier intervention and treatment would have a large systemic impact that would reverberate within the juvenile correction system. He said that the predictable consequences of nontreatment are as severe as they are dire. Of the juveniles currently in custody, approximately 30% have severe emotional disturbances, 25% to 50% have mental health diagnoses that may include psychosis, depression, anxiety and others. He said the Department of Juvenile Corrections is known as a place where a juvenile can obtain mental health care but added that it is certainly not the least restrictive or most effective place for such treatment. **Mr. Calicutt** said every reasonable effort should be made to prevent commitment to the Department of Juvenile Corrections of juveniles with minimal criminal behaviors for the primary purpose of assessing and accessing mental health services. Those youths, properly treated for their mental health issues in the community, prior to the department's commitment, and post-commitment would seemingly be a much lower risk of offending or reoffending.

In response to a question from **Senator Corder, Mr. Calicutt** said he was not sure whether the Model Commitment Law would solve this problem. It would depend on how legislation was drafted. Rather than just take the Model Commitment Law as written, it would need to be fine-

tuned and some finite pieces would have to be developed. He said he would be happy to help the committee fine-tune any legislation from the juvenile correction perspective.

Mr. Ralph Blount, Office of the Attorney General Criminal Law Division, stated that the Model Commitment Law does not conflict with Idaho law as written. He said the Office of the Attorney General, Criminal Division, believes that the standards of a "danger to himself or herself" and "danger to others" would allow the state to intervene at an earlier time to protect the mentally ill and their families as well as the public. Creation of tools that will intervene earlier would allow the interests of justice to be better served.

Mr. Blount continued that the Model Commitment Law does not create a mental health defense to crime. It does not limit the state's ability to prosecute criminals who happen to be mentally ill. Treatment for these people can be provided under an existing statute. He said the definitions of "severe psychiatric disorders" in the Model Commitment Law are appropriate and correctly exclude those people with "personality disorders" or "characterological defects." These people include sociopaths, anti-social personalities, liars, kleptomaniacs, sadists, pedophiles and others with lack of conscience or the ability to empathize. Society needs to be protected from these people and this law does not interfere with that.

Mr. Bount added that the Model Commitment Law does not place any higher burden on prosecutors than exists under current law. He said prosecutors told commitment hearings all the time.

He noted that the Office of the Attorney General Criminal Division does not address the due process concerns that may arise under the Model Commitment Law's psychiatric treatment boards. He deferred all of that to **Ms. Kathleen Allyn, Department of Health and Welfare,** who is the next speaker.

Ms. Kathleen Allyn, Department of Health and Welfare, announced that Bonneville County had been awarded $1.24 in developmental grants by the Department of Health and Welfare.

Ms. Allyn noted that her testimony would be limited only to the involuntary commitment process for adults with mental illness. She stated that the involuntary commitment process is one of the rare instances that allows someone to be subjected to indefinite commitment without trial and usually against their will. This arises out of power given to the government to look out for the welfare of certain disabled individuals and to protect the public safety. The process used must also provide adequate procedural safeguards to protect the liberty interests of the individual subjected to this process.

Ms. Allyn stated that an important concern is that the commitment laws, as currently drafted, may require someone with mental illness to commit criminal acts before they can get the treatment they need to control their illness. This is what led to the drafting of the Model Commitment Law.

She explained that the Division of Behavioral Health took the opportunity presented by the subcommittee's review of the state's commitment law and process to draft recommendations. A summary of their findings is as follows.

Ms. Allyn said that in general her Division feels that the current Idaho involuntary commitment laws work very well and they do not recommend substituting the Model Commitment Law for present statutes.

They recommend that an additional category for commitment be considered, namely in the case of a person who is chronically mentally ill and, by refusing treatment, will present a serious and foreseeable risk to health or safety. This would be in addition to the categories of "danger to self or others" and "gravely disabled." This category would require showings that:

- The individual is chronically mentally ill based on both current behavior and past history;
- The individual is currently and historically noncompliant with treatment or incapable of understanding the need for treatment;
- There is a serious and highly probably risk to health or safety for that person not to receive treatment.

The current statutory provisions governing outpatient commitment should be modified, first, to make the standard for outpatient commitment the same as for inpatient commitment and second, to enable the court to switch the client to inpatient commitment based on a showing that the individual has been noncompliant with the terms of the outpatient commitment.

Until a secure psychiatric facility is available, the law should be amended to allow the Department to treat violent and dangerous people, as defined in Idaho Code 66-1305, in designated county jails, provided there is space available and they can be segregated from people charged with or convicted of penal offenses. The costs of the treatment would be borne by the Department of Health and Welfare.

Finally, with the proposed changes, they are expecting an increase in the caseloads currently managed by Department staff. Any consideration of these recommendations must include additional resources for the Department to carry them out successfully.

Representative Henbest commented that these were very substantial recommendations for changes to current law and in her opinion these would align closely with the Model Commitment Law. **Ms. Allyn** said that was correct, especially in the areas of being able to intervene sooner with the "danger to self or others" language and in making the outpatient commitment more functional. **Representative Henbest** asked with regard to the request for additional resources, how are these people being cared for today. She said these are not newly diagnosed but are already out there being cared for. **Ms. Allyn** said that some are being cared for, some are not. To the extent possible, some go to community hospitals and get care. She said in her opinion there are some people that are not committable currently that would be under their recommendation. Today their condition must deteriorate to a more dangerous point to get care.

The Division's recommendation allows for earlier intervention so it does not get to that point.

Senator Corder asked whether these suggestions help solve the problems that were discussed by the doctor at ISSH in being able to supervise patients in the community and tracking whether they are deteriorating to the point where they need more care. **Ms. Allyn** said it would provide some of the legal ability to resolve the transitioning of people back into the community. She said there is still the larger question of adequate resources in the community. She said that a comprehensive system of care that is community-based does not exist at this time and this is more than just a legal problem. **Senator Corder** said that there are examples of people committing serious crimes once they have been transitioned back into the community because the state does not have the ability to keep track of them. He asked what can be done to track these people. **Mr. Rob Luce, Attorney General's Office and Ms. Allyn** commented that developing a more functional outpatient commitment will help with this transition. Combining outpatient commitment with inpatient commitment makes patients more likely to comply with outpatient treatment requirements instead of going back to inpatient care.

Senator Corder asked whether these changes will give communities the assurance that the state can step back in if there are problems. **Ms. Allyn** said the additional category that allows earlier intervention relates to people with chronic mental illness and who are noncompliant. **Mr. Luce** commented that these proposals were more directed to the front-end, not the back-end portion of transitioning back to community. He said that combining inpatient/outpatient gives more ability to work both ways in the system and that could help in these situations. They were mainly focusing on the earlier intervention area.

Senator Stegner said that the list is substantial and complemented them on their efforts. He said the suggestion for chronically mentally ill is similar to the Model Commitment Law's "chronically disabled" wording. He asked if there was a difference. **Mr. Luce** said a lot of this came from the Hawaii statute. He said that when he first looked at the Model Commitment Law from a legal standpoint, he was of the opinion that it would not pass constitutional muster. In his opinion the "chronically disabled" recommendation from the Division, still preserves liberty interests and the Model Commitment Law does not.

Senator Stegner said he was assuming in making these recommendations, they looked at whether designating county jails for treatment will pass federal requirements. **Mr. Luce** said they did look at that issue and think language can be developed that will work and still protect the rights of individuals.

Mr. Tony Poinelli introduced Ms. Teresa Wolfe, Idaho Association of Counties. She stated that with the limited resources at both the state and county levels it is understandable that Idaho would consider looking at a different method of providing mental health services. The counties are requesting that during the investigation and testimony on the Model Commitment Law Law that consideration is given to funding and that responsibility be specifically outlined at the state, county, provider and individual levels.

The counties identified the similarities and differences that exist when comparing the structure of the Model Commitment Law with the current statute. One significant change is the Psychiatric Treatment Board. This Board as outlined in the Model Commitment Law would be the decision-making body for placement and treatment of individuals with mental illness. This Model Commitment Law places the Board into the position of making financial decision for those entities responsible for payment, including the counties. In order for the counties to ensure that sufficient funds will be budgeted – or even exist - for this level of treatment, a clear delineation of financial responsibility for each aspect of treatment will need to be designated.

Of concern to the counties in regard to the Model Commitment Law is that it allows individuals to drift back and forth between involuntary and voluntary admission/commitment as outlined in Section 6.1. This option allows the person to choose 10 day inpatient treatment instead of the assisted treatment proceedings (commitment). The person can then transfer to a voluntary status, but may then be put back to an assisted treatment status. If Idaho chooses to adopt the Model Commitment Law Law, the counties question who would then be the responsible party for payment and at what interval or point in the process. In the alternative, would the state choose to treat this situation under Idaho Code 66-339A as an outpatient commitment? The counties would need clarification on this issue in order to determine and budget for their financial responsibilities, if sufficient dollars exist to fund such requirements.

Ms. Wolfe noted the following issues like these need to be resolved before the Legislature considers adopting any law that does not provide a solution to the current issues and concerns.

Additional County Problem Areas

- Financial impact upon the individual seeking voluntary admission.
- Private hospitals are the most expensive setting for treatment.
  - Counties are required to seek reimbursement from all applicants, including individuals seeking voluntary psychiatric admissions who entered due to financial stressors adding to their anxiety.
  - If there was room at the state facilities for voluntary admission, that would alleviate, or remedy, both of the above concerns.
- Additional expense to county
  - Payment sources, standards and limitations need to be determined for voluntary admission
  - Counties must hire experts for records review
    - To determine appropriate length of stay
    - To determine if the individual was capable of making informed consent
    - To determine if the patient was placed in appropriate treatment setting
- Voluntary admissions have no oversight
  - Length of stay is determined by the treating facility with no review process in place

- Designated Examiners are not used for admission or discharge
- Counties can be overcharged if the appropriate bed/treatment area is not utilized
- Revolving Door - How many admissions does it take before someone determines long-term care would be better suited to the individual seeking admission.

Mr. Steve Millard, Idaho Hospital Association, said that, in his view, 85% of Idaho's commitment law is included in Model Commitment Law. He said that the Hospital Association likes the idea of combining inpatient/outpatient hearings. Hospitals in Idaho have always had mental health as a concern. He stated that capacity is very limited. Of their thirty-nine member hospitals, eight have inpatient mental health services. Many small hospitals receive those patients and do not know what to do with them. Sometimes these people are driven around in a police car. **Mr. Millard** said they would rather see legislation addressing some of the problems that have been mentioned today instead of adopting the Model Commitment Law.

Senator Stegner said the first time he heard of mental health issues was in Nez Perce County eight years ago and he thought it would be very easy to fix. He said he is assuming other hospitals in the state have some frustration about funding issues and lack of clear definition of who is responsible for the costs. **Mr. Millard** said that is a common frustration throughout the state and needs to be addressed. He stated the Hospital Association would be happy to work with whomever to help come up with that definition.

Richard Mr. Bangert, Intermountain Hospital, spoke in support of any legislation that makes it easier and provides more efficient ways of handling mental holds. He said this may have little impact on day-to-day operations but the main focus is on keeping patients safe during crisis.

Mr. Bangert stated that Intermountain would like to go on record in support of Mr. Jonathan Stanley, who spoke at the last meeting, regarding wider commitment standards. Mr. Stanley noted that there is a real need in Idaho to better evaluate and address the potential for future violence with chronic mental health patients and to expand emergency admission criteria when dealing with these patients.

Mr. Bangert said that Idaho's current mental hold law does not include a means to effectively deal with the chronically mentally disabled and potential future safety issues, leaving our law enforcement and health officials without the tools they need to ensure the long-term safety of these individuals and the general public. The Model Commitment Law appears to offer expanded language and definitions which could help clarify a number of potential hold situations. Intermountain would support any legislative change that assists in clarifying the hold process and how and when it can be used for the greatest benefit.

Intermountain also would support an expanded use of outpatient commitment. Oftentimes the success of a mental health treatment program is an ongoing, structured system that requires patients to utilize therapeutic options in a timely and regular manner.

Mr. Bangert recommended that this Subcommittee carefully examine any potential issues that might come with implementation of any new mental hold law. Issues such as increased utilization, limited financial resources, and lack of programs and facilities could all come in to play down the road.

He reiterated that any legislative change in Idaho's mental health law may not impact Intermountain Hospital to a significant degree and offered to be a resource and partner to this Subcommittee for information about mental health issues.

Mr. Gary Payne, Idaho Psychological Association, gave the following responses to the Model Commitment Law.

- Whatever the inherent value contained in the "Model Commitment Law," it is not a Model Commitment Law that reflects any broad consensus of professionals or consumers beyond the organization, Treatment Advocacy Center, that developed it.
- Outpatient commitment is a valuable concept and is currently enacted within Idaho Code 66-339 in a way that is substantially similar to that proposed in the Model Commitment Law.
- Outpatient commitment and the related concept of conditional release Idaho Code 66-338 and 66-339 are rarely used for a variety of reasons that include:
    - Agencies and providers believe their liability is less for patients if the commitment has been dropped and the individual alone is responsible for their own conduct.
    - Only cases involving involuntary commitment have clarity about the relative financial responsibility of the county, the state and the individual.
    - The system has a prioritized response based on levels of emergency. Getting a mental health, legal and law enforcement response that will get a patient to an outpatient treatment setting does not have the same priority as a "mental heath emergency."
- The defense bar does not appear to have adequate resources to adequately represent the numbers of clients who are facing commitment.
- The use of a 30 day abeyance in some jurisdictions is a practice that has merit for individuals who are willing to enter into treatment but don't have a mental health history required for outpatient commitment. If formalized this might result in an additional option for consumers.
- The Psychiatric Treatment Board described in the Model Commitment Law does not seem feasible in Idaho given the scarcity of psychiatrists and the fact that in rural Idaho practitioners may have dual relationships with local hospitals and agencies. If psychologists were included, as they should be, the same argument would apply.
- The current system of selecting Designated Examiners from a pool does not appear to be problematic and seems to provide the expert testimony required by the courts.
- The Psychiatric Treatment Board would not be able to function as described in the Model Commitment Law because the Helen True Case resulted in a district court decision in

Idaho (1982) that found that psychiatric hospitalization after conditional release involves a significant liberty interest and requires a hearing before a judge.

- The addition of local hospitalization across the geographic regions of the state is a requirement for being able to use outpatient commitment as an effective tool when individuals require brief hospitalization.
- Additional resources will be required to develop the community support that outpatient treatment requires. Changes in law alone will do little to reduce the rate of involuntary hospitalization or the shortage of psychiatric beds.

Mr. Jim Baugh, Comprehensive Advocacy, Incorporated, stated that it is important to understand that this "Model Commitment Law" is not like Model Commitment Law or uniform statutes from the Commission on Uniform Laws or other groups established for the development of Model Commitment Law statutes. It is prepared by the Treatment Advocacy Center. The Treatment Advocacy Center website has no information on who wrote the Model Commitment Law law or how it was vetted. There is no indication that any state has actually adopted the law, although many of its sections are more or less borrowed from different state codes around the country. Even for sections from other state codes, there is no information whether these sections have withstood constitutional scrutiny. Some of them do raise significant constitutional questions.

According to **Mr. Baugh**, it would be unwise to increase the number of involuntary commitments without giving people adequate access to voluntary care. There is abundant evidence that many people with mental illness are turned away from treatment when they seek it. While people who have Medicaid can generally get some services through private providers, most people with persistent mental illness in Idaho do not qualify for Medicaid because their Social Security Disability payments are too high for Medicaid's income criteria. The Idaho Department of Health and Welfare serves some of this population through its regional mental health authorities (RMHA), but the RMHAs are very restrictive on eligibility and short on treatment and service resources. Eligibility for regional services is limited to people with specific diagnoses, and requires a level of severity almost as severe as the criteria for involuntary treatment. If people are prevented from getting treatment on a voluntary basis until their condition deteriorates to a level of high risk, we continue to strain the judicial and law enforcement systems and we fail to address the terrible toll on people with mental illnesses, their families and communities. Relaxing the involuntary commitment standards concentrates on the "downstream" end of the problem, after much of the damage has already been done. Idaho desperately needs to address the issue much further "upstream" where investment of resources can have the most benefit and much more suffering and expense can be avoided.

Mr. Baugh stated that there is another "Model Commitment Law" which addresses this issue, prepared by the Judge Bazelon Center on Mental Health Law, which is aimed at ensuring access to mental health treatment at the point when it can do the most good, on a voluntary basis using evidence based approaches to treatment.

He went on to say that "Assisted Treatment" is not the term most people who have been through a commitment procedure would use to describe their experience. This euphemism for being arrested, handcuffed, transported by law enforcement, held against your will and subjected to forced treatment will not ring true with most people who have had the experience. It is important to remember that involuntary treatment laws represent the huge exception to our constitutional guarantee of liberty for law-abiding citizens. Under our statute and especially under the "Model Commitment Law," it is possible to do all these things and to hold a person against their will indefinitely even if the person has never harmed anyone or broken any law, so long as clinicians are convinced that they are likely to do so. We should be very careful about how we expand this constitutional exception.

A copy of **Mr. Baugh's** in-depth analysis of the Model Commitment Law is available at the Legislative Services Office.

Mr. Doug Call, National Alliance on Mental Illness, spent twenty-four years as a first responder. He agreed that earlier and easier access is necessary and people need to be able to identify and access this system.

He said there is a need to protect the public from those that have a propensity for violence and that laws should be enacted to help mental health providers and law enforcement deal with this issue. He said he is not in favor of using jails to treat mentally ill people.

Ms. Linda Hatzenbuehler, Licensed Psychologist and Designated Examiner, Bannock County, has worked in this capacity since 1979 and has seen hundreds of people involved in this process. She noted that most of her comments were covered by Mr. Baugh.

She noted that the student at Virginia Tech was under outpatient care at the time of the attacks. **Ms. Hatzenbuehler** went on to say that due to mental health professionals' inability to predict dangerousness, they tend to err on the side of false positives or are very conservative in their risk assessments both for suicide and assault. There are some practical liability issues involved in this as well.

The line is not always clear between behavior that results from mental illness and illegal behavior committed by a mentally ill person independent of that illness.

She said that mental illness is not a steady state. For the majority of persons, symptoms wax and wane.

She said few mentally ill persons are assaultive. If assaultiveness is a symptom of their mental illness, justice, in her opinion, indicates they should be treated and not punished.

Ms. Hatzenbuehler went on to say that tinkering with Idaho Code, Title 66 will not necessarily reduce the number of mentally ill persons in jail. She said the best way to do this would be to

study “jail diversion” programs. This has been shown across the country to be quite effective.

She explained that “jail diversions” are used in many areas. These are a large step above mental health courts. Jail diversions put people into treatment and if they do not meet the requirements of treatment, then they must go to court. It is handled by the behavioral health units and would be a whole new program for Idaho.

She said that voluntary treatment is better than coerced treatment.

In discussing inpatient/outpatient commitment, she explained that as a DE, she participates in the commitment but not in the disposition of the patient. She said in Bannock County, dispositioning is done by an employee of the Department of Health and Welfare. In that region some dispositioners have placed people in outpatient treatment. **Ms. Hatzenbuehler** said it would only require a small change in Idaho law to allow this specifically without changing our commitment law. She noted that many procedures used are not codified but they are good procedures including abeyance and stipulation.

She explained that in some cases judges use abeyances for 30 to 90 days and if the patient meets all of the requirements set forth, the case is dropped. **Ms. Hatzenbuehler** said abeyance is not specifically mentioned in Title 66 but it is an effective tool.

Another tool is stipulation. She said there are people that stipulate to civil commitment in her region. Sometimes there are people who are interested in treatment but for whatever reason cannot access it; can’t afford it or can’t voluntarily commit themselves to a state hospital because there is no room; so they will stipulate to commitment.

Ms. Hatzenbuehler stated that, in her opinion, psychiatric treatment boards are not a bad idea but are not practical. She said this would simply delay the process and increase the costs dramatically. In many areas finding three people to do these hearings would be very difficult.

She said one concept of the Model Commitment Law is that people in jail with mental illness are there because they refused to get treatment. She said this is not necessarily true. Sometimes this is an access issue or they do not meet the target definition of “mentally ill.” A person cannot get treatment in Idaho unless they meet the target definition.

The issue of chronically mentally ill flies in the face of recovery. This means that a mentally ill person is constantly in a state of mental illness. The concept with mental health treatment has always been recovery. She said a better way to deal with this would be to use “declarations of mental health treatment” that already exists in Idaho Code, Title 66. This is a most progressive statute that allows a mentally ill person, while in the recovery process, to come up with a plan stating what they want to have happen when they become symptomatic again.

Senator Stegner commented, regarding the idea that the changes in commitment laws will result

in a reduction in prisoners, that he did not think that has necessarily been a goal of this or other mental health committees. He said the committee recognizes that the growing jail population is a burden and that the general perception is that due to lack of treatment options, many times people have to commit crime in order to get treatment.

Dr. Hatzenbuehler said she brought that up because the preamble to the Model Commitment Law clearly targets the number of people in jails. She said some of this might be helped with increased coordination between the Department of Health and Welfare and the Department Correction.

Representative Wood commented that stipulated commitment seems like a method to get funding for treatment in lieu of paying for it themselves. **Dr. Hatzenbuehler** said it could be, but that there are also people that do not meet the target definition of mental illness to access publicly funded treatment, and that includes state hospitals. A person cannot voluntarily sign themselves into a state hospital because there is no room. State hospitals have become mandatory involuntary systems.

Dr. Bill Hazle, Medical Director, Business Psychology Associates (BPA), explained that he is a psychiatrist and has been practicing for 30 years. He stated that current Idaho law works fairly well. The Model Commitment Law introduces some concepts that are important and that other states have or are looking at changing. These include:

1. Expansion of access to care/treatment.
2. Reduces the criminalization of mental illness.
3. Brings the psychiatrist and other treating professionals into the commitment process making it more of a team effort. He said this could make a huge difference in the continuity of care and impact on the system.

Dr. Hazle went on to discuss the fact that the student at Virginia Tech was under outpatient care at the time of the shootings. He explained that as a result of those events, a commissioner that was part of a commission for mental health reform in Virginia talked about the problems in the system that were a factor in the deaths. These include:

- Fragmented and underfunded system.
- Lack of cooperation and collaboration between agencies and employees in agencies. There was no mutual respect.
- Strict eligibility requirements for treatment at mental health centers that excluded many patients.
- Reprioritizing of the target populations.

In summary, **Dr. Hazle** said that the Model Commitment Law concepts are good. One positive is that under the Model Commitment Law, treatment will begin sooner. Today, a commitment hearing alone does not mean that treatment begins immediately. Another hearing is required.

He cautioned that the subcommittee needs to be very careful and if any changes are made, the impact those changes will have on the system need to be studied carefully.

Several judges provided their personal observations on the Model Commitment Law in the form of written comments. **The judges included: Judge Bradly Ford (Canyon County), Judge Randy Robinson (Clearwater County), Judge Dave Epis (Elmore County) and Judge David Manweiler (Ada County).** These comments are available at the Legislative Services Office.

Dr. Roberto Negron, Idaho Psychiatric Association, spoke in favor of the Model Commitment Law and thinks it is a move in the right direction. In his opinion this population of patients has been neglected. He said that early intervention is the key. He said the hope is to get people treatment before they deteriorate and commit a crime or hurt someone or themselves. He spoke in favor of combining inpatient and outpatient commitment and stated that the DE system works quite well.

The next meeting was scheduled for October 30 and with no further business the meeting was adjourned at 4:35 p.m.