Minutes
Subcommittee on Mental Health
Tuesday, October 30, 2007
9:00 a.m. to 2:30 p.m.
Room 204, Capitol Annex
2nd Floor, 514 W. Jefferson
Boise, Idaho

The meeting was called to order by Cochairman Senator Joe Stegner at 9:05 a.m. Other committee members present were Senator Tim Corder, Senator Patti Anne Lodge, Representative Fred Wood and Representative Margaret Henbest. Cochairman Representative Sharon Block was absent and excused.

Others present were Benjamin Davenport, Evans Keene; Woody Richards, Intermountain Hospital; David Leach; Tony Poinelli, Idaho Association of Counties; J.R. VanTassel, Teresa Wolf and Jennifer Douglass, Nez Perce County; Carrie Parrish, Office of Performance Evaluations; Robert Luce, Deputy Attorney General Department of Health and Welfare; Gary Payne, Idaho Psychological Association; Jim Baugh, Comprehensive Advocacy; Kathie Garrett, Partners in Crisis of Idaho; Bob Seehusen and Carla Terry, Idaho Hospital Association; John Tanner and Martha Tanner, National Alliance on Mental Illness; Kathleen Allyn, Director, Behavioral Health Division Department of Health and Welfare; Amy Holly-Priest, Business Psychology Associates; and Martin Bilbao, Skip Smyser's Office. Legislative Services Office staff present were Eric Milstead, Amy Castro and Toni Hobbs.

After opening remarks from the Cochairmen, **Representative Wood** moved that the minutes from the last meeting be approved. **Senator Corder** seconded and the minutes were approved by voice vote.

Mr. Eric Milstead, Legislative Services Office spoke to the committee regarding an overview of possible modifications to Idaho Commitment Laws, Title 66, Chapter 3, Idaho Code. His complete handout is available at the Legislative Services Office.

Mr. Milstead began with a recap of the previous testimony on commitment laws. He stated that the general tenor of the testimony presented to the Subcommittee might be summarized in the following manner:

- The current statutory scheme related to commitment laws works reasonably well;
- No need or desire to make wholesale changes to the state's commitment laws;
- In general, earlier intervention in cases would be a positive step;
- Sufficient resources are necessary to deal with mental health issues, and there exist unmet needs both locally and at the state level. To the extent legislative action is taken to strengthen the state's commitment laws, there should be corresponding efforts to provide

for more robust mental health-related resources throughout the state.

Mr. Milstead said that there were three subjects that garnered positive testimony in terms of amending the current statutory theme. These included:

- 1. Provide a third category or standard in regard to involuntary commitment orders—a standard in the case of a person who is "chronically mentally ill."
- 2. Modify statutory provisions governing outpatient commitment in two ways:
  - a. make the standards for outpatient commitment identical to that for inpatient commitment; and
  - b. provide a mechanism that, in the event a person in outpatient commitment is noncompliant with treatment, the court would have the ability to order in-patient commitment based on a showing of noncompliance.
- 3. Provide a statutory mechanism authorizing a court to place a commitment order in abeyance for 30-days.

He went on to discuss each of the above three items separately.

- **1. New and Additional Standard or Category for Commitment**

Mr. Milstead said that there seemed to be general agreement for providing earlier intervention. In doing so, there was some agreement that the concept of providing an additional category or standard for commitment that would permit consideration of both current and past history. The new standard would apply in the case of a person who is "chronically mentally ill."

This standard would be added to Section 66-329, Idaho Code, where the current standards require a showing that the proposed patient is "mentally ill and either likely to injure himself or others or is gravely disabled due to mental illness." The proposed new standard would be added to this section providing for commitment in the case of a person who is chronically mentally ill and who, by refusing treatment, will present a serious and foreseeable risk to health and safety. The new category would require showing 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; and
- there is a serious and highly probable risk to health or safety for that person not to receive treatment.

Testimony suggested that this change might help in those situations where a family member is "chronically mentally ill" but under the current statute, little can be done absent significant overt acts threatening health or safety.

Senator Corder asked whether the assumption that earlier intervention might take place under the new standard. **Mr. Milstead** said that from research that has been done, being able to rely on past history, particularly noncompliant past history does allow for the matter to be brought before the court before a significant event occurs.

Representative Rusche asked whether any other jurisdictions have similar clauses in their commitment laws. **Mr. Milstead** said that the state of Montana has adopted something similar to this and he would check for others.

Senator Stegner said this is a concept that would broaden the law to allow an historic pattern of behavior to be considered in whether or not someone should be committed. **Ms. Martha Tanner, National Alliance for the Mentally Ill (NAMI),** commented that she admires the committee's work in this area and said it is very important. She said that currently there is good treatment available for chronic mental illness but that people without insight do not recognize their own need for treatment. She said to allow someone to remain psychotic just because they have refused treatment is inappropriate for the patient and terribly difficult for the family. She spoke in favor of this change.

Mr. Jim Baugh, Comprehensive Advocacy (CoAd), commented that the specific language of how this change is made will be important. Little differences in phrasing can make a lot of difference in what impact it will have. He said that the term "chronically mentally ill" is significant in terms of philosophy of treatment and its impact on people's mental illness. Current thinking is that the goal of treatment should be recovery. He stated that for people to be declared "chronically mentally ill" is more or less to tell them to give up hope of recovery. He said there may be reasons to change the standards of commitment but he hoped there could be a different phrase used to describe the category.

Mr. Robert Luce, Deputy Attorney General, Health and Welfare said in looking at almost every law across the U.S. he found that Alaska, Hawaii, Washington and Oregon have all created this category. He said he does not think any state specifically uses the term "chronically mentally ill." Most of the Law Review articles and other materials group these into a need for treatment category. This included people who refuse treatment and don't recognize that they need treatment and are in the revolving door. If they don't get treatment, something bad is going to happen in the future. He said it is a balancing of constitutional rights and liberty versus protecting society. He said there are many examples for Idaho to use in drafting this.

Senator Stegner stated this is a more progressive approach for Idaho to address the mentally ill. This change is warranted and he said he has had people say to him the scope needs to be broadened so more people have access to care. He noted that care does need to be taken to make sure we do not tread on individual rights.

Representative Henbest spoke in favor of the need to strengthen what is available for outpatient commitment and involvement of courts**. She made a motion to direct Legislative Services to draft language to create a new standard that would apply to people that meet the bulleted criteria stated above, leaving off the words "chronically mentally ill." Senator Lodge seconded.**

Mr. John Tanner (NAMI) suggested this address not only the chronically mentally ill but also

those who are not willing to accept their condition and are not getting treatment. **Senator Stegner** agreed. He said many families have someone who would benefit from treatment but who refuse. He said there are also other members of society that would benefit from treatment but under current laws, their family has difficulty getting them into treatment. He said there would still be an impartial judge reviewing the process to make sure individual civil liberties are protected. He said there needs to be a balance between the two.

Ms. Tanner commented that they have had to go through this with their son. After 4 months of treatment in the State Hospital he is working and feels better than ever before. She knows that without structured treatment he will stop his medication and will revert back.

In response to a question from **Senator Corder** regarding the cost component, **Senator Stegner** said he was not aware of any significant broadening of potential liability for the state in the commitment process. He said that this change could cause an increase in commitment hearings but there is no way to know that.

Representative Henbest asked for a population based review of how many commitments are sought in other states that have a similar law to get a sense of caseload. She said that compared to this population it would be good to know how many commitments could be expected.

Representative Wood suspected that this provision is not going to have that much fiscal impact since it deals with involuntary commitments. He said if it was voluntary commitments, it would have a much larger impact.

In response to the discussion of costs, **Ms. Amy Castro, Legislative Services Budget and Policy Office** said she would wait until the legislation was developed and work with the Department of Health and Welfare to put together a cost benefit ratio.

Senator Lodge asked whether this would be the same type of legislation as would be needed for juvenile commitments. **Mr. Milstead** said that he thinks this is in a different statute. **Mr. Baugh** agreed that children's mental health is located under a different statute. He said it was specifically crafted with the minor status of the child in mind. He said the same consideration regarding treatment does not apply to minors because parents consent to their treatment until they are 18 years of age. He noted that there is involuntary commitment for children if parents refuse and the child is a danger or if the child has no parent.

The motion carried unanimously on voice vote.

- **2. Modify Outpatient Commitment**

Mr. Milstead commented that there were a number of presenters who stated that the current statutory provisions regarding outpatient commitment could be strengthened. It was noted that perhaps the reason that outpatient commitment is little used in the state is that currently inpatient and outpatient commitment have distinct standards for commitment and require distinct findings.

Mr. Milstead explained that this proposal would require a blending of existing statutes: Sections 66-329 and 66-339A, Idaho Code, and would modify the current statutory provisions governing outpatient commitment in two ways:

- 1. Provide identical standards for ordering either inpatient or outpatient commitment. This would result in a single hearing with a single standard or test to determine commitment.
- 2. Provide a mechanism to allow the court to switch the person to inpatient commitment based on a showing that the individual has been noncompliant with the terms of outpatient commitment. This would provide a statutory mechanism to permit courts to more quickly address noncompliance issues.

Senator Stegner said that since outpatient commitment is almost never used in Idaho, he is skeptical that modification of the statute will result in increased usage. He added that it still seems prudent to put this option in front of judges, the mental health industry and families and let them consider if it is appropriate in certain circumstances. He said there is no way to know how effective it will be unless we try it. He said it could be that complications in the process are the reason this is not being used today.

Representative Wood said that the decision of whether someone needs either inpatient or outpatient care is a medical decision. He fears that this change will push more people toward outpatient care due to budget constraints. He said he would like to look at this more closely.

Representative Rusche agreed with **Representative Wood**. He said this is a clinical decision as to the type of treatment. He added that he thinks it makes sense to have one standard for the hearing process.

Mr. Gary Payne, Idaho Psychological Association, said they have seen this process of outpatient commitment work in the state of Wisconsin. He said there needs to be a joining of the courts and medical providers and that there needs to be a way to go to court and have a discussion of the ability to order certain treatment for those under outpatient commitment.

In response to a question from **Representative Wood, Mr. Payne** said that the law does not seem to provide for that now. He said orders do not give police clarity to take patients to hospitals. In Wisconsin under outpatient commitment, police do that as standard procedure.

Senator Corder commented that the judge that testified felt that he was pushing the limits and could be challenged. He agreed that there does need to be one standard. The judge seemed to say it would be better if they were given statutory authority.

Senator Stegner said the comments today are appropriate and accurate. He said it seems that they are working on two different levels. He does not think the concept of providing a mechanism for outpatient commitments will increase utilization until responsibility for payment

is figured out. He said he thinks there is value in developing language that would allow a single hearing for inpatient and outpatient commitments.

Representative Henbest commented in reviewing the existing inpatient and outpatient statutes, that the current inpatient statute requires a physician to be the designated examiner and that a psychiatrist also be involved. She said retaining these requirements would actually strengthen outpatient commitment. She said she would like to see what combining these two statutes would look like. A blended commitment process might give judges more tools to use in making their decision. **Representative Wood** said he has no problem with a single standard as long as the decision is a clinical decision for treatment of the patient.

Senator Corder moved to proceed in that fashion. Senator Lodge seconded. The motion was to draft language to combine the hearing process and maintain treatment as a clinical decision for inpatient and outpatient commitment. The motion carried by voice vote.

- **3. Thirty day abeyance of commitment order**

Mr. Milstead said that this concept would provide statutory authority allowing a court to order a thirty day abeyance of the Petition for Involuntary Mental Commitment. This concept was raised during testimony at the Subcommittee's September meeting and was discussed at some length by Linda Hatzenbuehler, Designated Examiner from Bannock County. The mechanism is used in the following manner:

- 1. Used in less problematic cases where it is agreed by all parties involved that something less than commitment could work;
- 2. Agreement is entered into prior to the commitment hearing;
- 3. All parties sign the agreement and the Court approves the agreement;
- 4. Includes provisions that the individual must comply with the treatment or else the state will refile the petition for involuntary commitment.

This mechanism provides an additional avenue to work with individuals who appear likely to comply with treatment and avoid the full commitment process.

Senator Stegner commented that this seems to be codifying what is already practiced. **Mr. Milstead** agreed that this is already used in many parts of the state.

Representative Wood asked whether this is working. **Mr. Payne** said this has been used in Ada County for at least six years for lower risk cases. In these situations the person says they are willing to get treatment at the time of hearing. The issue hinges on the opportunity that they will seek treatment and improve their conditions. He said this does work but judges are at some risk because of the dangerousness of the patient and if they were to commit a crime while under a thirty day abeyance. In his opinion, if this was codified, more people would use it.

Senator Stegner clarified that this is not about someone resistant to treatment, it is in the voluntary arena. **Mr. Milstead** said that was correct. The individual agrees to stipulated provisions as part of the order. If not, the commitment process is followed.

Mr. Luce said he is not familiar with this. In his opinion he said it sounds like judges have come up with a procedure to use instead of outpatient commitment. It seems to be a reaction to a statute that is not working.

Representative Wood moved that Legislative Services Office work with others to formulate language with respect to a thirty day abeyance order. Senator Corder seconded.

In response to a question from **Representative Rusche, Mr. Milstead** explained that if the person violates the provisions stipulated, the state reacts by filing a petition for commitment. **Mr. Baugh** said that as he understands this with abeyances, the person voluntarily agrees to get treatment, but the courts do not dismiss the petition. They maintain jurisdiction to make sure the person complies with treatment. The Model law allowed for 10 days of treatment and the petition was dismissed. In Idaho, judges have used rules of civil procedure to maintain the petition while the person goes through treatment. **Representative Wood** said, as he understands this, the person in this situation has already been through a designated exam and the designated examiner would decide whether the person is capable of making such a decision for himself.

The motion carried by voice vote.

The next part of the meeting was of a panel discussion consisting of **Mr. Tony Poinelli, Idaho Association of Counties, Teresa Wolf, Jennifer Douglas and J.R. VanTassel, Nez Perce County.** Their complete PowerPoint presentation is available at the Legislative Services Office.

Senator Stegner explained that their presentation is the result of the fact that Idaho has some very confusing laws dealing with indigent mental health issues. He said there is a classic conflict between who is responsible: counties, the state or the hospitals who get stuck in the middle.

Mr. Poinelli stated that placing Adult Mental Health as the lead agency for a comprehensive mental health program moves us towards an effective and efficient system for the patient, taxpayers, counties and state. He said there should not be two separate entities or multiple entities leading the picture. One lead agency needs to be able to make the decision.

Ms. Wolf discussed the process an indigent person goes through for a voluntary and an involuntary commitment. This is included in detail in their PowerPoint presentation.

Senator Stegner clarified that the counties are being asked to pay for indigent mental health care and state statute says the state should take care of that. He understands that numerous counties in the state do not provide or pay for indigent mental health care. There are different interpretations throughout the state as to their responsibilities. Many choose not to get involved in any indigent mental health care.

Senator Stegner explained indigent adult voluntary commitment. For example a young adult male, not incarcerated or detained by police, where no crime has been committed and is not

really a threat to himself or others but has abused a substance and checks into a hospital and is accepted for evaluation and admitted to a psychiatric ward. No one is involved as to the appropriateness of treatment but the county gets the bill for indigent treatment. **Ms. Douglass** said that the county does evaluate the application for reimbursement but after the fact. **Senator Stegner** said the appeal process is cumbersome and expensive and the hospital is stuck in the middle and just wants payment.

Mr. VanTassel said that in many cases the only contact the county has with the patient is one of means testing. He said this involves a nonmental health profession as the only county person who comes into contact with the patient in a setting that is probably negative and emotionally stressful. **Senator Stegner** said in addition to means testing, there is a residency test because the entire statute is based on assigning the responsibility based on county of residence. He said in some cases the clients do not even know what their county of residence is. **Ms. Douglass** said it is a very invasive process for a medical indigency determination and this adds a lot of stress to the patient.

Representative Henbest asked if in their county survey, there was any interaction in terms of not being able to separate medical costs from mental health costs from substance abuse costs. **Mr. Poinelli** said they have had that issue in the past because it is divided into different budgets. He said they tried to address it and this is probably one of the best in terms of information gathered in quite some time. He said they cannot identify substance abuse treatment costs. He said it is much easier to identify mental health costs, especially if they come from the indigent fund.

In response to a discussion on venue, **Senator Stegner** explained that there are only so many treatment centers across the state primarily in larger metropolitan areas. A resident from another county comes into one of those large counties and is hospitalized and the process is started for an involuntary commitment, an attorney is assigned to represent that person. In an attempt to provide the best defense, he uses the statute to deny waiver of the venue on behalf of his client so that the county cannot proceed with the involuntary commitment. That person must then be transported back to their county of residence along with the support staff that will testify. This increases the costs and time in terms of making a determination for appropriate treatment. **Ms. Douglass** noted that in some cases, if their county of residence does not do commitments, these people are set loose. **Senator Stegner** said this is a result of antiquated system tying jurisdiction and venue to the county that will be paying.

After more discussion on this issue, **Representative Henbest** suggested a statutory fix of the indigent statute that specifically mentions mental health care. **Ms. Douglass** said that if mental health is specifically exempted out of the statute it would solve the issue instead of it being left silent. She said there could be other areas that need additional clarification.

Mr. Bob Seehusen, Idaho Medical Association commented that Nez Perce County is more progressive than others on this issue which is very good for the people in their county. He said

that many counties just say no to mental health care period. In his opinion, counties need some financial responsibility in this because they do have some capabilities that the state does not have. This would include determination of eligibility and so on. He agreed that the statute needs clarification. He said there are a lot of patients that fall through the cracks and are let go.

Mr. Poinelli noted that the counties are involved in the process today. He said the issue left in limbo is voluntary treatment. He said the statute seems to clearly identify the responsible party with the voluntary issue. The courts do not necessarily see it that way. He said for involuntary commitment the counties are paying up to the point of commitment. He noted that the hospitals are left out.

Mr. Poinelli said there was a Mental Health Substance Abuse Committee that worked on this issue in the past. The intent was to try to create a unified system with one entity in charge to better serve the patient. He said they still feel that way.

Mr. VanTassel said that county commissioners are creatures of Idaho Code. He said when they are given direction and authority, that is what they do. He said currently they do not have direction regarding financial responsibility through the Idaho Code. It is in case law. He said arguably a person in Nez Perce County could file suit against the Board of County Commissioners for collecting and distributing tax moneys without code authority. He said should the state choose to give the counties some responsibility, they will comply. He said the state needs to consider the county's appropriateness to be involved in mental health care. According to **Mr. VanTassel** counties are not homogenous with mental health care. He noted that counties are not even consistent amongst themselves as to how they approach that. He said there is a need for solid direction.

Representative Rusche asked whether county eligibility standards are consistent for appeal process. Mr. Poinelli said those are pretty standard. He said there is a uniform application that is mandatory for all counties. **Representative Rusche** asked whether standards for indigency for counties could be different. **Mr. Poinelli** said the only way that should be different is due to the boards of county commissioners. They do have some discretion. **Representative Rusche** asked if the state took catastrophic mental health events that are being paid through indigent funds off the table, is there a way to seek federal reimbursement for those. **Mr. Dick Schultz, Health and Welfare** said the person would have to be proven to be medicaid eligible. He said that would put the state in the same position as counties are in now. **Representative Rusche** said that may be worth exploring. He said it is a fact that the state gets no match today from the federal government for indigents.

Representative Rusche asked how many admissions are single episode and how many are chronic. **Ms. Wolf** said she did not have a percentage. She said there are a lot that are single episodes but she does not know if those people are getting care after the episode and whether that is keeping them from returning to the system.

It was clarified that Health and Welfare does see indigent mental health patients. If the law is changed, people will still get care. Today counties just pay for the care, they do not provide the care. It was stated that there needs to be a single stream.

Mr. Payne said that many people believe that a single system would be a solution. He reinforced **Mr. Baugh's** statement that mental illness is a medical illness. He commented on the number of people in jail or other places where they receive county services who have psychiatric disorders, take psychiatric medication or have substance abuse problems. He cautioned doing such a broad carve out without being attentive to the details would suggest the counties not provide these services in jails or other settings. He suspects that is not the intent.

Dr. Mary Perrien, Department of Correction was introduced to give an update on the status of ongoing activities of mental health service delivery in Corrections as well as the secure mental health facility project that is being developed.

Dr. Perrien commented that as of about two weeks ago, 31% of the inmates in the Department of Correction were identified as having mental health issues. She stated that she does believe these numbers are high and she thinks these numbers will decrease due to diagnostic issues that exist within the facility.

Dr. Perrien went on to say that as of today, there are two civilly committed individuals at the Idaho maximum security institution in the secure mental health program. She said that neither one of those individuals has pending criminal charges at this time. She noted that one of these individuals will soon be moved to State Hospital South freeing up another bed at their facility. The facility has the capacity for three civilly committed individuals.

Dr. Perrien defined "civilly committed individuals" as those who have not been convicted of a felony and are not under the jurisdiction of the Department of Correction as an inmate. If these people were not found to be dangerously mentally ill and in need of such care, they would not be there. She said there is a second population of individuals under the Department's jurisdiction and who were convicted of felony that have mental illness and have decompensated to such a point that they meet the criteria of being gravely disabled, are a danger to self or others and refuse treatment, usually medication.

When this happens the Department is forced to step in and get an involuntary treatment order to stop the person from decompensating further. The statute for forced medication is through the commitment statute. **Representative Henbest** asked how many clients in Corrections have decompensated mentally and have had to use the civil commitment process in order to treat. **Dr. Perrien** said about 14. She said part of the reason for this low number is due to under identification. From her experience she has found that the person who acts out comes to the attention of mental health officials. If someone is psychotic and having hallucinations or delusions, those people tend to get referred to mental health resources. People that do not get referred as often are those that "don't cause a problem." When an individual experiences

negative symptoms of psychosis and is withdrawing from the population, those people are often not referred. She said the Department is trying to educate clinical and security staff to be able to identify those people as well as those who are acting out.

In response to another question from **Representative Henbest, Ms. Perrien** said the Department has two people located at the facility that are civilly committed. **Mr. Schultz** commented that he did not know how many are in State Hospital North or South that have been civilly committed. He said he will get that for the committee.

Dr. Perrien again thanked the Legislature for all they have done in terms of helping the Department in providing mental health services and improving the continuum of care for inmates with mental illness. She went on to say that during the last session the Legislature funded a behavioral health unit. This is unit 16 at the medium security prison that holds 236 inmates. It was designed to provide shelter living for inmates who are vulnerable because of their mental illness. This gives the Department the ability to provide safe housing for this population. The Legislature also provided staffing that allows more clinical services for these people and helps increase the functional level to make them safe among the prison population and make others safe around them so they can benefit from programs offered for treatment and vocational education. This also helps them better prepare for the reentry process back into the community.

Dr. Perrien said a large piece of this was a remodel of the unit and they expect that to be completed around the third week of November. The security staff for the unit has been selected and training is almost complete. She said there will be enhanced training for security staff. She said everyone is very excited about this enhanced training. People bid into these positions so they want to be a part of the therapeutic milieu. She stated that the Legislature funded this therapeutic milieu in a sheltered living situation. She said that the hiring process is ongoing and that there is a challenge in finding clinicians. She said they are expecting current inmates in that unit to be transitioned out and all identified mental health inmates will be moved in by December 15.

The next item for discussion was the Competency Restoration Unit (CRU). This is part of the secure mental health program at the correctional institution. She said this is a staffing based program. She said they did not have adequate staffing to be able to get the pure civilly committed individuals out of their cells. This is not beneficial for their mental health. This staffing package will now allow these people to spend the majority of their time outside of their cell in treatment. The full activation of this program is contingent on hiring which will be happening this week.

Dr. Perrien mentioned that there is also program development going in with regard to the competency restoration piece. She said they are working closely with the Department of Health and Welfare and their staff who participate with competency restoration.

In response to a question from **Senator Stegner, Dr. Perrien** explained that the 31% of inmates with mental health issues equals about 2,100 and those are primarily males. She noted that there

is a large part of the population that are able to function in a regular facility and to participate in treatment groups and such. She said there is not a specific number for the group that will most benefit from sheltered living. She said it was approximately100 males when they last reviewed the roster but she feels the need is greater than that.

Dr. Perrien reiterated that there is the problem of under identification and of not recognizing how severe the mental illness is until it reaches a certain point. She said there are certain symptoms of mental illness that require more exploration. Unfortunately, staff at this time spend a lot of time doing board reports so they are not always able to spend sufficient time with a patient to find that they have a very strong underlying delusional system. They may present very well but are still very ill. She added that there are also individuals who are maintained fairly well on medication. Another group exists that may function fairly well but whose ability to judge social cues and interact with a high risk population is problematic. She said there is not a way to tag or track how vulnerable someone may be. She said they are working on this with the tracking system for the future because they need to be able to identify these people so they can be housed appropriately.

Representative Rusche asked how many similar types of prisoners are located in county jails. **Dr. Perrien** said she did not know. She said there is an unknown, unmet need in this area.

Dr. Perrien went on to discuss the secure mental health facility. She said she is very excited about the collaboration between the Department of Health and Welfare and the Department of Correction. She said one of the unintended benefits is that they have been talking in more detail about the reentry process because both Departments see many of the same clients at different points in their lives.

Dr. Perrien said that they visited sites in California, Kansas and a federal medical center in Missouri. This was to give everyone an opportunity to look at a variety of maximum security facilities to see how they look and feel. The point was to make people realize the facilities can be therapeutic, secure and cost-effective. She said there has been a conceptual planning meeting with the consultant and both departments to work out the details of the facility.

Dr. Perrien explained that this facility will have 260 beds for the Department of Correction (DOC) and 40 beds for the Department of Health and Welfare. This will be shaped like a rectangle with various units located around the rectangle. The middle of the rectangle will be called the treatment mall. This is going to be a multipurpose facility with a complex mission and multiple levels of care.

She explained that at times some of the inmates will decompensate to the point where they cannot leave their units. This makes it necessary to have adequate treatment space located within the housing units. For those that can get off of the unit, they will be able and required to leave their units to go to treatment or therapy. She said the treatment mall will also help with the transition back to the community because patients will have to go there just as they would have

to go to the market or to the doctor.

Dr. Perrien noted that since this is a prison and there will be lockdowns, it is necessary to have a type of recreation yard off of the housing units so people can still go out to those areas.

She explained that the Department of Health and Welfare will determine staff to work with their patients and DOC would determine staff for inmates. She said that there will be a facility head that is a DOC staff member and there will be two deputy heads: one from H&W and one from DOC so both agencies have an equal seat at the table.

Representative Henbest asked how the decision is made as to who goes into this facility. **Dr. Perrien** said this will be for the individual designated by statute as dangerously mentally ill. It is a very high level of security and the operations will be different than going to a state hospital. For the DOC it will be more about treatment needs and the inmate's functional level. If they require inpatient treatment or high level intensity treatment, they would go to this facility. This will allow the closed custody beds in the maximum security prison to be used for their original purpose and move these patients into this facility. This decision will be based primarily on clinical needs.

Dr. Perrien stated that two site locations are being considered at this time. One is located on the Idaho State School and Hospital (ISSH) campus in Nampa and one is on DOC land south of Boise. They are looking at the cost of each location as well as the ability to expand. She said that at the last planning meeting there was discussion of the need for outside 24/7 lighting and how that will affect either of these sites. Other areas of impact include a PA system and perimeter patrols driving around.

She said they are also doing a cost benefit analysis to look at the difference between this being publicly run with DOC and H&W employees versus privately run. They are also looking at licensing and accreditation options.

Representative Wood asked whether any patients in state hospitals would be better off in this type of a facility. **Mr. Schultz** said the last number was around eight individuals and that there are a few more that are questionable. He said there are also people in community care that will be moved to such a facility at some point. These are people that are dangerous to others.

In response to a question from **Senator Corder, Dr. Perrien** explained that cost-effectiveness today compared to the past involves multiple dimensions. Some of that is theoretically based and some is policy driven. The question is what do we believe as a community needs to be provided for the mentally ill. This is hard to quantify. She said from a correction perspective there are several areas. One is institutional safety. When someone is experiencing mental illness, if they are not treated, the likelihood of incidents where someone is harmed increases.

She said they look at the incidents within an institution including use of force incidents

including the proportion of the mentally ill that have a use of force against them. These crisis experiences should decrease as time goes on if the treatment program is doing what it is supposed to. She said the amount of crisis intervention should also be looked at. She added that an inmate needs to be stable at the time of reentry and needs to have appropriate care when released so they do not return to the system.

In response to a question from **Representative Rusche, Dr. Perrien** said there will be 260 in the secure mental health facility and 40 secure H&W beds.

Mr. Brent Reinke, Director of the Department of Correction, thanked the committee for allowing them to participate in this. He noted that on January 8 there will be an enhanced education tour that will only consist of three stops. He invited the committee to visit Unit 16 on that day.

Mr. Schultz agreed that being able to work with DOC has been very valuable and H&W has learned and gained perspective that is different from what they usually deal with.

Senator Stegner commented that the committee does have interest in what the Department is thinking about the ISSH campus but they decided to wait for a report on that at the next meeting. **Mr. Schultz** said they look forward to that and that they have had some reaction from the Governor's office and are modifying their decision to meet those needs. He said there will be a revised proposal for the committee's consideration after **Director Reinke and the Governor** meet on November 14. This will include a number of options in terms of providing services to the developmentally disabled population on the ISSH campus and elsewhere.

Representative Rusche asked whether there has been any concern from mental health providers or advocates about housing both civilly committed and inmates in a joint facility. **Mr. Schultz** said the design of the facility has addressed the legal issue of this. He said on the philosophical side, he is not sure where the professional community is. He thinks they are mitigating as many of the concerns as they can. Two of the three facilities visited had both populations housed there and one was a federal facility. This facility houses people that have pending federal criminal charges but are not able to stand trial.

In response to a question from **Representative Henbest, Dr. Perrien** said that due to the fact that the H&W criteria for placement into the facility is dangerousness, and the fact that this is not the case for DOC, it is important that they know their populations. It will be important to maintain as much separation as possible. They want to minimize the interaction due to the risk level involved.

The meeting was adjourned at 2:35 p.m.