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**Written Testimony of the Department of
Public Health and Human Services
In Opposition to Senate Bill No. 316
Before the House Human Services Committee
March 30, 2015 - 3:00 p.m.**

Introduction:

Mr. Chairman, members of the committee, my name is Paulette Kohman, Special Assistant Attorney General with Department of Public Health and Human Services Office of Legal Affairs. Montana State Hospital Superintendent John Glueckert is also here to provide additional information about the effect of this bill on operations and safety at Montana State Hospital. We have prepared a handout of information to assist you evaluate this bill in context. DPHHS is charged with protecting the life and safety of some 400 Montana citizens in its health care facilities, and firmly opposes this bill.

When you see how this bill increases the level of risk at DPHHS facilities, and contravenes sound principles of administrative procedure, correctional security, and health care facility management for the safety of patients at Montana State Hospital and Montana Developmental Center and the state employees who care for them, we believe you will agree that it does not deserve your support. In your handout is information correcting some major misconceptions that are circulating in the legislature about the population affected by this bill and the proponent's claims. [Handout pages 2-5.]

Most persons with mental illness or developmental disability are far more likely to be the victims of crime than the perpetrators. This bill does not apply to them, except as they may be the victims of criminal acts by other inmates in a health care setting. The special hearing rights in this bill apply only to a small minority of convicted felons, sentenced to the custody of the Director of DPHHS as Guilty But Mentally Ill (GBMI). These inmates have no liberty interest in freedom from confinement, having been found guilty and sentenced to the custody of the state after full due process in the criminal courts. As GBMI inmates, they have the opportunity, if recommended by their treating and evaluating professionals, to begin serving their sentence in a healthcare facility

instead of a prison. An even smaller minority, two or three per year, are transferred to prison when the director of DPHHS, on the clinical recommendation of the inmate's treating and evaluating professionals, finds that prison will better serve the inmate's custody, care and treatment needs, because the inmate is violent and requires a higher level of custody than a health care facility can provide, or has a low level of symptoms and no longer needs inpatient care and treatment, but has continued with antisocial behavior by preying on more vulnerable patients, disrupting the therapeutic community, undermining the treatment of others, or refusing to participate in the treatment offered.

Inmate classification and placement has long been recognized as a discretionary duty, outside the authority of the sentencing court. Even parole and revocation are beyond judicial review. GBMI inmates already have a special right no ordinary prisoner has, to ask the sentencing court review their sentence under 46-14-312(3), and resentence them to probation instead of confinement. SB 316 gives a small group of the most antisocial inmates the additional right, not granted to any other prisoner, to challenge a correctional placement through a formal hearing process, and to be released from prison to a healthcare facility on the word of a single correctional officer. This bill interferes with the director's ability to provide for the custody, care and treatment needs of these inmates and endangers the staff and other patients at state healthcare facilities.

I. The proposed hearing process poses a significant safety and security risk to other patients and staff.

The inmates recommended for correctional transfer can be expected to take advantage of the legalistic opportunities of a full evidentiary hearing, with thirty days -- or potentially more under the Montana Administrative Procedure Act (MAPA) -- to explore every critical reference in their records. Some may retaliate against staff who have made honest entries in the chart. Some may frankly feign symptoms or engage in unsafe behavior to convince the outside evaluator and the hearing examiner that they are too ill to transfer. Some may feel they have nothing left to lose, and react with violence toward other patients or those they blame for the transfer.

In the past five years Superintendent Glueckert has been working with his staff to reduce the risk on the forensic unit. After experiencing a serious unprovoked assault of a staff member on the unit, MSH hired a consultant to recommend ways to improve safety for patients and staff on what the consultant called a "medium security" unit. MSH doubled its restraint and seclusion space on the unit, remodeled to increase safety, implemented team staffing and expanded off unit options for more stable forensic patients. If it passes, SB 316 will be the first action of the past 5 years that would actually increase risk on the forensic unit. Thirty days' notice represents thirty days of

increased risk. When the treatment team has, on average, cared for and observed GBMI patients transferred to DOC for 3 years before transfer, an additional thirty days for review of a treatment decision is dangerous, unwarranted and unnecessary.

What is the treatment setting on the forensic unit and why is it high risk? The hospital is required to treat all patients in the least restrictive manner possible. Patients are not locked in their rooms. The vast majority of patients on the unit are restricted to the unit. Into this setting can come at any time, persons from across Montana that are being evaluated or have been found to be "unfit to proceed." [Handout, Page 6, "Forensic Commitments."] When a person who is being evaluated or has been found to be unfit to proceed arrives on the unit at the hospital, they have a right to refuse treatment. Many of these patients do refuse treatment. This means that the treatment team must petition the court to get permission to treat the person who has been declared "unfit to proceed" against their will. This can take anywhere from 30 to ninety days, sometimes longer. Until the court authorizes involuntary treatment, the treatment team can only medicate the patient on an emergency basis. A patient can be delusional and actively psychotic on the open unit as long as they are not hurting themselves or others. These patients are both vulnerable and unpredictable. Is this the kind of environment into which you want to introduce more risk?

II. SB 316 interferes with the Director's ability to consult with trusted professionals to assess the care and treatment needs of the inmates in his or her custody, and the other patients with whom they are housed.

Instead of a thorough, clinically-guided process under existing law, SB 316 inserts outside evaluators, lawyers, and hearing officers with no clinical credentials, between the expert advice of these trusted professionals and the director who must rely on them to make the transfer decision. The director needs to be able to consult face to face with his staff to address his or her specific concerns, not by reading a hearing officer's summary conclusions and a cold written transcript of a hearing held without his or her participation.

III. SB 316 permits unqualified correctional personnel to override clinical professionals and the DPHHS director and force a GBMI prisoner to be transferred back to a health care setting with no process at all.

Prison provides a high level of custody no hospital or health care facility can match. Even so, prisoners do receive appropriate care and treatment. The Montana State Prison has nationally accredited physical and mental health services, and was reaccredited for three years in 2014. [Handout, pages 17-18].

Statistics do not support proponents' assertions about GBMI inmates being punished with solitary confinement at Montana's prisons. According to information from DOC, most of them have earned medium or low security classification, few live in locked housing, and many have jobs. [Handout, page 5.] They are placed in more restricted housing only due to their behaviors, and under MSP procedures, mental health professionals participate in reviewing restrictions to ensure that persons with active symptoms of mental illness are not placed in the most restrictive housing settings. If this bill were about protecting GBMI inmates from solitary confinement, it would be groundless.

What this bill does is create a lengthy formal process to transfer an inmate to prison, but completely eliminate any semblance of due process to transfer a prisoner, still in the director's custody, back to a health care facility. New Section 3(2)(b) of the bill [Page 4, line 29, - page 5, line 4] permits a single correctional officer to force a transfer within 10 days, with no clinical input, no review of records, no assessment of risk to the patients and staff at the health care facility, no due process for the offender, and no participation of the director of DPHHS or the receiving facility. If due process applies at all to transfers under the GBMI statute, this arbitrary authority flies in the face of the only court case applying due process to transfers -- from prison to hospital. [*Vitek v Jones*, see Handout, page 7.]

IV. The proposed hearing process is unnecessary, unwieldy and seems designed to create maximum confusion.

A. The existing statutory transfer process is legal, fair, thoughtful and relatively quick, which is vital for the safety of others.

The proponents of SB 316 have claimed that the existing statutory transfer process violates the constitutional rights of GBMI inmates. This is completely unfounded. No court has ever recognized a constitutional right to additional due process before placing an inmate serving a criminal sentence in prison. Existing case law is entirely to the contrary. In fact, the only situation where any court has imposed a constitutional due process requirement is when a prison inmate is transferred FROM a prison TO a psychiatric hospital, and then only when the transfer is "is not within the range of conditions of confinement to which a prison sentence subjects an individual." [Handout page 7.] This is obviously not the case under the GBMI statute, which specifically identifies a "correctional facility" as a potential placement. Your handout contains a summary of some of the relevant case law. In addition, in 2014, the Montana federal district court dismissed a complaint filed by Disability Rights Montana challenging the existing transfer statute on constitutional grounds.

The statute requires the director to consider the recommendations of the inmate's treating and evaluating professionals. For MSH inmates, they include Dr. Virginia Hill, a Board Certified forensic psychiatrist. For MDC, they include Dr. Michelle McCall, who is a Board Certified general psychiatrist. These experts have observed the inmate closely over many months or years. They are most qualified to tease out the symptoms of mental illness or developmental disability from ordinary criminal thinking and behavior, and advise the director on the custody, care and treatment needs of their patients.

In the current scheme, when the treatment team recommends transfer to a correctional facility, the recommendation is peer-reviewed by the Forensic Review Board of the facility. A copy of the MSH FRB policy is in your handout. [Handout, Pages 8-14]. The information the treatment team must present is exhaustive [Handout, page 14]. The FRB invites input from DOC representatives on their ability to provide for the care and treatment needs of the inmate, and from the Board of Visitors on behalf of the patient. The director receives a comprehensive report [Handout, page 13], and also has the opportunity to speak directly to the professionals to answer any additional questions he or she may have.

The fact that few GBMIs are transferred to DOC for care custody and treatment, and even fewer need to return, is evidence of the sensitivity of the existing process to the needs of patients. Occasionally an inmate's sentencing order provides for notice or review of a correctional transfer. None of those courts has ever overruled or denied the recommendations of DPHHS professional staff.

The flow of GBMI inmates between MSH/MDC and Montana prisons goes both ways. [Handout, page 6, "Forensic Commitments" and "Forensic Discharges."] MSH is currently caring for 3 GBMIs who were previously transferred to prison, as well as 3 non-GBMI prisoners who were civilly committed to MSH from MSP.

Your handout also includes a report by Legislative Services Research Analyst Sue O'Connell to the Children, Families, Health and Human Services Interim Committee in November 2013, describing the transfer process in detail. [Handout, pages 15-16.]

B. The hearing procedure in the bill is inconsistent with MAPA and creates significant confusion.

Section 1 of the bill begins in 46-4-312(2), which currently authorizes the director, after considering the recommendations of the defendant's treating and evaluating professionals, to place the newly convicted defendant in "an appropriate correctional,

mental health, residential or developmental facility.¹” The same section also currently authorizes the director, “after considering the recommendations of the professionals providing treatment to the defendant and recommendations of the professionals who have evaluated the defendant, subsequently [to] transfer the defendant to another correctional, mental health, residential, or developmental disabilities facility that will better serve the defendant's custody, care, and treatment needs.”

The bill proposes a formal contested case hearing, described in Section 2 [Page 3 line 3, through page 4 line 15], instead of the informed discretion of the director. Section 4 of the bill codifies the new hearing section in Title 53, Chapter 21, Part 1, which is the portion of the code dealing with mental health treatment and civil commitment,² instead of the criminal procedure section where all other sentencing provisions are located.

Under the bill, the inmate is initially placed through 46-14-312(2), and the director's standard for transfer remains there (“better serve the custody, care and treatment needs of the defendant”). The process then jumps to a hearing described in Title 53, Chapter 21, Part 1. This hearing is also a “contested case,” as defined in 2-4-102(4), and is therefore covered by 2-4-601 et seq. of MAPA. If there is an appeal, in addition to the MAPA process in 2-4-701 et seq., the process jumps back to title 46-14-312 with a new sub-section (4) [Section 1, page 2, lines 23-28]. Prosecutors, defenders, and most importantly sentencing and appellate courts will be confused merely by the constant juggling of code books.

But in addition, the bill has some very odd appeal procedures. It requires the MAPA appeal of the transfer hearing to be filed with the sentencing court for judicial review, but it may also be appealed to the district court where the inmate is currently housed [Page 4, lines 2-5]. The appeal provisions in the new subsection (4) are placed ahead of an existing provision renumbered (5) which currently refers to existing section (3)'s provisions for a review of sentence by the sentencing court [Page 2, line 23 through page 3, line 1]. This juxtaposition appears to allow the MAPA judicial review to be transformed into a resentencing hearing. This would be impossible if the appeal were filed in a different court, but even in the sentencing court, this is so vague and unworkable it will inevitably lead to appeals.

¹ The statutory definition of “residential facility” is “Montana Developmental Center.”

² Placing the GBMI transfer procedures in the mental health code ignores that approximately 10% of GBMI inmates, and 10% of transfers, are sentenced to DPHHS with developmental disabilities, not mental diseases or defects. Treatment of persons with developmental disabilities is covered by Title 53, Chapter 20, Parts 1 and 2. It makes no sense at all for these inmates to be governed by anything in Title 53, Chapter 21, Part 1.

V. SB 316 requires DPHHS to make unfunded expenditures for unnecessary legal procedures.

The fiscal note estimates the cost of the various legal requirements of this bill at about \$130,000 per year, about half of which is for the hearing process. The sponsor's rebuttal suggests these costs can be absorbed, but the bill actually prohibits DPHHS using its existing resources to meet the requirements of the bill.

- A. DPHHS employs fully-funded hearing officers who travel all over the state, but the bill specifically prohibits using them, and requires the department to hire outside hearing officers for prisoner transfer hearings instead.
- B. The Board of Visitors employs a fully-funded attorney, who is on-site on a daily basis at MSH and has an established attorney-client relationship with each of the GBMI prisoners at MSH, but the bill specifically prohibits using the BOV legal counsel in transfer hearings, and requires the department hire outside counsel for the transferred inmates.
- C. DPHHS employs fully-funded licensed professional mental health evaluators, but the bill says the department cannot use them, and must hire outside evaluators for each prisoner for the transfer hearing.

VI. SB 316 requires DPHHS to make unfunded expenditures for duplicative mental health services for GBMI prisoners.

The other half of the fiscal note is for mental health services which the bill requires DPHHS to provide at DOC facilities, which have fully accredited mental health providers already. [Handout, pages 17-18.] Again, the sponsor suggests these services can be provided from existing resources, but the bill prevents DPHHS from using them.

Section 2 (4)(c) [Page 4, lines 12-14] requires a DPHHS employee to interview each transferred GBMI prisoner in person weekly during the transfer hearing waiting period, and section 3 (1) [Page 4, lines 16-22] requires "a professional person employed by the department" to meet with the prisoner monthly for the duration of the sentence. DPHHS employs mental health professionals in its facilities, but none of them is located in Deer Lodge, Billings or Shelby, where the transferred GBMI prisoners are housed.

Many more mental health professionals work at community mental health centers, with offices near the prisons and able and willing to provide mental health visits with transferred prisoners, but in this case, the bill says DPHHS must send an employee.

With travel, this is a full caseload for a mental health professional, so the department must hire or contract with a new employee to travel the state and conduct these meetings.

In Conclusion, The Department of Public Health and Human Services strongly opposes this bill because:

- I. The 30-day hearing process increases the risk of harm to patients and staff by disgruntled inmates in an already high-risk environment;
- II. It deprives the Director of the close contact and advice he or she needs from highly experienced clinical professionals who are best qualified to assess the custody, care and treatment needs of GBMI inmates at DPHHS facilities, and substitutes a legalistic hearing process;
- III. It eliminates any rational process for transfer back to a health care facility, and instead allows unfettered discretion to DOC correctional officers with no clinical background to override the DPHHS director's carefully made transfer decision and instantly return even unsafe GBMI prisoners back to the high risk hospital environment with no consideration of safety or appropriateness of the transfer.
- IV. It requires unfunded expenditures for hearing officers, attorneys, evaluators that are not legally required for a transfer of an inmate who has already been sentenced by a court;
- V. It requires unfunded expenditures for mental health services duplicating existing prison mental health services.

DPHHS urges you to table this bill or give it a "do not pass" recommendation