

LAW AND JUSTICE INTERIM COMMITTEE

March 21, 2022

1. My name is Ginny Hill. I'm a forensic psychiatrist who recently retired after working 35 years at Montana State Hospital (MSH), specifically on the forensic program. I spent the last six years of my employment at the Forensic Mental Health Facility (FMHF) at Galen, which opened in 2016. My opinions are those of a private citizen and do not represent the views of the DPHHS.
2. I understand the committee was formed to review forensic statutes, Title 46-14, MCA, and also to review the use of the FMHF at Galen. I'm grateful to have an opportunity to share my thoughts on these topics. As Attorney Julianne Burkhardt noted in her 1/2/22 Legal Overview of the Criminal Commitment Process Conclusion, p. 15, "The Criminal commitment process that is the subject of the House Joint Resolution 4 study is a **very complex and detailed process.**"
3. At the outset, I would like you to have a picture of the typical patient I evaluated and treated at the FMHF. These were not persons in crises who stole a loaf of bread. Although there are always exceptions, the patients I admitted typically had **tragic psychosocial histories, replete with trauma, abuse, and neglect; interrupted educational and occupational careers; extensive substance abuse histories; early evidence of antisocial personality dysfunction with longstanding involvement in the criminal justice system; onset of serious mental illness in their late teens or early twenties; chronic homelessness; an enduring pattern of treatment rejection; medical complications from their lifestyle choices; and finally allegations of a serious or several serious felonies.** A few had some family contact, but most did not as it became too overwhelming and dangerous for families to stay involved. I need to remind you that my experience is only with a small segment of persons with mental illness, but these are the persons consuming significant state resources.
4. As to the matter of a return to an affirmative insanity defense in Montana, I'm not convinced it would be in the best interest of patients or a better allocation of state resources. Instead of considering our Title 46-14 statutes as archaic and dissimilar to 46 other states, I view them as visionary and far-sighted, and appropriate to the complexity of the patients we were currently serving. These statutes provide the Court with myriad evaluation and adjudication options, so that judicial decisions can be tailored to meet the unique needs of this challenging population. I recognize that Montana abolished an affirmative insanity defense in 1979, but Title 46-14 still contains language that allows for a severely mentally ill defendant to be found not guilty by reason of mental illness. Even in states that have an affirmative insanity defense (NGMI), this defense is only raised in 1% of felony trials and only successful in 25% of those trials. The affirmative insanity defense is rarely successful in jury trials, and is most successful in bench trials where the prosecutor agrees. Significantly, in a recent United States Supreme Court decision, *Kahler v. Kansas*, the United States Supreme Court affirmed that states have the right to determine how they will define insanity and adjudicate mentally ill defendants.
5. If Title 46-14 needs any revision, I would ask the Committee to consider some type of additional language to manage individuals determined unfit to proceed and non-restorable. As it is currently interpreted by the judiciary, these individuals can commit serious crimes, and after a couple 90-day commitments, their charges are dismissed. They then are often released abruptly into the community as they remain incompetent and don't qualify for civil involuntary commitment. Even if they do qualify for a civil involuntary commitment, in this era that usually lasts two to four weeks. Each state has different processes for managing the unfit/unrestorable population, and I think this issue needs serious attention. Also, despite the tragic backgrounds and multiple impairments of our typical patient population, they are quite savvy about their legal rights and are less and less motivated to become fit to proceed, as they are aware that non-restorability results in a dismissal of charges.
6. I recognize that the most serious problem that needs be addressed is the delay that occurs when defendants are referred to the FMHF for evaluation or treatment. All forensic patients begin their admission to MSH at the FMHF

as it is a high security environment. We have had a waiting list for at least 10 years, which has been exacerbated by Covid. I know there was some earlier suggestion made to the Committee that patients could be evaluated or treated faster. I would caution you not to accept this as the norm. The patients I was admitting were often chronically symptomatic, had used a plethora of illicit substances, and were militantly opposed to medication treatment. This would result in weeks or months before a Sell Hearing (to order compliance with the Treatment Plan) could be obtained. In addition, even if they were ordered to undergo medication treatment, their recovery time was significantly slower than an individual without chronicity, substance abuse, and treatment rejection.

7. There are two excellent articles about the competency crisis that have been distributed to the Committee. They present an excellent overview of competency issues, and essentially recommend community restoration and treatment whenever possible. When crimes are less serious, the mental disorder symptoms are non-dangerous, the person respects the authority of the Court, and the person is accepting of treatment, this is the ideal solution. Even though these characteristics are not typical of the population served at the Galen FMHF, there are some excellent reminders/recommendations in these articles that I believe are pertinent to our discussion today.

Just and Well: Rethinking How States Approach Competency to Stand Trial

- 1) Recognize the escalation of nationwide competency restoration hospitalizations: increase of 72% from 1999 to 2014; 91,000 competency evaluations performed in 2019; half of these related to misdemeanor crimes. P.3.
- 2) Be mindful of the Ninth Circuit decision in Trueblood v. Washington requiring timely admission for restoration. Washington Department of Social and Health Services continues to struggle to comply. They have already paid \$85 million in fines. P.4.
- 3) Convene diverse stakeholders to develop a shared understanding of the current competency to stand trial process. P.10.
- 4) *Examine system data and information to pinpoint areas for improvement: age, gender, race, ethnicity, health insurance, housing, current charges, prior criminal involvement, prior competency adjudications, duration of competency process, final disposition of cases, etc. P.11-12.
- 5) Create and fund a robust system of community-based care and supports that is accessible for all before, during, and after criminal justice contact. P.14.
- 6) Be aware that many communities are facing a shortage of behavioral health professionals across a range of disciplines, from psychiatrists to community health workers. According to the most recent national data, 120 million American live in mental health Professional Shortage Areas. P. 14.

Leading Reform: Competence to Stand Trial Systems

- 1) Divert cases from the criminal justice system when possible. P.3.
 - 2) Restrict which cases are referred for competency evaluations. P.5.
 - 3) Develop and impose rational timelines on competency restoration. P.10.
 - 4) *Coordinate and use data. P.18.
 - 5) Homelessness is also often a companion to mental illness and arrest. P.19.
 - 6) Conclusion: **The complexity of the system and the siloed nature of the services cry out for collaboration and for leadership.** P.20
8. Although this is a very unpopular suggestion, if shorter wait times for inpatient forensic evaluation and treatment are being demanded by the Court, than more beds need to be available. We need to ask ourselves if 54 inpatient forensic beds are sufficient for a general population of over a million. Prior to Community Mental Health Act of 1963 and the resulting deinstitutionalization movement, I would remind you that MSH housed 2000 patients in 1955 (Montana population was ~587,000). We currently have 270 licensed beds and a census of around 200. Essentially, we have 1/10th the number of hospital beds for at least twice the population.