MONTANA STATE SENATE

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Chair & Vice Chair's BHSFG Commission, LJIC, CFHHSIC, CJOC, IBC Sec B & Sec D,

As all of you know, my area of interest and experience in the legislature has been Criminal Justice (CJ), the CJ system and CJ reform. I have benefitted from participating in over 40 meetings and "site visits" with the National Conference of State Legislatures (NCSL) over the last several years.

My goal has been to find solutions that have been tested in other jurisdictions that can be replicated and tailored to work in Montana. These NCSL meetings & "site visits" have sparked my interest in those who are CJ involved but have co-occurring mental health and/or addiction issues. This is definitely an issue we have not solved in Montana and one that has both enormous monetary costs and human costs in our state. I have learned a lot and continue to learn more with each meeting, training, and site visit.

The most relevant "site visits" for CJ/mental health solutions for people with co-occurring diagnoses have been in Charleston, SC, and Portland, OR. Charleston has a Crisis Triage Center with detox and mental health services, a mental health professional in their 911 dispatch center, and EMS Supervisors that carry tablets for on scene tele-mental health when someone is in a mental health crisis. Additionally, they have co-responder teams where a mental health professional responds WITH law enforcement. Portland had CIT trained officers, a Crisis Center, and a transitional housing program.

During these meetings I also learned that Arkansas recently passed a bill to fund providing all state Troopers with tablets for tele-mental health intervention. I understand San Antonio, Texas has a great system as well. There are many other communities around the country who are doing a lot of good work to enhance public safety, better utilize taxpayer dollars and address the significant crisis of citizens suffering from behavioral health issues.

I have found the following:

- People with mental illness are 10 times more likely to be victims of violent crimes.
- Bystanders typically call law enforcement when witnessing someone having a mental health crisis.
- Those with mental illness are more likely to come in contact with law enforcement rather than a mental health professional.
- Law enforcement is not typically trained to deal with those in a mental health crisis.
- Over 75% of those in our Montana County Jails have mental illness or addiction issues.
- The majority of these people who are incarcerated will return to our communities and need proper services to help them become more stable and productive neighbors.
- Earlier interventions that connect people to treatment can be less expensive than jail or prison and help these people avoid additional consequences that come with incarceration such as loss of jobs, housing, and custody of children.

In the CJ arena, the Judiciary Committees, Law & Justice Interim Committee & Criminal Justice Oversight Council, we have all discussed and brought many bills to address some deflection & diversion programs and some training for law enforcement but have hit resistance due to monetary constraints or due to the perception of duplication of efforts, or frankly a lack of information on the actual cost of funneling people with behavioral health issues through the criminal justice system rather than through an appropriately funded network of community mental health services and programs.

What I see is that as a state we ALL need to get together and work together to tear down the walls and individual silos to figure out the right solution with the right outcomes for our citizens. If we all can collaborate in the Criminal Justice/DPHHS arenas to solve these issues, we will save money and have better outcomes.

Recently Julia Hamilton, Montana Legislative Fiscal Division and I attended an NCSL "site visit" in Pennington County (Rapid City) South Dakota.

The meeting objective was to: **Learn about collaborative efforts to create greater access to a network of treatment and community-based resources**.

South Dakota is similar to Montana in demographics, geography, and the population of Rapid City is a little less than Billings. What I observed in Rapid City struck me as a viable option which we could use to model our Montana specific solutions.

While there, we heard how they are collaborating with and receiving funding from US Federal Government, Medicare, State DPHHS & Legislature, Pennington County, Pennington County Human Services, Pennington County Sheriff's Office, Rapid City, Rapid City Police Department and local charities/philanthropists.

We visited the Care Campus, (70,000 sq ft with another 14,000 across the alley) with services that include:

- Detox 28 male beds/16 female beds

    - Provides 24/7 monitoring and withdrawal management services while detoxing for up to 5 days
- Safe Solutions 30 male beds/16 female beds
    - Harm reduction model providing a safe place to sleep for individuals who are intoxicated
    - Attempts to connect people with services to facilitate sobriety
- Isolation Units 3 male/3 female
- Residential Treatment 32 male/32 female
    - 64 residential treatment beds (meth, opioids, alcohol or heroin)
- Outpatient treatment
    - Intensive meth treatment/MRT (Moral Recognition Therapy)/CBISA (Cognitive behavioral Interventions for substance abuse)
    - IOP (Intensive outpatient services)/ICIP (intermediate correctional intervention program
    - After Care
- Pennington County Human Services
    - Transitional coordination (Safe Solutions, Crisis Care Center, Rebound Reentry Program) economic assistance (rent, utilities), transitional housing assistance, veterans' services, medical and medication assistance
- Pivot Point (Assessment Center and Crisis Stabilization Unit) 16 beds male/female and 8 medical recliners
    - Operates 24/7 serving acute behavior needs allowing clients to stay up to 5 days (more if needed)
    - Mental health stabilization
    - Objectives include establishing vital service connection for individuals and providing transitional coordination services until a sustainable, long-term solution is established
- Rapid City Police Quality of Life Unit
    - Proactively engage the most vulnerable to prevent victimization and reduce crime.
    - Partnering with other social services stakeholders and the criminal justice system

These centralized services occur through the collaboration between numerous partners and programs to collectively pursue the common objective of delivering timely & suitable services to meet the needs of the community members who are in crisis. Community members seeking assistance engage with the Care Campus through a centralized intake area. This campus has emerged as a crucial resource, which is evident by over 100,000 admissions. Programs on the campus address the diverse & complex needs within the community and the individuals seeking care.

The Care Campus serves as an effective diversion tool for law enforcement, providing a centralized campus where individuals can be referred to receive an array of services that address the diverse and complex needs within this community. This streamlined approach significantly reduces the need for transporting individuals to higher levels of care, such as emergency room, the jail or the state hospital for evaluation. This campus minimizes the intake process for law enforcement to an estimated 3-5 minutes. The efficient process allows law enforcement to return to their patrol duties, ensuring the effective utilization of law enforcement resources and

maintenance of public safety.

The Care Campus is run by the Chief Deputy of the Pennington County Sheriff's Office and the 2nd/right hand person is from the Pennington County Human Services. Talk about the positive collaboration.

With Rapid City being so close to Montana, the Care Center people with whom we met have offered to replicate the 1 ½ days of discussions/tours for Montana if we are interested. They believe so deeply in what they have created, they are willing to share with neighboring states and stakeholders. I do believe there is funding for a field trip (before the snow flies) if we want to have a couple of people from each of the committees and we could invite other stakeholders/interested parties (they pay their own way), such as DPHHS, local city officials, county commissioners, county attorneys, sheriff, local PD, hospital and local public health official.

Right now is the right time. With the 872 Commission in full swing, Heart Fund dollars awaiting uses and Opioid Settlement funding coming into the state among others, we have the funding to bring in effective solutions like this. I know we have the will and now we have to find the way. We have to work together to create the community based behavioral health system/services the citizens of our state expect and deserve.

There are many options about how we can move forward. We could start with a pilot community... with Community grants from this, providing ample amount of funding… Then use this proof of concept to get the rest of the state on board.

However, even before we start talking about pilot programs, we need to bring all of the collective resources, expertise, and stakeholders to the table to identify both the real and perceived barriers to sustainable community mental health services, review models from other states/cities/communities, and begin to craft solutions to fit the unique needs of our rural, expansive, and growing state.

I urge you to make the commitment to send a Montana delegation of interested parties and stakeholders to Rapid City, SD to start our collaboration. We are all working toward the same goal, so let's do it together.

Respectfully

Barry M Usher
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