

**REVISED MINUTES OF THE
TASK FORCE ON INVOLUNTARY COMMITMENT OF THE MENTALLY ILL**
Wednesday, June 12, 2002 – 9:30 a.m. – Room 303 State Capitol

Members Present:

Sen. Leonard M. Blackham, Senate Chair
Rep. Katherine M. Bryson, House Chair
Sen. D. Edgar Allen
Sen. Karen Hale
Sen. Lyle W. Hillyard
Rep. Douglas C. Aagard
Rep. Chad E. Bennion
Rep. Judy Ann Buffmire
Rep. Neil A. Hansen
Rep. Carol Spackman Moss
Rep. Mike Thompson

Members Absent:

Sen. David L. Gladwell

Staff Present:

Arthur L. Hunsaker, Research Analyst
Esther D. Chelsea-McCarty, Associate General Counsel
Joy L. Miller, Legislative Secretary

Note: A list of others present and a copy of materials can be found at <http://www.image.le.state.ut.us/imaging/history.asp> or by contacting the committee secretary, Joy Miller, at 538-1032.

1. Task Force Business

Rep. Bryson called the meeting to order at 9:40 a.m. Sen. Gladwell was excused from attending the meeting.

MOTION: Sen. Allen moved to approve the minutes of the May 15, 2002 meeting. The motion passed unanimously. Sen. Hillyard and Rep. Thompson were absent for the vote.

2. Staff Reports

Mr. Hunsaker distributed a handout "Civil Commitment Criteria" that outlines the danger criteria used in the states. He pointed out that Arizona has removed "immediate" and Idaho, Kansas, South Dakota, and Wyoming have removed "imminent" as danger criteria from their statutes. Mr. Hunsaker distributed a copy of S.B. 200 "Mental Health Commitment Amendments" from the 2000 session. Sen. Montgomery sponsored the legislation which attempted to replace the word "immediate" with "substantial." The bill's Legislative Review Note outlined the statutory concerns of the proposed legislation. Mr. Hunsaker also distributed a handout "Release Procedures From Civil Commitment." He indicated that all but 12 states require some form of notification to the courts when a mental health authority determines that a patient should be released.

Ms. McCarty distributed a handout "Civil Rights Actions for Involuntarily Committed Persons." She explained that she was asked to look into court decisions related to civil rights and involuntary commitment and governmental immunity issues related to involuntary commitment. She found that very often the two issues were intertwined. The requirements for bringing a civil rights action are that the defendant acted under color of law and the action complained of deprived the person of their rights, privileges, or immunities secured by the constitution or laws of the United States. Very often, a person who is committed will bring an action against the state hospital or others involved in the process alleging that they have been falsely imprisoned or forcibly medicated. She explained that qualified immunity protects

government officials performing discretionary functions from liability for civil damages if their conduct does not violate clearly established statutory or constitutional rights that a reasonable person would have known. Ms. McCarty briefly reviewed three recent criminal and noncriminal cases regarding immunity.

3. Involuntary Commitment Treatment Methods

Mr. Randy Bachman, Director, Division of Mental Health, pointed out that about three-fourths of the individuals under commitment with the community mental health centers are not at the state hospital. Less than 2 percent of the individuals in the public mental health system are actually under commitment. The majority can be served without commitment. He noted, however, that commitment is sometimes a necessary tool to achieve treatment.

Mr. Mark Payne, Superintendent, Utah State Hospital, distributed a handout "State of Utah Mental Health Continuum of Care." The objective of the state hospital in the mental health system is to provide services to meet the needs of those individuals who come for care whether they enter the system voluntarily or involuntarily. He explained that a person can enter the mental health system through self-referral, other referral, law enforcement, or through a physician. The person is screened by the mental health center for treatment needs. He reviewed the many types of treatment provided by the mental health center. If the patient is not willing to accept treatment, an application can be filed for court commitment. Many patients improve sufficiently to make commitment unnecessary before a court commitment proceeding takes place. In such cases the patient often chooses to accept treatment on a voluntary basis. Mr. Payne outlined the treatment provided by the Utah State Hospital. He pointed out that of the 16,553 individuals served by the Valley Mental Health system in 2001, only 75 were committed to the state hospital.

Dr. Richard Spencer, Clinical Director, Utah State Hospital, stated there are some misconceptions about what goes on in state hospitals. The state hospital uses many modalities of treatment but the major form of treatment is medication. There have been huge advances in terms of chemically treating mental disorders. He shared a letter from a former patient expressing gratitude for the treatment they received at the state hospital.

Ms. Robin Potochnick, Four Corners Mental Health, said it is the desire of community mental health centers to return the person to the community as rapidly as possible. When there is a legal commitment, there is a legal burden on the local mental health authority to provide treatment. She said they have to pay for the beds in the hospital and would much rather use their own resources to keep someone in the community.

Dr. Ted Wander, Valley Mental Health, emphasized that treatment for people with mental illness is not just medication. Group and individual therapy, education about relapse prevention, safe and affordable housing, job training, and other community issues are also important. He pointed out that there is a finite length of time to persuade the person that treatment is valuable to their lives.

4. Mental Illness in the Prison Population

Mr. Jesse Gallegos, Deputy Director, Department of Corrections, said the objective of the department is to provide the recognized constitutional care for these individuals once they come under the department's jurisdiction. Treatment is not limited to while they are incarcerated.

Dr. Frank Rees, Department of Corrections, gave a slide presentation of the Department's mental health programs. He explained that from the 1960s through the 1980s, there was a nationwide movement to deinstitutionalize state hospitals. This has resulted in correctional facilities becoming de facto mental health institutions. Over the last two years, the daily average population of the Department's prison facilities has ranged from approximately 5,300 to 5,500. Of these offenders, approximately 600 to 1,000 at any time have been treated for serious mental illness. Dr. Rees indicated that all offenders entering or reentering the institution are screened for mental illness the day of arrival. Followup evaluations, placements, and medications are initiated based upon the screening. He said inmates identified as needing more intensive mental health interventions are brought to either the Olympus Mental Health/Forensic Facility or to the prison Infirmary for care and closer observation. Prior to release to the community, a coordinated effort of mental health discharge planning occurs in an effort to arrange continuity of care for paroling offenders. Only those offenders who are believed to be too mentally disturbed and potentially harmful to themselves or others to be maintained with less structure are referred for civil commitment evaluations.

Dr. Rees commented that every incarcerated offender's civil liberties have already been restricted through imprisonment. More often than not, rather than seeking civil commitment, the Department will seek to involuntarily treat individuals that meet the criteria of dangerousness to self or others and a serious mental illness. Transfers to the state hospital for those incarcerated can be done through a legal due process hearing known as the Vitek hearing process. Dr. Rees pointed out that the approximate average cost per year to house an inmate is \$22,000 - \$24,000. The total mental health care costs per year is over \$5 million. He commented that the Department is currently in the process of redesigning and implementing a higher efficiency, broader scope service delivery system for mental health care, utilizing only existing resources.

5. Public Comment

This is a record of comments given as the opinion of those who testified before the committee.

Mr. Ray Davis, citizen, said his wife was diagnosed with depression in 1996 and was given Zoloft. His wife was later diagnosed with other disorders and prescribed more drugs. She reacted badly to the drugs and became suicidal which she had not been prior to taking the drugs. He related an incident that involved his wife accidentally shooting herself in the foot. After discussions with the doctor and investigating police officer, it was determined that the shooting was an accident. Three weeks later his wife went to her regular session with her psychiatrist who questioned what happened. He assumed that she tried to kill herself based on her past history. The psychiatrist refused to look at the emergency room and police reports. He filed a commitment application and she was given a commitment hearing. The evidence showing that the shooting was an accident was not allowed. She was committed to the state hospital for three months. While in the state hospital, she was isolated, sexually harassed, over-drugged, and emotionally abused. Mr. Davis said he had to hire a private attorney and obtain the help of a citizens

commission on human rights to get her out of the hospital. His wife is off of all the drugs now and is doing very well. He stated that to loosen the commitment laws would only create more abuse of people.

Ms. Nancy Hughes, citizen, stated she has a daughter in the involuntary commitment program. She related the events that took place prior to the commitment. She expressed her appreciation to the Legislature for the involuntary commitment program. As a result, her daughter is now able to receive the treatment she needs.

Ms. Dawn Rider, citizen, outlined the events that have taken place in her family as a result of chronic severe depression. Her husband and youngest son were given Prozac to treat the problem. Her husband has suffered many negative side effects as a result of using the drug. She said she is convinced that her 12 year old son's suicide was a result of taking the Prozac. He had told her many times that he felt the medication was not right for him.

Dr. Ann Tracy stated she is an expert witness in many medication lawsuits. She said LSD and PCP create the same type of action within the brain as the new antidepressants on the market. Between 8-11 percent of those admitted to hospitals for psychosis are there as a direct result of reactions to particular medications. Utah is the antidepressant capital of the nation. She expressed concern that by prescribing these drugs it is making more people dependent on them than is necessary. She stressed the need to complete a full evaluation of individuals before committing them.

Dr. Richard Ferre, Primary children's Medical Center, distributed a handout "Restoring Health to Families Traumatized by Mental Illness." He suggested the members review the questions outlined on the handout. He stated that compliance with proven treatment is the central factor in maintaining good mental health as demonstrated by scientific research. He said that studies conducted in the United States demonstrate that legal support to help patients and families comply with demonstrated effective treatment has been shown to be successful where it has been implemented.

6. Task Force Discussion and Business

Rep. Bryson indicated that the next meeting of the task force was scheduled for Wednesday, July 10 at 2:00 p.m.

7. Adjourn

MOTION: Sen. Allen moved to adjourn the meeting. The motion passed unanimously with Sen. Blackham and Sen Hillyard absent for the vote. Chair Bryson adjourned the meeting at 11:55 a.m.