# MINUTES

## MONTANA HOUSE OF REPRESENTATIVES
## 52nd LEGISLATURE - REGULAR SESSION

## COMMITTEE ON HUMAN SERVICES & AGING

**Call to Order:** By Rep. Angela Russell, Chair, on February 18, 1991, at 3:00 p.m.

## ROLL CALL

**Members Present:**

Angela Russell, Chair (D)
Tim Whalen, Vice-Chairman (D)
Arlene Becker (D)
William Boharski (R)
Jan Brown (D)
Brent Cromley (D)
Tim Dowell (D)
Patrick Galvin (D)
Royal Johnson (R)
Betty Lou Kasten (R)
Thomas Lee (R)
Charlotte Messmore (R)
Jim Rice (R)
Sheila Rice (D)
Wilbur Spring (R)
Carolyn Squires (D)
Jessica Stickney (D)
Rolph Tunby (R)

**Members Excused:** Stella Jean Hansen and Bill Strizich

**Staff Present:** David Niss, Legislative Council
Jeanne Krumm, Committee Secretary

**Please Note:** These are summary minutes. Testimony and discussion are paraphrased and condensed.

## EXECUTIVE ACTION ON HB 400

**Motion:** **REP. MESSMORE MOVED HB 400 DO PASS.**

**Motion/Vote:** **REP. STICKNEY MADE A SUBSTITUTE MOTION THAT HB 400 BE TABLED.** Motion carried 18-2 with **REPS. DOWELL and KASTEN** voting no.

## EXECUTIVE ACTION ON HB 530

**Motion:** **REP. BECKER MOVED HB 530 DO PASS.**

**Motion:** **REP. BECKER** moved to amend HB 530. **EXHIBIT 1**

**Discussion:**

**REP. MESSMORE** stated that with this amendment this legislation is permissive. **REP. BECKER** stated that it was basically permissive before. The feeling was that it was an uncertain permissiveness.

**REP. TUNBY** stated that he thought that the committee was mandating basic health care coverage. **REP. SQUIRES** stated that a broken leg or tonsils are normal things that can happen for to normal child. We are looking at a Down Syndrome child, which is a whole other spectrum.

**REP. TUNBY** stated that under the present law, an insurance company wouldn't necessarily have to take care of those type of things, then this will mandate it. **REP. SQUIRES** stated that Down Syndrome is a condition, a broken leg or the removal or tonsils can also incur a child and its normal. **REP. BECKER** stated that in section 6, it says that no person shall make or permit any discrimination between any individual in the rates charge.

**David Niss** stated that it was not clear whether the amendment was mandated coverage for a developmentally delayed, developmentally disability or a genetic condition. That was the way the original bill was drafted. It wasn't clear whether the bill was only preventing discrimination based on the conditions in affording other insurance for the broken leg, tonsillitis, other conditions, or whether it was required coverage for any of those other three conditions related to genetic problems. The subcommittee put three subsections of the Arizona law, which were previously to be added by Rep. Brooke's request, on the bill as introduced and added them to a section of the law which we all felt was more clear in that it did not require those benefits. It only prohibited discrimination in other types of coverage based upon the fact that those genetic conditions existed.

Vote: Motion carried 19-1 with **REP. KASTEN** voting no.

Motion: **REP. BECKER MOVED HB 530 DO PASS AS AMENDED.** Motion carried 19-1 with **REP. KASTEN** voting no.

## HEARING ON HB 780 & HB 761

**Presentation and Opening Statement by Sponsor:**

**REP. ROBERT PAVLOVICH, House District 70, Butte,** stated that this bill relates to AIDS and sexual offenders. When a prosecution is commenced the offender shall be given a test by the request of the victim. The victim will know the result of the test. The test will be kept confidential and this will let the victim know what will happen.

**Presentation and Opening Statement by Sponsor:**

**REP. RAY PECK, House District 15, Havre,** stated that if someone has been sexually offended then they should have some recourse in determining whether the person that offended them is carrying a

sexually transmitted disease. In section 1, page 1, line 14, it is questionable whether you want a "must" or "may". On line 15, it says "a standard serological test", for two sexually transmitted diseases, gonorrhea and chlamydia. These diseases would not be discovered by the serological examination. We need to be aware of this. This bill is complicated and may need to be put into a subcommittee. The use of the test would be forwarded to the county attorney to do as ordered and could be released to various people as listed on page 2 of the bill, depending on a need to know situation. On page 3, it says how those results may be used by a public health agency. We may use the test results for the purpose of determining appropriate custodial care for statistical record keeping and for treatment. On section 3, page 3, the liability for the disclosure section is null and void if the bill does not pass by a 2/3 vote.

Proponents' Testimony:

**Mike McGrath, Lewis and Clark County Attorney,** stated that Lewis and Clark County appears in support of HB 761. Lewis and Clark County has a number of situations where a victim of sexual assault wants information and, in some cases, has been denied information about whether or not the offender has some kind of disease, particularly AIDS. Lewis and Clark County has had a number of cases where the offender has informed the victims that they have AIDS.

**Diane Sands, Montana Womens Lobby (MWL),** stated that MWL is very concerned about the victims of sexual assault as 1 in 4 women are sexually assaulted in their lifetime. Women, in general, are very concerned and have every good reason to be concerned about sexually transmitted diseases as part of that attack. MWL supports the bill with the amendments. It is important to lay out that testing also require tests for chlamydia and other diseases that are not showing up in blood work with other tests. That testing, as a result, must be used for treatment.

**Edwin L. Hull, Administrator, Department of Justice,** submitted written testimony. **EXHIBIT 2**

**Ellen Leahy, Health Officer, City-County Health Department,** submitted written testimony. **EXHIBIT 3**

**Bruce DeSonia, Program Manager of the AIDS/STD Program, Montana Department of Health & Environmental Sciences,** submitted written testimony. **EXHIBIT 4**

Opponents' Testimony: None

Questions From Committee Members:

**REP. STICKNEY** asked if the intention of the bill is to consider putting everything in the AIDS act in this legislation without consent. **Mr. Desonia** stated that the question is that the AIDS

Prevention Act currently requires pre and post AIDS counseling and informed consent. The current legislation doesn't address that. It is assumed that convicted sexual offenders will be required to have informed consent of pre and post test counseling which would be helpful to reference these prevention acts. **REP. BECKER** stated that it is worded that if you were convicted, you wouldn't get pre and post test counseling.

**REP. SPRING** stated "must" is a stronger word than "may". **Mr. McGrath** stated that the provisions of the bill as written, now requires testing of everyone who is convicted of a sexual assault. This means changing the "must" to "may" then it would be clearly a discretionary matter of the County Attorney, case by case.

**REP. TUNBY** asked if a County Attorney would be reluctant to do testing even if there was little of suspicion. **Mr. McGrath** stated that the reason for changing the "must" to "may" would be basically volunteer.

**REP. S. RICE** stated that she is concerned about the list of people that will be given the information. It seems that from the testimony they are primarily interested in the victims privacy.

**REP. J. RICE** asked if this is a standard uniform act. **David Niss** stated that it is not from the uniform act.

**REP. TUNBY** asked if there is a big difference between HB 780 requiring the testing of someone charged and HB 761 requiring that if someone is convicted they will be tested. **REP. PAVLOVICH** stated that once it commences in court and if that person requests that they take an AIDS test then it should be done.

**REP. CROMLEY** asked it the County Attorney's Association has a position on the testing of a person charged. **Mr. McGrath** stated that the association doesn't have a position on that.

Closing by Sponsor:

**REP. PECK** stated that requiring a test before conviction, from the standpoint of the person who was sexually offended, the would like the test taken the day the person was arrested. He assumed the County Attorney's Association considered this when they had the bill drafted and felt that we probably couldn't require this when they are merely charged. Then the Department of Health and Environmental Sciences (DHES) points out chapter 15-18-108 and says the examination and treatment of prisoners, or any person confined or imprisoned in any state or county or municipal prison within the state may be examined for sexually transmitted disease. If infected, the person must be treated by health authorities. Then we talk about permissible release of information concerning infected persons. This may be a redundant piece of legislation, but we need to pursue this.

Closing by Sponsor:

**REP. PAVLOVICH** closed on HB 780.

## HEARING ON HB 713

Presentation and Opening Statement by Sponsor:

**REP. DICK KNOX, House District 29, Winifred,** stated that this bill is at the request of the Department of Institutions. This bill addresses the Montana Center for the Aging. This serves people 55 years or older with a mental illness that needs nursing care. It is questionable whether any mental illness should be considered as part of the aging process. This bill simply verifies in the statute that patients, who are appropriately served at the center, are all elderly and that their mental illnesses are not necessarily related to an aging process.

Proponents' Testimony:

**Dan Anderson, Administrator, Mental Health Division, Department of Institutions (DOI),** submitted written testimony. **EXHIBIT 5**

**Hank Hudson, Coordinator, Governors Advisory Council on Aging,** stated that one goal the program fosters is a positive image of older citizens. Younger Montanans need to appreciate the ongoing contributions and values senior citizens are to our society. This proposed change will remove a misconception from our laws. There is no scientific basis to say any condition, physical or mental, is directly related to the aging process. Citizens of the advanced age display the entire range of mental and physical abilities. To link age with mental disability, even indirectly, is a form of prejudice no more acceptable than race or sex discrimination. Removing this language sends a message that we are freeing ourselves from these types of counter productive stereotypes.

**Kelly Moorse, Director, Mental Disabilities Board of Visitors,** stated that they are charged with reviewing patient care and treatment at the Center for the Aging along with other mental health facilities. We stand in support of this measure. We basically see this as a housekeeping bill in terms of changing the language. In addition, the admission procedure at the Center for the Aging is basically covered through rulemaking and the admissions screening process which would take the diagnosis into consideration. This language is unnecessary because mental illness diagnosis' are not associated with aging.

**Kathy McGowen, Montana Council Mental Health Centers (MCMHC),** stated that there are a number of bills that MCMHC has worked on with DOI throughout the last couple of months, this being one of them. MCMHC does support this bill.

Opponents' Testimony: None

Questions From Committee Members: None

Closing by Sponsor:

**REP. KNOX** stated that this bill simply clarifies an issue in the statute that elderly patients were appropriately serviced and that all their mental illnesses are not necessarily related to the aging process. These clarifications are needed.

## EXECUTIVE ACTION ON HB 713

Motion/Vote: **REP. JOHNSON MOVED HB 713 DO PASS AS AMENDED AND BE PLACED ON THE CONSENT CALENDAR.** Motion carried unanimously.

## HEARING ON HB 820 & HB 860

Presentation and Opening Statement by Sponsor:

**REP. HOWARD TOOLE, House District 60, Southwest Missoula,** stated that this bill grants local authorities the option of proceeding with the designation of non-smoking zones in communities. The bill simply modifies the existing law on smoking by allowing regulations adopted by the local board of health which allows designation of non-smoking areas in buildings. Section 2, contains a provision that says unless the non-smoking designation covered by state law applies, it is inconsistent with local regulations. Section 3, allows the local board of health to carry out those regulations. It is true that a large number of merchants and others are unaware of the obligation to designate non-smoking areas within public places. In certain communities, it is desirable to give the local authorities the authority to act on reasonable regulations on their areas much more than the state has.

Presentation and Opening Statement by Sponsor:

**REP. TIM DOWELL, House District 5, Kalispell,** stated that the problem and the issue that this bill addresses isn't smoking. Smoking is a persons right to do or not to do. 80% of Montanans choose not to smoke, but there are 20% that have chosen to smoke and that is their choice. The issue is second hand smoke or passive smoking, which you can get a couple of different ways. One is when a person is holding a cigarette, cigar, or pipe and some of that second hand smoke comes off the end of the burning tobacco and into our lungs. Some of that is filtered through their lungs and out of their mouth. The issue is not whether you smoke or you don't. The 80% of people that do not smoke decide to go into a state building that has a smoking area ends up smoking anyway. All state buildings, by matter of policy, should be smoke free. He submitted a page of the Montana Constitution. **EXHIBIT 6**

Proponents' Testimony:

**Brian McMiddle, Montana Environmental Information Center,** stated that they believe that Montanans have the right to a clean and healthy environment indoors as well as outdoors. They believe this bill will support that.

**REP. THOMAS LEE** stated that it is time that we recognize the medical realities of this situation and that we do something positive.

**Paulette Kohman, Executive Director, Montana Council for Maternal and Child Health,** the council is an independent public policy research education organization which researches and advocates in the public arena for things that help the health of mothers and children. In the area of tobacco, the expertise that our board directors has brought to us and has made us aware, is that passive smoking is growing in its remission as a major contributor to child health problems and the problems in fetal development in pregnant women. We favor this bill as a way of decreasing some of that passive smoke that is inevitable.

Opponents' Testimony:

**REP. ROBERT PAVLOVICH** stated that HB 820 is a local option bill. We have other bills that are local option, if we are going to vote for one then we should vote for them all or kill them all. This bill brings up the issue of taverns, he doesn't serve breakfast and dinner at his tavern, but he does serve lunch five days a week. He is very concerned about the little tavern that might only serve a few things, does this include them in the bill. All of the state buildings were built with cigarette money. Now we can't smoke in these buildings, which is fine, but now we should take the money out of long range building and use it for something else.

**Mark Staples, Montana Tobacco and Candy Wholesalers & Montana Tavern Association,** stated that they oppose these bills for a number of reasons. He also submitted written testimony. **EXHIBIT 7 & 8**

**Jerome Anderson, Tobacco Institute,** submitted written testimony. **EXHIBIT 7 & 8**

**John Delano, Philip Morris Ltd.,** submitted written testimony. **EXHIBIT 7 & 8**

**Roger Tippy, R.J. Reynolds Co.,** submitted written testimony. **EXHIBIT 7 & 8**

**Scott Morton, 4B's Restaurant Corporation in Montana,** stated that they employ approximately 500 people. They oppose HB 820 and believe the present law works very well. They have a designated non-smoking area in our facilities and have received no complaints for the tens of thousands of customers we serve each year.

**Leon Stalk, Montana Restaurants Association,** stated that of the several thousand restaurants in the State of Montana, he doesn't know of any that do not respond to 50-40-103, MCA that is now a law. The public has been well served by this statute.

**James Mullar,** stated that these two pieces of legislation are a violation of equal rights. We are addicted to tobacco and we are not afraid to admit it. We did build those state buildings that we cannot smoke in and he feels that this violates my equal rights to smoke where he wants to smoke. If you are going to keep taking that away, the people that advocate this should be taxed for the buildings that we had to build.

**Charles Brooke, Montana Retail Association (MRA),** stated that if HB 820 is passed there will be a patchwork of requirements and enforcements. Where there are multiple store locations this will create quite a management problem. MRA recognizes that they must provide in their current establishment those smoking and non-smoking areas. It seems that the bill is currently working properly and that to turn it over to the local communities would create an undue burden on many of the merchants in which represent.

Questions From Committee Members:

**REP. BROWN** asked what the effects are of second hand smoke. **Dr. Robert Shepherd** stated that second hand smoke can be divided into both sidestream smoke and mainstream smoke. Mainstream smoke is the smoke that the smoker lightly filters through his own lungs before he exposes the rest to us. Sidestream smoke comes straight off the cigarette. Approximately 85% of the smoke in a given room in a given time is sidestream smoke which is much more deadly than mainstream smoke because it contains higher concentrations of all the known carcinogens and all the known bad elements, nicotine and carbonmonoxide that is found in smoke. It is very clear that nonsmokers are exposed to that. Cigarette smoke is very quickly absorbed by the nonsmokers. There is no question that occurs. In studies of infants whose mothers smoke, they can measure the nicotine byproduct in the infants urine and the amount that is measured is directly proportional to the amount that the mother smokes. There is no doubt in anybody's mind that cigarette smoking causes lung cancer. What can be demonstrated and demonstrated very clearly is that the amount of lung cancer that you are at risk for getting is strictly depending on the number of cigarettes they smoke. A person that smokes one cigarette a day has a 30% higher chance of developing lung cancer than a nonsmoker. All the studies on nicotine levels in nonsmokers urine who are exposed to that, either at home or at the work place smoke cigarettes on the order of one cigarette a day. That means that the nonsmokers exposed to smokers have a 30% higher rate of lung cancer. 390,000 Americans die every year from cigarette smoke and approximately 50,000 die from the cigarette smoke as nonsmokers.

**REP. CROMLEY** asked if the county health board makes regulations that are not as strict as the current law. **REP. TOOLE** stated he agrees with that as the way the bill is drafted. It says "unless inconsistent with regulations adopted by the local board of health".

Closing by Sponsor:

**REP. TOOLE** stated that in response to HB 820 and the surprising lack of trust in the ability of the locals to enforce and develop reasonable and sensible regulations in this area and a great deal of skepticism expressed, concerning local health departments is the only comment that made any sense to me. Local and political entities and county commissions would be as appropriate as some departments to regulate this. There are communities that are going to want to develop and implement their own regulations and those regulations could well have merit. The problem that led to the introduction of this bill is the enforcement problem. There are parts of the community that are subject to this law. The communities aren't aware that they are not doing anything about this. DHES is involved in the operation of this law. It is a law that is not very well known or understood. It is not really being brought to the attention of businesses by local governments because it is not the local governments responsibility by destination to be involved in it.

Closing by Sponsor:

**REP. DOWELL** stated that smoking is a voluntary act, passive smoking is often times not. Many people in this state have no choice, among those people are children. Do the children have rights, whose rights are really being infringed upon. The long range building fund was in regards to legislation in the 1940's. It wasn't until the 1960's that the Surgeon General said that smoking was bad for you, that was twenty years after the big building fund. We can solve all of our budgetary problems, lets just encourage smoking. If we doubled smoking think how much money we could get. Why wasn't something done about this issue of second hand smoking earlier. One cigarette a day can increase your chances of getting lung cancer by 30%. He submitted testimony. **EXHIBIT 9 & 10**

## EXECUTIVE ACTION ON HB 820

Motion: **REP. DOWELL MOVED HB 820 DO PASS.**

Discussion:

**REP. MESSMORE** asked if under the current law, does a restaurant in the state have to have a designated non-smoking area and if they don't who are they reported to. **REP. DOWELL** stated that they do have to have a designated non-smoking area. The local board of health has the authority to charge them with a violation.

**REP. CROMLEY** stated that if a proprietor wants to, he can designate all non-smoking or smoking areas. The local departments of health would have a hard time enforcing this.

Motion/Vote: **REP. WHALEN MOVED HB 820 BE TABLED.** Motion carried 19-1 with **REP. S. RICE** voting no.

## EXECUTIVE ACTION ON HB 860

Motion: **REP. DOWELL MOVED HB 860 DO PASS.**

Discussion:

**REP. WHALEN** stated that there was suppose to be a provision in the bill that says there would have to be at least one place designated in each public building where a person can smoke. **REP. DOWELL** stated that was his intention and he would not resist an amendment, unless it would take a state building that might have one room where smokers can go in a corner of a room or designating one half of a room non-smoking and the other half smoking that would not be acceptable to the concept of what the bill is saying. There must be a physical barrier between smoking and non-smoking. **David Niss** said that can be accomplished in two ways. Page 2, section 3, line 12, change the "may" to "shall" which will maintain and use the discretionary language on line 15 and line 19. Or we could strike section 6, from the bill. That would maintain the status quo.

**REP. STICKNEY** asked why this couldn't be covered in the current act. It seems we are already doing what this bill wants to do. **REP. DOWELL** stated that the language is that a supervisor may designate areas as non-smoking or may designate areas as smoking. Designating a smoking area in one corner of a non-smoking room won't work, people will have to walk by the smoke and will inhale the smoke if the smokers are in a corner or not. The state needs to go on record with a policy saying we believe a building should be smoke free and here is place for you to smoke. It shouldn't be in places where a majority of any particular worker must go in order to carry out their duties.

**REP. SPRING** stated that he supports this bill. The 80% of nonsmokers need more protection in our society.

**REP. J. RICE** asked if state buildings can, under the present law be declared totally smoke free if they have at least 7 employees working in the building because of section 6. This bill is basically saying that we want the ability to declare state buildings totally smoke free, but they will give the smokers a smoking area somewhere.

**REP. MESSMORE** stated that we want as much of a smoke free environment as we can get, however, in this bill there is permissive language.

**REP. WHALEN** stated that until everyone quits smoking and until we recognizing that these people have addictions, we are going to have to make some accommodations in these buildings for these people to smoke so that they don't have to go too much out of their way.

Motion: **REP. WHALEN** moved to amend HB 860.

Discussion:

**REP. WHALEN** stated that there has to be one designated place that a person can smoke.

**REP. MESSMORE** stated that she works in a facility that has eight floors, 1,200 employees and many of visitors. We have one area on the first floor designated as smoking. This has worked very well. **REP. WHALEN** stated that is in a hospital. This issue is public state buildings and at least one smoking area for every two floors is reasonable.

**REP. TUNBY** stated that he agrees with the amendment.

**REP. GALVIN** stated that he is allergic to smoke and his wife has cancer from smoke. Neither of them smoke but they have to deal with the circumstances from other smokers.

Motion: **REP. WHALEN MADE A SUBSTITUTE MOTION TO AMEND HB 860.**

Title, line 5.
Strike: "ALLOWING"
Insert: "REQUIRING"

Title, line 6.
Strike: "DESIGNATED SMOKING AREAS"
Insert: "AT LEAST ONE DESIGNATED SMOKING AREA IN EACH STATE BUILDING"

Page 2, line 12.
Strike: "may"
Insert: "shall"
Following: "establish"
Insert: "at least one"

Page 2, line 13.
Strike: "areas"
Insert: "area"

Page 2, line 13.
Strike: "agency"
Insert: "building"

Discussion:

**REP. WHALEN** stated that he talked with one representative who

smokes and has signed on to this bill. He signed the bill because he was assured that at least one place in each building would be set aside for smokers.

**REP. TUNBY** asked who would be the agency head in this building that would make the determination of where the smoking area would be. **REP. WHALEN** stated that it would be the Department of Administration.

**REP. BECKER** stated that she would like to support the amendments.

**REP. MESSMORE** asked what happens on page 4, section 5, line 3, subsection 6. Do the state smoke free buildings have to find one spot where smokers can go. **REP. DOWELL** said yes, section 3 is the definition of smoke free buildings.

Vote: Motion carried 18-2 with **REPS. LEE and SPRING** voting no.

Motion/Vote: **REP. WHALEN** moved to amend HB 860. Motion carried 11-7 with **REPS. BROWN, CROMLEY, JOHNSON, LEE, MESSMORE, J. RICE, and SPRING** voting no.

Page 3.
Following: line 14
Insert: "(4) In buildings of historical significance, the department shall place signs that are aesthetically pleasing and that fit the architectural style of the building.

Motion: **REP. DOWELL MOVED HB 860 DO PASS AS AMENDED.**

Discussion:

**REP. J. RICE** asked if section 3 becomes part of the Indoor Clean Air Act. **David Niss** stated that it will be codified in the same place and it has to do with the same subject.

Vote: Motion carried 17-3 with **REPS. KASTEN, SQUIRES and STICKNEY** voting no.

## HEARING ON HB 666

Presentation and Opening Statement by Sponsor:

**REP. BEVERLY BARNHART, House District 80, Bozeman,** stated that this is an act providing examination to determine the mental condition of a person accused of a crime to be conducted by a licensed social worker. This bill lists licensed social workers (LSW) throughout the law so that they can be expert witnesses for testifying on the mental conditions of persons accused of crime. LSWs, along with psychologists and licensed psychologists, would be called on to examine an accused person of a mental condition. Not all LSWs will want to do this type of examination, but there are those that will want to. They have the education and many

have the experience to make them qualify. LSWs can assess the mental condition of persons under the civil section of the law.

Proponents' Testimony:

**Bill Evens, Licensed Social Worker, National Association of Social Workers,** stated that LSWs are licensed to provide psychotherapy in Montana and have been for some time. LSWs are called upon frequently to testify in mental health commitment hearings that are involved in providing expert testimony in child abuse cases, criminal, sex abuse cases, and custody cases. We feel that it is logical to include LSWs in the definition of expert witnesses in the state laws. Some LSWs have experienced being discriminated against due to not being included in the statutes. This would serve as a point of clarification for the court and the people.

**Craig Simmons, National Association of Social Workers,** stated that he is typical of the kind of social worker who has clinical training and who may be in a position to be called on to give expert testimony. There are many specializations in the field of social work. In 1984, LSWs were given licensure in the State of Montana. **EXHIBIT 11**

**Judith Carlson, Montana Chapter National Association of Social Workers,** submitted written testimony. **EXHIBIT 12**

**REP. ANGELA RUSSELL** went on record in support of the bill.

Opponents' Testimony:

**Mary McCue, Montana Mental Health Counselors Association,** stated that both LSWs and LPCs possess masters level degrees, are licensed by the same board in Montana, and are also well trained and competent to perform these evaluations by our background. Not every LPC wants to perform evaluations and not all feel that they are competent to do it. Presently there are numerous LPC who are performing this kind of examination for the courts. If you are going to include LSWs, it may appear that LPCs are not qualified, and that LPCs will not be called upon to continue to perform these examinations. LPCs would gladly support this bill if the committee would amend it to simply include LPCs in each of the places where LSWs are included because all of the arguments that they have made to you with their inclusions, which could be made on LPCs behalf.

**Hank Winters, Licensed Professional Counselors, Montana Mental Health Counselors Association,** submitted written testimony. **EXHIBIT 13**

**Dr. Susan Sachsenmair, Montana Association,** submitted written testimony. **EXHIBIT 14 & 15**

**Dr. Jeffrey Ritow, Forensic Psychologist,** stated that he has

conducted 100 to 200 forensic evaluations over the last three years. Prior to that he conducted approximately 3,000 clinical evaluations for general treatment units at the state hospital. There is a large difference between clinical assessment and forensic assessment. In clinical assessment, a person is brought to a counselor, social worker, psychologists or psychiatrist with a problem and wants help and wants to talk about it. Generally, in these settings, people are telling the truth, sometimes they minimize, sometimes they exaggerate, and sometimes they blame others, but they tell you what is basically going on. In forensic assessment the people that you are seeing have a very good reason for lying to you. It is difficult to see who is lying. The people that break the laws are more often than not sociopaths, which are called an antisocial personality and are very good liars. People who have these characteristics do not give out the ques that we normally judge others by. They are usually lying, but we do not know if they are lying or not. LSWs have considerable training in diagnosis, therapy and understanding human behavior.

Questions From Committee Members:

**REP. KASTEN** asked what is the difference between licensed and certified social workers. **Mr. Simmons** stated that the licenses are given with the backing of the National Association of Social Workers. Each chapter chooses to call it certified or licensed. Sometimes the requirements are greater when they are called licensed.

**REP. CROMLEY** asked if he diagnoses specific mental diseases. **Mr. Simmons** said yes, that is a part of clinical work. We have to refer to the diagnostic and statistical manual of the American Psychiatric Association.

**REP. TUNBY** asked how would you feel about adding licensed professional counselors into this bill. **Mr. Simmons** stated that LSWs would prefer LPCs had their own bill.

**REP. LEE** asked would LPCs normally have a doctorate in psychology. **Mr. Winter** stated that four or five do and have chosen that licensure to be affiliated with.

**REP. LEE** asked does a doctorate in psychology require to be a licensed practitioner. **Mr. Winter** said no.

**REP. LEE** asked why this bill is necessary. **REP. BARNHART** stated that we need this bill because in a couple of places it says "or other experts" and we want to add the LSWs so that it expands that field to them.

**REP. JOHNSON** asked what licensing board are LSWs under. **Mr. Winters** stated that LPCs and LSW share the same licensing board called the Licensing Board for Social Workers and Professional Counselors.

**REP. JOHNSON** asked how many people are involved in each one of these particular disciplines. **Mr. Winters** stated that based on last years licenses, there are a total of 252 LPCs in the state and by no means is that represented by the people who qualify for this.

**REP. JOHNSON** asked how many more professions would be qualified under this particular paragraph. **Mr. Winters** stated that there are only basically four mental health professional disciplines: licensed clinical psychologists, licensed social workers, licensed counselors, and psychologists.

**REP. WHALEN** asked if social workers are performing this service in cases with regard to children. **Dr. Ritow** stated that currently the courts use social workers more often in child custody and child abuse cases. If this laws passes, it will state that a social worker, who wishes to do so, can give testimony as an expert in doing the criminal evaluations.

**REP. WHALEN** asked if social workers are not generally doing crimes outside of the sex area, such as deliberate homicide. **Mr. Simmons** said no.

**REP. WHALEN** asked if the LSWs position was that they are capable of making a determination under the law as to what extent these people can appreciate their crimes. **Mr. Simmons** stated that there are certain LSWs who have prepared themselves in those areas and yes they could.

**REP. WHALEN** asked what are the qualifications of those individuals that would be capable of making this determination of a defendants ability to appreciate his conduct. **Mr. Simmons** stated that you may have had experience that approximates this, plus you can attend workshops or graduate training.

**REP. LEE** asked is forensic training common. **Mr. Simmons** said no it isn't common.

**REP. SPRING** asked who is going to make the determination if some LSWs are qualified and some aren't. **Mr. Simmons** stated that the court and the attorneys who call upon you will want you to be able to demonstrate that you have the ability to render the type of diagnostic interviews that they will be able to render that you are competent.

Closing by Sponsor:

**REP. BARNHART** stated that the law, as it stands of qualified psychiatrist, doesn't mean that all psychiatrists are called or wish to be called as expert witnesses. We want the LSWs to be put on the list and so that they can be chosen as expert witnesses if the court says that they are expert witnesses. LSWs can be called right now under the list where it says "other witnesses", but they aren't being called because they are not

specifically listed.

## EXECUTIVE ACTION ON HB 666

Motion: **REP. RUSSELL MOVED HB 666 DO PASS.**

Discussion:

**REP. TUNBY** spoke against the bill.

**REP. SPRING** stated that he opposes the bill.

**REP. CROMLEY** stated that he is concerned with the bill being heard in this committee, instead of the Judiciary Committee.

**REP. DOWELL** stated that he agrees with REP. CROMLEY.

**REP. LEE** stated that not all LSWs are going to be interested in being expert witnesses. They can do this now if they want to.

Vote: Motion carried 14-6 with **REPS. BROWN, DOWELL, MESSMORE, J. RICE, RUSSELL, and STRIZICH** voting no.

## ADJOURNMENT

**Adjournment:** 6:30 p.m.

Angela Russell
ANGELA RUSSELL, Chair

Jeanne C. Krumm
Jeanne Krumm, Secretary

AR/jck

**HOUSE OF REPRESENTATIVES**

**HUMAN SERVICES AND AGING COMMITTEE**

**ROLL CALL** **DATE** 2-18-91

| NAME | PRESENT | ABSENT | EXCUSED |
|---|---|---|---|
| REP. ANGELA RUSSELL, CHAIR | ✓ | | |
| REP. TIM WHALEN, VICE-CHAIR | ✓ | | |
| REP. ARLENE BECKER | ✓ | | |
| REP. WILLIAM BOHARSKI | ✓ | | |
| REP. JAN BROWN | ✓ | | |
| REP. BRENT CROMLEY | ✓ | | |
| REP. TIM DOWELL | ✓ | | |
| REP. PATRICK GALVIN | ✓ | | |
| REP. STELLA JEAN HANSEN | | ✓ | |
| REP. ROYAL JOHNSON | ✓ | | |
| REP. BETTY LOU KASTEN | ✓ | | |
| REP. THOMAS LEE | ✓ | | |
| REP. CHARLOTTE MESSMORE | ✓ | | |
| REP. JIM RICE | ✓ | | |
| REP. SHEILA RICE | ✓ | | |
| REP. WILBUR SPRING | ✓ | | |
| REP. CAROLYN SQUIRES | ✓ | | |
| REP. JESSICA STICKNEY | ✓ | | |
| REP. BILL STRIZICH | | ✓ | |
| REP. ROLPH TUNBY | ✓ | | |
| | | | |
| | | | |
| | | | |
| | | | |

CS05HUMSER.MAN

HOUSE STANDING COMMITTEE REPORT

February 19, 1991



Mr. Speaker: We, the committee on Human Services and Aging report that House Bill 530 (first reading copy -- white) do pass as amended .

Signed: _____
Angela Russell, Chairman

And, that such amendments read:

1. Title, line 4.
Strike: "HEALTH"
Insert: "DISABILITY"

2. Title, lines 5 and 6.
Strike: ", HEALTH" on line 5 through "ORGANIZATIONS" on line 6

3. Title, lines 6 and 7.
Strike: "OR MEMBERSHIP"

4. Title, line 7.
Following: "TO"
Insert: "OR REFUSING TO CONSIDER AN APPLICATION FOR INSURANCE COVERAGE FROM"

5. Title, line 8.
Following: "DISABILITY"
Insert: "; TO DEFINE UNLAWFUL DISCRIMINATION IN THE APPLICATION OF INSURANCE RATES OR TERMS OR IN THE ISSUANCE OF AN INSURANCE POLICY; DEFINING TERMS; AMENDING SECTION 33-18-206, MCA "

6. Page 1, line 12 through line 8 on page 2.
Following: line 11
Strike: sections 1 and 2 in their entirety
Insert: " Section 1. Section 33-18-206, MCA, is amended to read:
"33-18-206. Unfair discrimination prohibited -- life

insurance, annuities, and disability insurance. (1) No person shall make or permit any unfair discrimination between individuals of the same class and equal expectation of life in the rates charged for any contract of life insurance or of life annuity or in the dividends or other benefits payable thereon or in any other of the terms and conditions of such contract.

(2) No person shall make or permit any unfair discrimination between individuals of the same class and of essentially the same hazard in the amount of premium, policy fees, or rates charged for any policy or contract of disability insurance or in the benefits payable thereunder or in any of the terms or conditions of such contract or in any other manner whatever.

(3) An insurer may not refuse to consider an application for life or disability insurance on the basis of a genetic condition, developmental delay, or developmental disability.

(4) The rejection of an application or the determining of rates, terms, or conditions of a life or disability insurance contract on the basis of genetic condition, developmental delay, or developmental disability constitutes unfair discrimination, unless the applicant's medical condition and history and either claims experience or actuarial projections establish that substantial differences in claims are likely to result from the genetic condition, developmental delay, or developmental disability.

(5) As used in this section, the following definitions apply:

(a) "Developmental delay" means a delay of at least 1 1/2 standard deviation from the norm.

(b) "Developmental disability" means the singular of developmental disabilities as defined in 53-20-202.

(c) "Genetic condition" means a specific chromosomal or single-gene genetic condition."

Renumber: subsequent section

7. Page 2, line 10.
Strike: "health"
Insert:"disability"
Following: "contracts"
Insert: "applied for,"

HOUSE STANDING COMMITTEE REPORT

February 19, 1991



Mr. Speaker: We, the committee on Human Services and Aging report that House Bill 713 (first reading copy -- white) do pass and be placed on consent calendar .

Signed: _____

Angela Russell, Chairman

HOUSE STANDING COMMITTEE REPORT

February 19, 1991


Mr. Speaker: We, the committee on Human Services and Aging report that House Bill 860 (first reading copy -- white) do pass as amended .

Signed: _____
Angela Russell, Chairman

And, that such amendments read:

1. Title, line 5.
Strike: "ALLOWING"
Insert: "REQUIRING"

2. Title, line 6.
Strike: "DESIGNATED SMOKING AREAS"
Insert: "AT LEAST ONE DESIGNATED SMOKING AREA IN EACH STATE BUILDING"

3. Page 2, line 12.
Strike: "may"
Insert: "shall"
Following: "establish"
Insert: "at least one"

4. Page 2, line 13.
Strike: "areas"
Insert: "area"

5. Page 2, line 13.
Strike: "agency"
Insert: "building"

6. Page 3.
Following: line 14
Insert: "(4) In buildings of historical significance, the department shall place signs that are aesthetically pleasing and that fit the architectural style of the building.

EXHIBIT 1
DATE 2-18-91
HB 530

Amendments to House Bill No. 530
First Reading Copy

Requested by Rep. Becker
For the Committee on Human Services and Aging

Prepared by David S. Niss
February 17, 1991

1. Title, line 4.
Strike: "HEALTH"
Insert: "DISABILITY"

2. Title, lines 5 and 6.
Strike: ", HEALTH" on line 5 through "ORGANIZATIONS" on line 6

3. Title, lines 6 and 7.
Strike: "OR MEMBERSHIP"

4. Title, line 7.
Following: "TO"
Insert: "OR REFUSING TO CONSIDER AN APPLICATION FOR INSURANCE COVERAGE FROM"

5. Title, line 8.
Following: "DISABILITY"
Insert: "; TO DEFINE UNLAWFUL DISCRIMINATION IN THE APPLICATION OF INSURANCE RATES OR TERMS OR IN THE ISSUANCE OF AN INSURANCE POLICY; DEFINING TERMS; AMENDING SECTION 33-18-206, MCA "

6. Page 1, line 12 through line 8 on page 2.
Following: line 11
Strike: sections 1 and 2 in their entirety
Insert: " **Section 1.** Section 33-18-206, MCA, is amended to read:
**"33-18-206. Unfair discrimination prohibited -- life insurance, annuities, and disability insurance.** (1) No person shall make or permit any unfair discrimination between individuals of the same class and equal expectation of life in the rates charged for any contract of life insurance or of life annuity or in the dividends or other benefits payable thereon or in any other of the terms and conditions of such contract.
(2) No person shall make or permit any unfair discrimination between individuals of the same class and of essentially the same hazard in the amount of premium, policy fees, or rates charged for any policy or contract of disability insurance or in the benefits payable thereunder or in any of the terms or conditions of such contract or in any other manner

EXHIBIT 1
DATE 2-18-91
HB 530

whatever.

(3) An insurer may not refuse to consider an application for life or disability insurance on the basis of a genetic condition, developmental delay, or developmental disability.

(4) The rejection of an application or the determining of rates, terms, or conditions of a life or disability insurance contract on the basis of genetic condition, developmental delay, or developmental disability constitutes unfair discrimination, unless the applicant's medical condition and history and either claims experience or actuarial projections establish that substantial differences in claims are likely to result from the genetic condition, developmental delay, or developmental disability.

(5) As used in this section, the following definitions apply:

(a) "Developmental delay" means a delay of at least 1 1/2 standard deviation from the norm.

(b) "Developmental disability" means the singular of developmental disabilities as defined in 53-20-202.

(c) "Genetic condition" means a specific chromosomal or single-gene genetic condition."

Renumber: subsequent subsection

7. Page 2, line 10.
Strike: "health"
Insert:"disability"
Following: "contracts"
Insert: "applied for,"

EXHIBIT 2
DATE 2-18-91
HB 761

STATE OF MONTANA

# DEPARTMENT OF JUSTICE

## BOARD OF CRIME CONTROL

**Marc Racicot**
**Attorney General**

**303 North Roberts**
**Scott Hart Building**
**Helena, MT 59620**

February 14, 1991

Representative Angela Russell, Chair
House Human Services and Aging Committee
PO Box 333
Lodge Grass, MT 59050

Re: HB 761

Dear Chairperson Russell:

I submit this letter in support of HB 761 which provides for HIV testing for offenders in sexual offenses. The intent of this legislation is important because of impending federal requirements which relate to Montana's ability to obtain, in FY 92, $2,225,000 in Anti-Drug Abuse Act funds. The federal Crime Control Act of 1990 made amendments which indicate that states should have legislation requiring, at the request of the victim, testing for HIV by FY 94 or suffer 10% reductions in funding.

I have enclosed a copy of the federal revisions which make passage of HB 761 or similar legislation of great importance to the state and to this agency.

Respectfully,

Edwin L. Hall
Administrator

cc: Representative Peck

eh\leg\hb761.ltr

**Tel. (406) 444-3604** **Fax (406) 444-4722**

2
2-18-91
761

## Revision to Purpose Area 10

## (Effective Date - FY 1991)

The Crime Control Act of 1990 changed purpose 10 under Sec. 501(b) of the Omnibus Crime Control and Safe Streets Act, as amended, to allow for the expansion of prosecutorial and defense services. The following is the revised language of purpose 10:

10. Improving the operational effectiveness of the court process by expanding prosecutorial, defender and judicial resources and implementing court delay reduction programs.

## Changes Which Take Effect After FY 1991

The Crime Control Act of 1990 made a least two substantial amendments to the Omnibus Crime Control and Safe Streets Act of 1968, affecting the formula grant program in the future. These provision do not take effect in FY 1991, but states should be aware of them for future planning.

- Beginning in FY 1992, Congress expects each state to allocate not less than five percent of its total formula grant award for the purpose of improving its criminal justice records.

- Beginning in FY 1994, each state should have in place a statute requiring, at the request of the crime victim, testing for the presence of human immunodeficiency virus (HIV) in persons convicted under state law of a sexual act as defined in 18 U.S.C. § 2245. States not having such a statute will receive only 90 percent of the allocated formula grant funds.

Attached are copies of these provisions from the Crime Control Bill.

MISSOULA CITY-COUNTY HEALTH DEPARTMENT

EXHIBIT 3
DATE 2-18-91
HB 761

February 18, 1991

Honorable Representative Angela Russell
Chairperson
Human Services and Aging Committee
House of Representatives
Capitol
Helena, MT 59620

Dear Representative Russell,

I am writing in SUPPORT of HB 761 requiring tests of sex offenders for sexually transmitted diseases WITH AMENDMENTS linking testing to treatment and limiting disclosure to the offender, those involved in treatment and the victim(s).

As a local health officer and director of our department's sexually transmitted disease (STD) clinic, I am familiar with the aspects of STD testing and treatment. I believe that a convicted, (not merely accused) sexual assailant has shown to be a threat to society and that the state has a compelling interest in testing the offender for STD's if such testing is for the purpose of treating disease, thereby limiting at least this aspect of the offender's potential to harm should recidivism occur. It follows that treatment of any identified and treatable STD's should be required.

I believe disclosure should be limited to the offender, persons necessarily involved in the testing and treatment, local and state health officials as required by state law, and the victim. I must add that the victim will not be protected by this information alone and should have been advised to undergo testing, treatment, and counseling for all STD's as part of the initial and follow-up intervention - long before the accused is convicted.

I see no useful purpose in enacting HB 761 without these amendments.

Sincerely,

E. Leahy

Ellen Leahy
Health Officer

MISSOULA CITY-COUNTY HEALTH DEPARTMENT

EXHIBIT 3
DATE 2-18-91
HB 780

February 18, 1991

Honorable Representative Angela Russell
Chairperson
Human Services and Aging Committee
House of Representatives
Capitol
Helena, MT 59620

Dear Representative Russell,

I am writing to OPPOSE HB 780 allowing HIV related testing of persons charged with sexual offenses.

As overseer of our department's HIV counseling and testing program, I am familiar with the uses and limitations of HIV testing. I have also been directly involved in the HIV testing and counseling of sexual assault victims. Based on these experiences, I believe that requiring testing of the accused does not tell the victim what she or he needs to know - that is, whether or not the victim has been infected.

Because the HIV antibody test can only identify infection that occurred at least three months prior to testing, a negative test does not mean that the accused is not infected. The false sense of security that can be created in this situation is furthered by the chance that the accused is not, in fact, the offender. Also, a positive test of the accused does not mean that the victim became infected. It is certainly understandable that the victim wants to know if she or he became infected with HIV. The truth is, however, that the only way to answer this question is for the victim to undergo testing.

A victim of sexual assault needs a great deal of emotional and medical attention including specific attention to HIV risks. For this and the above reasons, I believe that focusing on the accused in the manner proposed in HB 780 is misleading and creates a risky distraction from focusing on the victim's real need for confidential HIV testing and counseling. I urge your opposition to HB 780.

Sincerely,

E. Leahy

Ellen Leahy
Health Officer

EXHIBIT 4
DATE 2-18-91
HB 761

# DEPARTMENT OF HEALTH AND ENVIRONMENTAL SCIENCES

STAN STEPHENS, GOVERNOR

COGSWELL BUILDING

STATE OF MONTANA

FAX # (406) 444-2606

HELENA, MONTANA 59620

## House Bill 761 Testimony--2/18/91

Madame Chair and members of the Committee, I am Bruce Desonia, Program Manager of the AIDS/STD Program with the Montana Department of Health & Environmental Sciences and wish to provide technical information on House Bill 761.

1. Under the current STD statute, 50-18-101, there are 7 diseases defined as Sexually Transmitted Diseases (STD's). Testing for all 7 is not available by serological test, although syphilis and HIV antibody for AIDS are the ones that commonly are. Other STDs common in Montana that could be considered are gonorrhea and chlamydia genital infection, which would require collection of a culture specimen for testing, not a serology. Testing for the 4 diseases listed above are available from the state Public Health Laboratory.

2. The proposed bill states "the test must be conducted by a health care provider, as defined in 50-16-504,: which may not necessarily be a physician. It is unclear who will "determine whether the person [sexual offender] suffers from a sexually transmitted disease." A physician may diagnose an STD without a standard serological test. A standard serological test result alone may be falsely positive or falsely negative, and requires clinical interpretation.

3. Section 50-18-108 of the STD statute states that "any person confined or imprisoned in any state, county, or municipal prison within the state may be examined for sexually transmitted disease. If infected, the person must be treated by health authorities." The cost for treatment of most of the diseases is minimal, but a person identified as infected with the Human Immunodeficiency Virus (HIV) could require significant health costs. Under the proposed legislation, sexual offenders infected with HIV may be identified earlier than they may have without the legislation.

4. There is a potential conflict with the current bill and 50-16-1007 (the AIDS Education and Prevention Act) which requires pre- and post-test counseling and informed consent by the patient. The current bill does not address pre- and post-test counseling and informed consent by the patient or applicability of 50-16-1007. MDHES is proposing revisions to the AIDS Education and Prevention Act through House Bill 917.

cc: Representative Ray Peck

EXHIBIT 5
DATE 2-18-91
HB 713

**TESTIMONY ON HB 713**

**by Dan Anderson**

**to House Human Services Committee**

**February 18, 1991**

The Department is proposing this legislation to clarify the admission criteria for the Montana Center for the Aged.

It is not appropriate to refer to a mental disorder as "associated with the aging process" because it implies that the process of growing old in some way is or causes a mental disorder.

The patients admitted to the Montana Center for the Aged are older people, the minimum age is 55. All of them have a mental disorder which makes placement in a less restrictive community setting impossible.

The mental disorders of Center for the Aged residents span the diagnostic gamut from schizophrenia to organic disorders. In some cases the onset of illness was at a young age and in some cases the onset was later in life.

Ex. 7
2-18-91
HB 713



For none of the patients is the mental disorder attributable to the aging process and therefore, the Department requests that this language be deleted from this statute.

DA/jeb

MONTANA CONSTITUTION



EXHIBIT 6
DATE 2-18-91
SB 860



---

**Section 1. Popular sovereignty.** All political power is vested in and derived from the people. All government of right originates with the people, is founded upon their will only, and is instituted solely for the good of the whole.

**Cross-References**

Self-government, Art. II, sec. 2, Mont. Const.

Right of participation in governmental affairs, Art. II, sec. 8, Mont. Const.

Right to know, Art. II, sec. 9, Mont. Const.

Right of suffrage, Art. II, sec. 13, Mont. Const.

General government, Art. III, Mont. Const.

Constitutional revision, Art. XIV, Mont. Const.

Government Structure and Administration, Title 2.

Basic political rights, Title 49, ch. 1, part 2.

**Constitutional Convention Transcript Cross-References**

Adoption, Trans. 2933, 2934.

Committee report, Vol. II 620, 626, 957, 962, 967, 969, 1038.

Cross-references, 1889 and 1972 Constitutions, Vol. II 646.

Debate — committee report, Trans. 1635, 1636.

Debate — style and drafting report, Trans. 2476, 2921.

Final consideration, Trans. 2627, 2628.

Text as adopted, Vol. II 1087.

**Section 2. Self-government.** The people have the exclusive right of governing themselves as a free, sovereign, and independent state. They may alter or abolish the constitution and form of government whenever they deem it necessary.

**Cross-References**

Popular sovereignty, Art. II, sec. 1, Mont. Const.

General government, Art. III, Mont. Const.

Local government, Art. XI, Mont. Const.

Constitutional revision, Art. XIV, Mont. Const.

**Constitutional Convention Transcript Cross-References**

Adoption, Trans. 2933, 2934.

Committee report, Vol. II 620, 626, 957, 962, 967, 969, 1038.

Cross-references, 1889 and 1972 Constitutions, Vol. II 646.

Debate — committee report, Trans. 1636.

Debate — style and drafting report, Trans. 2476, 2921.

Final consideration, Trans. 2628, 2629.

Text as adopted, Vol. II 1087.

**Section 3. Inalienable rights.** All persons are born free and have certain inalienable rights. They include the right to a clean and healthful environment and the rights of pursuing life's basic necessities, enjoying and defending their lives and liberties, acquiring, possessing and protecting property, and seeking their safety, health and happiness in all lawful ways. In enjoying these rights, all persons recognize corresponding responsibilities.

**Cross-References**

Right to bear arms, Art. II, sec. 12, Mont. Const.

Environment and natural resources, Art. IX, Mont. Const.

Department of Health and Environmental Sciences, Title 2, ch. 15, part 21.

Department of Agriculture, Title 2, ch. 15, part 30.

EXHIBIT 7
DATE 2-18-91
HB 820

**COMMENTS IN OPPOSITION TO HB 820**

The following are comments of the Tobacco Institute, the Montana Association of Tobacco and Candy Distributors, Philip Morris Ltd., and R.J. Reynolds in opposition to House Bill 820.

We oppose HB 820 which would amend the existing "Montana Indoor Clean Air Act" by placing the regulation of smoking in "enclosed public places" under the control of Local Boards of Health, thus taking the enactment of such regulatory control from the State Legislature and placing it in the hands of unelected public officials who may or may not relate to or seek public input.

The present "Montana Indoor Clean Air Act" (Sections 50-40-101 through 50-40-201, MCA) is recognized nationally as one of the most stringent state regulatory acts in the United States. Regulations regarding smoking in enclosed public places are already in place in that act.

The present state act defines an "enclosed public place" as any:

(a) Indoor area, room, or vehicle used by the general public; or
(b) serving as a place of work;
(c) including but not limited to restaurants, stores, offices, trains, busses, educational or health care facilities, auditoriums, arenas, and assembly and meeting rooms open to the public. (Section 50-40-103, MCA).

The act requires that the proprietor or manager of an "enclosed public place" shall take the following actions:

(a) Designate non-smoking areas with easily readable signs;
(b) reserve a part for non-smokers and post easily readable signs designating a smoking area;
(c) designate the entire area as a smoking area by posting a clearly visible sign stating this designation; or
(d) designating the entire area as a non-smoking area.

The proprietor or manager must also post signs at all public entrances stating whether or not areas in the establishment have been reserved for non-smokers. Such signing is not required in an establishment containing both a restaurant and a tavern in which some patrons may choose to eat their meals in the tavern. (Section 50-40-104, MCA).

<u>Health care facilities</u> are <u>required</u> to <u>prohibit</u> smoking in most areas in the hospital or facility except patients' rooms and

parts of waiting rooms. A health care facility may ban smoking in all of its premises. (Section 50-40-106, MCA).

No smoking is allowed in elevators, museums, art galleries, kitchens, and libraries of any public establishment. (Section 50-40-105, MCA).

The only exemptions declared in the act are:

(a) Rest rooms;
(b) taverns or bars where meals are served;
(c) vehicles or rooms seating 6 or fewer members of the public; and
(d) school and community college facilities where trustees have declared those facilities to be tobacco free. (Sections 50-40-107 and 50-40-201, MCA)

The act places enforcement in the Local Boards of Health under the direction of the State Department of Health (Section 50-40-108, MCA), and anyone violating the act is guilty of a misdemeanor (Section 50-40-109, MCA).

The Montana act as now constituted is very inclusive. We do not believe it needs amending or expansion as proposed in HB 820.

House Bill 820 suddenly expands the provisions of the "clean air act" by allowing Local Boards of Health, which include city, county, or district boards (as defined in Section 50-2-101, MCA) to enact more stringent regulations than contained in the state act. Under HB 820, the state act may be enforced "unless inconsistent with regulations adopted by the local board of health." (Lines 17 and 18, pg. 2, HB 220).

What is a "local board of heath"?

It is a city, county, city-county, or district Board of Health (Section 50-2-101, MCA).

All members of such boards are appointed. Non are elected. They are therefore not directly responsive to the electorate. (Sections 50-2-104 through 50-2-107, MCA, inclusive).

City-county Boards of Health have jurisdiction over the entire county. District health boards can be created by two or more adjacent counties and have jurisdiction over all counties which participate in the creation of the board.

The bill would allow an unelected health group, undoubtedly influenced by special interest groups, to institute regulation that could result in a complete ban on smoking in public places.

Such action could be taken by a city-county or a district Board of Health, which action would cover a large geographical area.

As an example, the city-county board of health in Missoula County could issue non-smoking regulations that would effect not only residents of Missoula, but also all the other communities in Missoula County, such as Seeley Lake, Condon, Milltown, Bonner, Clinton, Evaro, Alberton, Huson, Frenchtown, Lolo, and Lolo Hot Springs, as well as many public establishments that do business throughout the county. How much representation do those outlying communities have on the Missoula City-County Board of Health? How much opportunity will they have with regard to notices of intended board action and appearances before the board to let their views be known?

The interests of outlying communities many times are much different than those in urban areas. Under HB 820 unpalatable regulations could be imposed on those least capable of and with a minimal opportunity of representing themselves and having their personal rights preserved.

This bill is not presented to provide a reasonable opportunity for accommodation between non-smokers and smokers. That reasonable accommodation has already been reached in the present "Montana Indoor Clean Air Act." This bill is offered to provide a means for the institution of total area-wide bans on the use of tobacco products. All you have to do is to note the identity of the special interest groups supporting the legislation to reach that conclusion.

We urge you to vote no on HB 820 for the following reasons:

1. Maintaining uniformity in smoking restrictions on a statewide basis is critical to avoid conflict and confusion for the public and an unnecessary and unjustified burden on business. Statewide uniformity also prevents conflict among state, county, and local laws, and facilitates predictable, consistent compliance with and enforcement of the law.

2. Without statewide uniformity, smoking policies in restaurants, for example, would vary from town to town or county to county. Restaurants or stores having more than one location, such as 4B's, McDonald's, Arby's, or grocery chains, would be particularly subject to confusion and conflict, with smoking policies potentially varying from location to location.

3. Confusion among the smoking public, particularly among tourists, is inevitable unless there is uniformity. It would be unrealistic and unfair to expect people to know the nature of the restrictions that would be in effect in each locality. Such confusion could adversely affect the public's

ability and willingness to comply. Compliance is facilitated by a reasonable statewide law.

4. Tailoring smoking policies for each location to local ordinances imposes an unnecessary and disruptive burden on business. Where a business has one location, it can be unfairly disadvantaged by less restrictive non-smoking requirements on competitors just across the city or county limits.

5. Unless smoking laws are maintained at the state level, conflicts can also develop between city and county ordinances, increasing the confusion and burden on business and making enforcement difficult.

6. Placing the power to establish smoking regulations in the hands of unelected Boards of Health with area-wide jurisdiction throughout Montana can subject individuals in business within those areas to the control of such boards which can be heavily influenced by special interest groups.

7. Preventing these real and substantial burdens can be easily accomplished by continuing state jurisdiction over smoking restriction laws.

We would appreciate your opposition to HB 820.

JEROME ANDERSON
Representing The Tobacco Institute

MARK C. STAPLES
Representing the Montana Assn.
of Tobacco and Candy Distributors

JOHN DELANO
Representing Philip Morris' Ltd.

ROGER W. TIPPY
Representing R.J. Reynolds

EXHIBIT 8
DATE 2-18-91
HB 860

**COMMENTS IN OPPOSITION TO HB 860**

In 1985 and 1989 the Montana Legislature spoke and passed legislation regarding the regulation of smoking in offices and work areas of all buildings maintained by the state or its political subdivisions, other than those maintained by schools or community colleges. Schools and community colleges regulate smoking in their facilities through their boards of trustees. The remainder of buildings maintained by the state or political subdivisions of the state are regulated by the provisions of Section 50-40-201, MCA, a part of the "Montana Clean Indoor Air Act." The provisions of that statute are short and to the point. The statute provides that in offices and work areas in buildings maintained by the state or its political subdivisions in which seven or more employees are employed, the manager or person in charge of the work area shall arrange convenient smoking and non-smoking areas.

The statute makes no statement as to the specific location of the areas.

The statute makes no statement as to the specific size of the areas.

These matters are left, by the statute, to the discretion of the person in charge of those work areas where more than six people are employed.

The statute contains no definition of a work area, so the determination of what constitutes such an area is also left to the discretion of the person in charge.

The present regulatory statute does recognize the rights of the smoking minority by guaranteeing them some sort of smoking area in a convenient location.

Now, through the provisions of HB 860, the question of whether or not a smoking area is to be established is left solely to the discretion of agency heads. Agency heads can, under the provisions of HB 860, ban smoking totally throughout areas under their control. This can be done with no regard to the rights of a minority.

But even more disconcerting is the fact that so many areas of the work place are designated by the bill as areas where smoking is entirely prohibited that there is not much space left for smoking areas if the agency head should choose to provide any.

An agency head who is a non-smoking advocate could, under the terms of HB 860, simply issue an order prohibiting smoking throughout all of the buildings or facilities under his management and control. Smoking employees would have absolutely no recourse. Smoking employees could, of course, be subject to discipline if they smoked in areas designated as non-smoking. This discipline could ultimately result in suspension or even job termination.

EXHIBIT 6
DATE 2-18-91
HB 860

If any other statute were proposed in this legislature that sought to erode other personal rights of an employee, such as those eroded by this bill, labor and the majority of this legislature would arise in righteous wrath and vote down the measure. Workers' rights regarding drug testing and other like matters are being jealously guarded in this session. We respectfully suggest that the rights of employees being taken away by this bill merit the same concern.

On any work day, you can drive around this state campus and see smokers smoking outside buildings because they are not now, even though the present law requires it, being afforded the opportunity of having an indoor smoking area. This is of particular concern when employees are observed smoking outside buildings in 20° below zero weather.

Many of the buildings in the Capitol Complex were paid for by tax revenues generated from the sale of cigarettes and other tobacco products. The same is true of buildings and units of the University System. The buildings in the Capitol Complex and at University System locations are being maintained by revenues derived from the sale of cigarettes and other tobacco products.

The very people who are contributing to the construction and maintenance of the buildings in which the work areas covered by HB 860 are located are being harassed by those supporting this legislation.

We respectfully request that you oppose HB 860.

JEROME ANDERSON
Representing The Tobacco Institute

MARK C. STAPLES
Representing the Montana Assn.
of Tobacco and Candy Distributors

JOHN DELANO
Representing Philip Morris Ltd.

ROGER W. TIPPY
Representing R.J. Reynolds

NATIONAL CANCER INSTITUTE

Office of Cancer Communications
Building 31, Room 10A24
Bethesda, Maryland 20892



May 1990

# INVOLUNTARY SMOKING

Although many terms are used to describe a nonsmoker's exposure to environmental tobacco smoke (passive smoking, secondhand smoke, etc.), the most common is "involuntary smoking." This term is used to suggest that nonsmokers' exposure to environmental tobacco smoke (ETS) is an unavoidable consequence of being near smokers, often in indoor closed environments.

## What Is ETS?

Environmental tobacco smoke (ETS) is the combination of smoke from a burning tobacco product between puffs (sidestream smoke) and smoke exhaled by the smoker (mainstream smoke). More than 4,000 individual compounds have been identified in tobacco and tobacco smoke. Among these are some five dozen compounds that have been clearly established as carcinogens (cancer-causing agents), tumor initiators (substances that can result in irreversible changes in normal cells), and tumor promoters (substances that can lead to tumor growth once cell changes begin). Some of the compounds identified are tar, carbon monoxide, hydrogen cyanide, phenols, ammonia, formaldehyde, benzene, nitrosamine, and of course, nicotine. The levels of many of these compounds are greater in sidestream smoke than in mainstream smoke.

Although the smoke to which an involuntary smoker is exposed is less concentrated than that inhaled by active smokers, numerous studies have shown that individuals exposed to ETS in real-life situations absorb nicotine and other harmful compounds. The levels of these compounds become elevated in the blood, saliva, and urine. Further, the greater the exposure to ETS, the greater the level of these harmful compounds in the body.

In 1986, two very important reports were published on the association between ETS exposure and adverse health effects in nonsmokers: one by the U.S. Surgeon General and the other by the Expert Committee on Passive Smoking, National Academy of Sciences' National Research Council (NAS/NRC). They reached similar conclusions about ETS in three important areas:

14. Powars DR, Sandhu M, Niland-Weiss J, Johnson C, Bruce S, Manning PR. Pregnancy in sickle cell disease. Obstet Gynecol 1986; 67:217-28.
15. Charache S, Scott J, Niebyl J, Bonds D. Management of sickle cell disease in pregnant patients. Obstet Gynecol 1980; 55:407-10.
16. Koshy M, Burd L, Dorn L, Huff G. Frequency of pain crisis during pregnancy. Prog Clin Biol Res 1987; 240:305-11.
17. Milner PF, Jones BR, Döbler J. Outcome of pregnancy in sickle cell anemia and sickle cell–hemoglobin C disease: an analysis of 181 pregnancies in 98 patients, and a review of the literature. Am J Obstet Gynecol 1980; 138:239-45.
18. Cunningham FG, Pritchard JA, Mason R. Pregnancy and sickle cell hemoglobinopathies: results with and without prophylactic transfusions. Obstet Gynecol 1983; 62:419-24.
19. Faikpui EZ, Moran EM. Pregnancy in the sickle hemoglobinopathies. J Reprod Med 1973; 11:28-34.
20. Ricks P Jr. Further experience with exchange transfusion in sickle cell anemia and pregnancy. Am J Obstet Gynecol 1968; 100:1087-91.
21. Morrison JC, Wiser WL. The effect of maternal partial exchange transfusion on the infants of patients with sickle cell anemia. J Pediatr 1976; 89:28[illegible].
22. Brumfield CG, Huddleston JF, DuBois LB, Harris BA Jr. A delayed hemolytic transfusion reaction after partial exchange transfusion for sickle cell disease in pregnancy: a case report and a review of the literature. Obstet Gynecol 1984; 63:Suppl:13S-15S.
23. Tuck SM, James CE, Brewster EM, Pearson TC, Studd JW. Prophylactic blood transfusion in maternal sickle cell syndromes. Br J Obstet Gynaecol 1987; 94:121-5.

# MEDICAL PROGRESS

## HEALTH EFFECTS OF INVOLUNTARY SMOKING

JONATHAN E. FIELDING, M.D., M.P.H., AND KENNETH J. PHENOW, M.S., M.P.H.

ALTHOUGH each year since 1964 the Surgeon General has identified smoking as the single most important cause of preventable mortality, of late attention has been focused increasingly on the health effects of involuntary, or passive, smoking. When this topic was first raised in the 1972 *Report of the Surgeon General*,[1] only a handful of studies addressed the issue. In 1979, the encyclopedic report on cancer[2] devoted a chapter to passive smoking. The 1984 report on chronic obstructive lung disease[3] devoted more attention to passive smoking, on the basis of studies suggesting that nonsmokers who were exposed to spouses who smoked had an increased risk of lung cancer.

In 1986, two landmark reports by the Surgeon General[4] and the National Academy of Sciences[5] reached similar conclusions about the adverse health effects of involuntary smoking on healthy adults and children. The Surgeon General's report[4] asserted for the first time that the involuntary inhalation of cigarette smoke by nonsmokers causes disease, most notably lung cancer. Although the report cited smaller risks from involuntary smoking than from active smoking, it noted that the number of people injured by involuntary smoking was much larger than the number injured by other environmental agents that are already regulated.

These conclusions, and the finding that separating smokers from nonsmokers within the same physical space does not eliminate involuntary smoking, have engendered an extensive debate on the medical, social, and legal aspects of the problem and on alternative strategies of controlling it. Since the mid-1980s, movements to ban smoking in offices and public places have accelerated nationally and internationally, among them a recent federally mandated smoking ban applying to all domestic airline flights of less than two hours' duration. Forty-two states have legislated smoking restrictions, most of them applicable to public transportation (35 states), hospitals (33), elevators (31), indoor cultural or recreational facilities (29), schools (27), and libraries (19).[4]

The ubiquitousness of tobacco smoke in homes, workplaces, public areas, and private establishments makes exposure to environmental tobacco smoke unavoidable. In a large population study[6] of nonsmokers and former smokers, 63.3 percent of the nonsmokers reported some daily exposure; 34.5 percent were exposed at least 10 hours per week, and 15.9 percent at least 40 hours per week. Approximately 70 percent of the children in the United States live in homes where there is at least one adult smoker.[7]

### ENVIRONMENTAL TOBACCO SMOKE AND PASSIVE SMOKING

Involuntary smoking occurs when nonsmokers are exposed to the tobacco smoke of smokers in enclosed environments.[7] Environmental tobacco smoke is derived from two sources — mainstream and sidestream smoke. Mainstream smoke is the complex aerosol mixture inhaled by the smoker, filtered in the lungs, and exhaled. Sidestream smoke is the aerosol emitted directly into the surrounding air from the lit end of a smoldering tobacco product. Qualitatively, the two types of smoke share similar components, including oxides of nitrogen, nicotine, carbon monoxide, and various carcinogens and cocarcinogens. However, undiluted sidestream smoke has a higher pH, smaller particles, and higher concentrations of carbon monoxide, as well as many toxic and carcinogenic compounds that are also found in mainstream smoke, including ammonia, volatile nitrosamines, certain products of nicotine decomposition, and aromatic amines.[4,5] Although an estimated 85 percent of the smoke generated in an average room during cigarette smoking is composed of sidestream smoke, pas-

From the Schools of Public Health and Medicine of the University of California, Los Angeles (J.E.F., K.J.P.), and Johnson and Johnson Health Management, Inc., Santa Monica, Calif. (K.J.P.). Address reprint requests to Dr. Fielding at CHS 31-326, University of California at Los Angeles, Los Angeles, CA 90024.

New York Law Journal

SERVING THE BENCH AND BAR SINCE 1888

VOLUME 194—No. 1 NEW YORK, MONDAY, JULY 1, 1985 PRICE $1.75

2-18-91
3666

**CRIMINAL TERM, PART 81**
**Justice Crane**

PEOPLE, v. MATTHEW SCALA—This case presents two issues. First, may a certified social worker be appointed to examine a defendant in relation to a potential defense of lack of criminal responsibility and to provide "psychiatric evidence" as defined in CPL section 250.10? Second, may a certified social worker be appointed to examine a defendant and to render an expert opinion, as a "psychiatric examiner" under CPL 330.20(15), in the determination of the current mental state of a defendant who has been found to be not responsible by reason of mental disease or defect?

State of the Case

The defendant, Matthew Scala, was originally charged with the crimes of criminal mischief, third degree (PL 145.05) and aggravated harassment, first degree (PL 240.31), class E felonies. These charges arose from his conduct in damaging portions of a building used by The Christophers, a Roman Catholic charitable and educational organization. He also allegedly sent obscene and threatening letters to the director and other staff members of this organization. Defendant had worked for The Christophers several years ago for a few weeks.

Concerned about the defendant's mental state and its effect on a disposition of this case, defense counsel and the assistant district attorney moved jointly, pursuant to CPL 390.20(3), for an order directing a prepleading examination of defendant's mental state.[1] The court appointed Hillel Bodek, M.S.W., C.S.W., a forensic clinical social worker, to conduct this examination on a longitudinal basis[2] at the Bellevue Hospital Psychiatric Prison Ward.

Mr. Bodek examined the defendant and submitted a report.[3] It concludes, inter alia, that at the time he engaged in his allowed criminal conduct, Mr. Scala was "suffering from a mental disease, to wit: paranoid schizophrenia in acute exacerbation, as a result of which he lacked the substantial capacity to know and appreciate the nature, consequences and wrongfulness of his behavior." After reviewing this report, the defendant indicated that he would interpose a defense pursuant to PL 30.05 of not responsible by reason of mental disease.[4]

The People moved pursuant to CPL 220.15(1)[5] for a hearing to examine Mr. Bodek with regard to his opinion of the defendant's mental state and criminal responsibility.[6] At the hearing, I qualified Mr. Bodek as an expert with regard to the issue of the defendant's lack of criminal responsibility by reason of mental disease.[7] Based on his testimony, the People indicated that they could not at trial disprove beyond a reasonable doubt the defense of not responsible by reason of mental disease.

After defendant's plea was accepted, he was committed in accordance with CPL 330.20(2) to the Commissioner of Mental Health for an examination of his current mental status. The defendant was examined by Beneb Ting, M.D. and Paul Chellappa, M.D., two psychiatrists designated by the Commissioner. They both opined that the defendant suffered from a dangerous mental disorder as defined in CPL 330.20(1)(c). Defense counsel then moved for an order authorizing an additional examination by a psychiatrist retained by the defense. That motion was granted on consent. The court, not being satisfied with the findings of the psychiatric examiners designated by the Commissioner of Mental Health, again appointed Hillel Bodek, M.S.W., C.S.W., as a psychiatric examiner, in accordance with CPL 330.20(15).[8] Mr. Bodek reexamined the defendant and filed another report with the court. He opined that the defendant suffered from a mental illness, as that term is defined in CPL 330.20(1)(d), but that he did not suffer from a dangerous mental disorder.

Pursuant to CPL 330.20(6), the court conducted an initial hearing. The People called Drs. Beneb Ting and Paul Chellappa. Each testified that the defendant suffered from a dangerous mental disorder. Defendant called his psychiatrist, Dr. Azariah Eshkenazi. He testified that although the defendant suffered from a mental disorder, he did not suffer from a dangerous mental disorder or require inpatient psychiatric treatment and could be released conditionally. The parties stipulated that the extensive report submitted by Mr. Bodek be received in evidence as an expert opinion.

At the conclusion of the hearing, the court found that the defendant did not currently suffer from a dangerous mental disorder but did currently suffer from a mental illness, as defined in CPL 330.20(1)(d).[9] Pursuant to CPL 330.20(7), the court issued an order of conditions and an order committing the defendant to the custody of the Commissioner of Mental Health under Article 9 of the Mental Hygiene Law.

The use of certified social workers to provide "psychiatric evidence" (CPL 250.10).

This first issue raises several considerations.

A. Whether certified clinical social workers[10] may examine defendants and provide psychiatric evidence depends on their qualifications and license.

(1) Qualifications

It is helpful in understanding the qualifications of a clinical social worker in performing these tasks to learn what such a social worker is supposed to be.

The National Registry of Health Care Providers in Clinical Social Work 1984-85, published by the Board of the National Registry of Health Care Providers in Clinical Social Work, adopts the definition of clinical social work composed by the National Federation of State Societies of Clinical Social Work:

"Clinical Social Work Practice includes the provision of mental health services for the diagnosis, treatment and prevention of mental and emotional disorders in individuals, families and groups. Clinical Social Work practice is based on knowledge and theory of psychosocial development, behavior, psychopathology, unconscious motivation, interpersonal relationships, and environmental stress. Treatment interventions include, but are not limited to, individual, marital, family and group psychotherapy." Id. at 2.

Illuminating this definition is the Registry's description of the education required for the practice of clinical social work.

"A Clinical Social Worker is an individual who has a Master's Degree from an accredited school of social work, and whose educational preparation includes a study of psychosocial development, normal behavior, psychopathology, unconscious motivation, interpersonal relations and the effects of environmental stress, physical illness and disability. Theoretical knowledge is specifically related to direct intervention with individuals, couples, families and small groups. A field practicum is required in order to integrate theory with practice. A minimum of two years supervised clinical work beyond the Master's Degree is required as preparation for clinical practice." Ibid. (emphasis added)

My former colleague, Benjamin Altman, J., has ruled in favor of the capacity of a certified social worker to testify as an expert with respect to a defendant's mental capacity to proceed. Dealing with the qualifications of such an expert to diagnose mental disorders, Justice Altman wrote in People v. Gans, 119 Misc2d 843, 844 (Sup. Ct. N.Y. County, 1983),

". . . [C]linical Social Work, as a profession, is one of the core mental health disciplines. As are psychiatrists and clinical psychologists, clinical social workers are skilled in the diagnosis and treatment of mental disorders. . . . [C]linical social workers, also nonmedical mental health professionals, bring their expertise in dealing with the relationship between social and emotional functioning as well as their expertise in social policy and in environmental intervention to the mental health field."

Properly trained clinical social workers are manifestly competent to diagnose mental disorders.

(2) Licensing

The Education Law provides for the licensure of certified social workers. Section 7701 of the Education Law defines practice as a certified social worker as, "engaging, under such title, in social casework, social group work, community organization, administration of a social work program, social work education, social work research, or any combination of these in accordance with social work principles and methods. The practice of social work is for the purpose of helping individuals, families, groups and communities to prevent or to resolve problems caused by social or emotional stress."

Chapter 893 of the Laws of 1977 added sections 162(first 16) and 253(8) to the Insurance Law. This legislation extended coverage of optional medical insurance to services rendered by qualified certified social workers. This coverage now embraces services of such social workers among the professionals who diagnose and treat mental, nervous and emotional disorders and ailments. The legislation contemplates the option of reimbursement for the services of such social workers when these services would have been reimbursable if provided by a psychiatrist or certified psychologist."

Clearly, the diagnosis and treatment of mental disorders by certified social workers in accordance with clinical social work principles and methods falls within the scope of their license.

B. May a certified social worker who is qualified testify to an opinion of a defendant's criminal responsibility?

(1) Status as a nonphysician

It has been established that a properly qualified person, although not a physician, may be sworn as a medical expert. See People v. Rice, 159 NY 400, 410 (1899); Matter of Boyle, 271 AD 614, 616 (4th Dept., 1947). "[A]nyone who is shown to have special knowledge and skill in diagnosing and treating human ailments is qualified to testify as an expert, if his learning and training show that he is qualified to give an opinion on the particular question at issue. . . . It is not essential that the witness be a medical practitioner." Jenkins v. United States, supra, at 644, quoting 32 C.J.S. Evidence section 537 (1942).

In determining whether a nonphysician is qualified to provide an opinion with regard to the mental status of a defendant, a sound principle applicable here was set forth in People v. Hawthorne, supra, 293 Mich. 15, 291 NW at 209:

"When a non-medic is offered as an expert on subjects in the orbit of medical science, the trial court is put on guard and should take greater precaution in the preliminary inquiry to determine the witness' qualifications and the extent of his knowledge than might be necessary when a graduate of a medical school is proposed. Yet it may well be that for some purposes, as where the issue concerns proper medical treatment, even a licensed physician would not possess sufficient knowledge in a particular branch of his calling to satisfy a trial judge who, within discretionary limits, insists upon a high standard of reliability. There is no magic in particular titles or degrees and, in our age of intense scientific specialization we might deny ourselves of the best knowledge available by a rule that would immutably fix the educational qualifications to a particular degree."

The enumeration of psychiatrists and, in some cases, psychologists in various statutes dealing with mental health expertise follows the historical progression that has developed nationwide concerning expert testimony on mental health issues. Originally, only physicians and psychiatrists provided testimony is such cases. However, over the past three decades courts have shwon an increasing willingness to accept the testimony of qualified clinical psychologists and, more recently, of qualified clinical social workers, as experts, with regard to mental health issues."

For instance, in relation to defendants' capacity to proceed—the forensic mental health issue arising most commonly in the criminal courts—under the present statutory framework set forth in CPL Article 730, the defendant must be examined by two qualified psychiatrists. The only exception was added when the former Code of Criminal Procedure [section 659] was replaced in 1971 by the Criminal Procedure Law [section 730.10(8), as originally enacted by L. 1970, Ch. 996; now CPL 730.10(7)]. In the case of a mental defective, a certified psychologist may be substituted for one of the qualified psychiatrists. See CPL 730.20(1).

Nonpsychiatrists not enumerated as psychiatric examiners under CPL Article 730 have, nevertheless, been permitted to testify as experts concerning the capacity of defendants to proceed. See People v. Gans, supra, at 846-47 (expert testimony by a clinical social worker) and People v. Burgess, 85 Misc2d 1057, 1058 (County Ct., Suffolk County, 1976) (expert testimony by a school psychologist and by a special educator).

Firm support of the view that properly qualified nonmedical mental health professionals could provide expert testimony as to a defendant's mental state relative to the issue of criminal responsibility was given by the United States Court of Appeals for the District of Columbia Circuit, in Jenkins v. United States, supra, at 645-46. There, the court held,

"The determination of a psychologist's competence to render an expert opinion based on his findings as to the presence or absence of mental disease or defect must depend upon the nature and extent of his knowledge. It does not depend upon his claim to the title 'psychologist.' . . . We hold only that th elack of a medical degree, and the lesser degree of responsibility for patient care which mental hospitals usually assign to psychologists, are not automatic disqualifications. Where relevant, these matters may be shown to affect the weight of their testimony, even though it be admitted in evidence. The critical factor in respect to admissibility is the actual experience of the witness and the probable probative value of his opinion. The trial judge should make a finding in respect to the individual qualifications of each challenged expert. Qualifications to express an opinion on a given topic are to be decided by the judge alone. The weight to be given any expert opinion admitted in evidence by the judge is exclusively for the jury."

See also Annotation, "Qualification of nonmedical psychologist to testify as to mental condition or competency," 78 ALR2d 908, 920-21 ("It appears, however, that the use of the psychologist in present society is growing and with this will come an increasing tendency to call him as an expert on the question of mental condition or competency.").

In 1965, the California Supreme Court held that, "The trial court erred in ruling that only one with medical training could testify on the issue [of the diagnosis of mental disorder and the defense of lack of criminal responsibility]." People v. Davis, 62 Cal2d 791, 799-801, (1965). Subsequently, in United States v. Riggleman, 411 F2d 1190, 1191 (4th Cir., 1969), the Court wrote,

"Riggleman urges and invites this court to adopt a rule that only a psychiatrist be permitted to testify as an expert on the question of an accused's responsibility for his acts. However, we think the better rule is that the determination of a psychologist's competence to render an expert opinion based on his findings as to the presence or absence of mental disease or defect must depend upon the nature and extent of his knowledge; it does not depend upon his claim to the title of psychologist or psychiatrist."

In People v. Diaz, 51 NY2d 841 (1980), over a vigorous dissent by Meyer, J. (in which he was joined by Fuchsberg, J.), the Court found no error in the refusal to accept testimony of an experienced, though not certified, psychologist concerning his interpretation of tests he had administered because his expertise in such interpretation had not been established. Yet, the court cautioned that, "[t]his is not to say that only a psychiatrist may testify in this regard." 51 NY2d at 842-43.

Prior to the implementation of the Insanity Defense Reform Act of 1980 (L. 1980, Ch. 548), CPL 330.20 enumerated only psychiatrists as examiners to aid in determining the release of a defendant acquitted by reason of mental disease or defect. Nevertheless, the testimony of clinical psychologists was admitted in this area when it was determined that they had the necessary training and qualifications to give expert opinions regarding the mental status of defendants. Of course, the Insanity Defense Reform Act of 1980 expanded the category of psychiatric examiners to include certified psychologists, CPL 330.20(1)(f) (defining such persons as "licensed"; but see CPL 730.10(6)).

(2) Omission of certified social workers from statutory enumeration

CPL 250.10(1)(a) defines "psychiatric evidence" as "evidence of mental disease or defect to be offered by the defendant in connection with the affirmative defense of lack of criminal responsibility by reason of mental disease or defect." The statute does not limit "psychiatric evidence" to the opinions of psychiatrists and psychologists. CPL 60.55 sets forth rules of evidence relating to "psychiatric testimony."

EXHIBIT 11
DATE 2-18-91
HB 666



It is clear that although psychiatrists (and, since 1980, psychologists) have been enumerated in statues relating to the insanity defense, psychiatric evidence cannot be limited to the testimony of experts from these disciplines alone. Otherwise, for instance, the expert testimony of a neurologist as to a defendant's mental condition caused by a neurological ailment would be excluded, and no neurologist could be appointed to examine such a defendant relative to the issue of criminal responsibility. The opinion of anyone who is qualified as an expert in mental disorders may be received as the sole "psychiatric evidence" in a particular case, even if the expert is neither a psychiatrist nor a psychologist. Though they are not enumerated under CPL 250.10 and CPL 60.55, properly qualified certified social workers, nonpsychiatric physicians and other properly qualified licensed nonphysician mental health professionals not otherwise excluded by statute may be appointed to examine persons with regard to the issue of the affirmative defense of lack of criminal responsibility due to mental disease or defect.

**C. What weight is to be accorded to the opinion of a certified clinical social worker?**

It has been well established that the determination of the competence of a nonmedical mental health professional to render an expert opinion depends on the nature and extent of his knowledge. It does not depend on his professional title or discipline. See Jenkins v. United States, supra, at 645. The opinion of a nonmedical mental health expert is not, in and of itself, outweighed by the contrary opinion of a psychiatrist. See In Interest of C.L.M., 625 SW2d 613, 615 (Mo., en banc, 1981). The weight to be accorded to the opinion of either expert must depend on the thoroughness of the investigation, the persuasiveness of the opinion and the training, experience and professional demeanor of the witness."

To summarize: Even though not enumerated under CPL 250.10 and CPL 60.55, properly qualified certified social workers may be appointed to examine defendants for the purpose of rendering opinions as to their mental condition with regard to the affirmative defense of lack of criminal responsibility by reason of mental disease or defect. They may provide expert opinions that may serve as the sole "psychiatric evidence" in relation to such affirmative defense. The weight to be accorded to the testimony of any forensic mental health expert is within the province of the trier of fact. This weight is unrelated to the particular professional discipline of the expert. Rather, it depends upon the assessment of the training and professional experience of the expert, the nature, extent and thoroughness of the examination and evaluation, the reasonableness and persuasiveness of the conclusion or opinion the logic with which it is derived and the demeanor of the expert as a witness.

**The use of certified social workers as psychatric examiners in relation to the determination of current mental status and current dangerousness pursuant to CPL 330.20(15)**

CPL 330.20(1)(s) defines a, "psychiatric examiner" for the purposes of CPL 330.20 as, "a qualified psychiatrist or a licensed psychologist *who has been designated by the commissioner* to examiner a defendant pursuant to this section, and such designee need not be an employee of the department of mental hygiene." (emphasis added). CPL 330.20(15) entitled, "Designation of psychatric examiners," establishes two classes of "psychiatric examiners," those designated by the commissioner, and those who may be designated by the court or by a party, rather than by the commissioner. That section provides, "*In addition, the court may* on its own motion, or upon the request of a party, may [sic] *designate one or more psychiatric examiners* to examine the defendant and submit a report of their findings. The district attorney may apply to the court for an order directing that the defendant submit to an examination *by a psychiatric examiner designated by the district attorney*, and such psychiatric examiner may testify at the hearing." (emphasis added).

It is clear that CPL 330.20(15) distinguishes between psychiatric examiners defined in CPL 330.20(1)(s) who are designated by the commissioner and those designated by the court or by one of the parties. Although a psychiatric examiner designated by the commissioner must be either a qualified psychiatrist or a certified psychologist, the statute places no such definitional limitation on a psychiatric examiner designated by the court, by the defense, by the People or by another part (e.g., the Mental Health Information Service).

It is reasonable that the commissioner have strict guidelines for the appointment of examiners form among the numerous persons of varying levels of skill who are in the employ of his department (either as employees or consultants). Yet, there is no reason for such a limitation on the court or a party which, unlike the commissioner, can personally take the time to screen and obtain qualified experts from among a wide pool of mental health professionals.

Though they are not specifically enumerated in the statute, properly qualified certified social workers and psychiatric nurses have been permitted to provide expert testimony as to the current mental status and future prognosis of persons who have been charged with criminal offenses but acquitted by reason of insanity. See Mater of Torsney, 66 A.D. 2d 281, 290, 294 (2d Dept., 1979), *reversed on other grounds*, 47 N.Y. 2d 667, 679 (1979). A similar approach has obtained appellate approval in Colorado. See People v. Giles, 557 P2d 408, 413-14 (Col., 1976). Prior to the 1980 revision of CPL 330.20, only psychiatrists were enumerated in the current revision of CPL 330.20, had been accepted, as expert, with regard to these determinations. See Torsney, supra, 66 A.D. 2d at 289-94, 47 N.Y. 2d at 677-681.

Additionally, the regulations of the Commissioner of the Office of Mental Health issued pursuant to the 1980 revision of CPL 330.20 provide that certified social workers may serve on the institutional forensic committees which must review all requests for release, furlough and transfer of individuals coming under CPL 330.20. See 14 NYCRR section 541.3. In doing so, they serve on an equal basis with psychiatrists. There is no rational basis for finding that certified social workers, as part of an institutional forensic committee, are qualified to evaluate the mental state and need for treatment of a 330.20 patient once he is committed to the Commissioner, yet are not qualified to make the same assessment at an initial hearing pursuant to CPL 330.20(6)-(7) as an expert retained by the court, the People, the defense or another party.

Accordingly, I hold that a properly qualified certified social worker may be appointed to act as a "psychiatric examiner" appointed by the court, the defense, the People or a party other than the commissioner, pursuant to CPL 330.20(15).

Clinical social workers, who provide the majority of the psychotherapeutic services rendered in the United States (see "Social Workers Vault into a Leading Role in Psychotherapy," N.Y. Times, Section C, Page 1, April 30, 1985) are particularly suited to be of assistance to the courts in resolving clinical—legal issues and in facilitating the effective administration of individualized justice in cases where issues relating to psychosocial dysfunction and mental disorders are involved."

In his Memorandum approving Chapter 990 of the Laws of 1984, Governor Cuomo noted, "The bill recognizes the important role played by certified social workers in providing mental health care and eliminates unfair and unwarranted discrimination against these qualified professionals. The bill will, moreover, maximize client choice in the purchase of mental health services and increase access to mental health care.'" Indeed, during the past several years, the administration of criminal justice has been substantially enriched in this jurisdiction by the participation of Hillel Bodek, M.S.W., C.S.W., a dedicated and talented forensic clinical social worker. Participation in the court system by such forensic clinical social workers should be encouraged and facilitated.

---

(1) The court may order a prepleading mental health and physical examination of a defendant and a prepleading investigating by the Department of Probation to provide material that would reasonably aid in the administration of justice by facilitating the plea bargaining process. People v. Crosby, 87 Misc. 2d 1079, 1080 (Sup. Ct. Bronx County, 1976).

EXHIBIT 11
DATE 2-18-91
6666



(2) Effective plea negotiations depended heavily on a comprehensive evaluation of the defendant's mental state. This evaluation, unlike an examination pursuant to CPL Article 730 (which focuses on the issue of the defendant's competence to proceed), required a more extensive process including observations of the defendant's behavior and psychosocial functioning over a period of time ("longitudinal evaluation"). CPL 390.30(2) authorizes the court to remand a defendant for a thirty day period to a designated facility for the purpose of such a thorough examination. This statutory authorization, thus, contemplates examinations on a longitudinal basis.

(3) The report includes detailed reviews of the defendant's history and prior mental health records. It gives the results of a battery of psychodiagnostic tests, a complete mental status examination and interviews with the defendant's family. It ends with an assessment of the defendant's mental functioning.

(4) Chapter 668 of the Laws of 1984, effective November 1, 1984, repealed section 30.05 of the Penal Law and added a new section, 40.15 of the Penal Law. This changed the nature of lack of criminal responsibility by reason of mental disease or defect from a defense to an affirmative defense. However, the case at bar arose prior to the effective date of the new statute and is controlled by PL 30.05. This change has no effect on the issues now under consideration.

(5) CPL 220.15(1) provides that such a plea may be entered with the permission of the court and the consent of the People. This statute permits the acceptance of this defense by plea, without the need for a trial (formerly required), when the People, the defense and the court agree that a defendant lacks criminal responsibility because of mental disease or defect.

(6) Because this opinion was rendered by a certified social worker rather than a qualified psychiatrist or certified psychologist, there arose the first issue mentioned earlier.

(7) In doing so, I applied the following criteria:

(A) The proposed expert should be licensed as a certified social worker pursuant to Article 154 of the Education Law and deemed qualified pursuant to the provisions of Chapter 893 of the Laws of 1977 as eligible for medical insurance reimbursement (see footnote 11, infra).

(B) The certified social worker should have completed a clinical core curriculum or its equivalent during graduate training (not all social workers specialize in clinical work and, therefore, not all social workers have completed such coursework).

(C) The expert should have completed at least five, fifteen semester hour courses, or their equivalent, of postgraduate training in clinical social work. This criterion is based on the standard established by the New York State Society of Clinical Social Work Psychotherapists for advancement to Fellow status in that organization.

(D) The social worker should be certified by the National Registry of Health Care Providers in Clinical Social Work or by the National Association of Social Workers Clinical Register. Under this criterion, certification by the Academy of Certified Social Workers (ACSW), which is a certification of general rather than clinical social work competence, does not suffice.

(E) The clinical social worker's training and experience should include the prior performance of forensic mental health evaluations under supervision.

(8) At this point, because Mr. Bodek is neither a psychiatrist nor a certified psychologist, there arose the second issue mentioned earlier.

(9) This finding under the statute means that he "currently suffers from a mental illness for which care and treatment as a patient, in the inpatient services of a psychiatric center under the jurisdiction of the state office of mental health, is essential to [his] welfare and that his judgment is so impaired that he is unable to understand the need for such care and treatment. . . ." CPL 330.20(1)(d).

(10) Although many certified social workers provide direct services to clients, not all certified social workers possess the graduate and postgraduate education and supervised experience necessary to be properly considered clinical social workers (see criteria A-D set forth in footnote 7, supra). Cf. Jenkins v. United States, 307 F2d 637, 644045 (DC Cir., en banc, 1962) (distinguishing between psychologists in general and clinical psychologists in particular). Only individuals who meet such criteria should be deemed competent to render expert opinions, as certified social workers, of a persons's mental state. Cf. People v. Hawthorne, 293 Mich. 15, 291 NW 205, 209 (1940) (concurring opinion). These professionals are hereinafter sometimes referred to as clinical social workers.

(11) Certified social workers contemplated by sections 162 (first 16) and 253(8) of the Insurance Law must have, inter alia, three years of full-time supervised postgraduate experience in the provision of psychotherapy services. During the pendency of this case, the Insurance Law was amended by L. 1984, Ch. 990, to add sections 162(19) and 253(11). The amendment provided for mandatory medical insurance reimbursement for services in the diagnosis and treatment of mental disorders rendered by certified social workers with six years of such experience if the insurance policy provides for reimbursement for those services when provided by a psychiatrist or certified psychologist.

(12) See Barton E. Bernstein, "The Social Worker as a Courtroom Witness," Social Casework, November, 1975, p. 521-25, and Barton E. Bernstein, "The Social Worker as an Expert Witness," Social Casework, July, 1977, p. 412-17.

(13) See Mental Disability Law Reporter, Vol. 4, No. 3, p. 196, May-June, 1980, reporting the result of a comparative study of the performance of forensic psychiatrists, psychologists and social workers.

(14) Effective mental health intervention often enables the criminal justice system to dispense effectively the individualizes justice set forth as an ideal in People v. Selikoff, 35 N.Y. 2d 227, 233-34 (1974). To be effective, such mental health intervention requires a combination of clinical skills and ability to negotiate social systems. This combination is unique to clinical social work among the various mental health professions.

(15) See "Affordable Mental Health," New York Times, July 13, 1984, Editorial Page and "Mental Health for Flatbush, Too," New York Times, January 2, 1985, Editorial Page.

EXHIBIT 12
DATE 2-18-91
HB 666

Testimony on HB 666
An Act Providing that
An Examination to Determine the Mental Condition
of a Person Accused of a Crime May be Conducted
by a Licensed Social Worker

February 18, 1991

Madame Chair, members of the Committee, I am Judith H. Carlson, licensed social worker, representing the Mt Chapter, National Association of Social Workers.

This bill will make the criminal section of the code conform to the civil section with respect to examination of the mental condition of people. In the civil section, for commitments for mental illness, psychiatrists, psychologists, and social workers are all potential "expert witnesses." This adds the words "licensed social worker" to those sections of the law having to do with criminal trials.

The question is: are licensed social workers qualified to examine and assess the mental condition of a person? The answer is: often. Not all licensed social workers are practicing in the field of psychotherapy. For example, I don't. Thus, no attorney would call on me to be an expert witness on a person's mental condition. But many social workers do practice every day in the field of psychotherapy and ARE qualified.

Chapter 37-22-301 MCA states the license requirements:

1. pass an examination;
2. present letters of references;
3. have a doctorate or master's degree in social work from a program accredited by the council on social work education or approved by the board;
4. have 3000 hours of postdegree work experience in psychotherapy within the past 5 years; and
5. abide by the social work ethical standards in 37-22-201.

The master's degree in social work is a two year post-graduate program combining classroom education as well as field work (internship.) The 3000 hours required come after the MSW is received.

Making this law change does not mean that all licensed social workers will automatically become expert witnesses. Rather it is a signal to attorneys that they might look to social workers as possible experts. It will still be up to the Courts to decide whether an specific person is so qualified. It seems only right to make this section of the code consistent with the civil sections. Please give HB 666 a "do pass" nod. Thank you very much.

Judith H. Carlson, ACSW, LSW

EXHIBIT 15
DATE 2-18-91
HB 666

# MONTANA MENTAL HEALTH COUNSELORS ASSOCIATION

MMHCA

(RE: HB 666)

COMPETENT AND COST EFFECTIVE EVALUATION OF THE MENTAL CONDITION OF CRIMINALS IN MONTANA COURTS TO INCLUDE L.P.C.'s and L.S.W.'s

Testimony Before MT Legislature, 02/18/91
By: Hank Winters Ph.D. Candid.,L.P.C

By amending HB 666 to include Licensed Professional Counselors (L.P.C.'s),with L.S.W's, the MT legislature has one more positive opportunity to save the tax payers significant money-and at the same time provide needed competent mental health clinical assessment services to the community, Courts and law enforcement.

1). L.P.C.'s by law have a broad degree of training and experience in the process of clinical assessment of individual psychopathology, and treatment evaluation and planning.

As a practicing L.P.C. and mental health professional for the past twenty five years, and as Director of the Mental Health Center in Ravalli County, among other programs, I have had the privilege of supervising both psychologists and Lic. Social Workers, and L.P.C.'s.

I have seen that many in all these professions who are competent to assess the mental condition of clients and criminals. Also, many do not wish (or feel competent) to clinically evaluate criminals.

Accredited graduate programs in counseling, counseling psychology, (as do LSW programs) require a solid basis in clinical evaluation--and this is a core of all L.P.C.'s training for daily work with clients. Providing sound clinical assessment is the foundation of a treatment plan, and is based on a differential diagnosis- using the valuative techniques and protocol to assess the mental condition of client, patient or accused criminal.

2). L.P.C.'s and Lic. Social Workers have the same licensing Board. The educational and experiential requirements of the two disciplines are very similar, and the strict Code of Ethics for both disciplines are essentially the same and strictly adhered to by both.

If any particular licensee does not feel competent, or is not competent to preform a certain function, then that individual may not perform same. This is monitored by the profession as well as the Lic. Board.

This applies to this particular bill- and by amending this bill to include L.P.C.'s, the legislature is expanding the possible pool of experienced and trained clinical evaluators to further save tax payer's money-- and provide needed services at reduced costs to the State and Counties.

EXHIBIT 15
2-18-91
HB Celele

3). Precedent has already been set for the inclusion of L.P.C.'s into this bill. L.P.C's provide all sorts of expert witness to the MT court system, form involuntary mental health commitments, child custody cases, to criminal cases. All across the state, from Billings, Bozeman, to Missoula, Helena, Miles City,Butte and Kalispell, and all the rural ares in between. Most recently a tragic case, known to you all, of murder of a youth's father, by the youth, was evaluated not by a psychiatrist, but by a Licensed Professional Counselor, Dr. Kedric Cecil, L.P.C.

4). It is economically prudent to amend HB 666 now instead of later, to include L.P.C.'s and L.S.W.'s as both the need and cost effectiveness is well established.

Both disciplines (L.S.W.'s &L.P.C.'s) are competent, well trained, and dedicated to providing the most helpful and cost effective services to the citizens of Montana-- this has been well documented.

Research in trends in the mental health profession has shown a significant decline in diagnostic testing even among Licensed Clinical Psychologists. New roles and interests in doing counseling or psychotherapy are given as several possible reasons for this decline. Also, there is more emphasis on Clinical Assessment, which is broader in scope and is relevant to the training and experience of L.P.C.'s, and L.S.W.'s.

5). There is a great need for additional clinical expertise and pool of experts such as L.P.C.'s and L.S.W's- especially in rural communities.

A recent survey shows that Montana has increased from being ninth in the nation in suicide rates to sixth place. Many homicides and accidents are often masked suicides. There is a need for <u>timely</u> clinical assessment of the mental state of criminals as soon as possible in and close to the community. This not only saves significant tax and private money, but provides more valid data and results to the Court System.

Most major cities have similar numbers of mental health professionals. However there is a significant need in smaller and rural communities. 48% of rural communities have only by L.P.C.'s., and 33% of rural communities only by L.S.W.'s.

The remainder of rural communities are served largely by both L.P.C.'s and L.S.W.'s only. L.P.C.'s are in the majority of mental health providers in 56% of the larger and "urban" cities in MT.

Therefore, there is a need for the addition of both of these fine disciplines to competently assess the mental condition of criminals in the State of MT. HB 666 must be amended to include Licensed Professional Counselors.

EXHIBIT 14
DATE 2-18-91
HB 666

**Susan J. Sachsenmaier, Ph.D**
**Forensic Consultation in Mental Health**
**625 North Henry**
**Butte, Montana 59701**

February 18, 1991

TO: Members of the Montana State Legislature

RE: HB666, granting parity to licensed social workers with licensed clinical psychologists and psychiatrists in determinations of criminal responsibility and competency to stand trial.

HB666 seeks to grant licensed social workers the legal authority to submit clinical determinations of criminal sanity at the time of the alleged crime and criminal competency to stand trial to the courts. This action is unprecedented throughout the 50 states and in the federal government. Its initiation would prove disastrous to criminal justice proceedings.

I will explain why. I speak as a doctor of the philosophy of clinical psychology, with five years of practice in the specialty area of forensic clinical psychology, during which time I have performed approximately 400 forensic clinical evaluations of court-referred criminal defendants. I have recently reviewed the professional literature in this area from the viewpoints of the mental health practioners, the legal practioners, and the policy makers. I have conducted substantial independent research into the determinations of criminal responsibility and competency to stand trial, and I am familiar with the research of other experts in the clinical/legal arena. I am a member of the Montana Psychological Association, the American Psychological Association, and of the Psychology/Law division of the American Psychological Association. It is my greatest concern that the quality of psychological and psychiatric evaluations performed to facilitate legal proceedings be maintained at the highest standards possible.

The consequences of expert witness testimony in a criminal case on an individual's life can be severe and even fatal. Invalid or unreliable testimony affects not only the individual defendant, but also those with whom the individual interacts, and ultimately, the State itself. A typical court order for psychological or psychiatric examination of a criminal defendant stipulates, (1) The report of the examination shall include the following:

(a) a description of the nature of the examination;
(b) a diagnosis of the mental condition of the defendant;
(c) if the defendant suffers from a mental disease or defect, an opinion as to his capacity to understand the proceedings against him and to assist in his own defense; and
(d) when directed by the court, an opinion as to the capacity of the defendant to have a particular state of mind which is an element of the offense charged.

(2) If the examination cannot be conducted by reason of the unwillingness of the defendant to participate therein, the report shall so state and shall include, if possible, an opinion as to whether the unwillingness of the defendant was the result of mental disease or defect (MCA 46-14-203).

A mental status examination is typically conducted for the purpose of establishing an intake diagnosis. It is performed by a psychiatrist or a clinical psychologist during an interview. A mental status examination gathers data regarding the person's orientation, attention and concentration, judgement and comprehension, perception and coordination, thought processes, ability to reason abstractly and fund of general knowledge, recent and remote memory, insight, and future goals.

A diagnosis alone does not indicate whether or not an individual is competent. There is a relationship between diagnosis and competency, but it is not a causal link. One might suspect that a person with the diagnosis 'Schizophrenia, Paranoid type, Chronic' is likely to be incompetent, but it is impossible to know for sure. Some schizophrenic people are incompetent and others are not; some are incompetent only when not taking their prescribed medication; some are incompetent only when using alcohol or other drugs; some are incompetent only when confronted by overwhelming stress. Clearly, the establishment of a diagnosis is not sufficient determination of competency.

In addition to the mental status examination, the interview is used to gather other important information about the individual being evaluated. Personal and family history, presenting psychopathological symptoms, behavioral and emotional approach to the situation, knowledge of the legal proceedings against him/her, and ability to aid in one's own defense, are essential data that can be gained.

We carefully study all impressions obtained during the interviews in light of the data revealed by a standardized battery of psychological tests. This testing provides the substantive basis upon which the interview data can be validly interpreted. I will briefly outline here the reasons why psychological testing is essential to a valid and reliable competency determination:

1. Many people are extraordinarily successful at presenting a deceptive picture of themselves and of their motivations during an interview. Simply put, people lie. Some court-ordered admissions would like us to believe they are psychotic and incompetent when they are not. A person with an antisocial personality disorder can be adept at creating false impressions in an attempt to escape sentencing at Montana State Prison. Some psychotic patients try very hard to convince us (and themselves) that they are not psychotic. Testing offers a more objective assessment than interviewing alone.

2. There are standardized psychological tests, such as the MMPI, which have validity scales designed to elucidate the exaggeration of symptoms by the testee or the attempt to cover up symptoms. When the validity scales indicate that the person attempted to manipulate the results of the test, it is likely that the person also attempted to manipulate the evaluator's impression of him/her during the interview.

3. Utilization of a formal psychological test battery allows the standardization of assessment between different interviewers. A valid and reliable assessment is one that different evaluators could achieve consensus on. As the final determination becomes based more on standardized testing and less on individual impression, the greater the liklihood of consensus among professionals. This is very important in light of the many criminal cases which are appealed and more than one expert is asked to testify.

4. Testing allows the evaluator to elicit patient responses to both structured and unstructured stimuli. Psychosis may show up in one area and not the other.

5. There is information available from testing which is not available from a person's performance during an interview. There are certain indications during testing of subtle aspects of a person's perceptual and response style which help to predict the probability of future behavior. For example, indicators of impulsivity make the probability of future occurences of dangerous behavior more likely than if no such indicators were revealed.

6. An important factor in a competency determination is testing an individual's Intelligence Quotient. A person need not be insane to be incompetent to stand trial. An individual who lacks the intelligence to have knowingly or purposely performed the act with which he/she is charged is considered legally incompetent. A person's IQ can be accurately determined only through formal testing.

7. Testing provides an opportunity to measure how a person

EXHIBIT 7
DATE 2-18-91
HB 666

responds to the stress of being tested. For example, psychosis can be revealed through a person's inability to cope with timed items, but may not show up on less stressful tasks.

8. Another important component to competency determinations is the consideration of organic brain damage in the person being evaluated. Only gross organicity is apparent on interview, and some criminally charged persons attempt to fake brain damage. Formal testing is a reliable way to assess the presence of organic brain damage.

14
DATE 2-18-91
HB CeCeCe

Other clinical psychologists working in forensic environments could no doubt offer more reasons than these for the necessity of psychological testing in determining competency issues. However, I hope I have impressed upon the reader the importance of maintaining the highest possible standards among those professionals granted authority by the State to provide expert witness testimony in criminal proceedings. The profession of Social Work does not train its graduates in psychological testing and interpretation. Neither are 'certified mental health professional persons' trained in diagnostic testing and interpretation. I believe that a competency determination based on interview data only, without the substantiation of objective data made possible through the use of a standardized test battery, would be substandard and open to the bias of individual misperception. Were this to be allowed by the State, it would not be long before the courts would make a mockery of expert witness testimony regarding competency.

***VOTE AGAINST HB 666

402[b][1984]; cited in Melton et al., 1987, p. 125). There are two major approaches to this issue. In the first, the courts stand primarily on the premise that just as an unlawful act is an element of every crime, so is sanity an element of every crime. And just as the prosecution must prove that the crime was committed, so must the prosecution prove "beyond a reasonable doubt" that the defendant was sane at the time (about 1/3 of the states follow this approach). In the second approach, the burden of proof is placed on the defendant to prove "by a preponderance of the evidence" (about 2/3 of the states) or by "clear and convincing evidence" (Arizona and the federal courts) that he or she was insane at the time of the offense (Melton et al., 1987). The State of Montana follows the first approach. A more detailed look at Montana statutes regarding the insanity defense is presented next.

Montana law. In Montana, the State retains the burden of proving each element of the offense beyond a reasonable doubt. The two necessary elements of the criminal offense are (a) a voluntary act, and (b) a mental state meeting the definitions of knowingly, purposely, or negligently (MCA 45-2-103). In 1979 the subsection of the law that provided for acquittal if "at the time of the conduct a mental disease or defect resulted in inability to either appreciate the criminality of one's conduct or to conform one's conduct to the requirements of law" was deleted (MCA 46-14-101, p.232).

Notice that Montana had already rejected the "substantial impairment" doctrine for one of "inability." The new Montana standard was introduced by the Honorable Michael Keedy, then a legislator and now a district judge (Nash and Sachsenmaier, 1990). Current statutes exclude "repeated criminal or other antisocial conduct" from the realm of mental disease or defect (MCA 46-14-101); and "A person who is in an intoxicated or drugged condition is criminally responsible for conduct unless such condition is involuntarily produced and deprives him of his capacity to appreciate the criminality of his conduct or to conform his conduct to the requirements of the law...." (MCA 45-2-203). The law further provides that evidence of mental disease or defect is permissible in criminal proceedings to prove state of mind, which is an element of the offense charged (MCA 46-14-102). It is specified that a person's state of mind at the time of the offense must have resulted in a criminal act which was performed knowingly, purposely, or negligently (45-2-101).

These elements of mental status deal with intent, which is subsumed by the *mens rea* (culpability) inquiry. The ALI's Model Penal Code attempts to simplify the *mens rea* inquiry by defining four components, in descending degree of culpability:

1. "purpose," when the criminal conduct is the offender's conscious object;

2. "knowledge," when the offender is aware of the circumstances that make the conduct criminal;

3. "recklessness," when the offender "consciously disregards a substantial and unjustifiable risk" that the conduct will produce a given result; and

4. "negligence," when the offender "should be aware of a substantial and unjustifiable risk" that the conduct will produce a given result (Model Penal Code 2.02 [Official Draft 1962]; cited in Melton et al., 1987, p.127).

Montana statutes are based on the ALI criteria but are more specific:

1. "Purposely"- a person acts purposely with respect to a result or to conduct described by a statute defining an offense if it is his conscious object to engage in that conduct or to cause that result. When a particular purpose is an element of an offense, the element is established although such purpose is conditional, unless the condition negatives the harm or evil sought to be prevented by the law defining the offense. Equivalent terms such as "purposely" and "with purpose" have the same meaning [45-2-101 (58)].

2. "Knowingly"- a person acts knowingly with respect to conduct or to circumstance described by a statute defining an offense when he is aware of his conduct or that the situation exists. A person acts knowingly with respect to the result of conduct described by a statute defining an offense when he is aware that it is highly probable that such result will be caused by his conduct. When knowledge of the existence of a particular fact is an element of the offense, such knowledge is established if a person is aware of a high probability of its existence. Equivalent terms such as "knowingly" or "with knowledge" have the same meaning [45-2-101 (33)].

3. "Negligently"- a person acts negligently with respect to a result or to circumstance described by a statute defining an offense when he consciously disregards a risk that the result will occur or that the circumstance exists or when he disregards a risk of which he should be aware that the result will occur or that the circumstance exists. The risk must be of such a nature and

> degree that to disregard it involves a gross deviation from the standard of conduct that a reasonable person would observe in the actor's situation. "Gross deviation" means a deviation that is considerably greater than lack of ordinary care. Relevant terms such as "negligent" and "with negligence" have the same meaning [45-2-101 (37)].

Another necessary definition for the forensic examiner to be aware of is that of mentally defective:

> 4. "Mentally defective" means that a person suffers from a mental disease or defect which renders him incapable of appreciating the nature of his conduct [45-2-101 (34)].

Thus, if due to a mental disease or defect, a person was unable to form the requisite state of mind, which is an element of the offense charged, that person may not be held criminally responsible for his or her actions. It becomes more and more clear that the psychological assessment of mental status at the time of the offense, especially when the examination takes place long after the offense occurred, is a complicated task upon which the outcome of a criminal proceeding may depend, and thus the future of a person's life. It is for this reason that forensic examinations must adhere to the highest professional standards, both technical and ethical.

Montana's abolition of the traditional insanity defense was challenged in court almost immediately. A Viet Nam veteran accused of attempted deliberate homicide and aggravated assault contended that Montana's statutory scheme

violated the Due Process Clause of the 14th amendment. The "defendant claimed that the traditional insanity defense was so firmly embedded in the common law that it was a fundamental right" (MCA 46-14-102 Case Notes, p. 234, 235) The Montana Supreme Court ruled against him (*St. v. Korell*, 213 M 316, 690 P2d 992, 41 St. Rep. 2141[1984]) and the state's new *mens rea* doctrine stood firm.

Competency to stand trial. The 1979 modification also addressed the defendant's competency to proceed to trial (46-14-103), using the standard set forth in *Dusky v. United States* (362 U.S. 402, 1960). The standard has two main parts: The defendant must have (a) a rational as well as factual understanding of the charges against him or her, and (b) the capacity to rationally assist his or her attorney with the defense. If the defendant does not meet this standard, a trial on the charges cannot be held. Evidence of mental disease or defect may be introduced pretrial to determine competency to proceed to trial (MCA 46-14-103, 46-14-221). If this finding is contested a hearing may be held, but not a jury trial. If a finding of Incompetent to Stand Trial is upheld, criminal proceedings must be suspended until fitness is regained, and the defendant remanded to the state hospital for treatment (MCA 46-14-202). The court requires a review of the defendant's fitness to proceed within 90 days; if fitness is regained, criminal proceedings may continue; but if it appears that

fitness will not be regained "within the reasonable foreseeable future, the proceeding against him shall be dismissed" (MCA 46-14-202). At that point, the county attorney may petition the court under civil commitment statutes (MCA Chapter 53) for involuntary commitment due to serious mental illness resulting in recent or imminent dangerousness to self or others. If the defendant does regain fitness and goes to trial, evidence of mental disease or defect may be considered at the guilt determination phase and again at the sentencing phase. A defendant with proven mental disease or defect may be sentenced to the state hospital rather than to the state prison (MCA Chapter 46).

Historically, the idea that a person must be competent to undergo trial originated in 17th century common law with the requirement that the defendant enter a plea to the charge before being tried. American courts adopted the same principle (Harvard Law Review, 1967). The man who attempted to assassinate President Andrew Jackson was found unfit to stand trial in 1835 (*United States v. Lawrence,* 26 F. Cas. 887 [D.C. Cir. 1835]). The concept was given constitutional status in 1899 under the Due Process Clause of the 14th amendment (*Youtsey v. United States,* 97 F. 937, 940-41 [6th Cir. 1899]). Blackstone, a prominent legal scholar of the early 20th century, noted that if a defendant

> becomes mad, he ought not to be arraigned for it; because he is not able to plead to it with that advice and caution that he ought. And if, after he has pleaded, the prisoner becomes mad, he shall

> not be tried; for how can he make his defense? (Blackstone, 1916, Commentaries on the Law of England; cited in Melton et al., 1987, p. 66).

The concept of competency to stand trial is rooted in the basic idea that an adversarial process should be fair to both parties; thus in the 1960s the U.S. Supreme Court handed down its well-known decisions that guaranteed certain rights to the defendant, including the right to counsel, the right to confront their accuser, and the right to introduce witnesses in their own behalf (Melton et al., 1987).

Typically, it is the defense counsel who raises the issue of a defendant's competency to stand trial; however, some jurisdictions allow the issue to be raised also by the prosecution or by the court. The American Psychiatric Association and the American Bar Association both advise that examiners have an ethical obligation not to perform an evaluation until defense counsel has been appointed (American Psychiatric Association, The Principles of Medical Ethics, with Annotations Especially Applicable to Psychiatry, 1981; and American Bar Association, Criminal Justice Mental Health Standards, 1984; both cited in Melton et al., 1987; and Harvard Law Review, 1967). An examination performed without the knowledge of defense counsel may violate the defendant's constitutional rights to counsel and to avoid self-incrimination. The clinician must also bear in mind that the examiner's role is only to provide a clinical opinion; the actual decision is made by the triers

of fact. This has been clearly delimited since 1957 when one federal court of appeals opined

> [T]he chief value of an expert's testimony in this field, as in all other fields, rests upon the material from which his opinion is fashioned and the reasoning by which he progresses from his material to his conclusion....The conclusions, the inferences, from the facts, are for the trier of the facts (*Carter v. United States,* 252 F. 2d 608, 617-18 [D.C. Cir. 1957]; cited in Melton et al., 1987, p. 72).

In practice, many courts defer to the clinical opinion and, just as with pleas of insanity, hearings are often not held; the parties simply stipulate to the results of the clinical evaluation. Studies have shown clinical-legal agreement to be greater than 90% in most jurisdictions (Harvard Medical School Laboratory of Community Psychiatry, 1973; Melton et al., 1987). This finding is important to the methodology utilized in the current study in that it was deemed appropriate to use the clinical opinion as the measure of the dependent variable, without also obtaining the legal decision.

Frequency of competency evaluations. Data show that referrals for restoration of competency to stand trial or for evaluation of competency to stand trial are by far the most frequent for the forensic clinician (Melton et al., 1987). According to a study by Cooke, Johnston, and Pogeny (1973), however, referrals are often based on some legal strategy other than desire for a mental status exam. Hence, referral rates tend to be higher for more serious crimes but

do not reflect more serious psychopathology. In Montana, the referral for competency and for insanity is generally part of the same court order (MCA 46-14-203), but need not necessarily be so. Overall, the percentage of those referred who are found incompetent may be around 10. Data are difficult to interpret due to (a) a lack of standards in evaluation, (b) a lack of specialized training provided to examiners, and to (c) inappropriate referrals by uninformed or manipulative attorneys, who ask for an incompetency exam but want to use the results for another purpose (Melton et al., 1987; Cooke et al., 1973). To counteract these inconsistencies, and to improve the communication and relationship between two diverse disciplines--mental health and law--the Harvard Medical School Laboratory of Community Psychiatry undertook the task of developing the Competency Assessment Instrument, which is described in the next section of this paper.

Innovative Psychological Assessment Techniques

This section will describe nontraditional psychological assessment tools developed specifically to assist the forensic clinician in determining criminal responsibility and competency to stand trial. This discussion is limited to the instruments utilized to assist in making determinations in the current research project. For a more exhaustive treatment of this area the reader is referred to

Melton et al., 1987, and to Rogers, 1986. Both are excellent resources.

Criminal responsibility. In response to growing criticism of expert testimony offered by clinicians which depend on traditional methods of assessment along with individualistic and unvalidated approaches, Rogers and his associates developed the Rogers Criminal Responsibility Assessment Scales (RCRAS) (Rogers, 1986; Rogers, Seman and Wasyliw, 1983; Rogers and Cavenaugh, 1980). The RCRAS is divided into two parts; the first a systematized approach to evaluating mental status at the time of the offense; and the second an explicit decision model which applies the results of the first part to the American Law Institute legal standard (with supplementary applications to the Guilty But Mentally Ill standard used by Michigan and to the M'Naghten standard).

A primary purpose of the RCRAS is to reduce criterion variance. The examiner is required to quantify relevant situational and psychological variables at the time of the offense based on symptoms and degree of impairment. According to Rogers (1986), the RCRAS

> requires the clinician to make judgements regarding malingering, organic mental disorders, major psychiatric disorders, loss of cognitive control, loss of behavioral control, relationship of this loss of control to the mental disorder, and finally, whether or not the defendant meets the ALI standard (p.167).

Rogers and his colleagues conducted three validation studies from 1981 to 1983 at five forensic centers throughout the country. Moderate reliability (mean reliability coefficient .58) was demonstrated on individual variables, much higher reliability on decision variables (kappa coefficient .81), and a 97% concordance rate between examiners on clinical opinion regarding sanity/insanity (kappa coefficient .94). Thus, although there is some disagreement between examiners on individual variables, and much less disagreement on decision variables, there is almost no disagreement on whether a defendant is sane or insane. These results held up in cross-validation studies regardless of age, sex, type of crime committed, and location of forensic center (Rogers et al., 1983). Construct validity was assessed in both current- and cross-validation studies by statistical testing of specific derived hypotheses. Findings show general support for the construct with significant differences between sane and insane groups found on four of the five summary scales: patient's reliability, psychopathology, cognitive control, and behavioral control; not on organicity, which may have been due to the low rate of representation in the samples (Rogers et al., 1983). The authors conclude, "In summary, the RCRAS represents a significant advance in establishing an empirically based protocol for insanity evaluations" (p.559). Until development of the RCRAS, clinicians had little to guide

them in their assessments of mental status as it bears on certain legal standards. Although more data is needed on the RCRAS and is in the process of being gathered, the instrument is a welcome addition to the repertoire of the forensic examiner.

Competency to stand trial. Work on the development of an instrument to assist in the determination of a defendant's mental status as it bears on the *Dusky* standard occurred much earlier than did the work on the RCRAS. Perhaps this is because the *Dusky* standard was clearly delineated in 1960 while legal standards for the determination of criminal responsibility continued to be subject to extensive controversy and inconsistency. A group at the Harvard Medical School Laboratory of Community Psychiatry--Lipsitt, Lelos, and McGarry--first developed the Competency Screening Test, a fill in the blank screening assessment. This instrument yielded many false positives, but was a step in the right direction (Lipsitt et al., 1971; Melton et al., 1987). For more in-depth and accurate evaluations, the Competency Assessment Instrument (CAI) was introduced. The authors state that their purpose

> was to develop an instrument which delivered clinical opinion to the court in language, form, and substance sufficiently common to the disciplines involved to provide a basis for adequate and relevant communication. The purpose of the instrument is to standardize, objectify, and quantify the relevant criteria for competency to stand trial (Lipsitt and Lelos, 1985, p.278).

The CAI is designed to assess the defendant's ability to cope with the trial process in an adequately self-protective fashion. It involves Likert-type ratings of 1-5 (Total Incapacity to No Incapacity) on 13 functional items. These items were culled from previous lists which had as many as 21 items. These items have commonly come to be referred to as "the McGarry functions." The 13 items are these (Harvard Medical School Laboratory of Community Psychiatry, 1973):

1. Appraisal of available legal defenses.
2. Unmanageable behavior.
3. Quality of relating to attorney.
4. Planning of legal strategy, including guilty plea to lesser charges where pertinent.
5. Appraisal of role of: (a) Defense counsel, (b) Prosecuting attorney, (c) Judge, (d) Jury, (e) Defendant, and (f) Witnesses.
6. Understanding of court procedure.
7. Appreciation of charges.
8. Appreciation of range and nature of possible penalties.
9. Appraisal of likely outcome.
10. Capacity to disclose to attorney available pertinent facts surrounding the offense including the defendant's movements, timing, mental state, actions at the time of the offense.
11. Capacity to realistically challenge prosecution witnesses.
12. Capacity to testify relevantly.
13. [redacted]lf-defeating v. self-serving motivation (legal sense).

As of 1987 no predictive validity studies had been undertaken and reliability studies utilized small samples with inconsistent results due both to degree of incompetence of the offender and to variability in examiner ratings (Melton et al., 1987). Thus, the CAI is designed to assist

15.
DATE 2-18-91
66666



the forensic examiner in issuing an opinion about a defendant's mental state as it relates to competency to stand trial; it is not meant to make that decision without the integration of all available data and specialized forensic training on the part of the examiner.

Issues which the examiner is likely to confront in the course of a competency assessment include (a) the degree of impairment which is necessary to a finding of incompetency, (b) the defendant who claims amnesia for the time of the offense only (thus interfering in CAI function number 10), and (c) medication-induced competency and its effect on opinions formed by the judge and jury. Each of these is discussed briefly here so the reader will have a better understanding of those issues which went into the determination of competency as a dependent variable in the current study. For a more detailed discussion, the reader is referred to Melton et al., 1987, and to Grisso, 1986).

First, the requirement that the defendant possess a reasonable degree of understanding highlights the feasibility of the *Dusky* standard. A great deal of sophistication about the criminal process is not necessary; the defendant need demonstrate only a rudimentary understanding. The mere presence of a mental disorder is not a sufficient basis for a finding of incompetency to stand trial (*Feuger v. United States,* 302 F.2d 214 [1962];

and *United States v. Adams*, 297 F. Supp. 595 [1969]; cited in Grisso, 1988, p. 95).

Second, a defendant's claim of amnesia for the time of the offense is not cause for an automatic finding of incompetency (46 A.L.R. 3d 544 [1972]; cited in Melton et al., 1987). Judicial authorities, as well as forensic clinicians, tend to distrust claims of amnesia that might be self-serving in motivation, especially in light of the ease of feigning amnesia. Even if the amnesia appears biologically based, a finding of incompetency is not automatic. Guidelines have been laid out in *Wilson v. United States* (129 App. D.C. 107, 391 F.2d 460 [1968]) and *United States v. Stubblefield* (325 F. Supp. 485 [D.C. Tenn.1971]). The reader is referred to Melton et al. (1987, p. 76-77) for more detail.

Third, the most common method of restoring a defendant's competency is to treat with psychoactive medication. Of those referrals deemed incompetent, the diagnosis is typically one of psychosis (Melton et al., 1987). Although some courts refuse to honor competency based on chemotherapy due to the misconception that it distorts thought processes, the trend is to acknowledge medication-induced competency (Melton et al., 1987). In response to this issue, some jurisdictions have included instructions to the jury regarding effects of psychoactive medication (Criminal Justice Mental Health Standards, 7-4.14

[1984]; cited in Melton et al., 1987). Another approach, introduced in New Hampshire in *State v. Hayes* (389 A.2d 1379 [1978]; cited in Melton et al., 1987), allows the defendant to appear at trial without medication, so long as the decision to do so was made when the defendant was competent due to medication effects. Montana follows a variation of this approach for civil commitment hearings (MCA Title 53-Chapter 21, Treatment of the Seriously Mentally Ill) but does not address the issue specifically in regard to competency to stand trial (MCA Title 46-Chapter 14, Mental Competency of the Accused). The Montana Code guarantees certain procedural rights to any person against whom a petition to involuntarily commit has been filed, one of which is "the right to refuse any but lifesaving medication for up to 24 hours prior to any hearing held pursuant to this part" (MCA 53-21-115 [10]). In the current study, no attempt was made to identify which defendants were on psychoactive medication and which were not at the time of the determination of competency to stand trial. The discussion now turns to the statistical techniques employed in the analysis of data in the current study.

## Profile Analysis and Discriminant Analysis: Theory and Research

History and development. Classic work in this area dates to Fisher's 1936 research, "The use of multiple measurements in taxonomic problems." He was concerned with

HOUSE OF REPRESENTATIVES
VISITOR REGISTER

Human Services & Aging COMMITTEE BILL NO. HB 780

DATE 2-18-91 SPONSOR(S) Rep. Bob Pavlovich

PLEASE PRINT PLEASE PRINT PLEASE PRINT

| NAME AND ADDRESS | REPRESENTING | SUPPORT | OPPOSE |
|---|---|---|---|
| James T Lynch | mt. Rest. Assn | ✓ | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

PLEASE LEAVE PREPARED TESTIMONY WITH SECRETARY. WITNESS STATEMENT FORMS ARE AVAILABLE IF YOU CARE TO SUBMIT WRITTEN TESTIMONY.

HOUSE OF REPRESENTATIVES
VISITOR REGISTER

Human Services & Aging COMMITTEE BILL NO. HB 761

DATE 2-18-91 SPONSOR(S) Rep. Bay Peck

**PLEASE PRINT** **PLEASE PRINT** **PLEASE PRINT**

| NAME AND ADDRESS | REPRESENTING | SUPPORT | OPPOSE |
|---|---|---|---|
| Bruce Desonia | MDA'S | — | |
| L Desonia | | | |
| Dione SANDS | MT. Women Lobby | X w/Amendments | |
| Janet Jeadby | mt. med assn | ✓ | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

PLEASE LEAVE PREPARED TESTIMONY WITH SECRETARY. WITNESS STATEMENT FORMS ARE AVAILABLE IF YOU CARE TO SUBMIT WRITTEN TESTIMONY.

HOUSE OF REPRESENTATIVES
VISITOR REGISTER

Human Services & Aging COMMITTEE BILL NO. HB 713

DATE 2-18-91 SPONSOR(S) Rep. Dick Knox

PLEASE PRINT PLEASE PRINT PLEASE PRINT

| NAME AND ADDRESS | REPRESENTING | SUPPORT | OPPOSE |
|---|---|---|---|
| Dan Anderson | Dept. of Institutions | ✓ | |
| Kathy McGowan | MCMHC | ✓ | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

PLEASE LEAVE PREPARED TESTIMONY WITH SECRETARY. WITNESS STATEMENT FORMS ARE AVAILABLE IF YOU CARE TO SUBMIT WRITTEN TESTIMONY.

HOUSE OF REPRESENTATIVES
VISITOR REGISTER

HUMAN SERVICES COMMITTEE BILL NO. HB 820

DATE 2/18/91 SPONSOR(S)

PLEASE PRINT PLEASE PRINT PLEASE PRINT

| NAME AND ADDRESS | REPRESENTING | SUPPORT | OPPOSE |
|---|---|---|---|
| Jerome Anderson - Helena | Tobacco Institute | | ✓ |
| Roger Tippy | R J Reynolds | | ✓ |
| James T. Mular | TCH | | ✓ |
| Leon Stalcup | Mont Rest Assoc | | X |
| Scott Martens | 4B's Restaurants | | X |
| Charles R. Brooks Jr | MT. Retail Assoc | | ✓ |
| Mark Staples | MT Oil Men Assn: MT Wholsers | | ✓ |
| John DeLano | PM | | X |
| Stuart Doggett | MT Innkeepers | | X |
| Jean T Henry | MT. Med Assn | ✓ | |
| | | | |
| | | | |
| | | | |
| | | | |

PLEASE LEAVE PREPARED TESTIMONY WITH SECRETARY. WITNESS STATEMENT FORMS ARE AVAILABLE IF YOU CARE TO SUBMIT WRITTEN TESTIMONY.

HOUSE OF REPRESENTATIVES
VISITOR REGISTER

HUMAN SERVICES COMMITTEE BILL NO. HB 860

DATE 2/12/91 SPONSOR(S)

**PLEASE PRINT PLEASE PRINT PLEASE PRINT**

| NAME AND ADDRESS | REPRESENTING | SUPPORT | OPPOSE |
|---|---|---|---|
| [illegible] - Helena | Tobacco Institute | | ✓ |
| Paulette Kohman | Mt Council for Mat/Child Health | ✓ | |
| Roger Tippy | R J Reynolds | | ✓ |
| J T MULAR BUTTE | TCU | | ✓ |
| Thomas Lee | H.D.I.A.G. Bigfork | ✓ | |
| Brian McNitt | MEIC | ✓ | |
| Diane Sands | Mt Women's Lobby | ✓ | |
| Margaret Lloyd | Myself - | ✓ | |
| Jerome T Lueders | Mt. Med Assn | ✓ | |
| John DeLano | PM | | + |
| | | | |
| | | | |
| | | | |
| | | | |

PLEASE LEAVE PREPARED TESTIMONY WITH SECRETARY. WITNESS STATEMENT FORMS ARE AVAILABLE IF YOU CARE TO SUBMIT WRITTEN TESTIMONY.

HOUSE OF REPRESENTATIVES
VISITOR REGISTER

Human Services & Aging COMMITTEE BILL NO. HB 6666

DATE 2-18-91 SPONSOR(S) Rep. Beverly Barnhart

**PLEASE PRINT PLEASE PRINT PLEASE PRINT**

| NAME AND ADDRESS | REPRESENTING | SUPPORT | OPPOSE |
|---|---|---|---|
| Jeffrey K Fitzer Ph.D | M S H | | X |
| Susan Sachsenmaier PhD | MPA | | X |
| Dick Martens | 4B's Restaurants | | X |
| Mary McCue | Mt Mental Health Counselors | | X |
| Hank Winters | ASAN " " " " | | X |
| Jim Smith | Me. Psych. Assoc. | | ✓ |
| Bill Evans | Nat. Assoc of Social Workers | X | |
| Craig Swanson | N.A.S.W. | X | |
| Dean Sado | MH Women Lobby | X | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

PLEASE LEAVE PREPARED TESTIMONY WITH SECRETARY. WITNESS STATEMENT FORMS ARE AVAILABLE IF YOU CARE TO SUBMIT WRITTEN TESTIMONY.