

## MINUTES

### MONTANA HOUSE OF REPRESENTATIVES 53rd LEGISLATURE - REGULAR SESSION

#### JOINT SUBCOMMITTEE ON HUMAN SERVICES & AGING

Call to Order: By CHAIRMAN JOHN COBB, on February 2, 1993, at  
7:00 A:M

#### ROLL CALL

##### Members Present:

Rep. John Cobb, Chairman (R)  
Sen. Mignon Waterman, Vice Chairman (D)  
Sen. Chris Christiaens (D)  
Rep. Betty Lou Kasten (R)  
Sen. Tom Keating (R)  
Rep. David Wanzenried (D)

Members Excused: None

Members Absent: None

Staff Present: Lisa Smith, Legislative Fiscal Analyst  
Lois Steinbeck, Legislative Fiscal Analyst  
Connie Huckins, Office of Budget & Program  
Planning  
John Huth, Office of Budget & Program Planning  
Billie Jean Hill, Committee Secretary

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

##### Committee Business Summary:

Hearing: DEPARTMENT OF FAMILY SERVICES  
Executive Action: DEPARTMENT OF SOCIAL AND REHABILITATION  
SERVICES

#### EXECUTIVE ACTION ON DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

Tape No. 1:Side 1

##### EXHIBITS 1

Motion/Vote: SEN. KEATING moved to reconsider previous action on  
the five-percent personal services reduction on the 10.25 FTEs in  
the eligibility determination program. Motion **FAILED** with  
CHAIRMAN COBB, SEN. CHRISTIAENS, REP. KASTEN, and REP. WANZENRIED  
voting no.

Motion/Vote: SEN. WATERMAN moved to restore 6.5 FTEs removed by

the Joint House Appropriations and Senate Finance and Claims Committees in the eligibility determination program. Motion FAILED with SEN. CHRISTIAENS, SEN. TOM KEATING, REP. KASTEN, and REP. WANZENRIED voting no.

Motion/Vote: SEN. KEATING moved to accept executive budget for contracted services in child support enforcement program. Motion CARRIED with REP. KASTEN voting no.

Motion: CHAIRMAN COBB moved to restore 1.0 FTE made vacant 1-29-92 in the child support enforcement program.

Motion/Vote: CHAIRMAN COBB moved to reconsider contracted services for the child support enforcement services program by two additional FTEs. Motion CARRIED with REP. KASTEN and REP. WANZENRIED voting no.

Motion/Vote: CHAIRMAN COBB moved to allow the child support enforcement program to transfer contracted services to personal services for additional FTE. Motion CARRIED with SEN. KEATING and REP. KASTEN voting no.

Motion/Vote: REP. KASTEN moved to approve executive budget under insurance and bonds for the administrative and support services program. Motion CARRIED unanimously.

Motion/Vote: SEN. KEATING moved to restore federal indirect costs for the administrative and support services program. Motion CARRIED unanimously.

Motion/Vote: SEN. KEATING moved to approve executive budget under equipment for administrative and support services program. Motion CARRIED with CHAIRMAN COBB and REP. KASTEN voting no.

Motion: SEN. WATERMAN moved that all four positions that were vacant 12-92 in the administrative and support services program be reinstated.

Substitute Motion/Vote: REP. KASTEN moved to restore one FTE that was filled at the time for administrative and support services program (position #09615). Motion CARRIED with CHAIRMAN COBB and SEN. KEATING voting no.

Motion/Vote: REP. WANZENRIED moved to restore five-percent personal services reduction (11.0 FTEs) for state assumed county administration program. Motion FAILED with CHAIRMAN COBB, SEN. KEATING and REP. KASTEN voting no.

Motion/Vote: SEN. CHRISTIAENS moved to accept executive budget for equipment in state assumed county administration program. Motion FAILED with CHAIRMAN COBB, SEN. KEATING, and REP. KASTEN voting no.

Motion/Vote: SEN. KEATING moved to accept the executive funding

mix for the state-assumed county administration program. Motion **CARRIED** unanimously.

Motion/Vote: SEN. CHRISTIAENS moved to restore positions vacant 12-29-92 for the state-assumed county administration program. Motion **FAILED** with CHAIRMAN COBB, SEN. KEATING, and REP. KASTEN voting no.

Motion/Vote: SEN. CHRISTIAENS moved to restore the five-percent personal services (2.0 FTEs) in the Medicaid services program. Motion **FAILED** with CHAIRMAN COBB, SEN. KEATING, and REP. KASTEN voting no.

Motion/Vote: SEN. CHRISTIAENS moved to accept the LFA level for contracted services with funding mix for the Medicaid services program. Motion **CARRIED** with CHAIRMAN COBB and REP. KASTEN voting no.

HEARING ON DEPARTMENT OF FAMILY SERVICES

Tape No. 1:Side

The following people appeared before the committee:

Mr. Jim Smith, Montana Residential Child Care Association (MRCCA, now known as Montana Association of Home and Services for Children

Mr. Glenn McFarlane, MRCCA

Ms. Jane McCall, Youth Dynamics, Inc.

Mr. Dick Meeker, Corrections/Probation, Lewis and Clark County

Ms. Joy McGrath, Executive Director, Mental Health Association of Montana EXHIBIT 2

Mr. Gary Walsh, Administrator, Child Protective Services, DFS EXHIBIT 3

Mr. Richard Kerstein, Administrator, Field Services Division, DFS

Ms. Colleen Lippke, Community Social Work Supervisor, Child Protective Services, DFS, Lewis and Clark County

Ms. Chris Purcell, Supervisor for Intake and Investigation Unit, Child Protective Services, DFS, Yellowstone County

Ms. Bonnie Rushford, Intake Worker, Child Protective Services, DFS, Lewis and Clark County

Ms. Larriann Murphy, Child Protective Services, DFS, Lewis and Clark County

Ms. Judith Carlson, Montana Association of Social Workers

HOUSE HUMAN SERVICES & AGING SUBCOMMITTEE

February 2, 1993

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Mr. Dave DePew, Montana Public Employees Association      EXHIBIT 4

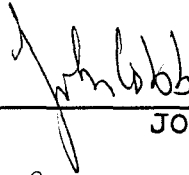
Ms. Paulette Kohman, Montana Council Maternal and Child Health

Ms. Joan-Nell Macfadden, DFS Advisory Council

Ms. Laurie Peterson Yamamoto, Adult Protective Services,  
Yellowstone County

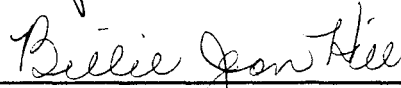
ADJOURNMENT

Adjournment: 11:35 A:M



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JOHN COBB, Chairman



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BILLIE JEAN HILL, Secretary

JC/bjh

HOUSE OF REPRESENTATIVES

HUMAN SERVICES

SUB-COMMITTEE

ROLL CALL

DATE

2-2-72

NAME	PRESENT	ABSENT	EXCUSED
REP. JOHN COBB, CHAIRMAN	✓		
SEN. MIGNON WATERMAN, VICE CHAIR	✓		
SEN. CHRIS CHRISTIAENS	✓		
SEN. TOM KEATING	✓		
REP. BETTY LOU KASTEN	✓		
REP. DAVID WANZENRIED	✓		

# HOUSE OF REPRESENTATIVES

HUMAN SERVICES

SUB-COMMITTEE

## ROLL CALL VOTE

DATE Feb 2, 1993 BILL NO. \_\_\_\_\_ NUMBER \_\_\_\_\_

MOTION: \_\_\_\_\_

*Position vacants 12/93. 6.5 Vacant*  
~~FTE~~  
*Personal Serv. Reduction*  
*Remove 5% 10.25 FTE*

NAME	AYE	NO
REP. JOHN COBB, CHAIRMAN		X
SEN. MIGNON WATERMAN, VICE CHAIRPERSON	X	
SEN. CHRIS CHRISTIAENS		X
SEN. TOM KEATING	X	
REP. BETTY LOU KASTEN		X
REP. DAVID WANZENRIED		X

*lies*

# HOUSE OF REPRESENTATIVES

HUMAN SERVICES

SUB-COMMITTEE

## ROLL CALL VOTE

DATE Feb 3 1993 BILL NO. \_\_\_\_\_ NUMBER \_\_\_\_\_

MOTION: \_\_\_\_\_

~~to 6.5~~

Positions vacant 12/92 - 6.5, vacant  
F.T.E's

NAME	AYE	NO
REP. JOHN COBB, CHAIRMAN	X	
SEN. MIGNON WATERMAN, VICE CHAIRPERSON	X	
SEN. CHRIS CHRISTIAENS		X
SEN. TOM KEATING		X
REP. BETTY LOU KASTEN		X
REP. DAVID WANZENRIED		X

*dis*



# HOUSE OF REPRESENTATIVES

HUMAN SERVICES SUB-COMMITTEE

## ROLL CALL VOTE

DATE 2-2-93 BILL NO. \_\_\_\_\_ NUMBER \_\_\_\_\_

MOTION: Chief Support Eng

Contracted Serv. To Exec Budget

NAME	AYE	NO
REP. JOHN COBB, CHAIRMAN	X	
SEN. MIGNON WATERMAN, VICE CHAIRPERSON	X	
SEN. CHRIS CHRISTIAENS	X	
SEN. TOM KEATING	X	
REP. BETTY LOU KASTEN		X
REP. DAVID WANZENRIED	X	

# HOUSE OF REPRESENTATIVES

HUMAN SERVICES

SUB-COMMITTEE

## ROLL CALL VOTE

DATE 2-7-93 BILL NO. \_\_\_\_\_ NUMBER \_\_\_\_\_

MOTION:

Chief Enforcement  
positions vacant 1-29-92 1.0 FTE

NAME	AYE	NO
REP. JOHN COBB, CHAIRMAN	X	
SEN. MIGNON WATERMAN, VICE CHAIRPERSON	X	
SEN. CHRIS CHRISTIAENS	X	
SEN. TOM KEATING	X	
REP. BETTY LOU KASTEN	X	
REP. DAVID WANZENRIED	X	

# HOUSE OF REPRESENTATIVES

HUMAN SERVICES

SUB-COMMITTEE

## ROLL CALL VOTE

DATE 2-2-93 BILL NO. \_\_\_\_\_ NUMBER \_\_\_\_\_

MOTION: 2 Continuation FTE ←

Reconsider on Consolidated bill for  
Child Enforcement

NAME	AYE	NO
REP. JOHN COBB, CHAIRMAN	✓	
SEN. MIGNON WATERMAN, VICE CHAIRPERSON	x	
SEN. CHRIS CHRISTIAENS	✓	
SEN. TOM KEATING	x	
REP. BETTY LOU KASTEN		x
REP. DAVID WANZENRIED		x

# HOUSE OF REPRESENTATIVES

HUMAN SERVICES

SUB-COMMITTEE

## ROLL CALL VOTE

DATE 2-2-93 BILL NO. \_\_\_\_\_ NUMBER \_\_\_\_\_

MOTION:

*Chief Support*

*None Concluded & Personal  
for additional FTE*

NAME	AYE	NO
REP. JOHN COBB, CHAIRMAN	X	
SEN. MIGNON WATERMAN, VICE CHAIRPERSON	/	
SEN. CHRIS CHRISTIAENS	X	
SEN. TOM KEATING	X	X
REP. BETTY LOU KASTEN		X
REP. DAVID WANZENRIED	X	

# HOUSE OF REPRESENTATIVES

HUMAN SERVICES SUB-COMMITTEE

## ROLL CALL VOTE

DATE 2-2-93 BILL NO. \_\_\_\_\_ NUMBER \_\_\_\_\_

MOTION: Admin & Support Serv.  
Restored Personal Serv. Reduce

NAME	AYE	NO
REP. JOHN COBB, CHAIRMAN		
SEN. MIGNON WATERMAN, VICE CHAIRPERSON		
SEN. CHRIS CHRISTIAENS		
SEN. TOM KEATING		
REP. BETTY LOU KASTEN		
REP. DAVID WANZENRIED		

*no motion*

# HOUSE OF REPRESENTATIVES

HUMAN SERVICES

SUB-COMMITTEE


## ROLL CALL VOTE

DATE 2-1-93 BILL NO. \_\_\_\_\_ NUMBER \_\_\_\_\_

MOTION: \_\_\_\_\_

*None*  
*Insurance & bonds*

*Admin & support services*

NAME	AYE	NO
REP. JOHN COBB, CHAIRMAN		
SEN. MIGNON WATERMAN, VICE CHAIRPERSON	✓	
SEN. CHRIS CHRISTIAENS	x	
SEN. TOM KEATING	x	
REP. BETTY LOU KASTEN	✓	
REP. DAVID WANZENRIED	✓	

# HOUSE OF REPRESENTATIVES

HUMAN SERVICES

SUB-COMMITTEE

## ROLL CALL VOTE

DATE 2-2-93 BILL NO. \_\_\_\_\_ NUMBER \_\_\_\_\_

MOTION: \_\_\_\_\_

*R* Postage & bonds

NAME	AYE	NO
REP. JOHN COBB, CHAIRMAN		
SEN. MIGNON WATERMAN, VICE CHAIRPERSON		
SEN. CHRIS CHRISTIAENS		
SEN. TOM KEATING		
REP. BETTY LOU KASTEN		
REP. DAVID WANZENRIED		

*no motion*

# HOUSE OF REPRESENTATIVES

HUMAN SERVICES

SUB-COMMITTEE

## ROLL CALL VOTE

DATE 2-2-93 BILL NO.                      NUMBER                     

MOTION:                       
*Sen K*                      *money to restore*  
                     *Federal Indirect Costs*

NAME	AYE	NO
REP. JOHN COBB, CHAIRMAN	<del>X</del>	
SEN. MIGNON WATERMAN, VICE CHAIRPERSON	✓	
SEN. CHRIS CHRISTIAENS	✓	
SEN. TOM KEATING	✓	
REP. BETTY LOU KASTEN	✓	
REP. DAVID WANZENRIED	X	



# HOUSE OF REPRESENTATIVES

HUMAN SERVICES SUB-COMMITTEE

## ROLL CALL VOTE

DATE 2-2-93 BILL NO. \_\_\_\_\_ NUMBER \_\_\_\_\_

MOTION: Move  
Equipment Free Budget

NAME	AYE	NO
REP. JOHN COBB, CHAIRMAN	<del>X</del>	X
SEN. MIGNON WATERMAN, VICE CHAIRPERSON	X	
SEN. CHRIS CHRISTIAENS	X	
SEN. TOM KEATING	X	
REP. BETTY LOU KASTEN	<del>X</del>	X
REP. DAVID WANZENRIED	X	

# HOUSE OF REPRESENTATIVES

HUMAN SERVICES

SUB-COMMITTEE

## ROLL CALL VOTE

DATE 2-2-93 BILL NO. \_\_\_\_\_ NUMBER \_\_\_\_\_

MOTION: \_\_\_\_\_

*Restore 1 FTE  
Reinstated position that was filled @*

*time budget 0965 09615*

*Administrative & Support Unit*

NAME	AYE	NO
REP. JOHN COBB, CHAIRMAN		X
SEN. MIGNON WATERMAN, VICE CHAIRPERSON	X	
SEN. CHRIS CHRISTIAENS	X	
SEN. TOM KEATING		X
REP. BETTY LOU KASTEN	X	
REP. DAVID WANZENRIED	X	

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HOUSE OF REPRESENTATIVES

HUMAN SERVICES SUB-COMMITTEE

ROLL CALL VOTE

DATE 2-2-93 BILL NO. \_\_\_\_\_ NUMBER \_\_\_\_\_

MOTION: Restored 5% personal Services Reduction  
11.0 FTE's

State assumed Counties Admin

NAME	AYE	NO
REP. JOHN COBB, CHAIRMAN		X
SEN. MIGNON WATERMAN, VICE CHAIRPERSON	X	
SEN. CHRIS CHRISTIAENS	X	
SEN. TOM KEATING		X
REP. BETTY LOU KASTEN		X
REP. DAVID WANZENRIED	X	

# HOUSE OF REPRESENTATIVES

HUMAN SERVICES

SUB-COMMITTEE

## ROLL CALL VOTE

DATE 2-2-73 BILL NO. \_\_\_\_\_ NUMBER \_\_\_\_\_

MOTION: \_\_\_\_\_

*Sen. Chris*

*Exec Budget in Equipment*  
*State Revenue*

NAME	AYE	NO
REP. JOHN COBB, CHAIRMAN		X
SEN. MIGNON WATERMAN, VICE CHAIRPERSON	X	
SEN. CHRIS CHRISTIAENS	X	
SEN. TOM KEATING		X
REP. BETTY LOU KASTEN		X
REP. DAVID WANZENRIED	X	

*failed*

# HOUSE OF REPRESENTATIVES

HUMAN SERVICES

SUB-COMMITTEE

## ROLL CALL VOTE

DATE 2-2-93 BILL NO. \_\_\_\_\_ NUMBER \_\_\_\_\_

MOTION:

Eyes funding map for funding  
issue State assumed

NAME	AYE	NO
REP. JOHN COBB, CHAIRMAN	X	
SEN. MIGNON WATERMAN, VICE CHAIRPERSON	X	
SEN. CHRIS CHRISTIAENS	X	
SEN. TOM KEATING	X	
REP. BETTY LOU KASTEN	X	
REP. DAVID WANZENRIED	X	

# HOUSE OF REPRESENTATIVES

HUMAN SERVICES SUB-COMMITTEE

## ROLL CALL VOTE

DATE 2-2-93 BILL NO. \_\_\_\_\_ NUMBER \_\_\_\_\_

MOTION: \_\_\_\_\_

Restore position vacant 12-29-92  
2.50 FTE State assumed

NAME	AYE	NO
REP. JOHN COBB, CHAIRMAN		X
SEN. MIGNON WATERMAN, VICE CHAIRPERSON	X	
SEN. CHRIS CHRISTIAENS	X	
SEN. TOM KEATING		X
REP. BETTY LOU KASTEN		X
REP. DAVID WANZENRIED	X	

# HOUSE OF REPRESENTATIVES

HUMAN SERVICES

SUB-COMMITTEE

## ROLL CALL VOTE

DATE 2-2-93 BILL NO.                      NUMBER                     

MOTION: 57, <sup>move</sup> pass zero reduction  
2.0 FTE's  
Medicaid Zero Program

NAME	AYE	NO
REP. JOHN COBB, CHAIRMAN		X
SEN. MIGNON WATERMAN, VICE CHAIRPERSON	X	
SEN. CHRIS CHRISTIAENS	X	
SEN. TOM KEATING		X
REP. BETTY LOU KASTEN		X
REP. DAVID WANZENRIED	X	

# HOUSE OF REPRESENTATIVES

HUMAN SERVICES SUB-COMMITTEE

## ROLL CALL VOTE

DATE 2-29-93 BILL NO. \_\_\_\_\_ NUMBER \_\_\_\_\_

MOTION: Motion to accept <sup>to</sup> contracted services  
in spec level with funding mfg

NAME	AYE	NO
REP. JOHN COBB, CHAIRMAN		X
SEN. MIGNON WATERMAN, VICE CHAIRPERSON	X	
SEN. CHRIS CHRISTIAENS	X	
SEN. TOM KEATING	X	
REP. BETTY LOU KASTEN		X
REP. DAVID WANZENRIED	X	



# HOUSE OF REPRESENTATIVES

HUMAN SERVICES

SUB-COMMITTEE

## ROLL CALL VOTE

DATE 2-2-93 BILL NO. \_\_\_\_\_ NUMBER \_\_\_\_\_

MOTION: Posterior Decant 12-92

4 FTE Restore 4 FTE's

Delete 3 + home

NAME	AYE	NO
REP. JOHN COBB, CHAIRMAN		
SEN. MIGNON WATERMAN, VICE CHAIRPERSON		
SEN. CHRIS CHRISTIAENS		
SEN. TOM KEATING		
REP. BETTY LOU KASTEN		
REP. DAVID WANZENRIED		

*no vote*

## Executive Budget Modifications

EXHIBIT

DATE 2-2-93

Social & Rehabilitation Services		Fiscal 1994				SR Fiscal 1995		
Budget Modification	P G	FTE	General Fund	Total Funds	FTE	General Fund	Total Funds	Committee Action
1 Local JOBS Match	01	0.00	\$0	\$1,100,000	0.00	\$0	\$1,650,000	
2 Food Stamp Outreach	01	0.00	0	157,349	0.00	0	157,349	
3 AFDC At-Risk Day-Care	01	0.00	0	1,176,774	0.00	0	1,176,774	
4 General Assistance Work Program	01	0.00	522,142	698,569	0.00	522,142	698,569	
5 GA Payment At 32% Of Poverty	01	0.00	(520,596)	(520,596)	0.00	(520,596)	(520,596)	
6 Daycare Administration To SRS	01	0.00	0	2,800,492	0.00	0	2,800,767	
7 Continue Non-Assumed Co. BA	03	6.00	0	170,787	6.00	0	170,888	
8 Restore 5% Reduction-A	03	10.25	0	236,323	10.25	0	236,792	
10 Additional FTE	05	14.00	0	0	14.00	0	0	
11 Increased Communication Costs	05	0.00	0	45,990	0.00	0	49,240	
12 Restore 5% Reduction-C	05	6.42	0	160,923	6.42	0	161,457	
14 Medicaid Managed Care	07	1.00	(1,059,198)	(3,850,244)	1.00	(1,387,072)	(4,858,840)	
15 Psychiatric Utilization Review	07	0.00	(103,525)	(417,250)	0.00	(106,125)	(417,250)	
16 State Medical Cost Containment	07	0.00	75,000	75,000	0.00	75,000	75,000	
17 Medicaid Claims Processing	07	0.00	69,300	277,200	0.00	69,300	277,200	
18 Medically Needy Cost Savings	07	0.00	(1,691,500)	(639,509)	0.00	(1,691,500)	(639,509)	
20 Teams Facility Management	09	0.00	0	0	0.00	74,926	149,853	
20A Restore 5% Reduction-TDD	09	0.20	0	3,549	0.20	0	3,553	
22 MSED Administration	10	0.00	0	5,176	0.00	0	1,310	
23 MSED Benefits	10	0.00	0	459,614	0.00	0	116,288	
24 MonTECH Administration	10	0.00	0	6,098	0.00	0	6,403	
25 MonTECH Benefits	10	0.00	0	565,414	0.00	0	593,683	
26 Funding Switch	10	0.00	244,027	0	0.00	433,944	0	
28 Additional FTE	11	3.00	0	78,339	3.00	0	78,414	
29 Restore 5% Reduction-H	11	2.50	0	68,475	2.50	0	68,534	
Totals		43.37	(\$2,464,350)	\$2,658,473	43.37	(\$2,529,981)	\$2,035,879	

NOTE: Items in this table are explained on pages B-55 to B-59 in the LFA Budget Analysis (Vol.II).

The number and title of the items listed ties to the number and title of items discussed in the budget analysis. The Racicot amendments to the Stephens budget removed budget modifications to reinstate general fund FTE removed to comply with section 13 of House Bill 2. Those budget modifications are not listed in this table.

EXHIBIT

DATE 2/2/93

The original is stored at the Historical Society, 225 North Roberts Street, Helena, MT 59620-1201. The phone number is 444-2694.

(Please refer to microfiche for 2/1/93, exhibit 1, for a copy of this document.)



# Mental Health Association of Montana

*An Affiliate of the National Mental Health Association*

State Headquarters • 555 Fuller Avenue • Helena, Montana 59601  
(406) 442-4276 • Toll-Free 1-800-823-MHAM

EXHIBIT 2  
DATE 2-2-93  
SB \_\_\_\_\_

February 2, 1993

## Board Members

### President

Dorothy M. Leonard  
Billings

### President-Elect

LuAnn McLain  
Haure

### Vice President

James Dorr Johnson  
Butte

### Secretary

Mary Piper  
Bozeman

### Treasurer

Mardi Millons  
Helena

Ed Amberg

Warm Springs

Larry Bain

Plentywood

Nona Chambers

Lewistown

Judy Hayhurst

Helena

Maralyn Kailey

Missoula

Jeffrey Krott

Missoula

Wyllis (Burke) MacMillan

Helena

Cliff Murphy

Billings

Michael M. Newman

Kalispell

Mary Alice Reinbein

Lambert

Terry Ripke

Missoula

Connie Skiftun

Helena

Jo Shipman

Lewistown

Craig Simmons

Helena

Richard Traynham

Bozeman

Marilyn Turwiler

Helena

Eleanor Yurkovich

Great Falls

## Executive Director

Joy McGrath

## National M.H.A.

### Board/Committee

Carroll Jenkins

Helena

## Chapters in:

Billings

Daniels County

Great Falls

Shenando County

Sweet Grass-Stillwater

Counties

## COMMENTS TO THE JOINT APPROPRIATIONS SUBCOMMITTEE ON HUMAN SERVICES DEPARTMENT OF FAMILY SERVICES OVERVIEW & HEARINGS

Madam Chairman, Members of the Committee:

Thank you for the opportunity to speak to you today. I am Joy McGrath, Executive Director of the Mental Health Association of Montana. The Association is a statewide, nonprofit, education and advocacy organization, we do not provide treatment services and we do not receive any governmental funds for our work.

Senator Waterman, in inviting me to talk with you today, asked me to talk some about mental health in general and some things this committee should keep in mind about the work of other committees.

I would like to begin with a few comments about the mental health of Montanans. Using national statistics:

- \* 1 in 4 American families is affected by mental illnesses
- \* At least 12% of our children suffer from emotional problems that warrant mental health treatment. In Montana, that means 31,500 children and youth have diagnosable emotional disturbances; 6,000 have severe emotional disturbances. In the 1991 school year about 1/3 of them were identified.
- \* 60% of all older Americans suffer from depression.
- \* 5-6% of older people have Alzheimers or other related dementia; most are over 65. 1/2 of the people who live in nursing homes have Alzheimer's or related dementing disorders.
- \* 25% of all women, 11.5% of all men will have a depressive episode

As a rural state, Montana has some unique problems in delivery of services. Our mental health is unique as well, and it is not very good. We have:

- \* increased rates of alcohol abuse
- \* increased rates of child and spouse abuse
- \* depression among adolescents is at twice the national average
- \* the stigma of getting treatment is higher; only 1 in 5 seek treatment.

Suicides are especially alarming in rural states too. In mid 1989, the National average was about 12 suicides per 100,000 people. Montana was 18 suicide deaths per 100,000. We ranked among the top 11 states in the highest suicides. Elderly and children (in that order) have the highest rates.

*A Non-Profit Education & Advocacy Organization*

**Working for Montana's Mental Health and Victory over Mental Illness**

*A National Voluntary Health Agency*

*A Montana Community Shares Agency*



Printed on

understand that he will be commenting later this week. (Copy of a portion of the mental health plan attached.)

Our frustration with the lack of clarity of the roles and responsibilities is exemplified by comments made by the former director of DFS. He said on more than one occasion that it was not his responsibility to serve ED children. Without adequate funding, someone would have to fall through the cracks and it would probably be ED children and youth. This is not acceptable!

To get services, children have had to come under the categories of abuse, neglect or delinquent youth. **A child should be able to access services by virtue of the illness and not have to fall under one of these conditions.**

Another source of frustration has been the lack of data. **We support the full implementation and funding of the Management Information System (MIS)**

Other frustrations: The lack of community-based services and alternatives to residential and inpatient psychiatric care; the lack of clear state policy as to who should be treated in inpatient settings, and the lack of a comprehensive continuum of care. **We support the concept of a comprehensive continuum, as described by Mr. Hudson. It must be implemented now if we are to shift the levels of care to a child-centered, family and community based system.**

Some of the priority services in the continuum include: case management, day treatment, family counseling, respite services for parents of SED children and youth and crisis intervention services.

We don't deny, in fact we fully endorse, the value of quality inpatient and residential services as essential components to a system of care. But we do concur with the statistics used in the Mental Health Plan which shows that we have too many beds at the top end of the spectrum.

**We support bringing our children and youth home to quality and appropriate community based treatment programs.** The MHAM coordinated efforts with several other agencies several years ago to identify, by hand tabulating, the "invisible children" - those who were placed more than 100 miles from their home community. Montana was well above the national average - and we are not much better at this point in time

**The MHAM supports the concept of providing long-term care for youth in Montana in specialized group homes which are close to their home communities. But any programs developed must take into consideration successful programs from states such as Vermont, North Carolina, Alaska, Florida and Hawaii as well as considering the unique needs in Montana.**

**We support the Missoula Demonstration Project which you will hear about later on and the Medicaid Waiver to allow the purchase of community-based services.**

**YOUTH CORRECTIONS:** If the proposal comes before you that youth are not to be placed in correctional facilities if they are seriously emotionally disturbed, then we must be sure we are planning for the appropriate services. We would agree that they do not belong in the correctional system. **We must have the alternatives in place.**

**SCREENING OF YOUTH FOR PLACEMENTS:** The MHAM supports the concept of screening children and youth for placements to be certain that they are receiving the most appropriate, least restrictive placement, close to home and family, if possible.

**PREVENTION:** Patt Franciossi, of Minnesota who is the past president of the National Mental Health Association and Chair of the National Prevention Coalition, opened a conference recently by comparing our efforts today with those of the past when we decided as a society that we wanted to do something for the health of our children, we set out on a systematic immunization program to prevent disease. She pointed out that that made a tremendous difference in our society in the lives of millions of children.

She suggested that today, we need to take that same framework and develop a systematic immunization process for the mental health needs of our children, to protect those children. Just as with physical health we will never prevent all of the mental illnesses that our children may develop. But we can begin to lessen the figures. As a society, we will never have enough dollars to treat all of the individuals who need mental health care. **We must begin to focus on prevention efforts.**

I also want to share a thought from a presenter at a conference last fall on services to children and youth with serious emotional disturbances. She reminded us that **children are not raised by institutions or systems - they are raised by families.** It is our challenge to figure out how to bridge the systems to meet those needs and to fill the gaps.

**It is our challenge as we deal with the budgets and services which may not fill the all the gaps.** As we rely on services in communities, we build more reliance upon the mental health centers, private practicing mental health professionals across Montana. We must remember that there must be funds to meet the increased demand for services.

As I stand here before you citing needs for more services and therefore more funds, I want to share two final thoughts in closing.

**One- WE MUST KEEP THE DOLLARS IN THE SYSTEM!** Any monies that are saved from refinancing or reorganizing or any kinds of cost-saving measures, must stay in the human services and mental health delivery system to meet those gaps in services.

And as we meet here, another meeting is going on considering the sales tax. The MHAM has long been an advocate for increased revenues for human services. Now we are ready to support a sales tax IF some of the monies come to the human services system, including the mental health services AND IF the tax does not impose a heavy burden on Montanans living on fixed and limited incomes.

Thank you for the opportunity to present our concerns before you.

DATE 2-2-93  
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**CHART 2**  
**MENTAL HEALTH DIVISION'S SERVICE SYSTEM PLAN FOR CHILDREN AND**  
**AND ADOLESCENTS WITH SEVERE EMOTIONAL DISTURBANCE**  
**COMPARED WITH CURRENT SERVICE CAPACITY**

SERVICE;	PLAN NEED (slots)	CURRENT STATUS (slots)	PERCENT OF ATTAINMENT
HOME BASED SERVICES	422	200	47.4
RESPIRE FOR PARENTS	91	0	0
CASE MANAGEMENT	884	102 <sup>1</sup>	11.5
DAY TREATMENT	442	130	29.4
VOCATIONAL EDUCATION	68	0	0
VOCATIONAL EVALUATION	41	0	0
VOCATIONAL PLACEMENT	39	0	0
OUTPATIENT THERAPY	1769 <sup>2</sup>	1087 <sup>3</sup>	61.4
PARENT SUPPORT SERVICES	177	64 <sup>4</sup>	36.2
INPATIENT TREATMENT:	247	380	154%
HOSPITAL	22	152 <sup>5</sup>	690.9
RESIDENTIAL	22	160 <sup>6</sup>	727.3
THX GROUP CARE	203	68	66.0
THX FOSTER CARE	111	140 <sup>7</sup>	126.1
SUPERVISED INDEPENDENT	8	0	0

<sup>1</sup>24 of these slots are temporarily funded by CASSP Project funds and are new services.

<sup>2</sup> The number of youth to be served at one time who are SED.

<sup>3</sup>The number of SED youth by public mental health programs.

<sup>4</sup>40 slots are temporarily funded by CASSP Project.

<sup>5</sup>Includes: Rivendell of Butte & Billings, Shodair Hospital, St. Patricks Providence Center (6 slots), Billings Deaconess Hospital Psychiatric Ward (6 slots), Great Falls Deaconess Hospital Psychiatric Ward (10 units assigned to youth).

<sup>6</sup>Includes Yellowstone Treatment Center, Intermountain Children's Home, Shodair Residential facility.

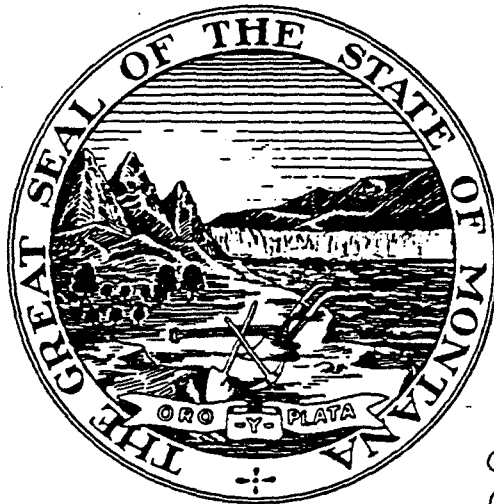
<sup>7</sup>This is the total number of slots licensed by DFS, however, the number assigned to SED youth is unknown at this time.

EXHIBIT 2  
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# Montana

## Public Mental Health System

Revised State Plan  
Fiscal Years 1992 - 1994



*Excerpts  
on children  
youth  
provided by:*

MENTAL HEALTH ASSOCIATION OF MONTANA  
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Montana Department of Corrections and Human Services  
Mental Health Division

#### IV. SERVICE SYSTEM FOR CHILDREN AND ADOLESCENTS WITH SEVERE EMOTIONAL DISTURBANCE AND THEIR FAMILIES

The following discussion presents the system of culturally sensitive mental health services the Department considers integral to the completion of its mission. It is an "ideal" system toward which the state should move. The system provides treatment and support services to children and adolescents with severe emotional disturbance and to their families. The system of services incorporates multiple values including maximum coordination among its many and varied components for the planning, implementing, and financing of its multiple services. The full system will be achieved through a partnership between the state and local governments, public and private providers, business, schools, funding resources, parents, and parent and child advocates. The design of the system acknowledges that preventive or early identification and intervention services are essential and valuable system components directed toward addressing needs before the illness develops into a severe disability. These early intervention services need to be identified, funded, implemented, and coordinated at the local community level as a part of the local continuum of services with the state providing appropriate supplemental support.

##### IV.1 Values

The core values for the system of mental health services to children, adolescents, and their families consist of the following:

1. The system of care should be child-centered, with the needs and rights of the child and family dictating the types and mix of services provided.
2. The system of care should be community-based, with the locus of services as well as management and decision-making responsibility at the community level.



3. The system of services should be designed, developed and implemented with the rights of the child to a safe environment and the preservation of his/her family dictating the nature, character, and intensity of the services received.
4. A child who is emotionally disturbed is a child suffering from an illness that is treatable and the child is entitled to receive treatment from qualified and trained providers.

#### IV.2 Principles

The values provide a basis for the structure of a mental health system of services. In addition to these values, underlying principles directing the creation and application of the system are also essential. The following principles flow from the Department's mission and the values stated above:

1. Children with severe emotional disturbance require a range of medical and mental health services which are appropriate and of varying levels of intensity.
2. Children with emotional disturbance almost universally manifest problems in many spheres including home, school, and community requiring intervention of other agencies and systems including special education, child welfare, health, vocational training, and juvenile justice.
3. Needs of children and adolescents with severe emotional disturbance cannot be met by the mental health system in isolation.
4. Children with emotional disturbance should have access to a comprehensive array of services that address the child's physical, emotional, social and educational needs. This array of services include services for substance abuse.

5. Children with emotional disturbance should receive individualized services in accordance with the unique needs and potentials of each child, and guided by individualized service plans.
6. Children with emotional disturbance should receive services within the least restrictive, most independent and normative environment that is clinically appropriate.
7. The families and surrogate families of children with emotional disturbance should be full participants in all aspects of planning and delivery of services.
8. Children with emotional disturbance should receive services that are integrated, with linkages between child-caring agencies and programs and mechanisms for planning, developing and coordinating services.
9. Children with emotional disturbance should be provided with case management or similar mechanisms to ensure that multiple services are delivered in a planned, coordinated, therapeutic, and accountable manner, and that they can move through the system of services in accordance with their changing needs. This principle includes having labels such as emotionally disturbed removed by a team of service providers which includes the child's parent or parent surrogate when services of the mental health system are no longer needed.
10. Early identification and intervention for children with emotional disturbance should be promoted by the system of care in order to enhance the likelihood of positive outcomes.
11. Children with emotional disturbance should be protected, and effective advocacy efforts for children and adolescents with emotional disturbance should be promoted.

appropriate for children and adolescents who are at risk for severe emotional disturbance.

A child or adolescent can be considered "at-risk" and appropriate for early intervention or prevention services when the child or adolescent has been or is:

Physically abused	Sexually abused
Involved in alcohol or drug abuse	Neglected
Learning disabled	Emotionally maltreated
Chronically physically ill or disabled	A child of a chemically dependent parent
In foster or group care	Living in poverty
Involved with the courts	A status offender
Experiencing social disruptions such as divorce, homelessness, death of a family member, etc.	Delinquent
	Emotionally handicapped

Native American youth may be considered at-risk because of the higher potential of exposure to poverty conditions on reservations and lack of culturally sensitive service resources to address the needs of these youth. Developmentally disabled youth are also at-risk when their problems are misdiagnosed or service responses to needs of the child or family are lacking.

Montana's 1990 census report indicates a population of 221,104 youth under 18 years of age. National prevalence rates applied to the youth population indicate as many as 31,500 youth have a diagnosable emotional disturbance classifiable under the DSM-III-R. Of this group, approximately 6000 meet the definition of severe emotional disturbance.

Of the estimated 6000 youth with severe emotional disturbance, 809 were identified by 127 of Montana's 546 local school districts in the 1991 school year. Indian Health Services have identified 141 youth with severe emotional disturbance

on six of seven reservations in the state. The Department of Family Services (DFS) is serving an estimated 847 SED youth within the child welfare service programs. At present time, the Department of Family Services has 63 of these youth in out-of-state residential treatment facilities. The Department estimates a minimum of 50% of these youth are severely emotionally disturbed.

In 1987, Montana incarcerated 20.5 youth per 10,000 population or 23.5% more than the national rate. Probation officers, courts, and other services providers maintain that a significant number of these are youth with severe emotional disturbance and have entered the juvenile system because of lack of community resources to meet their treatment needs.

#### IV.4 Current System

In 1988 Montana's Title XIX Program (Medicaid), spent \$900,000 on residential care. In 1989 this increased to over \$7 million, and the cost has increased since 1989. DFS in fiscal year 1989 spent \$1.1 million for out-of-state residential care and \$2.9 million for in-state residential care for a total of \$3.9 million.

In Montana today there are a variety of responses to the mental health needs of youth and their families. These responses range from using private practitioners (psychiatrists, psychologists, clinical social workers, professional counselors, ministers, drug and alcohol counselors), to public agencies (mental health centers, schools, Department of Family Services) and private in-patient psychiatric care and residential care facilities. However, with all these resources, Montana does not have a system of services which can fully respond to the service needs of youth and their families. Currently services are concentrated toward in-patient psychiatric and residential care rather than community-based family preservation and home-based services. Current services are not coordinated and require the child and family to fit into existing service definitions.

Montana has 5 community general hospitals that have licensed mental health units which may or may not serve youth. These are: St. James in Butte, St. Patrick's in Missoula, Deaconess in Billings, Deaconess in Great Falls, and St. Peter's in Helena.

In-patient psychiatric hospitals which are licensed to serve children in Montana include Rivendell of Billings licensed for 60 beds (actual beds available are 48), Rivendell of Butte licensed for 48 beds, and Shodair of Helena licensed for 22 beds. Rivendell of Butte has designated 10 beds for youth under 10 years and 38 for adolescents. Rivendell of Billings serves adolescents. Shodair serves youth 0-12 years of age.

Montana has a single residential treatment center, Yellowstone Treatment Center (YTC) of Billings (formerly Yellowstone Boys & Girls Ranch) with a current capacity of 78 beds for 6-18 year olds. In the past, this facility has had an average length in care of two years. YTC is currently undergoing program changes which will alter their target population. The Deaconess Home of Helena is currently licensed as a group home facility, but has many characteristics of a residential care facility. The Deaconess Home serves 30 youth 6-12 years of age and has an 18 month average length of stay.

Montana has several therapeutic group homes to provide services to adolescents with emotional disturbance. Horizon Home of Billings provides services to nine females who have been sexually abused. Youth Dynamics, Inc. of Billings and Bozeman provides group home services to ten dually diagnosed (developmentally disabled and emotionally disturbed) adolescents. Missoula Youth Homes, Inc. through their Talbot group homes provides services to sixteen adolescents with emotional disturbance. The AWARE program of Butte provides group home services to twelve youth who are dually diagnosed and emotionally disturbed youth. The REM Montana, Inc. program in Billings, through their Colton group home, provides services to four dually diagnosed adolescents.

Montana provides therapeutic foster care in several communities. Missoula Youth Homes, Inc. of Missoula provides this service to ten youth. Eastern Montana Community Mental Health Center of Glasgow provides therapeutic foster care to eight youth 3-17 years of age who have been sexually abused. Golden Triangle Community Mental Health Center of Great Falls provides a therapeutic program for 25 youth. Deaconess Home of Helena provides a therapeutic foster care program for six youth.

Services that are supportive of serving children and adolescents with severe emotional disturbance in their communities include the day treatment programs. Montana has four regional Community Mental Health Centers which, in cooperation with local school districts, provide adolescent day treatment services. Western Montana (Region V) Mental Health Center and the Missoula School District provide this program to 24 youth. Golden Triangle Community Mental Health Center (Region II) and the Great Falls School District provide day treatment to 24 adolescents. Mental Health Center (Region III) and the Billings school district provide services to 24 adolescents. Mental Health Services, Inc. (Region IV) and the Helena School District provide services to 24 adolescents. Day Treatment or partial hospitalization programs are also provided by St. Patrick Hospital of Missoula for eight youth, Deaconess Hospital of Billings for fourteen youth, and by Shodair of Helena for fourteen youth up to 15 years of age. Western Montana Mental Health Center and the Missoula Elementary School District provide day treatment services for eight youth from grades 1-6.

Montana's five Community Mental Health Centers provided out-patient services to 2999 youth in state fiscal year 1991. Children and adolescents with severe emotional disturbance are estimated to make up 50% of those served. Funding for these mental health services is provided by the Department through fee-for-service contracts. In addition to the centers, the Department also contracts with Friends To Youth of Missoula for services to SED youth between the ages of 10 - 18 years. Friends To Youth is a non-profit private service organization that serves approximately 100 youth a year of which approximately 25% are youth with severe emotional disturbance. The funding provided by the Department's Mental Health Division through these contracts for mental health services is \$752,124. The services include individual and group therapy, counseling to parents, family therapy, case management, community consultation, and day treatment. In addition, the Mental Health Division provided \$80,827 for mental health services through interagency agreements between local school districts and community mental health centers. The Division also provided \$35,000 for the development of therapeutic foster care. This is a total of \$867,951 for state fiscal year 1991.

The need for services is greater than currently available non-hospital or residential community care resources can provide. Therefore, Montana must target

its resources to address the youth and their families with the greatest need. At the present time the objective is to develop a system of care over the next decade capable of serving the estimated 6000 youth with severe emotional disturbance and their families.

#### IV.5 System Components

The system of care needed to address the needs of severely emotionally disturbed children, adolescents and their families has nine components. These components are:

1. Mental health services
2. Social Services
3. Educational services
4. Health services
5. Vocational services
6. Recreational services
7. Juvenile correction services
8. Operational services
9. Advocacy/Parent Advocacy

#### IV.6 System of Care for 1990's

The 1990's challenge is to review, redesign, and implement a true mental health service system for youth and their families that is children and adolescent driven. The challenge requires that the service providers, regardless of the service, be appropriately trained to assure effective and efficient services.

In order to implement the system, a method of determining the resources and their distribution is necessary. North Carolina developed, tested, and utilized a service distribution formula. This formula was utilized along with the distribution formula recommended by Robert Friedman, Ph.D.

The formulas when applied to Montana's 1990 population establish the Department's service system objectives for development over the next decade. The development requires a planned approach based upon available resources, including both funding and trained staff. This requires use of demonstration models to establish cost and impact of the various services. The service capacities for Montana's system of services for severely emotionally disturbed youth are affected by the following considerations:

- 1) These are estimates of resources needed and may need to be modified to account for the rural nature of Montana.
- 2) The estimates are minimums.
- 3) The various resources are interdependent services. Therefore, failure to provide one or more means the others may have a corresponding increase in demand which alters the effectiveness of the system.
- 4) Resource availability is dependent on the prevalence of youth with severe emotional disturbance in the Montana population.
- 5) Initially the demand for the services may be heavy because of the backlog of unserved youth and families.
- 6) The number of "slots" reflects the capacity of the system in number of persons who can be served at any one time.
- 7) Regardless of service resources, the services need to be community-based, child-driven, and family-supportive.



COMMUNITY-BASED NON RESIDENTIAL SERVICES

Home based: ----- 442 slots

An intensive method of service delivery providing services in the home directed at preventing family dissolution. The service focuses on the family and is directed at strengthening the family by utilizing family members' strengths as basis upon which to build.

Respite Care for parents: ----- 91 slots

A service provided by trained parent(s) who assume the duties of child caregiving and supervising for a planned brief period thereby providing the parent a break from the constant strain of parenting.

Case Management: ----- 884 slots

A service provided by a single individual which includes coordinating and monitoring of a case plan; identification, location, and arrangement of services in response to identified needs for the child and family; and advocacy.

Day Treatment Services: ----- 442 slots

A service that is frequently provided in a school setting and provides an integrated set of educational, counseling and family interventions which enable the youth to remain in the school and community.

Vocational:

Services directed toward gainful employment including career education, vocational assessment, job survival skill training, vocational skills training, work experience, job finding, retention services, and sheltered employment.

Vocational Education: ----- 68 slots

Vocational Evaluation: ----- 41 slots

Vocational Placement: ----- 39 slots

Outpatient: ----- 1769 slots

Services provided in a variety of community based settings including individual, group and family therapy; psychotherapy; chemotherapy; behavioral therapy; etc.

Parent Support Services: ----- 177 slots

Services provided to enable parents to care for their child in their own home and/or to participate fully in the treatment of their child. Services may include parent training, parent counseling, parent aides/assistants in the home, homemakers services, etc.

## OUT-OF-HOME CARE

### In-patient Hospital: ----- See Below\*

A service provided in a psychiatric hospital or a psychiatric unit of a community hospital which is used as short-term treatment and crisis stabilization for youth in acute distress, presenting a danger to him or herself or others.

### In-patient Residential: ----- See Below\*

A service provided in a highly secure and licensed psychiatric facility which is not a psychiatric hospital or community hospital unit. Treatment is provided for a moderate to long-term time period. Services are provided within the confines of the facility and may include individual, group and family therapy, chemotherapy, education, behavior management, etc.

### Therapeutic Group Care : ----- See Below\*

A mental health service which is provided in a home-like environment and may include all of the services of a residential care facility. The home may have from 2 to 12 youth residing in the home at one time. Supervision of the treatment is provided by a qualified mental health professional.

### Therapeutic Foster Care : ----- 111 slots

A service which provides treatment within the context of the treatment home with the foster parents serving as the primary therapists and supervision of the treatment provided by a qualified mental health professional. This service is limited to no more than 2 youth in the home at one time. Support services provided by community resources may include individual and group psychotherapy, chemotherapy, education, parent training, etc.

### Supervised Independent Living: ----- 8 slots

A transition service to assist in preparing youth to be able to live on their own including limited supervision of living arrangement and support services. The support services are to enable development of basic skills (e.g. apartment finding, opening checking accounts, budgeting, purchasing clothing, food, utilities, etc.).

\* The Department believes there is a need for approximately 247 in-patient/residential/group care beds for children/adolescents with severe emotional disturbance. The number of beds in each of these three categories has not been calculated.

Although the above system is a suggested response to service needs of youth with severe emotional disturbance and their families, experience of other states and common sense indicates that these same services are beneficial to emotionally disturbed youth in general as well as youth "at-risk". These services serve as a means of early identification and intervention reducing the number of youth who become severely emotionally disturbed.

#### IV.7 Role of the Mental Health Division, Department of Corrections and Human Services

The needs of children and adolescents with severe emotional disturbance are complex. The complexity of the service response dictates that no one agency or service provider can provide all the services the youth and his/her family need.

The role of the Mental Health Division, Department of Corrections and Human Services, is to facilitate a culturally sensitive, comprehensive, integrated and coordinated service response to identified needs of children and adolescents with severe emotional disturbance and to their families. The role includes seeking funding for pilot projects serving youth in their own community to demonstrate feasibility, cost, and replication potential; facilitating interagency agreements to assure community-based coordinated service planning and implementation at all government levels; and identifying, with the assistance of other State and local agencies, programs and methods to maximize current state and federal resources for serving children and youth with severe emotional disturbance. The Division also has responsibilities for funding selected components of the service system, assisting communities through technical assistance and consultation, collaborating with the various providers, and maximizing the role of parents, parent surrogates and advocates as partners in the planning of service systems.

*Gary Walsh*

EXHIBIT 3  
DATE 2-2-93  
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### **Child Protective Services**

**Legal Base** - It is generally recognized that the sanctity of the family will not be violated unless there is some compelling state interest that justifies the state's intervention. The sanctity of the family and the right of an individual to raise his or her children according to his or her personal beliefs has been recognized by the United States Supreme Court and the Montana Supreme Court as a fundamental right which is constitutionally protected.

Given the recognized importance of the family, intrusion into the family unit by the state is justified only when the health and welfare of a child may be adversely affected or threatened by the conduct of those responsible for the child's care. Even then, the intrusion should not go beyond the level necessary to protect the child.

The Department of Family Services (DFS) is designated by statute as the agency responsible for the protection of children who are abandoned, dependent, neglected or abused, and is specifically charged with the duty to investigate reports of child abuse or neglect and to provide protective services where necessary, including the authority to take temporary or permanent custody of a child when ordered to do so by the court.

The department's authority to intervene in people's lives is wholly statutory. Thus, the department must strictly adhere to the specific requirements of the statutes in providing protective services to children in need of such care.

Unless services are provided with the approval of the parent, the court must authorize or approve the actions taken by DFS to protect the child. It is through judicial proceedings that the interests of the state, the parents and the child are presented to the court for its determination as to the proper actions to be taken by the parties to assure continued protection of the child.

### **Definition of Abuse and Neglect**

#### **• Civil Law**

An abused or neglected child means a child whose normal physical or mental health or welfare is harmed, or threatened with harm by acts or omissions of his/her parents or persons responsible for the child's welfare. Abuse and neglect has been broadly interpreted by the Montana Supreme Court and can include such things as unexplained physical injuries to a child, prolonged uncleanness, and failure to supply the child with adequate food, clothing, shelter, education, or health care.

Harm to a child's health or welfare means harm that occurs whenever a parent or person responsible for the child's welfare:

- 1) inflicts or allows to be inflicted physical or mental injury. Physical or mental injury are defined as follows:
  - (a) physical injury means death, permanent or temporary disfigurement, or impairment of any bodily organ or function. It can also mean injuries that are a result of corporal punishment.
  - (b) mental injury means identifiable and substantial impairment of the child's intellectual or psychological functioning.
- 2) commits or allows to be committed acts of sexual abuse or exploitation.
  - (a) sexual abuse can mean any of the sexual crimes listed at Section 45-5-501, et seq MCA, including sexual assault, sexual intercourse without consent, deviant sexual contact, or incest.
  - (b) sexual exploitation means allowing, permitting, or encouraging a minor to engage in any of the offenses against the family, prohibited at Section 45-5-601, et seq., MCA. These acts include prostitution and sexual abuse of children.
- 3) causes failure to thrive or otherwise fails to supply the child with adequate food, clothing, shelter, education or health care, though financially able.
- 4) abandons the child under circumstances that make it reasonable to believe that he/she does not intend to resume care in the future or by willfully surrendering physical custody for a period of six months without evidence of firm intention to resume physical custody or make permanent legal arrangements for the child.
- 5) is unknown and has been unknown for 90 days despite reasonable efforts to identify and locate.

• **Criminal Law**

A child abuse and neglect situation can also involve several aspects of criminal law. Although criminal charges seem to stem more frequently from sexual abuse, certain acts of physical abuse also warrant criminal action. Particularly if the offender is not a close family member, criminal charges may be the only way

to ensure treatment of the offender, and may provide the only means to keep the child safe from the offender.

If the offender is a family member, the question arises as to whether criminal prosecution of the abusing parent helps or hurts the abused child or the family. The approach of county attorneys to criminal prosecution of abusive parents seems to reflect this division in theory. Some county attorneys readily charge parents with criminal abuse, while others do so reluctantly, choosing instead to use child abuse and neglect civil law, whereby they attempt to develop treatment options for the family. Those county attorneys who seldom file criminal charges believe that the civil law approach allows a better opportunity to reunite the family by providing a tool for treatment, while avoiding the serious disruption of the family and the stigma that criminal charges typically bring to the child and the family. However, the filing of a criminal charge may be essential in gaining the cooperation of the abuser and in encouraging him/her to work with the social worker and other professionals involved. Finally, in some cases, the abuse may be so severe that filing a criminal charge is imperative no matter what the effect on the family will be.

#### **Reports of Abuse and Neglect**

- **Mandatory Reporters**

Reports - A child abuse or neglect case is usually initiated by a report of suspected child abuse or neglect and a subsequent investigation of that report.

The Montana Legislature enacted a mandatory reporting law intended "to prevent further abuses, protect and enhance the welfare of these children, and preserve family life."

Section 41-3-201, MCA, requires certain professionals and officials who know or have reasonable cause to suspect, as a result of information they receive in their professional or official capacity, that a child is an abused or neglected child to report the matter promptly to the Department of Family Services (DFS). DFS must in turn notify the county attorney. Those professionals and officials who are required to report are:

1. physicians, residents, interns, or other members of a hospital's staff;
- 2) nurses, osteopaths, chiropractors, podiatrists, medical examiners, coroners, dentists, optometrists, or any other health or mental health professionals;
- 3) Christian Science practitioners and religious healers;

- 4) school teachers, other school officials and employees who work during regular school hours.

- **Failure to Report**

Failure to report known or suspected child abuse or neglect could expose a party, who is required to report, to civil liability for any damages or injuries suffered by the child as a result of failing to report. Additionally, a person who fails to report may also be found guilty of a misdemeanor. It is only reasonable cause to suspect, not actual knowledge, which triggers the reporting responsibility and mandatory reporters may not refuse to report by invoking a physician-client or similar privilege if the information is obtained as a result of the treatment of the child.

Any person who participates in reporting, investigating or prosecuting incidents of child abuse or neglect is immune from civil or criminal liability, unless the person acts maliciously or in bad faith.

#### **Response of Reports of Suspected Abuse and Neglect**

- **Investigation**

All reports indicating reasonable cause to suspect that a child is an abused or neglected child must be investigated.

Regional and county offices must develop effective methods for providing 24-hour coverage for protective services. At a minimum, law enforcement offices will have the names and telephone numbers of workers.

Upon receipt of a report of suspected child abuse or neglect, a social worker, the county attorney or a peace officer promptly conduct a thorough investigation of the home of the child, the circumstances surrounding the injury of the child and all other nonfinancial matters relevant to the report of suspected abuse or neglect.

As a practical matter, most investigations are conducted by social workers operating out of DFS offices located in each Montana county. The investigating social worker is responsible for assessing the family and planning for the child. While conducting the investigation, the social worker has the right of access to the child and to any relevant hospital and medical records of the child.

It is the policy of the agency that the child and his parent(s) be contacted regarding all reports of abuse and neglect. However, in extraordinary cases, it may not be in the child's best interest to contact the parents immediately. For example,

all serious physical or sexual abuse reports could result in criminal charges. Because the criminal defendant is afforded certain constitutional protection, social workers will discuss with their county attorney how the interview with the perpetrator will be handled and who will conduct the interview (i.e., the social worker or law enforcement officer).

All reports of child abuse and neglect must be reported to the county attorney of the county in which the child resides. The investigative role of the social worker, the county attorney and other governmental officials may be affected by the possibility of criminal prosecution stemming from reported instances of child abuse. If the evidence indicates violation of the criminal code, it shall be the responsibility of the county attorney to file appropriate charges against the offender. While in most instances the social worker will conduct the preliminary investigation of all reports of suspected abuse or neglect, this may change in situations where severe physical abuse or sexual abuse indicates the possibility of criminal prosecution. Because of the constitutional ramifications in the investigation and collection of evidence for purposes of criminal prosecution, most county attorneys involve law enforcement officials in the investigation if it appears criminal charges may be warranted.

• **Case Determinations**

The complaint is substantiated if, upon completion of the investigation, the reporting worker has determined that the complaint has occurred or is occurring. (Does not require that all evidence be court acceptable.)

If from the investigation it appears the child has suffered abuse or neglect, DFS is required to provide protective services to the child and may provide protective services to any other child under the same care if the child(ren) are also at risk.

The complaint is unsubstantiated if, upon completion of the investigation, the reporting worker determined that the complaint did not occur or is unable to make a determination due to lack of evidence.

**Provision of Child Protective Services**

• **Family Support Services**

It is the policy of the department to provide protective services to the child in his or her own home when able to do so without risking serious injury to the child.

The underlying philosophy of family support services is that the child's own family, when possible, is the best placement for the child. When services are available and there is no imminent risk



of harm to the child(ren) by remaining in the home, the goal of the agency is to enhance and maintain the family unit.

Family support services may be considered if the necessary services are available and if the family meets all of the following criteria:

- the parent displays the ability to provide minimally acceptable safe child care;
- the parent is willing to accept the service offered; and
- the home itself does not pose an immediate threat to the health or safety of the child or to the service provider.

#### **Placement in Out-of-Home Care**

Placement of a child out of his or her natural home should be undertaken only after careful consideration of alternatives and a determination that placement will not create more problems than it solves. When a child is in immediate or apparent danger of harm, placement of the child outside his or her present home is warranted.

When placement outside a child's home is necessary, relatives and family friends should be assessed as a placement resource if in the best interest of the child.

*Done*  
TO: Human Services Subcommittee Members  
FROM: Montana Public Employees Association  
DATE: February 2, 1993

EXHIBIT 4  
DATE 2-2-93  
SB \_\_\_\_\_

During the last biennium, DFS was subject to a review by the U.S. Department of Labor regarding the Fair Labor Standards Act. A review of all department positions was conducted and only 21 were determined to be exempt. A plan to resolve the situation was approved by the U.S. Department of Labor. The plan, according to law, requires non-exempt employees to receive compensation at time and one-half for working overtime.

DFS has a 24 hour-a-day, 7 day-a-week mandate for services and has never been funded for overtime. DFS has held direct care social work positions vacant to fund the payment of overtime in addition to making up vacancy savings. This creates a vicious circle. As DFS holds these positions vacant, other employees incur greater workloads, which results in more overtime being earned and paid, which results in vacant positions being held vacant longer.

This situation gets worse with the implementation of the Cobb 5% Amendment and the Swysgood Amendment. For example, the Cobb 5% Amendment reduces direct care social work positions by 15. The workload of these 13 FTE would shift to other social workers. This results in additional overtime being earned and paid. To pay this overtime, additional social work positions would have to be left vacant to provide money to fund the additional overtime

payments. The loss of 15 direct care social work positions actually results in a loss of 21 positions. Holding the 6 additional positions open to fund the overtime requires other positions to pick up additional workloads which results in more overtime and additional positions being left vacant to fund the payment of overtime. If a normal vacancy savings requirement is applied by the Legislature, then the issue compounds.

Reality provides three possible solutions: 1) Fund the agency to pay for overtime worked; 2) provide additional FTE to meet needs; or 3) change the legal mandate of DFS.

FISCAL IMPACT AND ACTION REQUIRED:

Option #1 would require approximately \$179,978 (\$152,982 G.F., \$26,996 FED) each year of the biennium, according to DFS figures. This would allow for roughly 9500 hours of overtime. This estimate is based on the assumption that direct care social work positions are kept at currently FY 93 levels. If the Cobb 5% and the Swysgood amendments are enacted, the amount of dollars to fund overtime payments will increase.

Option #2 would require additional staff to be distributed across the state.

Option #3 would require legislation. The mandate for the department would have to be changed. The result would have to be an agency with less than a 7 day-a-week, 24 hour-a-day mandate.

EFFECTS OF THE OVERTIME SITUATION

CURRENT SITUATION:

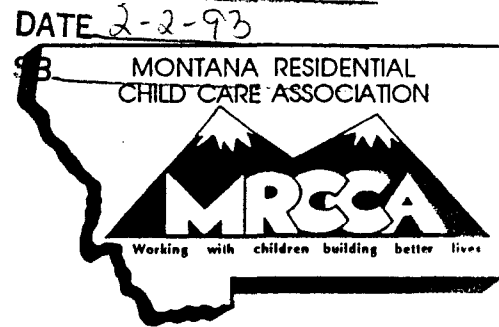
1.       Allocated Positions  
      - Overtime  
      - Vacancy Savings  
      -----  
      = Useable Positions
2.       Allocated Positions  
      - Useable Positions  
      -----  
      = Vacant Positions
3.       Useable Positions  
      + Additional Workloads  
      -----  
      = Increased Overtime
4.       Useable positions  
      - Increased Overtime  
      -----  
      = Fewer Useable Positions
5.       The process repeats itself.

ADD TO THE CURRENT SITUATION:

6.       Fewer Useable Positions  
      - Cobb 5% Amendment  
      - Swysgood Amendment  
      -----  
      = Even Fewer Useable Positions
7.       Even Fewer Useable Positons  
      + Additional Workloads  
      -----  
      = Additional Increased Overtime
8.       Even Fewer Useable Positions  
      - Additional Increased Overtime  
      -----  
      = Yet Even Fewer Useable Positions
9.       The process continues to repeat itself.

**MRCCA**  
324 FULLER AVENUE  
HELENA, MT 59601

(406) 442-7808



January 31, 1993

Testimony to the Joint Appropriations Subcommittee on Human Services

by

Jim Smith

Representing the

Montana Residential Child Care Association

Mr. Chairman and members of the Human Services Subcommittee, my name is Jim Smith and I am before you this morning on behalf of the organizations that belong to the Montana Residential Child Care Association (MRCCA). My Associate, Kathy McGowan, and I are also representing the Montana Juvenile Probation Officers Association during this legislative session. We welcome the opportunity that you have given us this morning to discuss who we are, what we do for the children who are in our care, and to share our perspectives on the Department of Family Services.

MRCCA is an association of organizations providing care, supervision and treatment to children. Most of our members are providing their services to children in residential, out-of-home settings. Most of our members are listed in the DFS Overview Document you were given yesterday. Historically, our members have been the Shelter Care Facilities, Youth Group Homes, Intermediate Level Facilities. Within the last five years, our membership has expanded to include Residential Treatment Centers, Inpatient Psychiatric Hospitals, Therapeutic Foster Care Providers and, most recently, Family Based Services.

As of January first, MRCCA changed its name to the Montana Association of Homes and Services for Children. That name change reflects our belief that a better, broader array of services must be offered to Montana's children and their families. Residential, out-of-home placements cannot be the only alternative for families that are trying to cease the abusive treatment of their children. We welcome non-residential providers into our association, and we believe that all these services are important and valuable.

All of these organizations have one thing in common: they do business with the Department of Family Services. As this week progresses, several of our members will be present to explain their programs, and to tell you first hand about their experiences with DFS. We have approached our dealings with DFS as a partnership. In February of 1993, however, we wonder whether or not DFS still wants to do business with many of our member organizations. Rather than being treated as partners, many of our members are treated as adversaries by the Department.

EXHIBIT 2  
DATE 2/2/93  
SB \_\_\_\_\_

of our concerns this morning, and respond to  
asked in her letter to our organization.

tion once again to the legal basis for DFS, which  
is in the Department's Overview. The legal basis for DFS, its

to children and adults that are in danger of  
exploitation within communities."

themselves as the providers of protective  
and neglect at the hands of adults in their midst.

any of law, regulation and policy regarding child  
? It is this:

children because they cannot protect themselves.

about prevention and early intervention.  
not at the expense of basic child protective

of \$1.5 million from SRS to DFS with which to  
Tana's children. Much of that building has  
and many of the programs begun with that  
intervention programs. We strongly support  
in the 1995 biennium; but not with funds  
Foster Care Budget. That budget is already in

has not been adjusted for a caseload increase since  
in the number of substantiated abuse  
by the Department.

understaffed in terms of its child  
in its clerical and support staff. More Social  
toward protecting children and toward  
to meet the basic standards published by the  
association, DFS should have been authorized to  
\$. Instead, DFS was funded for eight. With the  
Special Sessions, even those eight Social

underpaid for their services. In the 1989  
ved a rate structure for providers that was  
DFS and the MRCCA. The basic objective of  
State's financial responsibility to 80% of the  
0% was to be raised at the local, community

EXHIBIT 2  
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olunteer efforts. These providers  
80% of the cost of care. That will  
percent range for each year of the  
protective services are quality

ve come up yesterday. We would  
ow well the Department is  
protection.

ie personally, to listen to my  
of Foster Care in order to fund

ation referenced in the Budget  
Modification is a request for an  
ie therapeutic programs begun in  
ams in its Current Level, and  
Y '95.

ograms, then the proper way to do  
LFA Current Level for Foster

ay 'Family' we all think of Ozzie  
Mignon and Ron Waterman.  
nforting, warm. However, this is  
into contact with DFS.

l workers, or our MRCCA  
ibe the 'families' of the abused  
y day. Ask to see the case files of  
review before making your

ed as a 'road map' for the state of  
map is not the territory.' We did  
e in much of what it says and in

s not the territory of abuse,  
all too well. They are familiar  
talk to them before moving 50 or  
into prevention and early

Following are our responses to the specific questions Senator Waterman addressed in her letter of January 25:

Q. Has the original vision of the department been realized?

A. No. DFS was created to provide a single agency for youth services. The Department did not emerge from the 1987 session as that single agency for youth, and it has not become that single agency in the ensuing six years:

- The Juvenile Probation Officers remain outside DFS, and under the authority of the District Courts.
- The Juvenile Justice Council remains within the Department of Justice.
- Childrens Mental Health Programs are at DCHS.
- Early childhood health programs are at DHES.
- SRS is the state medicaid authority.
- The Office of Public Instruction is the state education authority.

Despite the good intentions of the sponsors and advocates who created DFS, services to youth remain fragmented, extending across several agencies. While some things have been done to improve coordination and collaboration among and between these agencies, much remains to be done.

Perhaps the greatest mistake, and we were a party to it, was in promoting DFS to the 1987 Legislature as a 'revenue neutral' agency. That initial design flaw is the source of many of the problems that have followed DFS these last six years.

Q. What have been the major accomplishments and shortcomings during the first six years of the Department's existence?

A. The Accomplishments, as we see them, include:

- Better factual information on the number and types of providers doing business with DFS.
- Development of services and programs designed to complete the 'Continuum of Care' in Montana.
- Development of a single application used for placement out-of-home.

The Shortcomings as we see them, include:

- Deviation from the basic mission of DFS. While it is clear that Protection is the statutory mission of DFS, for the past several years the emphasis within the Department has been on programs and services other than these.

- Lack of effective leadership and management within the Department.
- Lack of parental financial agreements for basic foster care services, despite passage of legislation mandating those agreements in 1991 (HB 243 by Tom Zook).
- Lack of interest in addressing the concerns with the 'Rule of One' for Inpatient Pyschiatric and Residential Treatment eligibility following the January, 1992 Special Session (See letter from Pat Melby to Tom Olsen, February 1992).
- The Department abandoned the model rate structure it had developed with its in-state providers. As new services were brought on line, and as requests for proposals were issued, new providers were invited to 'write their own ticket' with little or no regard to the existing rate structure.
- The regionalized structure of DFS is itself a problem. Regional Administrators were excellent Social Workers. They have not become equally outstanding administrators. They do not have genuine control of budget, personnel or program decisions. Final authority still rests in the Central Office in Helena. In many ways the Regional Administrators are in the worst position of all, with nominal but not real control over their staff and budget. Every year, along about April or May the Regions get the word from the Central Office: 'budget problems. No more placements. The one in one out policy is in force.' The authority of the regions is overridden by the state office.

In addition, the regional structure may mean that children in one part of the state are treated much differently than children in another part of the state. For example, in 1989 with unexpended foster care funds, DFS started its first Family Based Services program. All well and good, except that at the same time in the Western Region there were no funds and children that needed to be removed from abusive, neglectful situations were subject to the 'one in one out' policy.

Q. What specific actions by the Department and the Legislature would best serve the interests of Montana Families?

A. Here is our short list of recommended actions. We have divided them under two major headings--- 1) Recommendations to reduce placement expenditures and, 2) Development of a comprehensive state plan.

**Recommendations to Reduce Placement Expenditures:**

- Eliminate out-of-state Medicaid placements.
- Aggressively pursue utilizing parental financial participation across the



continuum.

- Develop/implement contracts for effective case management.
- Work with existing providers to qualify programs for increased Medicaid dollars.
- Pursue additional funding for chronically E.D. kids, i.e. S.S.I.

#### **Development of a Comprehensive Plan**

- Develop and implement an information system prior to developing any additions/expansions to the continuum of services.
- Develop and publish outcome goals and objectives associated with proposed additions/expansions of the continuum of services.
- Reorganize DFS administration to place qualified, knowledgeable people in positions of responsibility to accomplish the training, development, and reorganization required to fulfill the mission of DFS. This must be done with the input and cooperation of field workers, families, and providers.
- Utilize existing providers to develop community-based services.
- Require outcome studies and analysis of providers based on quality, success, and cost.
- Develop/implement contracts for effective case management.
- Require continual education of all DFS/Probation/Mental Health/Provider staff on options, levels of services, locations available, awareness of appropriate levels of treatment for each individual client.
- Require communication, coordination, and training between providers at different levels in the continuum.
- Approach existing providers requesting that they gear up programs to needs of kids with increasingly severe emotional problems.

It appears that this Subcommittee is ready to consider reducing services at both ends of the 'continuum of care.' On the one hand, it is ready to terminate Medicaid options and get rid of providers like Yellowstone Treatment Centers, Intermountain Children's Home and Shodair Hospital. On the other, it appears ready to approve transfers out of the lower end of the continuum--Shelter Care and Group Care--in order to fund prevention and early intervention programs.

I must say that either or both actions will have a negative impact upon this entire system. It is the system that needs help.

As I mentioned at the outset, many of our members will join you during the week. They will explain, as best they can, their programs, tell you more about the children they care for and the families from which they come. They will tell you what they mean by 'success' in their programs.

I know you will give them every opportunity to testify before this Subcommittee. Thank you all in advance for that; and for the consideration you have shown to me this morning.

**HOUSE OF REPRESENTATIVES  
VISITOR'S REGISTER**

JOINT HUMAN SERVICES COMMITTEE BILL NO. \_\_\_\_\_

DATE 2-2-92 SPONSOR(S) Donnen

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NAME AND ADDRESS	REPRESENTING	SUPPORT	OPPOSE
MIKE HANSHUEN	SPS		
JOHN DONNEN	SPS		
Kate Chulem	MT Women's Lobby		
JOHN WILLIGINSON	Inter maintain children's Home		
Richard Keuster	DFS		
John Ilgenfritz	_____		
Bonnie L. Rushford	DFS		
Colleen Suppke	DFS		
Janell Mayfield	DFS		
J. McQuinn	Herbol Health Center		
Therese M. Parker	Chippewa Cree Social Services	DFI/E	
Paullette Kuhn	MT Cancer Maternal + Child Health		

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ARE AVAILABLE IF YOU CARE TO SUBMIT WRITTEN TESTIMONY.**

**HOUSE OF REPRESENTATIVES  
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NAME AND ADDRESS	REPRESENTING	SUPPORT	OPPOSE
De Hughes	Mt Health Care Assn		
Cristina Medina	Mt Lou Tribune Foundation		
Craig Young	" " " "		
Toto Welker	MAPP		
Shirley Solomon	Great Falls Tribune		
Lana McCall	Youth Symposium		
GLENN McFARLANE	MAFEC		
Dave Wilson	TEC		
JUDITH CARLSON	MT CH. NASW		
Dan Shea	MLIC		
GLAN BRICE	SRE		
PEG WILLIAMS	"		
Ian Matthews	SRS		
Nancy Ellen	SRS		

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