Order of Non-Hospitalization Study Committee
July 26, 2018
9:00 – 11:00, WSOC – Cherry A Conference Room

Attendees: Mourning Fox, Jennifer Rowell, Amy Guidice, Diane Bugbee, Mary Teachout, Anne Donahue, Calvin Moen, Devon Green, David Gartenstein, Michael Sabourin, Kristin Chandler, Matt Viens, Samantha Sweet, Jeff Wallin, Mary Cox, Lindsey Babson, Jack McCullough

Via Phone: Phoebe Wagner

Introductions took place around the room.

Membership:
(1) the Commissioner of Mental Health or designee;
(2) the Commissioner of Public Safety or designee;
(3) the Chief Superior Judge or designee;
(4) a member appointed by the Vermont Care Partners;
(5) a member appointed by the Vermont Association of Hospitals and Health Systems;
(6) a member appointed by Vermont Legal Aid's Mental Health Project;
(7) a member appointed by the Executive Director of the Department of State's Attorneys and Sheriffs;
(8) the Vermont Defender General or designee;
(9) the Executive Director of Vermont Psychiatric Survivors or designee;
(10) the Mental Health Care Ombudsman designated pursuant to 18V.S.A. §7259;
(11) an individual who was previously under an order of non-hospitalization, appointed by Vermont Psychiatric Survivors; and
(12) the family member of an individual who is currently or was previously under an order of non-hospitalization, appointed by the Vermont chapter of the National Alliance on Mental Illness;

Charge of the Committee – There is created the Order of Non-Hospitalization Study Committee to examine the strengths and weaknesses of Vermont's orders of non-hospitalization for the purpose of improving patient care.

Comment: There was no public comment period on the Agenda. One was added at the end of the meeting, and questions/comments can be asked throughout the meeting.

Comment: Through the criminal court process of an ONH, it does not specifically reference ONH but instead orders of commitment. It is quite common for a defendant to be placed on an ONH who has been deemed incompetent/insane.

Comment: This would also affect the defendant through Title 18 V.S.A §7617 Reporting to the National Instant Criminal Background Check System.

Comment: The one-page letter from Deputy Commissioner Fox, where it states about a person violating the conditions of an ONH, in order to revoke the ONH, that is not quite accurate. Fox clarified that it is what happens in practice but is not what is in the Statute.

Question: The 4th paragraph of the one-page letter, you talk about the debate of the usefulness and ethicality of treatment that is brought through a coercive means and the topic is larger than this group, why would you say that? ***Answer:*** *I* was referring to the reference "beyond the scope" is around the legislative language of DMH to work towards a non-coercive system of care, because an ONH is a coercive piece of legislation.

Question: At the end of the day, are we still coming out of these group with an ONH system in place or something different. My perspective is the system is broken the way it is now. Is the purpose of this committee to put a system in place other than ONH? *Answer:* Anything is on the table.

Comment: Addressing whether it is an infringement on liberty that ONHs represent is justified and very much on the table. With regarding to the 2nd paragraph of the letter, I do not agree with that. The law is clear, and I think that happens "if the state proves they are in need of treatment and violating the ONH", these two things are sufficient to revoke the ONH.

Comment: For people who might not be familiar with the ONH process, we should explain the difference between criminal and civil. Another thing is that when someone in on an ONH, it is not available information to law enforcement officials through VCIC.

Comment: Regarding the memo, right now it is channeling defendants into DMH, the charge focuses on the efficacy of the ONH. A big part of the problem with ONH's is that a large population of people are coming from the criminal justice system. What should happen when people found incompetent/insane is informed by mental health care principals?

Question: Do you have statistics for people on ONH's?

ONH Numbers
300-350 on ONH's currently. FY17 we had 61 come out of criminal court, 300 that were civil/family court. FY18 40 are criminal court, 265 are civil and family. FY17 – of the 61 from criminal court, 14 were renewed in family court.

Question: How many ended up not comply? ***Answer:*** We don't have that information right now.

Criminal/Civil ONH (flow chart to be provided):

- Family court process – they usually begin just like any ONH proceeding, someone in the community has an EE exam done, they end up in the ED, 1st cert is done and 2nd cert, then judge determines where to be held. If they get well enough before that, they can get a stipulated ONH with legal aid, an order is drafted and followed, the attorney signs and goes to court, then judge signs.
- Another option is the state is asking for an OH, they determine we have not made a case, but that outpatient treatment is appropriate, and the judge can order a 90-day ONH, but that rarely happens.
- Alternatively, the state might ask for an order of ONH if the patient is unwilling to stipulate to one, the the court could order one for 90 days.
- Other versions in the family court would be an application for continued treatment. We could stipulate a longer order of ONH up to a year coming from an order of OH.
- Criminal court process – the AG's are not a party to this, they are litigated by the State's Attorneys Office. We have seen the repots by the forensic psychiatrists. Frequently the parties will agree to stipulated ONH's.

Question: Do you agree that through the Civil process, the Designated Agency (DA) is involved somewhat as opposed to the Criminal process where at times, the DA has no input whatsoever. *Answer:* The courts have expressed their frustrations that the outpatient forensic exams have no contact with a DA, versus when they have a treating psychiatrist through a DA.

Comment: DMH and legal ask for conditions of release with ONH's, that the defendant schedule an intake with the DA so they can evaluate them and establish a diagnosis and treatment plan.

Comment: We have tried to be creative in coming up with ways to get the information to the court. Another issue with criminal ONH's is they are less likely to engage in the process, even the initial intake process is difficult. I have also noticed a fair number of courts never provide DMH with the OH, and they have now expired.

Comment: A big frustration of the DA's are they have no information about the person, they have the court order with little else.

Criminal Process – people come into the system with a non-emergency situation and is grossly non-functional. A family member can apply under non-emergency and the statute does not distinguish between these. They can be charged with anything, either the defense, prosecutor or judge can raise the question if they are competent/sane and whether there is a need for hospitalization. An evaluation request can be made, a screener may come, they may be channeled into the hospital if the court lets them, but there is a lack of beds.

Comment: There are 45 level 1 beds. Forensic beds are a hot button item, how are they defined? There are 45 level 1 beds for the most acute, needing more intensive inpatient services. It so happens if they come from criminal court, hospitals are only willing to take then on the level 1 bed. Brattleboro Retreat has been willing to take someone coming through the criminal court onto a non-level 1 unit, however this is happening less.

Question: Which hospitals take forensic patients? ***Answer:*** RRMC, BR and VPCH take forensic patients. There are no beds designed forensic.

Question: Do they go to DOC? ***Answer:*** That depends on the court. They are in the beds for as long as it takes the evaluation to be completed, then referred back to court.

Comment: As a parent who has a child that has been on several ONHs, there wasn't a lot of recourse for the parent to do anything. Police say you have to wait until they do something, then they do something and get into the criminal court system. I don't think there is enough recognition that we force them into it by not being able to get them help to begin with. They don't belong in the criminal justice system, the belong in the MH system.

Comment: we have talked a lot of a legal issues, but there is also the social issues outside of legal, like lack of diversion, lack of response, lack of funding tied to ONH, this being treated as a guardian for the ONH.

Question: Another part of the ONH, what happens when they are on the ONH but not complying with treatment? ***Answer****:* We determine if the patient will consent to each condition of the ONH and willing to abide by them. This is a court order so if you violate the terms, the state can file a request for revocation. It is another filing in the family division, initiated by the DA. The state files the request for revocation, where the order was originated. Sometimes there has to be a change of venue, depending on where they live. Typically every court handles it a little differently - the court holds a status conference involving the attorneys for both sides. Sometimes the state will say things are going bad and we need to have a hearing right away, hearings are scheduled pretty quickly. Sometimes, things aren't going that bad, they may not be complying with all stipulations, but in communication with the agency (partly complying). You can put it off for a couple of weeks. Three things can happen with an ONH revocation.

1. The case goes to trial on revocation, the court hears all evidence and either revokes; or

2. The person gets back into treatment, stops doing things that are dangerous, etc., and withdraws request of revocation.
3. This happens with some frequency - the person does not get back into treatment, things get worse and they then get EE'd through the emergency process before revocation goes to trial. The state files an order for involuntary treatment and we then proceed to court on the application for involuntary treatment.
4. One small variation that can happen – the judges don't necessarily like it, but sometimes a person is in need of treatment, the state at that point might file an application for involuntary medication. There have been cases where all parties have agreed to only proceed on the involuntary medication case and hold off on the revocation of application of involuntary treatment.

Comment: Defendant comes in and a question comes up about insanity, the person goes on the list for an evaluation, which can take 15-30 days – they could be in custody that entire time (generally the people in a hospital or DOC seem to have a higher priority and seen much more quickly).

Comment: There are 4 forensic psychiatrists in Vermont.

Comment: the discretion of the prosecutor is different around the state. That is patently unfair. The defense attorneys, they don't know the mental health statues, it is a good thing they are found incompetent, so they do not go to jail, some spent more time in a hospital then they should have, etc. it would be an injustice.

Comment: To the person involved, being forced to be in the hospital is the same as being in the jail.

Comment: It is much easier to get someone committed in the criminal court versus the civil court. I don't really understand it. It is very different.

Comment: You are found incompetent; the statute then sets up a binary stipulation. If you are meeting Title 18 criteria, you may be subject to the ONH. Generally, people will stipulate to that result, criminal defendants. Once they go on the ONH, we have no further involvement for the State's Attorneys.

Comment: Orders were issued for an indeterminate period of time – the Vermont Supreme court ruled it meant 90 days on the first order, then up to a year, then the statute provides for a discharge hearing before DMH can discharge someone from the commitment order (involved personal injury or threat). Two years ago the supreme court changed the rules of discharge, when DMH wants to let someone off the ONH before the term expires there can be a discharge hearing, there is no notice requirement or discharge requirement if the ONH ends as a result of meeting its end date without renewal. Ever since that decision was made, we never hear when criminal defendant gets off the ONH.

Comment: Victim advocate act – there is no provision of that for people who are not found incompetent. For criminal cases with competent defendants, victims have the opportunity to be heard.

Comment: in criminal cases, the defendant who caused harm will be tracked by P&P, the victim gets noticed. When the person gets placed on an ONH, victims are not noticed for that.

Comment: In the way they are filed, it can take up to three months. They should be filed as a motion. A notice of non-compliance doesn't sound urgent.

Comment: I think the reason why they are called that is that is the language in the statute. I am surprised there wasn't a general understanding that when these are filed, they should be set for a hearing.

Comment: There is a big disconnect with the purpose of both criminal and civil/family ONH's. The goals are very different. States attorney is more with people's safety, and DMH is more about treatment

Comment: My son hasn't been hospitalized since 2011. When he went to assist in 2014, he went voluntarily for treatment and voluntarily back on meds. His outreach team and having good case managers was helping him. It is working out tremendously having him do things voluntarily versus ONHs and involuntarily. It is easy to shift into the parental role, without realizing that is a person who could cooperate towards their own recovery. Howard Center has First Call, and a lot of resources to help cooperatively versus coercive.

Question: Can we shift away from getting an order, instead get them involved in their own recovery?

Comment: The black robe effect mentioned in the TAC report – very intrigued about this. It is important to talk about the purpose of treatment and differentiate between criminal and civil issues.

Comment: They are nothing but an advocacy agency for expansion of involuntary treatment, expansion of force. The discussion he has heard before about the black robe effect really bothers me, it is patronizing.

Comment: Doesn't quite agree with that, everyone else has the black robe in front of them.

Comment: For people who end up on ONH and do see a black robe, they are not complying with the ONH's.

Question: Is the mental health court still happening in Burlington? ***Answer:*** Yes, with Judge Griffin.
Comment/Question: Could we start a pilot project to analyze how the mental health court works, get some data around it? *Comment:* This could work in Chittenden, but not in all counties.

Comment: There is very little continuity of treatment when they get put on an ONH and are decompensating. ***Answer:*** DMH is relying on the DA to keep track of this person. *Comment:* Sometimes the defendant doesn't show up for the evaluation or show up for treatment.

Strengths of ONH's

- Only way to resolve a criminal case
- Much longer periods of hospitalizations without ONH's, some people do comply with them
- One benefit is it can divert people from the criminal system who needs mental health care
- It provides an opportunity for those who might be falling of the treatment plan, to get them going again.
- Viewed as a less restrictive alternative to hospitalization, transition out of the hospital back to community base treatment with some form of judicial oversight. It can also serve a role channeling people into treatment charged with a crime. The bulk they see, when there is serious criminal conduct, the order of ONH is not functional to deal with that risk overtime.
- There probably would be some longer hospitalization if not for the ONH, were there an alternative in place, that might not be the case.
- From law enforcement, it is a way to get people into treatment, it is completely coercive, if they have good communication with local MH agency, what else could we do but charge them with disorderly and get them into the system.

Public Comment:

When there is serious criminal conduct – what do other states do? Seriously disturbed with comments here, when talking about the criminal court system, they have not yet been convicted of a crime, they are not criminals. There was not serious criminal conduct, there has been no legal proceeding – so to say we should be doing probation, oversight, this is a treatment issue, they are not guilty of a crime, but they have been found to be a person in need of treatment, so we are giving them treatment. We find the facts, ordering coerces treatment if they are found guilty, but even to purpose as the memo does, I find a great deal of this discussion extremely troubling form a public comment perspective.

I respect TAC but also have to say they are the one advocacy center that focuses on the families of people with serious mental illness, and their needs and the needs of their families.

CNN had a story from North Dakota about reducing inmate recidivism which I found interesting – they are making it more like college, go to classes, get high school diploma, changing cells to make them look more like dorm rooms, the data so far is that is dramatically reduces recidivism. I will send a link to this to consider a different way to look at it.

Next Steps:

1. Flow chart out processes of ONH through criminal and civil.
2. Send to the Committee:
    a. 1998 Acts & Resolve 114
    b. Title 18 §7617
    c. Title 18 §7617a
    d. Title 18 §7621
3. Data, is there other? People who ended up on ACT from an ONH. Review existing studies and reports – various opinions.
4. Before we meet – go through the different reports given. Please get us any reports and we can disseminate.
5. Focus next meeting on the different reports given.
6. Study done 20 years ago by Ben Joseph – see if we can get a copy
7. Schedule next meeting
8. Mental Health court stats?