Forensic Working Group
July 15, 2021
9:30 am – 11:00 am

Attendance – In person: Emily Hawes, Karen Barber, Kathy Hentcy, Jennifer Rowell, Sam Sweet, Tom Weigel, Zach Hughes, Annie Ramniceanu, Monica White, Jack McCullough, Deb Loring, Julie Tessler, Ed Riddle, Erik Filkorn

Via Phone: Alex Lehing, Anne Donahue, Margaret Bolton, Joanne Kortendick, Karim Chapman, Michael Hartman, Morgan Brown, Charity Clark, Ena Backus, Kimberly Blake, Wilda White, Matthew Valerio, Susan Aranoff, Todd Daloz, Jenney Samuelson, Matt Viens, Zachary Hozid, Simha Ravven, Dave Circles

Meeting minutes are intended to capture the substantive business of the meeting and should not be construed as an explicit transcript of all meeting commentary

Welcome and Introductions took place.

Commissioner Emily Hawes presented opening remarks and a welcome. This group is going to look at examining the gaps in mental health and the criminal justice system. Emily is originally from Kansas, worked in a community support program, working with adults, case management services. Transitioned to Vermont and worked for the Designated Agency Clara Martin for many years. She then went to the Department of Mental Health as the director of care management, and then was the CEO for the Vermont Psychiatric Hospital for the past 4 years, before becoming the Commissioner July 4, 2021.

Introduction of Alex Lehning - is currently the Executive Director of Vermont Cooperative for Practice Improvement & innovation [VCPI]. Alex has served in nonprofits, museums, and classrooms for over a decade. As a healthcare and hospice volunteer, he is dedicated to fostering cultures of well-being in both communities and organizations. Alex is an advocate for suicide prevention education as well as student mental health. In addition to his work at VCPI, he is also an instructor with the Community College of Vermont and a historian of medicine. A trained death doula, Alex holds a BA in History from the University of Maine, a Certificate in Nonprofit Management from Marlboro Graduate College, and an MA in History from the University of Vermont

Alex – Please see the slideshow: VCPI_Forensic_WG_Community_07152021.pdf (vermont.gov)

Karen Barber and Matt Viens Presentation

Background:

We do not have a forensic system of care; we have a civil mental health commitment system that interacts and overlaps with the criminal justice system. But as we all know, there are large gaps between the systems, and they do not meet the needs of all Vermonters.

How do you get into the system?

When you are charged with a crime, one of the attorneys or the judge can ask for a competency or sanity evaluation, or both. A DA screener will make a recommendation as to whether the evaluation should be done on an inpatient or outpatient basis, and the court will issue an order.

If it is an outpatient order, the person will return to DOC or the community pursuant to their conditions of release and an evaluation will be scheduled.

If the judge issues an inpatient order, a VPCH psychiatrist or an ED psychiatrist does an evaluation to determine whether the person actually meets hospital level of care. If the person does meet inpatient level of care, the patient will wait for a bed. If the psychiatrist determines the person does not meet hospital level of care the order converts to an outpatient order and the person is released pursuant to their conditions of release.

Note: Competency and sanity are legal terms. You can be found to be either without needing an inpatient level of care. It is also possible to be incompetent or insane for many reasons other than mental illness such as developmental disabilities, TBI, dementia, etc.

Vermont does not have a general fund hospital, like almost every other state. That means all hospitals are certified by the Centers for Medicare and Medicaid Services (CMS) and Joint Commission accredited and to assure compliance with those regulations and be able to accept federal money, no one can be admitted without a physician certifying that a person has a mental illness an that mental illness would benefit from the hospitalization.

This means that just being a public safety risk or being a public safety risk combined with some mental illness or other issues like a developmental disability or TBI, is not enough to have someone hospitalized in our system. It must be clinically indicated and certified. And that is the rub and where the two systems really diverge. The criminal justice system is about assuring public safety, but the mental health system is about treatment. Those do not cleanly overlap.

The other big rub is the statutory charge of DMH – we must serve people in the least restrictive setting, working towards a non-coercive system of care. So, assuming someone has been found incompetent or insane and cannot be prosecuted for their alleged crimes, they will not be hospitalized indefinitely. As soon as the individual no longer clinically needs a hospital level of care they must be released to a lower level of care. CMS, Joint Commission, and Vermont Statutes all require that we get people out of inpatient treatment as soon as clinically indicated.

It is important to note that people can be treated for their mental illness and continue to be dangerous for reasons other than mental illness. Our system is not equipped for these individuals currently because there is no secure setting for them to go to after an inpatient unit except the secure residential, but that also must be tied to mental illness clinical needs.

Orders of Non-Hospitalization (ONH): this is another point of interaction between the civil mental health system and the criminal justice system that tends to frustrate everyone involved. An ONH is an involuntary order in the community continuing someone in the custody of the Commissioner of Mental Health and requiring them to abide by certain conditions. ONHs are overseen by the DAs, who are providing the services. It is important to note that ONHs don't have a lot of teeth – the only tool for a violation is for someone to be hospitalized. But, again, someone can only be hospitalized if they meet inpatient criteria.

Matt - The additional thing to point out is the issue of involuntary medications. There is no forensic system of care and there is often disconnect between criminal cases that are governed by Title 13 and the family court/civil cases governed by Title 18. Sometimes when those systems are overlapping there is the expectation, particularly with States Attorney or courts, if they issue an order of hospitalization or non-hospitalization, that there is going to be an effort to restore the competency of the individual, if they have been found incompetent. Likely that desire or expectation encompasses the belief they may be treated with psychiatric mediation. The only mechanism to involuntary medication is outlined in Title 18 and does not take in restoration of competency in connection with the criminal system.

Question: How does the forensic system relate to developmental disability and not just mental health?
Answer: The Attorney General's Office for the Department of Disabilities, Aging and Independent Living would handle those cases, but individuals with intellectual disabilities can go through the same process, the difference is that somebody with that condition is not eligible to be placed on an order of hospitalizing or non-hospitalization like people with mental illnesses are. They may possibly be put on an Act 248 order and be placed into the custody of the Commissioner of the Department of Disabilities, Aging and Independent Living, there is a higher standard that has to be met in order for that to happen.

Question: What are the currently statistics on people on Act 248 Orders.
Answer: There are 24 people currently civilly committed, in the last decade about 30-40 people in that custody. People who have an intellectual disability can be placed on an order of non-hospitalization, because of a co-occurring mental health diagnosis.

Comment: I would recommend that rather than referring to the term involuntary medication, that we call it what it is for the ones that have experienced it, forced drugging.

Samantha Sweet's Presentation: Please see attached.

The Department of Mental Health has also put out an RFP for a consultant to navigate this group.
We may need more meetings after April so can conquer some of these large topics. Reminder we are always open to public comment.

Question: I don't see the dates of the meetings necessary lining up with the dates of the required reports. How are going to make the reports come out from the meetings we are holding?
Answer: –We did take what was needed for each of the reports and lined it up with what the content would be for each of the meetings. We will doublecheck the dates.

Comment: Vermont Care Partners works with a number of different agencies, if we have can have time between/before the meetings to bring options back to the folks we are working with in the field and then bring back to the group, that would be great

Comment/Question: Can materials from this meeting be disseminated to the group?
Answer: Yes

Question: Can Karen and Matt provide something written on the current system?
Answer: Yes, please see under Karen and Matt's presentation area.

Comment: since civil commitment and insanity defense are the topic of focus, I would recommend we consider including a conversation about any civil commitment. Would be a good opportunity to explore that consideration.

Question: What is the statutory basis for this group?
Answer: S.3

Re: Guardianship is a personal interest of mine; would this be a proper consideration of this group to look at the guardianship laws?
Answer: It would be a little outside of this group but have taken note.

Question: How can the Department of Mental Health respond to someone in a timely manner if that person is either presenting dangerous or not complying with the order of non-hospitalization?

We had the Vermont State Hospital for many years and now we don't, but we have other hospitals that have the legal authority to treat people involuntarily. Over the years there has been a lot of discussion about ONH's and where they are effective to ensure that people who have been determined by the court to require involuntary treatment will get it, comply with it and then can be admitted to a hospital, likely involuntarily if they are not complaint. Some people say ONHs are no good because it takes so long to get them back to the hospital when needed, but that overlooks the fact that for one thing, in the recent few years, DMH has worked with us and judiciary to get them to be a bit more responsive when the Department thinks they need to get someone heard in court quickly, that they should be involuntarily hospitalized. The other thing is that if you are on an ONH, anyone can be subjected to the involuntary process for EE. If someone is on an ONH and is right now doing something that presents as danger, that person can be elevated by the Screeners and potentially admitted involuntarily to a hospital and then the Law Project appointed to represent that person in the involuntary process. It is not unusual that the state initiates the application to revoke an ONH and that is pending the court and something goes bad, the person does something/allegedly, and the person gets screened into the hospital, even while the revocation process is going on.

Question: What if the person doesn't meet the stringent CMS/Joint Commissioner criteria?
Answer: even if person is violating the order, not a danger at present, doesn't meet the criteria of in need of further treatment, make the argument that the state can't prove their case and the person cannot be hospitalized. Another perspective would be if we did have a forensic hospital, that would be an option.

Comment: Backup would be very helpful i.e., workflows for the forensic system and the ONH process.