Forensic Working Group
Competency Restoration Subgroup
April 20, 2022
11:00 am – 12:30 pm

Attendance Via Phone: Jennifer Rowell, Kelley Klein, Matt Viens, Samantha Sweet, Karen Barber, Laura Lyford, Kelly Carroll, Jack McCullough, Emma Harrigan, Matthew Valerio, Heidi Henkel, Domenica Padula

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.

We realized we have been at this for several months and have been spinning our wheels. We thought the smaller workgroups can come up with some concrete recommendations, then bring it to the larger group to discuss. We are focusing on the legal system.

Karen – Try to identify more concretely the gaps in the system. This group, in the legal system, identify gaps we can agree on and see where we can start from. We got an extension until January 2023 for our final report to the Legislature.

Gaps in the System

- ✓ Karen – Gap in folks presenting a danger to the public for non-mental health reasons or has MH diagnosis but can't be served in the hospitals/jails. Gap between DMH/DAIL related diagnoses.

- ✓ Domenica – competency/restoration doesn't exist in Vermont, so this is a gap in and of itself. Hard to talk about different ideas, not knowing what tools we have to work with.

- ✓ Matt Valerio – One of things I have heard from folks is that what we don't seem to have once they get into the mental health system is an ongoing case work to support individuals to make sure they don't go off the rails. If it does exist, it is not robust enough to ensure for a period of time that things go as they should. We see people coming back who have been brought into the system where they don't have where all to stay safe.

- ✓ Karen – Probation/Parole model putting case managers in a position to revoke ONH's. Clinicians indicated that they don't revoke ONH's for a lot of reasons and don't want to get state's attorneys involved or don't feel that some non-compliance should result in revocation

- ✓ Kelly – S.3 testimony concerns: breaking level of trust. If plans were not followed and case worker was not comfortable making reports and breaking trust with clients. Disconnect here. Recommendations for ongoing follow-up via probation/case work.

- ✓ Jack – Defendants being held in corrections pending competency or disposition. They are not receiving treatment in corrections.

- ✓ Kelley – clinical role vs. probation/parole role: would potentially need to be a different individual providing this kind of oversight to provide therapeutic alignment. There shouldn't be an overlap.

- ✓ Domenica – I think a baseline conversation about a facility that could handle this that is not based on therapeutic conditions as far as that goes. It is difficult to talk about different ideas not knowing what tools we would have to work with.

- ✓ Karen – I do think there is that kind of overarching idea of a forensic facility and what that could do.

- ✓ Matt Valerio – When someone is found incompetent, doesn't it need to fall on the therapeutic side. To me it would be a monitoring of the stability of the person, if they become stabilized.

- ✓ Matt Viens – Not necessarily gaps, but it strikes me that maybe some of what is missing, there doesn't appear there are any legislative objects or goals of this system. There is a lack of clarity of legislative goals for this system. There also is a lack of uniformity in the way it works among courts. It seems each County does things differently [courts/states attorney].

- ✓ Emma – I think both Matt's covered my points. There are areas of lack of education on resources and other parts of the system. We struggle with people not understanding what an ED is and is not able to do. What are our options for folks who don't meet level hospital of care but are not willing to participate willingly in the community?

- ✓ Heidi – Why are we diving into 2 groups? We're spending a lot of time talking about community level gaps. This tells me that there is a need for overlap. Needs to be nuance, because most people are a grey area. Not doing involuntary competency restoration. Need to focus on voluntary so people are accountable to participate in treatment. Change sentencing guidelines to allow for rehabilitation.

What are the options for folks who don't meet hospital level of care but are not going to go voluntarily for treatment? Are there any positives that folks could see for a forensic facility?

- ✓ Matt Valerio – I always see the concept of one being a type of respite facility where they can receive treatment until they are better. I never perceived that type of facility that is something that is a punitive response to illness or where it is place where we are going to lock people up who are not compliant and dangerous. Be a resource on an outpatient level and also on a sort of a temporary level. When I hear forensic facility, I think of the one in Connecticut. I do not want to get to that point.

- ✓ Kelley – Assertive community treatment, instead of a facility, we could have a hub or team. Person centered, rather than putting them back into a facility. https://omh.ny.gov/omhweb/act/

- ✓ Jack – Someone who can't be convicted of a crime or are not dangerous should not be committed to a facility. Facility should not be viewed as punitive.

- ✓ Heidi - It doesn't make any sense to lobby for a forensic facility in a group on this topic. I find that inappropriate. The topic of this group is not "Forensic Facility" This is very disingenuous

- ✓ Matt Viens – this conversation makes me go back to one of the thoughts I initially had – I think there is an absence of legislative intent, what is the legislative philosophy here?

- ✓ Emma – Administration define intent of competency restoration in absence of legislative intent? Testimony of S.3 cause a lot of confusion. People arriving in the wrong place for care. Perhaps a psychiatric urgent care triage type facility could fill a gap

- ✓ Kelly – The system is letting people get away with murder. Agencies need guidance and support so they can provide services before it escalates to inpatient.

Karen – conversation of if we had a facility, what would that be used for, and I think that is a really important discussion. Could it be an urgent care, could it be more of a hub program? I think the legislative wants us to hear about that small but complex group of folks who remain a significant danger to the community but don't meet the inpatient level of care and cannot be served in our current hospital system. There remains a level of public safety concern. Some of the cases we are talking about is when they don't meet criteria, but there is a lot of public interest asking what we are going to do about those folks.

Emma – I think it is obvious VAHHS supports a forensic facility. I think we are lacking a defined system and the way that system operates. Questions will still persist even with a facility. Need to demonstrate that we have the resources, oversight, accountability.

Matt Valerio – This group of people who don't meet the legal standard for hospitalization, and maybe don't meet the legal standard for non-hospitalization. I don't know who we are talking about. I am not in favor of competency restoration programs so that we can find a way to put mentally ill people into the Department of Corrections.

Domenica – hopefully we are all talking about options here and currently we don't have any. What I am hoping we can talk about is what happens when we have violent attacks in which how do we address that for public safety concerns. Going through the criminal justice system doesn't have to end in prison. It is an all or nothing type of approach, and it is not working.

Matt Viens – Money/time spent on evaluating people who are charged with nuisance crimes. Attorneys who bring charges for nuisance crimes, found not competent, not prosecuted, what is DMH going to do with that. Inconsistency between Title 13/18. Competency should only be entertained with a certain level of crime.

Sam – There are a lot of discussion had of the individuals who are doing the nuisance crimes and they don't meet criteria to be inpatient. With VSH it was a general fund hospital so people could go there without even meeting criteria for inpatient, now every hospital is CMS certified so they have to meet criteria to go inpatient. We need to look at what are the gaps and what system can we put in place.

Karen - DMH is legislatively mandated to serve people in the least restrictive way possible and only if they meet criteria for hospitalization. What we run against is there is a lot of pressure for the mental health system to do more than it is designed to do.

Emma – Wherever the blame lies, it doesn’t get rid of the problem and maybe broadens who we should include in this group. Do other states have a solution for this group of individuals?

Jack - I know we're running short on time, but I'll just observe that a large percentage of the people charged with serious crimes of violence and are found incompetent to stand trial are also likely to be found insane, so competency is only part of the discussion.

Comment - Clarify legal parameters more [lawyers]