Order of Non-Hospitalization Study Committee
October 25, 2018
10:30 – 12:30, WSOC – Cherry B & C Conference Room

Attendees: **Members:** Frank Reed, David Gartenstein, Calvin Moen, AJ Ruben, Kristin Chandler, Mary Cox, Devon Green, Jack McCullough, Seth Lipschutz, Judge Teachout
**Phone:** Phoebe Wagner, Jeff Wallin
**Public:** Jennifer Rowell, Michael Sabourin, Samantha Sweet, Karen Barber, Matt Viens, Adam Arcoleo

Introductions took place around the room.

**Review Agenda:** No changes to the Agenda.

**9/27/18 Minutes Review:** Page 4, add bullet under Discussion: Eliminate ONHs altogether.

**Extension Request & Final Meeting:** Submitted extension request to the Legislative Committee and it was approved for December 1st. The final ONH Committee meeting will be on November 15th.

**Legislation on Incompetency and Insanity:** Jack found the legislation that was proposed a couple of years ago i.e. not having representation of people who are familiar with the mental health system who are not included in the criminal court proceedings. This recommendation comes out of the study committee of Offenders with Mental Illness that resulted in the bill being introduced in 2017, S.61.

With a criminal case, if the person is found incompetent or insane, there is then a hospitalization hearing to determine whether the person needs to be hospitalized – they can be ordered to be on an ONH, or they don't need any further custody or confinement at that time. Those hearings are conducted like any other criminal hearing by the States Attorney and the defense attorney (typically local public defender) and the basis of the recommendation is that when it gets to that point, the case is not if they are guilty or not, the question is do they meet legal standards that would require the person to be committed. The thinking of the committee was to make the quality of those hearings as great as possible. The two entities that specialize in mental health should be doing those hearings (the Mental Health Law Project and the DMH AAGs office for mental health). There is discussion about intellectual disability and how that would work and there is some discussion about that in this legislation, but this was not entirely resolved by the end. It costs money to do this.

Comment: One of the concerns was the lack of DA involvement when it comes out of criminal court. The DA doesn't know the individual and they are showing up at their doorstep to provide treatment. The hope that with the AAG from DMH involved, there would be a line of communication between the DA and what was happening with the criminal court. The DA's support this language and recommend this change.

One case Jack is working on, it is not a usual case. They got a case to represent a client where client had a guardian ad litem in a criminal case, then client's attorney agreed to an order of ONH without the consent of the client. When Jack got the case, he filed an order to vacate the ONH and is still litigating that issue in Orleans Criminal Division. The person was committed without due process and without consent.

Comment: The States Attorneys have substantial concerns about proposal: A lot of front-line prosecutors address these issues, there would then be a need for other lawyers to involved, then, the second scope of this

raises more questions than answers and seems to exacerbate the criminal justice system. It has been my experience that front-line prosecutors have full competency to litigate these cases and there is no evidence to show that there is a problem with the way in which ONHs are issued after filings of lack of competency. We have Judges reviewing those orders, and we are not aware of any issues. I would suggest that States Attorneys are better qualified to handle these cases based on our experience. We are the ones who get the calls for community members that the person is decompensating. We are also the agencies who see the defendants who are in a revolving door with the system. There could be other issues as well: who would have authority to dismiss the criminal case?

Comment: The Judiciary's point of view is that we were excited this was going to pass in the 2017 session and was looking forward to it. They would support it. They like to have cases tried with attorneys familiar with the underlying dynamics with what is going on. They understand there are some States Attorneys who are aware, but some of these cases can be tried by people who are new. Judges do not have much information on the ONHs to look at, we are not reviewing the underlying facts. Not only are they not substantially reviewing stipulated ONHs, they assume that when they get a stipulation to an ONH, it was worked out with the DA. It never occurred to them that the DA might not even know the person until after the ONH is issued. It would make sense for the notice about the ONH to be sent back to the State's attorney, so they can follow what is happening.

Comment: It seems to me that there are two types of criminal cases, one is where someone intentionally commits a criminal act and the other where the person is in psychosis and they don't even realize what they did. In that case they should be in the healthcare system. Is there some recognition about those two different cases?

Comment: The proposal that Jack and Kristin had submitted as well as legislation last year didn't include individuals who might be found insane. For this to be a comprehensive proposal, it probably should include both kinds. I want to make clear that there is communication between the DMH AAGs, DAs and States Attorneys office and the defense council in advance of an individual being placed on an ONH. In most cases a DA is aware they are going to be placed on an order, the problem is they do not have previous history with the DA and are unknown. That is really the problem.

Comment: That is not the experience of the DA at all. The DAs gave Kristin a lot of notes that they have no idea someone is going to be placed on an ONH, even if they know the individual.

Comment: One of the issues we are grappling with, no matter the heinous act, if the person is incompetent to stand trial, the criminal justice system has decided we can't enforce the law against that person. The issue should be the same, our constitution says you must have treatment and you can't be held culpable to something you don't know you did.

Public Comment: The trifecta being on involuntary meds, there should be one way to wrap it all in one court setting. There is something called an EE, it is all read into the record. I was in the hospital for two months; they wanted me on meds.

Comment: The question of what should happens if a person is found insane, it is legislative. One alternative is to provide treatment through DMH, but there are other mechanisms that are available as well, including public safety which needs to be considered.

Comment: When a court is considering putting someone on an ONH, the standard in the statute is the same, public safety is a part of those determinations and we litigate cases where the question is often raised does this person need to be in the hospital still or could they be safely released under some kinds of conditions that could be tailored in an ONH. They go from simple to detailed stipulations. The family divisions now are absolutely looking at public safety as part of the decision-making process.

**Data Update:** David presented and updated version of data from two meetings ago. For FY17 and 18, what is new is that the data on ONHs is broken up in two categories. Linking them should be straightforward, but the data is managed by the AG's office in Montpelier, and it has been problematic. We need to get this issue resolved before we can get the data.

Comment: Where it shows Civil ONHs, there are none in Chittenden County, is that a glitch?

**DMH Input – Memo from DMH Deputy Commissioner:**

Comment: Bullet point 1: I am opposed to that option. We need to identify the problem of not having enough forensic psychiatrists. We should build this up instead and not have less qualified people involved.

Comment: Agrees with that, psychologists is not the same equivalent as a psychiatrist.

Comment: Other states do use psychologists.

Comment: Defense routinely hires psychologists to give testimony to present opinions.

Comment: Are you talking about changing statute or policy about meds? MTCR/VPCH that exist in statutorily allowance would support this. We have a problem that expands the use of involuntary medications. Another thought I have is that the way the statue works it is written for people on an ONH – if that order is granted the way it works is the person would be re-hospitalized for a period of 72 hours to receive the involuntary meds and then discharged back to their placement. We are already seeing a lot of stress on inpatient resources and I think it is going to be a challenge to shoehorn an additional amount of people in the hospitals.

Comment: If there were no ONH, what would exist instead? I am looking for more of a proposal from DMH that would be non-coercive, recovery oriented, an alternate to ONH, i.e. enhanced voluntary services, Early Episode Psychosis, open dialogue.

Comment: The last bullet point, there has been a real change over in Judges to be very conscious to get decisions out fast. Have you been seeing this as a problem? Answer: The hospitals can perceive it has a problem as it can be an average of 7 days before a decision is made, some outliers have been 2-3 weeks. It is rare.

Comment: State's Attorney Department is in favor of increased time rather than less time.

Comment: No reason to seriously object to the last bullet point.

Comment: We have failed if we are coercive. We need to put money into resources.

Comment: Bullet 5, pilot project – not an advisable position to take.

**Public Comment:**

Comment: I have an ax to grind with BR and NCSS, everything you do gets used against you for job security.

Comment: ONH and involuntary medications is what is being discussed. Antipsychotics only subdued patients to appear sicker, like a chemical lobotomy. Throw out the concept of ONH as it is harmful, coercive.

**Recommendations:**

1. Set a date, a week or two before next meeting for the Department to circulate a list of proposed recommendations, and anyone else can submit their recommendations to the Department.
2. The evidence before the committee is that ONHs won't work well and other alternatives work better.
3. There was a TAC report hat discussed the possible pilot project for a heightened ONH system in a county, where the black robe effect would be used. I think it is worth exploring a pilot project around the use of non-emergency involuntary meds in a community setting like VPCH.
4. Have a true community system and not an artifact. Two side, one to have enhanced ONH and one to have enhanced services in the community.
5. First Episode Psychosis – get studies from other states.

Question: What would the DA's think about keeping the system? Are there legitimate concerns from the DAs? Answer: I have not gotten any recommendations from the DAs on the ONH system. The DAs do not support eliminating ONHs.

Comment: I would be surprised if the DAs don't find that we don't have enough funding, more funding is needed.

Comment: Request that DMH recommend what would it look like if we did something that was noncoercive in nature, what would it include, how much funding would it require? If it was doable, this is where we would put the money? How would extra money be used, etc.?

Public Comment: I fear the more money spent is more innocence swept up in the system.

Question: Do the DAs request that people come out on the ONH as a way of dealing with that person? That they won't take the person unless they are on an ONH?

Question: What are the current lines of communication between hospital staff and DAs when people are getting out? Are there weekly meetings to go over each patient, how that line of communication logistically works right now? What is the current perception of the process when an ONH is being discussed, especially being discharged from the hospital into the community? Answer: The DMH Care Management team is working with the hospitals, looping in the legal team and the DA and there is a lot of communication between all.

Question: Is it up to the DA if they really feel strongly they can't supervise without an ONH, it happens. The DAs voice is heard.

Comment: The hospitals want to get people out, but the DA doesn't want to take the risk, I believe the DAs have the veto power.

Comment: It is hardest when they come out of the criminal court and don't know the DA already and there is no meaningful treatment within the 90-day period. This is a problematic aspect of the system.

Comment: Communication is smoother if the person is hospitalized all the way around. The communication works well in that case.

**Next Steps:**

1. ONH Committee members to review 9/27/18 list of recommendations and add any that they feel are missing.
2. Members asked if a draft report could be ready for next meeting. Any final information to be considered and included was requested by November 1st to accomplish a draft being available.
3. We need a listing of what the original charge is and what we have done.
4. Jack is going to provide his data on revocations to help DMH analysis work.
5. The new forms for motions, Matt will work to finalize the last piece (the affidavit) and then bring the process to the DAs. Once ready, he will coordinate rollout with the courts. DMH supports statewide rollout if there is agreement all around.