Forensic Working Group
January 20, 2022
9:00 am – 12:00 pm

Attendance Via Phone: Samantha Sweet, Jennifer Rowell, Laura Lyford, Margaret Bolton, Karen Barber, Kelly Carroll, Michael Hartman, Annie Ramniceanu, Robert Knelson, Linda Cramer, Monica Hutt, Colleen Nilsen, Domenica Padula, Rebeka Lawrence-Gomez, Matt Viens, Jared Bianchi, Lindsay Mesa, Heidi Henkel, Zack Hughes, Matthew Valerio, Jaye Johnson, Simha Ravven, Jack McCullough

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.

Designated Agency/Specialized Service Agency – ONH Presentations [Lamoille County Mental Health, Howard Center, Pathways]

Michael Hartman, LCMH

Looking at when there was a success that worked well with a client on an ONH

2 cases [involved in homicide] ONH had a manner to engage with the legal system, victim advocate and state's attorney, able to titrate down supervision and increase autonomy in the community, able to live in the community without the supervision. The ability to have an ONH in a collaborative manner was important

When it doesn't seem to be effective:

- Not effective if the person lacks the capacity or willingness to collaborate with the agency doing the supervision.
- Persons with significant and active substance use disorders can be challenged to follow program criteria

Voluntary Program when on an ONH

Criminal court where people were ordered into mandated treatment, in my experience the question of voluntary program is really more a question for the program then it is for the client. If the client is again, willing to collaborate and work with the provider, I don't think that the program being a voluntary one has a huge impact on that except that there does need to be leadership on the treatment team to be comfortable with someone on a mandated order.

State's Attorney when not following conditions

This is a good question. I generally would say that we and also in other agencies, really look to try to do consultation whenever there is a question of someone following a condition. The conditions are often pretty broadly stated, also I think there is a challenge to the question of how somebody may have crossed a line that didn't endanger anyone, didn't pose a risk to the community and if we can work with them when they didn't follow the condition. I think it is a judgment call by the treatment team. I have

seen teams not completely agree with the decision, but it is important to see it as a risk mitigation and involve the systems that need to be involved.

Treatment, biggest barriers on an ONH

Capacity and agreement by the client on the conditions of the order, issues of substance use, threatening behavior. Generally, it is really a question of can we reach a common understanding of what needs there are to address treatment planning and maintaining safety if that is part of the question. The ongoing ONH orders and how we both as treatment providers take on that risk management piece and also take on the piece of how do we help that person gain recovery.

Questions:

Zach Hughes – I have heard that there are loopholes in these ONH's, thought they were stronger than they appear. Answer – I have heard many conversations that felt like ONHs are useless, worthless, I think there is a value in having a legal process where the community is represented by the courts and has the opportunity to engage with the person in the community and the conditions they are in the community on. I think it is a fair process to have that kind of open hearing for both the community and the person who is being considered on the order.

Matt Viens – I am wondering your thoughts about when an agency gets an ONH they don't necessarily think it is appropriate, I am often hearing the debate between usually states attorney or defense council, clinicians at the DA this individuals' behaviors are not a result of Mental Illness. How do you deal with this issue? Answer – I think that mental health treatment is a very common term but in my book I would consider treatment to be different then support or recovery. Are you going to be able to resolve or reach some kind of platform to say the person is better off then before? Can the provider in the community work to provide support and education and other kinds of interventions that might not be a therapeutic session, may or may not involve medication.

Jaye Johnson – I know that DOC/DCF and DMH are all struggling with issues of supervision in the community, what is the order of magnitude you are talking about? Answer – All of those things matter, but it's a case-by-case basis. Risk needs to be understood. Still figuring out best way to do this. Could be more personnel, better communication.

Jack McCullough – disagree with referring to ONH's as having loopholes. Modifications go through court process, which doesn't happen immediately, there is a gap in time, during which a number of things could happen including coming back into compliance or agency concludes things are going fine even without full compliance and may request to drop the order, or dangerous activity resulting in EE. There is some delay, but this doesn't make order unenforceable or useless, the agency and client can still work things out during this time

Heidi Henkel - So, you can do an ONH that involves supporting a person to change their behavior, without necessarily forcing them to participate in treatment in the form of drugs or psychotherapy? I'm concerned about the issue of potentially forcing people to take drugs- drugs don't work for everyone. People's responses to drugs vary widely. There's also the issue of adequate monitoring of the effect of the drug on the person, psychologically and medically. There is a shortage of psychiatrists in VT. It wouldn't be ethical to force someone to take a drug, but not adequately monitor the effect of the drug. So it would be important to be able to do an ONH without forcing a person to take a drug. The ONH

could focus on addressing behavior patterns, with treatment being voluntary and not the direct subject of the ONH. So ONH is a different thing than involuntary treatment? Answer - couldn't agree more needs to be tailored to an individual's needs, sometimes involves medication, sometimes it doesn't. There is never a one size fits all.

<u>Simha Ravven, Howard Center</u>

- Second what Michael had to say about the first issues, when are ONH are productive and effective when someone is engaged and invested, has a collaborative relationship with the agency and clinical team, that is when an ONH is most effective. They can also provide a really good frame for families supporting the individual on the ONH.
- Struggle with the ONH is coming out of criminal court and no have the structure they may need in the community
- When an ONH has not been an effective tool – one of the issues that came up is the issue of an alliance between the treatment team and psychiatrist and the individual. Having the dual roles can be an ethical conflict – not possible to be really effective as a risk tool when trying to create an alliance.
- When they are on an ONH and do not engage with the treatment team. We are responsible for these individuals and have a responsibly for their behavior in the community, yet they don't come to us for the treatment they are obligated to.
- Why would the agency not revoke if they are not following the ONH? It is not the ultimate decision of the treaters or DA to petition to revoke the ONH. My understanding with conversions with the department and Howard Center, that is a decision of the Department of Mental Health. Some of the barriers going forward to petition from the DA, if we are unsuccessful and the nonadherence puts the community at risk, we no longer have the tool of the ONH and often there is a damage to the alliance. I think those are some of the reasons we don't go forward, or there is not agreement with the treatment team and the Department of Mental Health.
- What is the biggest barriers ONH out of criminal court – having robust and highly trained case management who has familiarity and training in understanding some of the issues and framework of people who present with a variety of challenges and treatment needs. The Availability of visiting nurse services for daily medication administration would be helpful for clients willing but unable.
- A need for independent risk assessment not done by the clinical treatment team.

Questions

Jaye Johnson – I do appreciate the direct approach to order of magnitude in terms of success. It sounds like everyone needs robust, highly trained case managers or system. 2 high profile cases that the AGs office took up, they ended up with short prison sentences but long community supervision sentences. What do you think about those cases? Answer – can't comment specifically, but when talking about this narrow population who from my perspective need more robust monitoring support and structure to be successful in the community and safety. Because we lack that, we tolerate more risk for harm. Not potential, it's actual. See more of it. Harm to self and others.

Matt Viens – Problems for criminal ONH success due to lack of structure, is specialize case management (higher numbers and/or more experience/training) the missing structure? If so, is it feasible with the

current system the DA's have to adopt this more structured system? What are the barriers for this more specialized case management system? Answer - I think that we would need a multipronged approach. Need more specialized training. More stable housing with programmatic elements like monitoring and clinical support. Risk assessments separate from clinical treatment. Community forensic treatment models that are multipronged.

Jack McCullough – Nobody doubts that one of the key elements of all of this is a lot more money, right?

Jaye Johnson – On the issue of dangerousness, more about a severity issue not the size of population, the difficulty a team has when feeling afraid. I am wondering if there is an analogy to the mental health system, what you are facing and what treatment for those patients. Answer – how do we treat people who have active aggression or history of violence/aggression, how do we maintain our safety? We can have very strong reactions to people who have committed significant acts of aggression. I really struggle with advising my colleagues as I feel very strongly to not be in a situation where our physically safety is at risk. That can leave a gap and can be a real bind and very difficult.

Lindsay Mesa and Rebeka Lawrence-Gomez, Pathways

- They are designated to provide a particular service, specialize in adult mental health, Housing First.
- Serve through DMH 170, DOC is 98
- Worked well for ONH– removing someone from incarceration, institutional setting. Community based supports can be effective and support this. We have not experienced ONH to be a particularly effective tool in terms of ensuring particular behavior or meeting expectations.
- Conflict may arise when serving someone with an ONH, can be coercive.
- Most of the time when we participate in the creation of an ONH. We don't make recommendations about medication, etc. but more about working with the Pathways Team.
- Revoking if not following ONH – haven't had the experience that something does necessarily happen, usually something changes before something happens with the court. We are in regular conversations with DMH on what works, what doesn't.
- Notification to State's Attorney – This is not something we have had before. We have conversations with DMH. We do not have our own crisis teams as we are not a designated agency, we work with the local teams.
- Biggest barrier to treatment – we talk a lot about what are this individual needs outside of mental health, where are they in terms of their housing stability, food stability and financial stability. If folks aren't wanting to connect with us, what do we need to change to have a meaningful connection.

Question

Zack Hughes – alternative to the DA system, do you approach ONHs differently and how would that be? Answer – I am not sure what DA's do with ONH, can only speak about what we do. If and when we have a say in them, we don't usually request them or a renewal. What is this individuals goals, how can we support them, not because an ONH tells us to but that is what we do.

Sam Sweet – Substance use as a condition for ONH, how does that play into the monitoring/treatment at a DA, how do you handle it if someone is following the conditions of the ONH, but one of the conditions is not being followed, knowing someone is using substances?

- Simha Ravven: approach both those who are on ONH or not. Substance use treatment is often part of supports. Comprehensive on how someone is doing overall. What are the barriers to success?

- Michael Hartman: any problems for the consumer? More of an engagement issue. Be transparent. Keep working to see how it effects risk and ability to be in the community. If it's less problematic, will monitor and continue to discuss so long as its not providing challenges to providing support. Even if the order says there can't be any use, they do not look at that as a deciding factor as to whether the person can be worked with or not.

- Rebekah Lawrence-Gomez: focus on behavior and how do we practice engage in behavior modification. Conversations around how substance use effects behavior. Not necessarily because ONH dictates it, but because of the best interest of the patient.

- Matt Viens: with my role in DMH, we will see situations where an individual is very disruptive in the community, likely engaging in nuisance crimes that are likely not providing a danger to anyone's health, but damaging property, trespassing, and the treatment team will indicate these behaviors are really a result of substance use, not mental illness. They likely do have a mental illness, but regardless, that illness is not the driving behavior. Law enforcement will be very adamant that this individual should be hospitalized.

- Michael Hartman: substance use by itself doesn't mean someone should go to the hospital, that's not always the solution. Though they need to report to the court their concern or sense of risk. Not so much concerned whether someone is violating the order regarding substance use, but more whether it effects their behavior in the community. Hard to separate substance use from everything else when it's a daily part of someone's existence. Inpatient facilities should address substance use as part of daily presentation.

- Rebekah Lawrence-Gomez: get rid of silos. MH/substance issues. More in between options from meeting with case manager once a week or go to the hospital.

- Jaye Johnson: Housing programs that are more tolerate of relapse because they expect a certain amount of that. Could some of DOC's work be something DMH can tap into? Housing models for this population?
    - Michael Hartman - no specific housing model, however, supports for co-occurring MH/substance issues.
    - Rebeka Lawrence-Gomez: this is what we do. Focus on harm reduction. Support to move people in other directions

- Zack Hughes: I have always been very concerned from the peer side about prolonged ONHs. Do we get stuck in this vicious cycle, or has it been broken?

- Michael Hartman: As long as folks are transparent communication with those on the order and around indicators to continue the order. Some risk of automatic continuation. Fair consideration with clear sense of why it's being continued.

Heidi Henkel - Another reason to avoid putting people back in the hospital due to substance use is to leave those beds free for other people, who actually do need them. If someone's ONH says they're not supposed to use substances and they are using substances, what ways do we have of addressing that, besides putting them in the hospital or just accepting that they're using? Seems like there should be ways of actively addressing it, without that meaning putting them in the hospital? Or, if the plan is to just accept it, maybe those kinds of stipulations shouldn't be written in ONH's? Should we avoid writing into ONH's, things that we're actually not going to care about once the person is in the community?

Jack McCullough: when ONH's state no use of illicit substances, sometimes clients are in agreement other times, they want to be able to have a drink occasionally. So, they may try to have it say in the ONH no abuse, rather than no use. But psychiatrists may feel that substance use in combination with medications would not be in the best interest of the client and therefore it's written into the ONH no substance use at all.

Matt Viens - standardized language for ONH's. Conditions previously worded in various ways. Happy to discuss further specific language.

Jared Bianchi – caution on removing public safety conditions. Jaye is on track with cross pollination at agency level. AHS level issue, remove silos. Too big an issue for one department alone to handle. Take it as an agency of one approach, not agency specific.

Rebeka Lawrence-Gomez: Thanks Jared - agree that best practices can be throughout AHS.

Heidi Henkel - I like the idea of stipulating not abusing substances if the person's dangerous or criminal behavior is related to their substance use, and in those cases, finding ways to hold them accountable, without that meaning putting them in a hospital if they use substances. And offering them help with trauma, not just using behavior modification to address substance use. Yes, keep them in the community unless that poses a real risk to the community or the provider.

State's Attorney Discussion:

- Went back to the language this committee is supposed to be addressed, any current gaps?
- This kind of reporting provision can be important in a couple of ways – where we have repeated interactions with folks with law enforcement. When we are engaged with the court and asking the court to do something, specific provisions in an order, we can make more informed discussions how we interact with the court and treatment team.
- We would also want to share that information with victims in a protected manner. Folks often times can be in the same community who they have had a negative interaction with and times even where a person might be just as involved but not held criminally responsible and could pose a risk to that person in the public.
- What is the scope? It is hard to answer that without having a system of care I place where there are more robust options in place for more supervised care, having people who are public safety focused and more intense treatment on the ground, could reduce more direct reporting.

- Physical infrastructure in the few circumstances where there needs to be, could be the forensic facility.

Questions

Simha Ravven – sounds very promising and I would absolutely support going in that direction.

Matt Viens – proposal in writing anywhere? It would be a problem if legislature adopted language but then there's no change to the current system. What are the practical implications? Where is the funding for this? Clear the system that currently exists would not be adequate to address many of the behavior states attorneys are focused on. Many behaviors are as a result of something other than MH issues.

Jared B - S3 requesting language. Don't know if this is final language. Ideal system, with no conflicts DA's mentioned to focus on public safety. Information sharing is important to allow prosecutors to be less reactive, not just on non-compliance but what's being done about it. Might avoid additional charges if better communication. Including victims important as well and is permissible via HIPAA. Perhaps easy statute changes to allow for language change and agency ability/compliance with new language. Medicaid money could potentially be used. General fund monies as well. Need to know the data/numbers, scope of the issues. Emphasis on victim notification.

Matt Viens – creating a system we are taking about would require some additional funds.

Karen Barber – as we talked before about this, every inpatient psych hospital in the state of Vermont is certified by CMS and accredited by Joint Commission and funded in large part through Medicaid and Medicare funds and of course private insurance. Part of the hospitals being able to maintain the use of these federal funds is regulated through CMS and joint commissions. An admitting physician in the hospital itself, has the final say whether they can be admitted - they are the final decision maker, even if there is an order. To have something like Jared is talking about would have to be general funded and if this group agrees, not be afraid to say we need the funds to offset this cost.

Needs to be part of a larger package of things we are putting forward prosecutor notification, need to have more things in the system. It would be beneficial to everyone involved in the process as it sits. In order for us to be most effective to be a systematic reimaging of the state.

Simha Ravven – I think the point of reimaging the system is a really important one. Notification, what I would envision if we don't have a reimaging of the current structure, we would have notifications that aren't really reasonable. I am envisioning there are clinical treaters and a system of oversight and risk assessment that would also synthesis and make information of non-adherence to ONH and look at what is practical. I could also envision benchmarks of what is useful information to act on.

Jared - Public safety liaison – stands between the treatment folks and law enforcement as being sort of a bridge. I think that would make a lot of sense.

Jack M – disagrees with Jared, agrees with Matt Viens. Need method to treat behaviors/causes of behaviors, the idea of forcing them to get outpatient treatment or be hospitalized is misguided. The current MH system does consider public safety. S3 seemed to be more punitive more than anything else. System should not have any punitive component.

Jared B – I don't see it as being punitive in the least. It doesn't change the trauma a person experienced when their safety is called into question. You might be upset to use your store window, and that can be very traumatic for that person, worried that they might come back. Need to be mindful that the person who experiences the trauma, someone like a victim advocate reaching out saying you might see this person, is not punitive.

Michael H – I feel like there is all the challenges we have has been covered in the last 10-15 minutes about how we separate these pieces. As someone who has been working in the system for years, I got to start with the sense that we don't have an adequate care system in the first place. Right now with COVID it is a really compromised system. I do respect what you are saying Jared, I think the other challenge is certainly people who get impacted by this and their trauma and we don't treat that very well either. There is no victim's advocate. The cost we are talking about, trying to get the cost covered, getting yelled at by Legislators and others, if the money is not there to support the system, it is not going to happen. It is functioning as well as it can with the resources we have.

Jared – Identifying and not letting concerns stop us by what would be the best options. I think that having worked in AHS before this role, I think there is ways to find efficiencies and some of these processes might be duplicated.

Zack Hughes - I think we really need to be cautious because when I read about states attorneys wanting that notification, I worry about the whole principal that the person has not been found criminally responsible, what happens in my head is we are heading back to the legal side. I have been a victim myself, and I was informed that the states attorney would not prosecute because of mental health concerns.

Kelly Carroll – the system is not adequate, it's a large problem, think outside of the box, not be restricted by costs. Notification to victims isn't really there. What happens when people not charged/adjudicated and go on finding new victims. Victim could get a stalking order but that's not very effective. Get money from a federal level if not from Medicaid.

Joanne Kortendick: I am concerned with the discussion that ties the issue of Notification with Criminal Responsibility. It is a public safety issue irrespective of Criminal Responsibility.

Link for Legislative Reports: https://legislature.vermont.gov/reports-and-research/find/2022