Forensic Working Group
September 23, 2021
9:00 am – 12:30 am

Attendance: Samantha Sweet, Karen Barber, Jennifer Rowell, Matt Viens, Zach Hughes, Eva Dayon Annie Ramniceanu, Colleen Nilsen, Tom Weigel, Erik Filkorn

Via Phone: Joanne Kortendick, Margaret Bolton, Jill Sudhoff-Guerin, Kelly Caroll, Devon Green, John Wallace, Jared Bianchi, Stuart Schurr, Brian Grearson, Anne Donahue, Michael Hartman, Zachary Hozid, Domenica Padula, Alex Lehing, Clare Pledl, Deb Loring, Kim Blake, Simha Ravven

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.

Quick overview – Virtual and in-person, different teams link with small group activities.

Structured about public comment. Every meeting there will be set times for public comment. We are going to try not to use the chat as much as possible, people found it distracting.

Question: When in small group, what about public comment? Answer: There will be time for the public to comment once all back together, after each group.

<u>Matt Viens – Review flow chart for Criminal Cases</u>

High level overview of the Forensic System. It is complicated and all aspects are not covered in this flow chart. Forensic examinations begin in the criminal court context and in particular, begins when an individual Is asked to be assessed by a forensic psychiatrist or psychologist. Two questions are asked, is the individual competent to stand trial and possibly the second question, is the individual sane at the time of the alleged crime. Likely the defense council has asked for the competency/insanity evaluation. These can happen in a hospital or an outpatient basis deepening on what the court decides and also based on what the recommendation of what the Qualified Mental Health Practitioner [QMHP] is.

Vermont Superior Court Criminal Division issues an order for psychiatric examination pursuant to 13 V.S.A. 4814

- ✓ To determine defendant's competency to stand trial and/or sanity at the time of the alleged crime
- ✓ Applies to those with a "mental disease or defect" as defined by 13 V.S.A. 4801(a)(2).
- ✓ The examinations may occur on an inpatient [designated hospital] or outpatient [corrections, other appropriate facility or community] basis.
- ✓ Inpatient reserved for those believed to have a mental illness.

We are focusing on individuals who are considered to have a mental illness, Title 18 or a developmental disability

Question: Whether or not an inpatient examination can be ordered solely by the judge or is it the opinion of the QMHP? Answer: It was noted this area of the law has changed over time. The change happened close to 10 years ago. The statute requires that a QMHP assess the individual to see whether they need to be inpatient for the exam or an outpatient basis. They provide their assessment to the court and the court is supposed to base their determination on that.

Question: Who can request an evaluation? Answer: The law indicates that it has to be a court, defense council, or states attorney.

Mental Illness: Key criteria for an inpatient evaluation:

- ✓ Danger to self and others,
- ✓ No less restrictive, appropriate place than a hospital
- ✓ Otherwise, evaluation is on outpatient basis

Inpatient Examination:

- ✓ If found competent/sane – will be likely prosecuted for their crime and the process ends, cannot remain in the hospital.
- ✓ If incompetent and/or insane and found to need continued hospital level of care, 90-day Order of Hospitalization [OH}
- ✓ If incompetent and/or insane but does not need hospital level of care, 90-day Order of Non-Hospitalization [ONH], often stipulated to by parties and issued by the court but may also be issued by court after a contested hearing.

Individuals who have a developmental disability may be places on an order as well depending on the circumstances, the severity of the crime and their condition. They can be places on an Act 248, which is overseen by the Department of Disabilities, Aging and Independent Living [DAIL].

Question: Evaluations, you mentioned are either done by a psychiatrist or psychologist - how is it determined which professional is used? Answer: It is a little complicated, the statute allows an evaluation by either and there can be disagreement on what is meant by the language in the statute. The Department interprets the statute to mean that people who have only a mental illness will be accessed by a psychiatrist, developmental disability or possibly some other condition would be assessed by a forensic psychologist. We have both under contract. If they have multiple diagnoses, they may be assessed by both working together.

Outpatient evaluation process is similar to the inpatient evaluation process but for the fact they are not in the hospital. There is a process for working with the defense council, court and DMH to make sure these individuals have access to a computer, etc. so they get the evaluation done virtually. The same result applies. If they are found either competent or sane, that would end the process. If found incompetent/insane, first likely result they would to be put on an ONH, it stands to reason they are not going to need inpatient care. Having said that there are times that is not the case

If the induvial is put on an ONH, it is usually overseen by one of the Designated Agencies [DA]. The Preference is that people who are placed on an ONH always be connected with a DA. VT system of care relies on the DA to give mental health treatment to the communities. There are times where the court or defense council will want their defendant to get services through someone who is not a DA, but a private practitioner. DMH tries to persuade the court and parties not to do that. It is more difficult to

oversee an ONH for persons who are getting care through a private provider. They are placed into the care and custody of the Commissioner to oversee that order.

Question: Let's says they go with a private provider, has that every happened? Answer: Yes, it does happen. The attorneys in the mental health legal unit do their best to work with the States Attorney and defense council to have that not happen. The mechanisms do not exist to oversee with a private provider. There is very little authority to oversee an order that links that patient to a private provider as there is no contact or grant, no oversight.

Question: If they are in the Commissioner's care, would that give that authority? Answer: Up until recently, the Commissioners did not have a voice in commitment hearings the criminal court, they were handled by defense counsel, and the States Attorney

Application for Continued Treatment [ACT] - file in family court to seek further commitment. The expectation is they will engage in treatment with the Designated Agency i.e., case manager, psychiatrist, regular meetings, take meds as prescribed. In a perfect situation they would comply with all conditions. During the 90 days, DMH is working with the DA to see how they are doing. If the agency says we think this person needs to continue the order, or they have done really well, are engaged in treatment, and think they will continue voluntarily, DMH might decide not to file an application. This whole process happens behind the scenes. We have times where they are put on an ONH, and never engage with the DA. 90 days later, they've never followed through at all

Question: They didn't show up/engage, so they disappear off the radar, or do you enforce this order? Answer: The legal unit might give the DA and DMH time to file a revocation of the order or to modify the order, it would likely result in the individual getting hospitalized. There are a number of factors involved. Little can be done through enforcement. Comment: Seems like there is a large hole here.

Question: How many people go statistically into Act 248? Answer: DMH does not have that data. When a report comes back based on a developmental disability, that case goes off to legal council representing DAIL. That seems to be a much smaller group of individuals. Stuart – DAIL doesn't have statistics but can say the last time he checked we were in the mid 30's to 40 with the number of folks who are on Act 248.

Question: Going back to the Commissioner having no voice in court proceedings, when did that change? Answer: There was legislative this past session referred to as S3, which altered language in Title 13 in these cases. It allows DMH to have legal counsel present at commitment hearings in the criminal court. Patients can also have representation by Vermont Legal Aid.

Question: Not being able to enforce the ONH if they do not show up to the Agency, revocation? Modifying the order or seeking a revocation. No mechanism in the law for the individual to be arrested, not like a probation or parole order. That revocation process is geared towards providing hospital level of care.

First Group Break – Report Outs

Group A:

Sue A ○ Housing housing housing and treatment
○ Especially for people who straddle resource systems or who have other forms of non ID disabilities
○ Treatment-missing is psychiatrists who are familiar with autism and other DSM diagnoses that end up in DD land

• Jill Sudhoff Guerin ○ Concern re ONH, access to treatment but also tools for accountability and compliance with ONH
○ Workforce issues, standardized system for evaluators
○ Competency evaluation and restoration-consistency and getting best potential for restoration of comp

• Jonne Kortendick ○ Alarmed by enforcement of ONH from victims' perspective
○ Once individual was placed into DNH custody, communications re individual are cut off.
○ Once person out of criminal justice little being done to move case forward, lack of follow up to return to competency
○ Feels drop in communication came in jump between systems
○ Idea of restoration of competency
○ Emphasis on care leaves accountability for justice aside

• Peg Bolton ○ Times when person would need inpatient assessment but may not meet dangerousness
○ Observations of 30 days are lost and that hurts assessment
○ Yawning gap between voluntary and folks who will not act voluntarily
○ Feels restoration should be reserved for repeat offenses or serious offenses but we do need to focus on restoration
○ Enforcement-ONH is enforced by revocation-system is cumbersome and hard-may be a better way to hold people more accountable for their own treatment

• Matt Viens ○ No

• Annie Ramniceaneau ○ Agrees with ONH comments
○ Doc cannot get person on ONH unless they have been at VPCH
○ Doc can't enforce medications for persons on ONH unless transferred to VPCH
○ Behavioral or personality disorder needs care but no agency can direct care
○ No GF hospital so even very serious conduct not treated properly if behavioral
○ JR II – no criminal justice capable system-people need to understand crim. Risk and need and people in the sys. Of care, people often do noy
○ Pathways ACT/FACT needed everywhere-assertive community treatment
○ SFI – remain incarcerated due to lack of community capacity/diagnostic gap

• Colleen Nilsen ○ Multi diagnosis-DOC gets left with people who do not fill silos of other departments

• Jared Bianchi ○ Need a forensic facility-lack of capacity in current system as to beds but also requiring clinical criteria/hosp level of care. Leaves too many out.

○ Need to remove diagnostic gap- State defines DD/MI very narrowly-not all persons who are incomp/insane meet these-TBI, Huntingtons, behavioral/personality, bad language skills, anyone not within definition of mental disease-defect

○ Need to separate question of diagnosis and treatment from question of commitment/community supervision

○ Intellectual Disability but not Medicaid eligible/no 248

○ Need DA eligibility for assessment for 248-not part of screen

○ No option for person who is 248 but can't be overseen in community

○ MI/ID definitions do not capture full scope

○ Gap between DAIL/DMH priorities and public safety priorities

○ Need structured competency restoration process

○ Need a greater place for victims' voice

Group B

Discussing gaps in current mental health and criminal justice system:

- Competency and insanity are different things altogether— we want to frame the conversation with those as two separate terms.
  - Competency:
    - Does the person understand what is going on with this court process?
    - Looking at the time the person is presenting in court
    - Competency can be raised at any time during the court process
  - Insanity:
    - This is an affirmative defense raised by the defense
    - We are looking at the moment in time when the crime was committed
    - The defendant acknowledges that the crime occurred, but that they should not be held responsible
    - Preponderance of the evidence standard
- People can be found incompetent or insane for a variety of reasons
  - TBIs, mental health/illness, developmental disabilities, dementia, etc.
- What works well in the Criminal Justice system?
  - Consistent representation for defendants works well (MHLP, etc.)
  - S. 3/ Act 57 — acknowledging the differences between communities
    - Rural Vermont vs. more populated areas
- What doesn't work well in the Criminal Justice system?
  - Partner more between Corrections and mental health services
  - What do you do when you don't have an ideal situation?
    - Ex: someone is out (don't meet criteria for hospitalization) on ONH and they become more violent
  - What do we do when someone is released from the hospital and the dangerousness has not been addressed
    - The criminality falls on the person and not the Agency to intervene
  - Notification that someone has been released from hospitalization
    - Mental health could notify Corrections that they may have stopped treatment

        - Nothing in our statute requires law enforcement to notify if person has not been convicted of a crime
        - Could we create a statutory affirmative action of police to notify when someone is struggling?
    - We don't have a secure forensic facility
    - Core issues: balancing people's rights to liberty (if they have not been convicted of a crime) with dangerousness to community
    - Competency can be restored, but we don't have a vehicle to do that in Vermont
        - De facto removal from criminal court
        - How do we help someone restore competency to help this issue get resolved?
            - How do we rehabilitate this person so they can live and thrive in their community?
    - Inpatient exams are only for those believed to have a mental illness
        - We want evaluations/ screening done— we don't have secure settings besides corrections, but courts are hesitant to order this
        - Lack of evaluation beds for those with co-occurring conditions
        - We want a plan developed to enable designated agencies to support that person while their dangerousness is addressed
    - Balancing public safety with services for the individuals
        - Is this person safe enough to be in the community?
        - What supports and services can we provide?
        - Why is the individual not complying with treatment?
        - We want individuals to live and thrive in the community
    - The designated agency field is so understaffed and under funded
        - How do we refer to services if we know they are understaffed?
    - Goal of treatment is to get well
        - Is this also making them more competent?
        - Are we treating so they become more competent?
        - What do other states do?
    - Should the state respond differently depending on the accused crime?
        - Generally: yes
        - Treating misdemeanors as much differently
        - We would look at the violent felony crimes with a different lens

<u>Group C</u>

- Discussion around the idea that when victim advocates and states attorneys are working together well it is a real bonus for the process and the absence is quite noted when not there
- Lack of consistency across counties
- Lack of secure facilities, need for forensic beds
- ONH enforcement aspect
- Why have the system if you don't have to comply with it

<u>Group D</u>

o What is one area of the criminal court ONH process that work well?

- Process that can be supportive of persons who need some level of supervision—some individuals request the orders continue, helps provide a structure.

o Is there anything that does work well in the current system that could help in other areas?

- court diversion works has more community involvement

o Do you see Vermont having a gap in structures?

- lack of psych evals mandated psych eval and substance use eval to get individual to immediately connect people to resources
- EDs and individuals who commit assault, get arrested and then are found in need of inpatient care and return to the same ED
- need to consider the capacity to decline or consent to treatment
-- improve upon system of outpatient treatment community programs—more resources and structure and community involvement for people who are not engaging—look to Connecticut model
- reduce barriers to getting individuals on ONHs to inpatient care / better ways to enforce ONH needed

o Where do you see the biggest gaps?

o Should the system respond differently based on accused crime (felony vs misdemeanor)?

Public Comment

Comment: Original overview, developmental disability was part of the groups charge, I wanted to remind folks that anytime we are taking about the statute term mental disease of defect, by definition that includes both developmental disability and traumatic brain injury [TBI] and TBI as part of the statute- we don't discuss TBI much. There is no ability for the judiciary to mandate any kind of treatment for that. In addition, it is explicitly part of the groups charge to talk about developmental disability, TBI and dementia, which is not part of the statute now. This ought to be addressed as part of these discussions and part of S. 3 charge.

Second Group Break – Report Outs

Group A

Discuss opportunities to improve public safety and address the treatment needs for individuals incompetent to stand trial or who are adjudicated not guilty by reason of insanity and consider victim rights in the forensic care process.

• Peg Bolton ○ It enhances public safety to look at treatment needs of individuals-those needs need to be properly assessed

○ Lack of forensic facility hampers assessment
○ More focused treatment with greater oversight if treatment not fully engaged in-possible return from community oversight to facility
○ CT oversight board-board had duty to communicate with victims
○ In MA we had to write treat recos. Into assessment (statutory requirement)

• Joanne Kortendick ○ Liked reference to oversight board to communicate with victims
○ Victim advocate was great asset-increase their access/remove limitations to extent possible
○ Needs to be more facilitation of victim info and access
○ Balance between indiv. Rights and victims-need more tools to deal with non compliance-would help with public safety

• Jill-Sudhoff Green ○ Comment re enforcement and notification-Des. Agency does not want to be enforcer and treatment provider
○ Accountability Board may resolve the above
○ Agrees with other comments
○ All stakeholders need to be able to give and receive information as appropriate to role in system-goes back to Devon Green comments re ED system – can we flag for others as

• Jared Bianchi ○ Sever safety (whether to supervise/commit) from treatment (what to do once in community supervision/civilly committed) ▪ Look to DCF process/intervention then disposition plan

○ Need a facility
○ Pass law requiring victim access to defined set of info and to provide feedback at various points-HIPAA allows as required by law
○ Complications are of our own making-draft the law you want to see

• Annie and Colleen ○ Need a proper facility and a proper multi disciplinary assessment
○ Lack of access to already available information
○ Prioritizing systems over patients
○ If outpatient assessment, DOC has no access to assessment/barriers to info already held by court, DOC
○ Access to information depends on who ordered assessment
○ Preventing returns-how do we create nimble responses to support p and p if person going downhill

- Need assertive community treatment to address this to avoid returns to incarc. Supported by data.
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⓾ Matt Viens ○ Would like to see a system where crim court remains involved in some capacity- alternative to revocation and hosp. something more in terms of potential results of noncompliance

• General discussion of barriers to information access ○ DOC not granted additional access re assessment in S.3
○ Matt notes confidentiality issues
○ Courts do not always feel they have authority to order disclosure of med records to evaluator
○ Should fall into provider to provider
○ Confidentiality waiver may not be sufficient
○ Sometimes in discussing we miss that we all want something different and are adverse but this is not so. All want safe communities and this is aided by quality treatment

Group B

- Where are there opportunities to improve public safety?
  - How do we consider public safety if this person was not actually convicted of a crime?
  - Can we determine a threshold where we will provide public safety protections, but we aren't going through the criminal system?
    - Restoration of competency process might help resolve this issue
    - Staying in the criminal system indicates that there are issues to resolve once competency is restored
  - We want to treat small, minor crimes as different from felonies
  - Do we want the Emergency Department at hospitals to be responsible for handling these admits, especially repeats?
    - We are once again running into issues with staffing — do we have the psychiatric care and staff to accurately provide this care?
    - We need a more robust healthcare treatment response
  - Increasing employment efforts and housing efforts around the state
    - Community and peer supports
    - Developing local crisis units and non-police responses for mental health calls
  - Healthcare training in hospitals and facilities about available resources
- What is the role of victims in this?
  - Increase outreach and awareness of the rights that victims have
  - More utilization of Relief From Abuse Orders
    - How do we enforce these?
    - More legal representation for victims might help expand those abilities
  - Notifying victims of offender release
  - We don't necessarily have the legal proof to show the offender was the one who hurt the victims if they were found not guilty/ ONH
  - Does the victim want to participate? Asking victims to opt-in or opt-out
    - Who is the victim, who is the offender?
    - Likely a personal decision
  - How do we prevent the harm to future people?

- Utilizing Restorative Justice and Community Justice Centers as places where community members and victims can gather to work through and address harm without criminal convictions

<u>**Group C**</u>

Discuss opportunities to improve public safety and address the treatment needs for individuals incompetent to stand trial or who are adjudicated not guilty by reason of insanity and consider victim rights in the forensic care process.
Questions to start the conversation:

- o Is there anything that works in the current system?

Non-traditional victims (family members, children, animals, etc.) need an extra measure of representation. How do victims know to tap into advocacy? Is that working? John noted that States Attorney contacts or guardian ad litem. There is a decided lack of resources across the whole mental health system. Finding psychiatric care is a challenging endeavor. Not a lack of professionals, but a lack of beds and services.

If the offender is found incompetent, where does accountability and enforcement flow from there?

Must focus on future harm prevention, protection of potential victims. – Deb

- o What opportunities do you see?

More system capacity will allow more options for appropriate intervention—not just beds but early intervention and preventative care. Where can people go when they're feeling like they need help? All roads lead to the ER and sometimes it's a cull de sac.

Need to build more trust in the ONH screening process.

What can we do about ensuring people stay with voluntary treatment going forward?

- o Do victims have a role in this process?

Yes, but how? The victim should have confidence that the state will keep them safe and feeling safe. Lack of consistency. Is there an opportunity for victims to make an impact statement if there is not sentencing? A committee member had an experience where the states attorney declined to pursue action based on the disposition of the assailant.

- o How do you balance individual's rights with public safety?

In the absence of details about the treatment and diagnosis of the individual, it is difficult for victims to trust that they are safe. Is there a way to provide additional reassurance to victims—perhaps some kind of status within the system that is not specific to treatment or diagnosis. Fixing the non-compliance with ONH could go a long way to offering more security for victims. Status notification to states attorneys, etc. could be an avenue.

Group D

Questions to start the conversation:

- Is there anything that works in the current system?
    - Ideally, victim advocate stays involved afterwards
    - Victim's rights on the DOC side works really well in terms of support and notification
- What opportunities do you see?
    - Greater structure around process-- Harris County in Texas—9-1-1 call would go to the DA directly as opposed to police, DA has option of calling police if they feel they need it. At every juncture in the criminal process—when someone is arraigned, mental health provider available to offer services and engage if there are concerns. Mental health support at sentencing.
    - Forensic system of care outside of hospital
- Do victims have a role in this process?
    - Could victims' rights center, dv use their expertise?
    - Does restorative justice play a role?
- How do you balance individual's rights with public safety?
    - Need clarification on constitutional rights around notification
    - State's attorneys are notified re: criminal ONHs, but up to State's attorneys
    - Peers, family members, other supports need to be in process.
    - A lot of variability right now—need more standardization statewide.
    - More resources upstream
        - Pathways does a good job with wraparound services—need something like the Blueprint chronic care initiative
        - Housing

Public Comment

Comment: Victim advocate – stayed with us throughout the process, which was lengthy. Suggested giving the victim advocate more tools once they are places I the MH system,s o they can provide helpful information to the victim.

Comment: Used to have a statute that required a court review before someone was released the secure residential. I think that there are assumptions about HIPPA and/or constitutional rights that are not obstacles. Need to find out what the actual law is. We need to have that understanding about what other states are doing. A lot can be done, find out what they are. Find out what can be done and what things can't be done.

Comment – agree with these comments. One of the problems is educational. The people who are out in the trenches are going to say no you can't have that. It is a matter of getting people to understand where these lines are drawn.

Comment: Needs to be put into the statute.

Comment: Express appreciation for the views and second to looks at other systems and practices that work well that we can draw on. Can't agree more.

Next meeting: Examples from other jurisdictions. We have put out an RFP to ask for forensic psychiatrist to help with this process in hopes this is part of the requirement. Reached out to a couple of states, CT being one, waiting to hear back if they can present at our next meeting.

Public Comment

TO: Forensic Working Group

FROM: Kristin J. Chandler

RE: Gaps in the forensic system, public comment

DATE: September 13, 2021

I worked at DMH as an AAG for 8 years from 2005-2013. In that capacity, I handled the forensic cases in criminal court, working with both prosecutors and defense attorneys in every county in the state. By forensic cases, I mean any criminal case where the defendant had a mental illness or was found to be incompetent to stand trial or insane at the time of the crime. I testified at the legislature this past session about my experiences in court.

One of the gaps that became evident early on in my work in my capacity as an AAG is the lack of alternatives for defendants who are found incompetent not because of a mental illness, but because of an intellectual disability. This group of people do not fall under DMH's jurisdiction and by statute are not eligible nor appropriate for an Order of Non Hospitalization (ONH) or an Order of Hospitalization (OH). Because they are incompetent, these defendants cannot be prosecuted. The only option available for State's Attorneys in these cases is to dismiss the charges, with or without prejudice. If the underlying criminal offense was a sex offense or a crime of violence, I would refer them to my counterpart at the Department of Aging and Independent Living (DAIL). But the vast majority of the criminal offenses were not sex offenses or crimes of violence; they were misdemeanors.

During my tenure at DMH, I kept a log of these cases that fell into this category; at one point, there were 69 such cases, ranging from felonies to misdemeanors. There is no ONH alternative under DAIL's jurisdiction. I identify this as a gap in the system of care. No services are guaranteed for these defendants who are incompetent because of an intellectual disability. There may not be any services offered by any state agency for these defendants who truly fell into a gap. I often experienced repeat offenders who came before the criminal justice system because of their intellectual disability. Law enforcement is frustrated by handling repeat offenders who fall into this gap in our system. The victims of the crimes committed under this

category of defendants have little to no recourse. Restitution cannot be imposed upon these defendants.