Forensic Working Group
October 21, 2021
9:00 am – 12:30 am

Attendance: Samantha Sweet, Jennifer Rowell, Annie Ramniceanu, Laura Lyford, Emily Hawes, Tom Weigel

Via Phone: Michael Norko, Margaret Bolton, Joanne Kortendick, Kim Blake, Ed Riddle, Zack Hughes, Tom Weigel, Karen Barber, John Treadwell, Kelly Carroll, Ultan Doyle, Dillon Burns, Matt Valerio, Matt Viens, Jill Sudhoff-Guerin, Clare Pledl, Deb Loring, Rhonda Palmer, Simha Ravven, Matt Viens, Susan Aranoff, Colleen Nilsen, Alex Lehing, Devon Greene, Zach Hozid, Anne Donahue

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.

Connecticut's Forensic System of Care -Michael A. Norko, MD, MAR

- Director of Forensic Services, Forensic Psychiatric and Professor of Psychiatry at Yale. Involved since 1988 in Connecticut's system of care.
- Evaluations are done privately in Connecticut
- Competency evaluation system is done by evaluators hired by the State. All of insanity evaluations are done by private mental health professionals.
- Defense hires a psychologist or psychiatrist to conduct the evaluation. When they give notice, the state can hire their own expert, both sides prepare reports, and it goes to trial.
- 60 day eval – should person be committed, if so, at what security level. Court decides whether to commit and how long. Could be maximum amount of time had they been sentenced. Can be recommitted after initial time expires if necessary, so not necessary to commit for full sentence.
- If court agrees with conditional release, they stay with same program and living situation from when they were out on bond. Assigned a supervisor who follows case and reports quarterly and biannually. Memo of decision with various requirements including therapies and living arrangements, where they can and can't go or do. Work, school, car, relationship.
- Conditional Release – they get a supervisor who is responsible for following the case and reporting to the PSRB every quarter, with a full report every six months. Heavily monitored system and what the board does in response to the commitment is generate a memorandum of decision, usually quite specific and detailed and requirements are fairy lengthy.
- Team/unit assignment at hospital – stabilize person, assess, determine needs, adjust to being committed. Hearing every 2 years about recommendation for changes. Notify for recommendation for change in security level. Board makes decision about this. No recent restraints/fights, complying with meds.
- Hospital's responsibility is to make an argument that the person is doing well, ready to move to the next level - are they ready to leave maximum security and go to the other building known as enhanced security [medium security], the board makes the decision about that based on the hospitals report. The Board is looking at some level of insight and therapeutic alliance when they make a decision.

- Board was created in 1985 and modeled after the PSRB created in Oregon. We did what they did with a few exceptions. Our board is 6 members: a psychiatrist, psychologist, attorney, someone experienced in probation and parole, a member of the public, and a victim advocate was added later. They are appointed by the Governor and are not paid. They get reimbursed for travel expenses. They meet every other Friday for a full morning.
- Hearings – victims are allowed to make statements, are open to the public, local police department sends a Sergeant to every hearing [after a tragic incident involving a 9-year-old girl]. After that incident, Independent forensic psychiatrists were used to make assessments separately about what risk management needs the individual patients have.
- The State's Attorney represents the victim in the case and often invite them to speak at the hearing. As a society we do not provide enough support to the victims.
- A few years in max security 5-7 years, a few years in med security 5-7 years (these people are on a trajectory for community rehabilitation) extend privilege levels, supervised trips to community, unsupervised walks around the hospital grounds, confirm no sudden changes before leaving and frequent check ins while out, sign in at group therapy (confirm attendance), then conditional release.
- If someone is in medium security assaults someone, etc. we can move them back to maximum security. If they go voluntarily, the board won't do anything for six months. If it lasts longer than six months, the board wants us to come back and make an argument for why they should be transferred to medium security.

Questions and Answers

Question – Does the patient have legal representation while going through this process? Answer – yes, most of them are represented by the office of the public defender.

Question – what the PSRB made of and the qualifications – psychiatrist, psychologist, attorney, someone experienced in probation and parole, member of the public, victim advocate.

Question – could someone with a minor crime, say simple assault be committed to the PSRB? Answer – yes, if they use an insanity defense for a minor crime, then yes.

Question - What legal standards are applied at the PSRB level? Who has the burden of proof? Answer - any decision the board makes can be appealed to the superior court. The burden is on the side of the person who is asking for some change at the hearing.

Question – you described the factors considering the PSRB. If a defendant is symptomatic or is just not following the rules, but there is no evidence that the person would be a danger if released, is that a basis for release? Answer - there are no statutory criteria about that. How the board is considered public safety it is up to them. Usually both psychiatrist and psychologist have forensic experience, sometimes formal training and consider them forensic. All of them have had to make decisions on risk and use their own training and experience in making those decisions.

Question - Can you speak to those who have been found incompetent, where do they fit in, are they overseen by the PSRB? Answer - They are not overseen by the PSRB. if found incompetent they get referred to restoration. We do about 300 restorations a year, about 25 of those are done as an outpatient.

Question – What is the court process around NGBRI. Vermont stipulations – with no evidence taken and no finding of person having engaged in criminal behavior? There has to be finding that the person engaged in the behavior.

Question – What government entity oversees community supervision for those in PSRB custody on conditional release? Are there specific community treatment programs/staff for individuals overseen by the PSRB? All of those people have a lead mental health agency that are responsible. Half are state operated, and half are non-profit. Depending on the volume of forensic cases, they may or may not create a forensic unit. Others just have them mixed in and someone is assigned as the conditional release supervisor. The board has the option to name someone as a conditional release supervisor.

Question – You mentioned a report generated every 6 months that is submitted to the PSRB, is this report public information and/or available to the victim or victim's family/representative? The reports are not considered to be public information via the board. Anything that is testified to is public information and anything that is submitted as evidence will be public information.

Question – Can you do involuntary competence restoration? Answer – we have two procedures for involuntary medication, one of them is by going back through the superior court. The court appoints a healthcare guardian, hospital makes case and testifies. The healthcare guardian is appointed [is the medication in their best interest,] 120 day order and can be renewed one more time, then another hearing is required. The other procedure was what the legislature enacted where the supreme court ought to have a civil system to medicate people. We created a process that is parallel to our civil process, goes to the probate court. The factors the probate court consider, where they need the medication to treat the condition and not necessarily whether they need it to response to competence.

Question – Is there state licensure for forensic psychiatry? Answer – no, just the normal licensure in Connecticut. As long as they are qualified and deemed an expert by the court, they can testify.

Question – What is different for people with intellectual/developmental disabilities? Answer – they get sent to the Department of Disability. If there is a question of an overlapping depression, they might be sent to DEMAS for the restoration part. There are not many people who are found NGRI for intellectual disability.

Question - You said a person can be held for 18 months, is there consideration of danger in the decision to confine the person. Answer - No, not in Connecticut.

<u>Connecticut's Forensic System of Care debrief, Compare Vermont system and Connecticut's system</u>

- Jack M - Series opposition to this in the model in general. The idea someone can be committed for a fixed term for a minor, non-violent felony, would be an ataman to us and the values we have in Vermont. Question – do you think those things could be changed with tweaks to work for Vermont? Once we get rid of some of those particularly problematic issues, I don't know what is left to say we have the Connecticut model in place. One thing that is an issue is the key element is considered the decisions are made by some board rather then the court, that is something I would have a problem with. These are vital issues of personal liberty and should be done in court.
- Matt Valerio - What do you think about a restorative model? I think that a practical matter it won't make much difference. It seems the biggest issue I am hearing is the lack of resources and follow up from DMH or some other agency in supervising someone in their custody in the community. In Vermont they don't act like probation officers and don't have those resources

committed. How do we deal with the folks who are not confined but under mental health orders in the community? CT does it by effectively having parole officers, we have very few sanity cases. Do we have the resources in the community [supervision and treatment]?

- Tom W – I agree with Matt, the issue at hand is someone that gets out of the hospital who is not going to appointments, not taking medications and by history when that happens, something violent could happen. To note, not necessarily advocating, but CT does have a forensic hospital which we don't have. In that type of setting, someone could be placed without meeting the safety criteria that Jack mentioned. It does sound like this board is similar to a parole board, but you have to go to the weekly appointments, take meds or they will pull you back into the hospital which is very different from Vermont's non-hospitalization orders.
- The structure of their forensic hospital, they unified back in 1995, have a 500-bed state hospital and 229 are forensic beds. They have a small number of admits from DOC and a small segment [20%] of civil patients who are too aggressive to be in a regular hospital.
- Joanne – I agree with the last two commentors in relation to competent to stand trial. I feel like they are not doing much in CT with those issues, and I did think it was interesting the comments the speaker made for the 1986 proposal and the Oregon model. I did also find an article written by Michael H. that folks might find interesting.
- Dr. Bolton – I do think that in Vermont, we do not have a competence restoration system. I do think there are models who have an outpatient restoration. Vermont has a lack of a space to do a good thorough evaluation. In favor of court staying involved, good assessment with a good treatment plan.
- Matt Valerio – insanity versus incompetence concept, two different issues – for reference we have 100 competency to stand trial cases for every 1 sanity case that is even considered. CT virtually handles it by civil commitment. That is something we have not talked about here. Biggest bang for your buck is to go for the competency issues whenever those might arise.
- Deb L – In terms of the PRSB, do they actually make the decision or make a recommendation to the court who then makes the decision. Answer - They make the decision. In Vermont, is it an option to have something like the PRSB to make a recommendation to the court? If we are going to take this big chunk of time to look at this, we are really dealing with competency and non-hospitalization and that is the biggest chunk of our problem. Likes the supervision and 6 months reports about the PSRB.
- Susan A – I worked at an organization like DRVT in CT. I sent a two pager on some of the abuse that happened in CT. Things are not all rosy in CT. The CT system costs a lot of money. The PSRB is run by volunteers and very often they can't hold a quorum. CT does not have orders of non-hospitalization. There is no involuntary treatment outside of the hospital. Will look for other models to look at
- Rhonda P – Keep in mind folks with Intellectual/developmental disabilities, they need the same level of supports, sometimes more. Be sure to include these folks.
- Heidi – a big problem with forced medication is how people respond to the medications is very individual. If they are only seeing a psychiatrist 15 minutes every three months, they need to have adequate medical supervision. There are instances where there is a type of domestic abuse, in order to get control, they will accuse the person of doing something – process similar to an arraignment, is there significant evidence this person did this thing.
- Devon G – Restoration and competency piece that CT has and was wondering what the groups thoughts were on that? Simha – it would be very important in Vermont. We find a lot of people don't get to resolve their legal charges because we don't have a formal program to restore competency.

- Kelly C – Competency and restoration is a good thing. Likes the increased supervision. I am an advocate for community-based treatment where applicable. I think we need to have a better process for supervision.
- Tom W – a forensic facility is expensive to build and maintain/staff year after year. ONH system in Vermont – some people have claimed it is useless, and the only force is that a judge says they have to take meds/treatment.
- Jack M – Competency/restoration – I am hearing people say it is a good thing and am curious in CT, what kinds of cases are defendants being restored to competency for. In my project we represent who are put on orders after they are found incompetent to stand trial and a great majority of those cases are people who are charged with minor offenses. If agencies had enough money to provide adequate services, that is what we should be focusing on instead of doing things like massive new hospital projects like CVMC.
- Simha R – There are good models for competency and restoration programs that are community based in CT. It is a difficult bind for DAs that we are treating people on ONH's and called on to align with patients and try to look through their lens and that conflicts at times with the goal and the task of being objective evaluators of violence risk. We need to look at separating those two roles to strengthen that system.
- Deb L – committee a couple of years ago for the ONH system – was that a report to the legislative body and helpful to review? From a victim's perspective, competency/restoration is extremely important.
- Joanne K - flexibility idea with restoration models, should be emphasized where extreme cases were committed.
- Rhonda P – I think they are important for misdemeanors to be tracked. Should be put out to the community, if it hasn't, about this group that this is being looked at.
- Simha – effectiveness of competency and restoration, share the data how often this works – competence restoration program restores between 60-80% to competency. It generally works.