Forensic Working Group
November 18, 2021
9:00 am – 12:30 am

Attendance: Samantha Sweet, Jennifer Rowell, Laura Lyford, Emily Hawes, Erik Filkorn

Via Phone: Margaret Bolton, Joanne Kortendick, Linda Cramer, Rhonda Palmer, Matt Viens, Karen Barber, Jack McCullough, Jill Sudhoff-Guerin, Emma Harrigan, Jared Bianchi, Heidi Henkel, Michael Hartman, Kelly Carroll, Colleen Nilsen, Clare Pledl, Domenica Padula, Stuart Schurr, Susan Aranoff, Tom Weigel, Matt Valerio, Simha Ravven, Dillon Burns

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.

Jack McCullough Presentation –

https://mentalhealth.vermont.gov/sites/mhnew/files/documents/AboutUs/Committees/FWG/MHLP_Representation_in_Hospitalization_Hearings.pptx

Jared – Has the 90-day period of an initial order vs. the "indeterminate period" language in Title 13 been the subject of litigation? Answer: Yes, I believe there is a supreme court decision. Not certain at this time.

Susan – Describe briefly how this works for a person with an intellectual disability? Answer: This is still being worked out and specifically, we are anticipating there be very few cases of Intellectual Disability, and most would be mental illness.

How many people currently are on orders under Act 248? Answer: Don't have an exact number, somewhere around 30 to 40.

Matt V – What is Legal Aid's view of the new notice requirements - do those follow subsequent family court orders or apply only to the initial 90-day order issued under "this section" of title 13? Answer: No answer at this time.

Rhonda – Who pays for an independent eval? If evaluations have different outcomes is a third evaluation required or how is it determined? Answer: Payment is made by the State. Additional funding for Legal Aid, Attorney General, and independent psych evals.

Jared – The process is a little different under Act 248 for DAIL. When we are talking about Intellectual Disability and Developmental Disability, there are very specific definitions. It is not any crime committed, there are certain crimes that are qualifying for Act 248. The Commissioner must be able to provide a program that can meet the persons needs.

Jack – One of the big differences from the current statute and previous, under Title 13, it could be any crime at all from homicide all the way down to disorderly conduct. What I anticipate in some of those cases, the state might be able to prove that yes, without treatment, they can go out and still be a nuisance but that doesn't necessary mean that the person should be committed. That is one of the areas we will probably see litigation.

Thoughts on what Jack just said:

- Two very specific definitions of populations that can be served. Shows that possibly there are folks that cannot be served by either DMH or DAIL and that brings this to the forefront.

Jack – Could discuss when your department might be taking an active role on these cases? Karen - DMH internally is trying to figure out what the process will be going forward. We have weekly meetings with the leadership team on this to review all of the cases we know about that are coming through. There are a lot of cases I wasn't aware that were touching the mental health system coming out of the criminal system. Is this person really appropriate for an ONH, or OH. We are looking more critically at them. We have hired conflict counsel on a couple of those cases. DMH has allocated funding to be able to do these cases. We agree we will start seeing more contested cases as we look a little more closely.

Jared – When ONH or OH is proper and when it is not? Karen/Sam – There are two ways, statutorily does it meet it and it is also a clinical decision. We are reviewing each case to determine does the person have a severe mental illness. Does it make sense they fall under the criteria for inpatient hospitalization or do they meet the criteria to be served by a community mental health agency.

Peg – We do not access for need of treatment when we do these evaluations. I think in Vermont, we have made the choice to be treatment focus and non-coercive as possible. Advocate strongly for more community treatment.

Jack - Contractor from outside of Vermont is doing a majority of the evaluations and there is no direct contact with the defendant except via a video screen.

No Public Comments

Article and Webinar Discussion

Michael – Didn't finish the entire video, but going on my own experience, overseeing CRT programs for a coupe of decades, crisis work, DOC level, overall, I am glad to see this getting attention. Depending on where you live, you get better service, worse service. One o the aspects of this is looking at the State taking a lead on how to develop a really tight system that impacts every part of the state. Gives everyone equal access to whatever we come up with in the end. How do we make that upfront time not be very long? How do we make competent the community side of doing more assessment, more that these kinds of individuals who get caught on or near this border, often require pretty constructive approaches, and we might not have the expertise?

Kelly – Important to have the right-hand talk to the left hand, integrated computer system would be good. This could have a huge outcome to have one database.

Jared – Listening to what other states are doing, is there a conversation to be had to what Medicaid funding is driving the decision making? Answer: That is a good point and one DMH tries to stress to the

Legislator and anyone. I think in most States there are a forensic facility, usually general funded. CMS and joint commission have strict clinical and quality metrics via their admission procedures. There would be more flexibility if we weren't using Medicaid funding.

Jack – The speaker raises the medical ethics question, I know if you are a psychiatrist in this profession, you truly want to help people. I think it would be really tough if what is happening someone has been sent to you for treatment and the ultimate goal is to have them sent to prison for a long time. I think that would cause internal angst or conflict.

Peg – There is so much in the video. The issue about an inpatient facility and the need for separation of treatment. We have avoided a long list of people held to be resorted and I think we should not do that. We do need restoration with people with serious crimes and possible repeat misdemeanor. The old state hospital had a certified floor and a noncertified floor. I wondered if there were parts of VPCH that could be used for either holding folks in these unusual circumfuses. It is such a big issue.

Matt – Mental health court/treatment court, don't practice in it and don't really understand it. But what I do understand, there is some of that in Vermont to some extent but for those folks deemed to be competent.

Matt Valerio – We do have treatment courts in Vermont but a completely different kind of thing. They are not what we are talking about here. They are for individuals who are mentally ill, yet competent or in need of treatment of some variety, yet competent. Orders coming out of the public defense system, looked like they were prepackaged – this is what Legal Aid was seeing over the years. If we do a mental health type court that addresses these things, very different then the way these cases have been handled over the last 30 years.

Karen - We are hoping to get at is where do we want to go and how do we get there. I encourage people to think outside the box. We can put forward tings to the Legislature.

Jack – What we have now is we have more states attorney across the state who are likely to be receptive to this type of thing which is a good sign. I think this could very well be productive as the discussion goes forward. I agree that it would be wrong to put everyone that is a defendant to put any little charge through the restoration system. Back in 1985: JL vs Miller - involuntary medications at the state hospital. Substitute a judgment – would the person agree to take the medication. Are they constitutionally entitled to have?

Recommendations: may be support for some sort of a restoration of providence program, would need to be flushed out? And, some sort of diversion for folks who don; need a hospital level of care, like a mental health court, or some type of diversion?

Simha - Voice support for restoration, both hospital and community-based settings. Also give a strong consideration of community settings to monito, specialized treatment more funding and oversight.

Jared – Restorations of competency program would be a really important tool. The concept of both this and diversion program would be good. It will be important to change the structure of the definitions we are talking about. Some support for forensic facility.

Simha – Support the idea for a forensic hospital. Really important for the gap in clinical needs and competency and insanity folks who are hospitalized for competency assessment and potentially for restoration. The gap between the clinical program and funding.

Jack – My thoughts on the questions Karen raised are:

- Not sure if I agree with the principle that we should a have a competence restoration program
- I do agree with diversion
- If we do adopt competence restoration it should be limited to the most serious violent crimes and people who would be dangerous without treatment.
- Least restrictive alternative should be a core value

Comment: The CT state hospital had high acuity floors, there were folks who were the most acutely dangerous, In Vermont, there is no special floor for someone who is more dangerous or aggressive than someone else. It is hard to mix those populations.

Michael – I have heard from many inpatient doctors, since they are on the unit, you can have problems for assault from both sides. Some say it is not the forensic folks they worry about as much. There is tension between equity, victim rights, rights of the person accused, and community attitudes. One place to start is the commitment to making folks well.

Joanne - I can't speak much to the infrastructure in Vermont, from a victim's perspective, I think it is important the legislation around this should talk about restoration. That is lacking in Vermont statute.

Simha – CT system – that brought to mind for me, an important level of care they have there is a formal program to help people transition to the hospital setting to the community setting.

Peg – The sequential intercept model can be used to divert people to outpatient care.

Kelly – Since VT doesn't have a forensic facility, does this mean that the VT Psychiatric Hospital has the right to decline to admit an order of hospitalization admission and if so what happens to that person? Would that person stay in VT or get placed elsewhere? Answer: We are Medicaid funded, CMS and Joint Commission. The question is under what circumstances can our physicians submit someone - Yes, there are times when they do not meet clinical level of care and we say they do not meet admission criteria.

Tom – I think we do need to spec out the budget for creating a forensic facility and what it might cost to maintain and staff that each year. I also worry that the number of beds that were built would naturally end up full because things get stuck.

Jared – Important to not just create more beds to fill the, but to address unmet needs.

Emma – When things get stuck in the system, people tend to wait in the EDs for a long period of time. Our concern is healthcare workers can get hurt. I really wanted to include that point here.

Kelly – If someone goes through the system and they are not competent and they are violent, do we have a place for that person? Answer – it depends. If someone actually meets hospital level of criteria, VPCH, BR and RRMC accept forensic patients. They could have to wait until a bed opens up. If they are

in jail, they could continue to wait there, or in a hospital. We can't send anyone out of State. They are limited to Vermont. ED is not the appropriate place for someone in a crisis to wait.

Michael – In terms of my time as the Commissioner where we had to design a hospital, I was unable to find a model that said how many beds. There is not one piece of reliable information that can tell you population size for the number of beds. Also, I think the question about the need to really see this as a whole community issue that involve interactions with the criminal justice system, all of that should be addressed.

Jared – Note: the importance to having community focused treatment and instances where some of the DA staff who work with folks have been asked to and experienced some risks and harms that are probably not really reasonable to ask of them.

Emma – Agree there is no precise math for future bed needs, but there is a closer approximation of what we might need in the future with data gathered during COVID.

Rhonda – Difficult working with some of these individuals, worked with many tough clients over the years and it is challenging, hard to recruit and maintain the staff, which leads to safety issues. More collaboration and working with the teams are vital to success.

Sam – Care management team at DMH, both on the kids and adult side. Adult side - 4 care managers, what that does is we have 1 dedicated full-time staff only doing triage [ED, ES staff at the DA]. We know when a bed is available, who is going into that bed, preparing the paperwork etc. to get to the hospital. Other staff work solely with the inpatient units, once they go inpatient, we work with them if they are involuntary or the CRT program to break down any barriers to discharge. If on an ONH, we follow them in the community and help with that.

Joanne – wanted to clarify the population covered by Case Management? Answer – who is under the care and custody of the Commissioner – anyone on an involuntary order or on an ONH. That is who we have to follow. We also follow voluntaries on Medicaid and in the CRT program.

Jack – With a lot of the clients we represent who are admitted to an ED or med surge, we see a pattern of the person sending days or weeks in the hospital, then they get transferred to a psych hospital and are discharged almost immediately. It really kind of seems lie the general hospitals, when they get there, they cannot discharge the person. Answer: every hospital has different levels of comfort with discharging and being the last one to discharge. We are always having those conversations.

Colleen – I am wondering if it would make sense to map out the different buckets of people, in some ways, getting confused on what groups we are talking about. Where is the scope?

DMH is struggling with the number of requests that the Legislation is tasking us to look at. What can we really focus on?

Kelly – Care management team – what is the average ED wait time? Is it comparable across the state? Answer: several people look at wait times, we definitely track that. During the pandemic, wait times have gone up and there are a number of beds closed. We are seeing community services having enormous staffing issues as well. DMH leadership takes this very seriously and is constantly watching.

Restoration of competency, diversion, and forensic. Diversion – what other ideas do you have? Same with forensic, what questions, ideas do you have? Be thinking of these things.

Emma - Regarding Jack's example—are there still legal risk concerns that need to be addressed? I'm reflecting on the Kuligoski decision and whether we have fully addressed concerns about risk

Jack – I thought we fixed that, but we can take another look
https://legislature.vermont.gov/statutes/section/18/042B/01882

Joanne - I like Colleen's suggestion about mapping out populations- makes sense to understand the infrastructure and points of interception to come up with ideas about where intervention would be most effective