Forensic Working Group
December 9, 2021
9:00 am – 12:00 pm

Attendance: Samantha Sweet, Jennifer Rowell, Laura Lyford, Annie Ramniceanu,

Via Phone: Zack Hughes, Joanne Kortendick, Jared Bianchi, Colleen Nilsen, Margaret Bolton, Matt Viens, Michael Cassidy, John Wallace, Matthew Valerio, Kimberly Blake, Jill Sudhoff-Guerin, Stuart Schurr, Kelly Carroll, Clare Pledl, Zachary Hozid, Karen Barber, Jack McCullough, Michael Hartman, Ben Chater.

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.

Karen Barber

List of topics are so broad, trying to cram everything in and it is getting confusing. Are there somethings we should focus on, dive into and have hard conversations, if not recommendations, then different viewpoints on topics. Spend the next few months on these three topics, having different presentations, what are some concrete ideas we could put forward to the Legislature.

Competency Restoration
Diversion Programming
Forensic Facility

Jared – distinction between DMH and DAIL clients, but I would have concerns confusing on just DMH component now. Part of the reason for that is, I was thinking we need to focus on is removing diagnostic shiling that goes on and loses people in the middle. What are public safety standards that are uniform that does not hinge on a diagnosis?

Karen – because of the way our facilities are structed, you need to have a series mental illness to be hospitalized. The 1st priority maybe should be definitions, who is meant to serve, where is the most appropriate place for them to get treatment?

Peg – I think that makes sense, but diversion to what – what are we diverting people to? Where would the people who are trained in treating individuals who are legally involved, where would they be? CMHC's should have experienced people to treat those legally involved and also understand competency restoration I would advocate for a forensic facility for competency restoration.

Karen – Diversion to what – that is our opportunity to say what we think, where they should be diverted to for the Legislature? Also, need to identify staffing issues, funding, resources, etc.

Jared – Who would a forensic facility serve? There is a minor who is currently being supervised by AHS, they appeared to have a MH crisis including assaultive behavior. DCF does not have very many secure places to place these children and often results in insufficient placement. They engaged in hurtful behavior and were brought to the hospital then ultimately corrections, where they remain. They need

inpatient level of care but by the time they were reviewed by a psychiatrist they were determined to not meet hospital level of care at the time. They're not safe to be in the community however, so they remain in corrections.

Simha – Voice strong agreement with Dr. Bolton in building a diversion program. A lot of those people that need a diversion program are already being served be a designated agency.

Zach H – I agree with Jared's point about the siloing. It is really a look about our system of care as a whole and we need to keep that in mind while we look ahead. What is the process once criminally involved, what does that look like? What does current system provide on all angles? What's working, what needs more support/funding/services.

Zach Hughes – I agree with everyone here and agree we need to narrow the topics. I would be curious about if we had to narrow those, what were the priorities from the Legislature? Where they wide open?

Karen – I think one of the things we were planning to do when we presented out plan to the Legislature is this is what we are going to focus on now. There was a massive list of about 20 things from the Legislature. Everything they listed is very important, the problem is we don't have the time to do them all at once. What do we prioritize next?

Stuart – One of the things we w ill be touching on is the historical expansion of the Act 248, around issues such as developing program, the funding and staffing issues and the availability of expertise to do assessments. I think when we go through the presentation, you will see how that will be extrapolated and applied to the other areas.

Diversion Programs i.e Mental Health Court

Karen: Looks different on different days. MH Court in (AK) Statutory criteria for when someone would qualify for MH court based on misdemeanors or felonies. Specific judges for MH court. A lot of out of court meetings to discuss what the person needed and how long they needed to show improvement. Attend meetings to show progress. Everyone so involved and invested. Takes a lot of time, effort, staffing, resources.

Matthew V: as a statewide situation, we don't have one. I think maybe Chittenden County is the only one that has something akin to that, and it might only be family mental health court. They don't seem to get much traction unless they are supported from the top down. In certain areas in VT [drug courts] there have been times where they have had support that waxed and waned, whether the states attorney is supportive of that concept. Washington County has a drug docket but not a full court. In doing this as part of the mental health initiative has never been part of the discussion either from the top down or the grassroots up. We try to hire people, and we can't hire people, can't fill the spots. We had to go out of state to have competency and sanity evaluations done remotely over video. There is not a supervision organization like parole officers to make sure people who are on mental health orders are doing well, taking medications and doing the things they need to do to make sure they are not a threat to public safety. Maybe this is an area we can look at, maybe create a parole like system for mental health. It needs to be a treatment-oriented situation. What we heard from Connecticut scares the crap out of me to be honest.

Matt Vines – with respect to the mental health court you described, would they deal with individuals who may have a mental illness or intellectual disability, where are the lines drawn with regard to diagnosis? If this were to be done in Vermont, mental health is used to cover a broad section of people, what would the definition be for mental illness? Karen – In Alaska it needed to be a primary diagnosis of mental illness. They had a separate drug court there. If there were violations, they could go to prison.

Jared – I think it is an interesting idea of a mental health court. Concerned it is not sustainable in Vermont. I am looking at what can we do to make improvements without building new bureaucracy

Annie – Support for Matt Valerio and Jared. Support for this has been taking place and working on supervision model. Looking into Forensic ACT (clinically informed supervision model). Failing at sustainability and providing the numbers of staff. Multidisciplinary would be best framework.

Zach Hughes – I think VPS would share my view on this. I think we need to reform the current system [supervision/treatment], holes in the ONH system. This isn't to be a punitive situation. I want us to be careful with us talking about the supervision piece. If we can mesh in the Vermont values, including the deinstitutionalizing piece.

Matthew Valerio – I wanted to respond briefly to what Jared had said about these mental health and treatment courts focusing on the lower need people for public safety pieces. As I am understanding that is the wrong people to focus on with the studies out there. It is the high risk that would be the ones to focus on. We need to identify the folks who come to us and are asking us for help by their behavior or actual request to keep them out of a situation of housing folks with mental illness in Corrections.

Peg – I just wanted to really support Annie's ACT program. A point of history point years ago VSH had 1 floor certified for CMS, then 2 floors, then lost it. Could there be a forensic unit somewhere instead of a new facility?

Competency Restoration/Forensic Facility

Simha – Support forensic facility, I think that, and competency restoration goes hand in hand. I think a forensic hospital could also serve another important role, one thing that it can do is have structured stepdown and community integration for those who require higher security hospital setting, to lower security settings.

Jared – I think that is two really important things to accomplish and two necessary parts of the discussion.

Jack – I don't think people should be assuming there is universal agreement with adopting a competency restoration practice. As I have stated before it is far from clear that restoring someone's competency so they can be prosecuted and potentially imprisoned is in line with any kind of healthcare. In regard to what kind of facility people should be detained in, I think the forensic question is still a question in my mind the best way to palace people is based on the event that led them to be hospitalized versus their clinical needs and the needs and safety of the other people in the facility.

Zach Hozid – a facility, keep in mind it would be incredibly expensive to set it up and to run it. Who is going to be going there and for what purpose? That would need to be sorted out. The question becomes, what do we currently have that could currently serve those people.

Annie – The department houses 30-40 people who don't need the person in need of treatment standard and would benefit from being hospitalized, not at DOC. They do not deserve to be in DOC and we strongly believe that as well. Prison is not a compassionate place to recover for mental health.

DAIL Presentation

https://mentalhealth.vermont.gov/sites/mhnew/files/documents/AboutUs/Committees/FWG/Forensic_Working_Group_Act_248.pptx

Jack McCullough: Do you know how many people in the state are on Act 248 orders?

Chater, Ben: Between 25 and 35 at any given time

Jack McCullough: Thanks, Ben. That's a lot smaller population than people on ONH's.

Bianchi, Jared: Part of that stems from the limited set of qualifying charges and highly specific diagnostic criteria

Clare Pledl: How many people are on ONH's at any given time?

Sweet, Samantha: Jack is right. We have approx 210 adults on ONHs.

Zach Hughes – are we going to have time to discuss guardianship today? Sam – depends on the question, will play by ear. If not, will loop it in future meetings.

Jared – Great presentations. Ben, you referred that the care be required in the community. Is that a legal requirement? Ben - Community needs to be able to provide appropriate care. Need to look at the designated agencies programs. Least restrictive community-based settings available. Commissioner designates what programs are required.

Stuart – I think the legislative intent is to have these services provided in a community-based setting as well.

Jared – TBI study on the presentation – it is treating it as a treatment exercise when sometimes the cause for them not being competent is not the same as their criminogenic risk. It is not taking into consideration the question of public safety.

Guardianship Questions

Zach Hughes – He's heard of people wanting to take guardianship to help their loved one so they can assume the rights that they are actually still allowed.

January 15th Report

- File initial report of our progress, due January 15th, 2022
- Everything they listed was important, and the only way to have meaningful conversations, get into the issues is to spend more time, focus on ideas.
- Include the notes from the meetings
- Going to be in memo format

Jared – I think this sounds like a solid plan. Is there a drafting subcommittee? Karen – DMH will do this. Once we get into the meat of having recommendations, we will start drafts and send to folks for feedback.

Simha – Thank everyone for their work in this workgroup, sounds like an excellent plan and look forward to seeing the report.

Joanne K - A little concerned not enough discussion about restoration of competency. Feel this was skirted over. From a victim's perspective, this is very important.

Colorado Links from Joanne Kortendick:

https://leg.colorado.gov/sites/default/files/documents/2018A/bills/2018a_251_enr.pdf

https://leg.colorado.gov/sites/default/files/documents/2019A/bills/2019a_223_enr.pdf

Colorado law: create statewide liaison between courts and health professionals. Responsibilities around guidance with courts and greater understanding of health options in the community. Requirements for competency eval reports. Electronic system to track status of defendants. Where are they in the system and what's going on with them. Placement guidelines.

Karen – can look into this for future meetings, maybe have someone present from Colorado.

Other Comments

Zach Hughes – competency restoration, at the time of the crime? Which are we talking about? Competency for both?

Karen – Competency at the time of the event – either you were sane or not and Competency restoration speaks to competency to stand trial

Kelly – I like the idea of the mental health court and outpatient services that could come with that. Struggle to get and keep health professionals.

Next meeting: February 17, 2022.