# Forensic Mental Health Vermont Work group

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11.16.22

# Contents

# Court Diversion

- Sequential intercept model
- Collaboration
- Restorative Justice
- Community Service
- Mental Health and Substance Misuse Courts

# Mental Health Court, Substance Misuse Treatment Court, etc

- Improve via Pathways feedback
- Honor the confidentiality of peer mentoring and peer support
- Diversify, offer choices appropriate for mental health needs
- Run similar programs elsewhere in the state.
- Have alternatives for people for whom it’s inappropriate due to the overall content of their mental health condition

# Prioritize Optimal Treatment

"not taking a punitive approach to mental illness" has been said a lot.

Let's find a realistic policy we can put into action, based on that philosophical ideal.

"Prioritize Optimal Treatment"

Prioritize treatment, and don't let other agendas interfere with the quality and success of treatment.

# Competency Evaluations

- Grand Jury evaluation of whether there's sufficient evidence the person did the thing- for all cases
- If not, dismiss case- no competency evaluation needed
- Weed out false accusations
- Allow jury to dismiss case due to overwhelming evidence of insanity and no counterevidence- could be permanent- could prevent case from hanging over head of obviously insane defendant for the rest of their life
- NGRI could be plea bargained after grand jury finds enough evidence the person did it

- Psych evals of any kind should not be performed by the accusing party.

- Should we require medical records? (NO)
  Why do evaluators want to require medical records? What do they use them for?
- 1-year wait

# Pros and cons of using medical records in competency evaluations:

- Pros:
  - more ways of understanding what's going on with the defendant

- Cons:
  - Past medical records don't necessarily accurately reflect the defendant's past mental health struggles
    - not having accessed care due to fear or due to no openings
    - misdiagnosis
    - the defendant can be having new mental health struggles
  - there are other ways to learn about the defendant
  - The evaluation is supposed to be about the present
  - Invasion of privacy

# Options of what to do about medical record

- 1) Require medical records
- 2) Make medical records optional
- 3) Have a hearing if the defendant doesn't want to supply the medical record and the evaluator wants it, and let the judge decide

- If we continue to have evaluations without medical records, we could specify out the procedures and standards we want for that, so that the clinicians don't feel like they're violating their profession's standards of practice

- If medical records are used for this, it's important to make sure they don't go any further without a separate authorization process. Don't let anyone else have access and don't let them be used for another purpose.
  - Is this possible? Or is the judge for the competency hearing and the judge for a future mental health hearing, the same judge? If it's ever the same judge, don't make them required for competency evaluations, and write our own standards for the evaluations

There needs to be a better way for patients to correct inaccurate/dishonest medical records

# It’s usually the same judge, in Vermont!

- It’s not OK to require medical records, since it’s usually the same judge for the competency hearing and for the mental health hearing. The records would be viewed in opposite ways in each hearing, and the records are almost never appropriate in either hearing-
  - Both issues are supposed to be about the PRESENT condition of the defendant
  - Medical records can be very erroneous and not a reflection of the person’s past mental health- clinicians can fail to record things, they can try to cover up their own bad behavior, they can underdiagnose due to their philosophy, they can overpathologize because of racism….keep medical records optional.
  - Requiring medical records for competency hearings is probably a standard of practice that comes from places that have more judges, and don’t have the same judge for both hearings. We might need to write our own standard of practice for Vermont.

# 1-year wait, to get a competency hearing

- Reduce the backlog:
  - Get more clinicians doing it, by subsidizing additional education for psychologists who want to start doing these evaluations
  - Get rid of some of the cases if grand juries throw them out for no evidence of the defendant having done it
  - Improve outpatient mental health care to reduce the rate of new defendants needing competency hearings
  - Reducing the backlog is needed, before having competency restoration, which would require re-evaluations, which would put further demand on more competency evaluations

# If found Incompetent to stand trial

## Hospital? (voluntary or involuntary)

- Segregating inpatients
  - Voluntary, not a danger
  - Voluntary, possible danger (That's why they came)
  - Involuntary, danger to self
  - Involuntary, speculated danger (didn't hurt anyone, clinicians speculated based on symptoms)
  - Involuntary, actual danger (committed a crime hurting someone)

# Incompetent to stand trial and have dementia, intellectual disability, TBI, etc

- **Use Act 248, including for people with combinations of DAIL things plus mental illness / trauma**
- **Improve treatment**

- There is a huge need to improve the quality of treatment of a combination of TBI, and trauma- put a lot of effort and money into that. Same with combination of autism spectrum and trauma.
- Institutionalizing people with combination of DAIL-spectrum disabilities plus trauma/psychiatric conditions, when we haven't made the effort to improve quality of treatment, would be scapegoating the patients, and would likely be warehousing.
- Prioritize optimal treatment!
- We are especially deficient at treating TBI+trauma, and maybe at trauma+DAIL-spectrum of any kind
- schizophrenia and bipolar are often caused by trauma
- If the person isn't violent, no institutionalization outside of CMS criteria
- Is there a violent person in the DAIL spectrum, in Vermont? Is there a resource out of state, we can consult about individualized care?
- **Improve trauma treatment, to be inclusive of DAIL-spectrum**
- **Improve TBI treatment, to be inclusive of trauma and mental illness**

# If Found Incompetent: After hospital or if the defendant doesn't go to the hospital

(defendant doesn't have intellectual disability, dementia, TBI, etc)

DMH or an agency created for that purpose, gives conditions of release

- Public safety
  - Act 248 gives a useful model
  - Choose fail-proof strategies
  - Avoid conditions that are easy to violate without being caught
  - Avoid conditions that don't actually keep potential victim(s) safe
  - Choose strategies that pair restriction with support
    - Ex. Constant supervision when in the community

The new government agency doesn't mandate any specific treatment (not a licensed mental health provider)- treatment (including coercion or lack thereof) is up to DMH and treatment providers

Competency restoration might or might not be included in DOC's conditions of release

# conditions of release could include participating in  competency restoration

- Cognitive rehab
- Education about criminal court process
- Prohibit the use of psych medications for competency restoration
  - medication should only be used for **treatment** in the context of considering ALL the effects on the whole person, medically and psychologically, and can impair memory of the event, including thoughts, reasons, and feelings at the time, and that's not competency even if the person performs well on tests used for competency evaluations

DMH or the new government agency needs to monitor, and provide adequate transportation if needed.  Transportation strategy must accommodate defendant's disability under ADA.

# Mental health treatment is separate from conditions of release

- Mental health agency is  responsible for mental health treatment
- Only reports if there is a genuine danger to public safety (as is their responsibility in general anyway)

- Keeping them separate creates an opportunity for treatment to be consensual, which makes it much more effective for certain populations ex people who dissociate

# Mental Health Treatment Structure Options: choose the least restrictive

- Voluntary, optional (can include the person requesting or consenting to people initiating in their direction)
- Non-optional, collaborative ("you have to do something for treatment, you get to decide what, we will help")
  - Make this genuinely collaborative, listen to the person, educate them if you disagree
- ONH (requires a hearing)
- Defendant decides on voluntary hospitalization, perhaps because they feel it's the only way they won't violate conditions of release

# Advantages of Letting Defendant make treatment choices

- More effective treatment because their self-knowledge is considered
- More consensual- makes it more effective for treating trauma
- More engagement by defendant
- Defendant gets to practice making decisions and implementing them- a life skill

# Principles of facilitating voluntary mental health treatment

- Education instead of coercion
- Educate them about what the options are, with full truthful information about each
- Help develop options that are designed so they’re safe
- Be truly open to the person making their own decision, support them in it

# considerations for mental health treatment: if the crime was violent

- arrange it so clinicians and the public aren't put in danger. Some options:
  - Pairs or groups of clinicians
  - Psychotherapy by Doxy is an option for one-on-one privacy
  - Hold mental health treatment in a building where there are lots of staff
  - Escorted to and from mental health treatment and other allowed life activities
  - Constant supervision in the community
  - Help with food prep, making possession of a knife unnecessary
  - Make the housing situation appropriate for the person
  - Make sure the situations the person is in and the expectations of them, are things they can handle

# Considerations for treatment: dissociation

- consent is key for successful treatment
  - Dissociation is the mind running away, when it's impossible to get away from a non-consensual situation the person doesn't want
  - Violating consent, is likely to trigger dissociation.

- Consent opens the door to the potential for meaningful treatment.

- Could work: required to participate in treatment; a range of choices as to the content
  - All of the options being things that might help and won't hurt

# Some things that work well in psychotherapy for dissociation

- Psychotherapy at the same time on the same day each week if possible
- Offering 75 minutes, client doesn't have to use all of it
- Collaborating in designing a treatment plan.
  - Giving the client real input works for two reasons
    - helps with the therapy being consensual
    - helps create a more effective treatment plan due to self knowledge by client.
- Suggesting having some routines in the psychotherapy
  - Ex. Self-care check-in, talking about what's next
- Everything that happens, checking in and make sure client consents
- Some time in the session for whatever client wants to talk about
- play-based therapies as options (can be arts based therapies)
- Asking questions the client can answer if they want
- Welcoming direct expressions of feelings
- Being gentle if the client has trouble starting on time
- Therapists need a lot more training, than just reading this slide

# Other aspects of treatment: dissociation

- They might need help with practical things
  - Getting to appointments on time
  - Organization of belongings and time
  - Self care
  - Care of their car if they have one
- It's important that they be able to spend significant time doing things they like to do and that are meaningful to them, work toward goals they care about, stuff like that. It's leverage against the trauma, and it's time spent being present. It gives them a foundation for recovery
- Positive regard, kindness, focusing on strengths
- A lot of lead time for changes and transitions so they can prepare
- Avoid anything involuntary because it's likely to increase dissociation. Collaborative approach
- Treat them fairly, don't expect them to cope with unfair treatment that most people just let roll off their back- you probably need to examine the fairness of some things
- Avoid absurd and disproportionate consequences for small mistakes
- Restorative Justice might be helpful and something they can do, it should be optional

# Treatment considerations for defendants with addictions to substances

- Keep psychotherapy confidential, safe to talk about what's really happening
- Measuring whether the defendant is clean and sober would be DOC's testing
- It works better not to demand perfection and not to punish people for relapse
- Medically, opioid withdrawal needs to happen with a gradual taper, and possibly with medical care for withdrawal
- Don't progress toward related freedoms until clean and sober, but Don't put people in jail for relapses, no big dramatic punishments for relapse
- Reward/punishment model might work for some, is terrible for others, consider alternatives
- Trauma is usually a factor- make trauma therapy available
- Some people who dissociate, misuse substances

# Restorative justice

- The treatment team's job is to help their client toward the client's goals.
- Restorative justice can be a meaningful way for a client to become invested in goals having to do with how they affect other people.
- If the client is influenced to internalize a goal of improving their effect on other people, that can become a legitimate treatment goal. That's different from the treatment team enforcing something external.
- Offer to clients, opportunities to participate in restorative justice, anytime such an opportunity is available.

# Treatment consideration for all defendants

- Voluntary optional things should be in the treatment plan for everyone, including those on ONHs
  - Peer support
  - Participation at a drop-in center
  - Pursuing goals of theirs
  - Wide range of possibilities for physical activity
  - Participation in restorative justice
- Individualize treatment
- Opportunity for person to say what they need and the system respond by trying to meet needs, not just requiring person to choose from a menu of what the system already offers

# Medication considerations for defendants found incompetent to stand trial

- Make a lot of effort to handle this in a consensual, educational way
- Make a lot of effort to offer effective treatments other than drugs, and to make the drug optional- beware of starting people on drugs- it's hard to get off of them, and beware of force medicating people with trauma backgrounds / dissociation- it's likely to make it worse
- Make sure there is a psychiatrist appointment at least every month + if urgent
  - don't prescribe a drug that won't be monitored
- Genetic testing before prescribing, to reduce the odds of violence reactions
- Avoid prescribing a drug that exacerbates an existing medical problem
  - Ex. Do not prescribe an antipsychotic if the person has a history of stroke
- Good medical monitoring of drug effect on body and mind, including O2 sensor, monthly
- Listen to patient and consider their perspective about effect of drug on them
- Long Term treatment plan should include the possibility of meds not being permanent
  - Meet the needs in other ways, long term, and teach them to
  - Long term medication causes dementia, medical problems, etc

# Accountability to DMH or an agency created for that purpose

- DMH or an agency created for that purpose, is responsible for monitoring DMH's conditions of release
  - Can ask questions of treatment team
  - Treatment team reports on issues that are truly matters of public safety
- If defendant is slipping on the conditions of release
  - They notify the treatment team
  - The treatment team works with the defendant to get back on track
- If defendant is screwing up big time on the conditions of release:
  - Is it a need for hospitalization? Hearing, to create different restrictions or go to jail temporarily? Try to find a different adequate solution than jail if possible
  - Create different restrictions that will work better for the defendant
    - Ex. Accompaniment all the time, instead of restriction from a place

# If defendant is not following the treatment plan:

- Don’t progress them further toward freedom, until they meet current goals
- Ask them what’s going on, and listen
- Renegotiate a collaboratively arrived at treatment plan?
- ONH hearing to change the terms of an ONH or start an ONH? (more restrictive, not as good)
- Is this a need for hospitalization?
- The first 3 things on this list are the best ways to go, if possible- least restrictive, and preserves trust and therapeutic relationship

# Adjustments as needed

- Periodically or at the initiation of either party, there could be a negotiation or hearing to change the conditions of release.

# Competency restoration and re-evaluation

- Competency restoration only makes sense if the restored defendant will then have a fair trial- ensure fair trials first, then address CR
- **Prioritize optimal treatment**: optimal treatment takes priority over competency restoration
- Bring the competency restoration to wherever the defendant is
- Periodic competency re-evaluation at intervals
  - This means we need to clear the backlog of competency evaluation needs, first
- After twice the length of the sentence if convicted, charge is dismissed
  - (or by discretion of prosecutor or petition of defendant)

# Make competency less of a disadvantage

- Give mentally ill but competent defendants fair trial
- Giving a mentally ill, competent defendant an obviously, egregiously unfair trial, can make other defendants afraid to recover too much because they know if they're found competent, they won't have a fair trial
- It's easy to politically prey on defendants who are mentally ill and barely competent, by not giving them a fair trial and they probably won't ever figure it out.  But if that can be done, are they really competent?

# Competent but mentally ill defendants and fair trials

vtdigger.org/2022/11/03/burlington-man-found-guilty-in-meat-cleaver-attack-that-killed-his-wife-seriously-injured-her-mother/amp/

The judge didn't even explain to the jury, temporary insanity, when the jury asked about it directly.

Don't mislead juries via omission, into thinking they have to make a compromise verdict to protect public safety. Tell them honestly what the outcome will be if they vote for not guilty for reason of insanity. Failure to be entirely honest with the jury, and withholding information, doesn't make for a fair trial. (From the reporting, it sounds like the jury voted to convict, to protect public safety, not because they really believed their verdict.) If we don't have an honest justice system, what kind of society do we live in?

# What is insanity? / Guilty But Mentally Ill

https://www.ojp.gov/ncjrs/virtual-library/abstracts/pleasant-surprise-guilty-mentally-ill-verdict-has-both-succeeded#:~:text=The%20guilty%20but%20mentally%20ill%20(GBMI)%20verdict%20is%20premised%20on,by%20reason%20of%20insanity%20verdict.

Should Vermont add a GBMI category?

I would hesitate to have juries recommend psychiatric treatment though- I think treatment recommendations are best made by licensed mental health professionals.

How is it classified when a person knows right from wrong but is unable to control their own behavior (as can happen with a combination of TBI and trauma, and perhaps in some other circumstances)?

Vermont could create a category in between NGRI and the usual “guilty”

doesn’t have to be the same as this GBMI concept

# Make competency less of a disadvantage

- Competency struggle / restoration should be disclosed to judge / jury
- Mental health problems of defendants should be considered in sentencing
  - Rehabilitation-focused sentencing
  - Keep plea deals advantageous over post-trial sentencing
  - Allow sentences outside of typical minimum sentences for mental health reasons
    - don't make them shorter, but make them rehab focused and not necessarily in prison
    - Avoid prison if adequate public safety and rehabilitation can be accomplished without it
      - Prison: worse outcomes. We're going for outcomes.
      - Overly punitive risks public safety because worse outcomes
  - Stepwise progression
  - Be demanding, and include enough support
  - No revenge
  - Protect victims and the public

  Defendants should get fair and appropriate justice if they become competent

# Treatment-oriented sentencing

- Prioritize optimal treatment
- Avoid prison if possible because of poor outcomes of prison
- Participation in treatment, with input from defendant as to what is appropriate
- Restrictions as appropriate
- Possible other elements
  - Community service
  - Restorative justice- optional, can reduce the length of the sentence
  - Education
  - Employment or job training

# Mental health services should be offered in prison and probation / parole

- To all people in department of corrections custody
- Including peer support
- Post-discharge continuity in mental health care, including medication and psychosocial things like psychotherapy and peer support

# Victim counseling

- Victims have really been harmed, and need help
- Don’t spend all the resources on the offenders
- Victims won’t get all of their needs for healing met through punishing the offender
- Make sure victims’ mental health needs are met
- Can there be restitution from offender to victim?
- Keep victim safe from further harm

# Forensic Facility

- History of deinstitutionalization – outpatient programs not adequately funded
- Money – we need money to pay for solving the cause of the problem (the increase in defendants who are incompetent to stand trial and have committed serious crimes; crimes soon after release from inpatient)
- Bring competency restoration to where defendants are – we don't need a forensic facility for it (but we aren't even ready to do that, because it would increase the load on competency evaluations- we have a few other steps to do first, to reduce the backlog of competency eval needs)
- Involuntary hospitalization traumatizes people and increases suicide risk
- "Prioritize optimal treatment": don't do things that damage the defendant's physical or mental health or are counterproductive to their treatment. So it doesn't make sense to involuntarily hospitalize them, which can traumatize them and make it more difficult for them to engage in treatment, if not needed for treatment.

# Trauma

Trauma affects people more, and affects more people, than had been previously thought

ACE study (Kaiser Permanente)

Trauma is a major part of many different kinds of mental health issues

Treatment for trauma reduces recidivism, even in people with no mental health diagnosis

Trauma treatment should be central to mental health care

# Contents

# Identifying Causes of the Problems

- Increase in the number of people who commit violent crimes and are incompetent to stand trial. Due to a deficient community mental health system.
- Violence soon after discharge from psychiatric hospitals
  - Patients being traumatized in the hospitals
  - Medication changes in hospitals done too fast, causing (delayed) adverse reactions
  - Medicating people who tolerate medication poorly, reaction is delayed
  - Patients being discharged from inpatient settings with no follow-up mental health care and/or without appropriate housing
- Over-reliance on drugs, under-delivery of other services
  - Drugs have lower efficacy than we'd like to believe, and can cause violence
  - The most effective things are people-intensive, ex psychotherapy, peer support
  - Deficient outpatient mental health causes over-reliance on hospitalization, which causes over-reliance on drugs (hospitals mostly just give drugs), then people are in the community unable to get other, psychosocial, mental health services, while dependent on a drug in the face of too few psychiatrists

# Who falls through the cracks

- People with dissociation
- People who are don't cope well with reward/punishment schemes (dissociation, autism)
- People who are triggered by violations of consent (dissociation, PTSD, )
- People who have both brain injury and emotional trauma (professionals don't know the other field)
- People who don't respond well to psychiatric drugs (It's assumed that they work for everyone)
- People who benefit more from arts based or somatic therapy than from talk therapy (not available)
- People who were misdiagnosed in the past or are currently misdiagnosed
- People who have had a bad past experience of mental health care
- People who are traumatized/abused in inpatient psychiatric settings, then released
- People who are unable to find follow-up mental health care after release from hospital
- People without appropriate housing upon release from hospital
- People who are given a psychiatric drug in a hospital or prison, then, when in the community, are unable to find a psychiatrist to have continuity or to get help if it's causing a problem
- People who feel tempted to do something criminal, and are unable to find psychotherapy
- People who get abruptly cut off of prescription opioids or are unable to find medical attention due to being viewed as pain-seeking
- Outliers to the statistical majority, in "evidence based" settings (Overlap with dissociation)

# Make hospitals less traumatizing

- Reduce involuntary procedures by preventing the need for them
  - Evaluate how each instance's need for that, could be prevented
  - Phase out seclusion and restraint; instead, use a room with a plexiglass window and the ability to hear across the wall, and a staff person on the other side
- Improve Staff to patient ratio
- Improve Staff training/skills
- Teach staff not to think they're entitled
- Teach a mutuality model
- Have more peer supporters in the hospitals
- Make situations and expectations manageable for patients, gradual progressions
- Make staff relationships understandable to patients
- Kind, positive regard
- good conflict resolution
- Videotape to prevent and catch patient abuse.

# Better programming in hospitals

- Diversify in-hospital therapies and activities
- Arts-based (very important for a subset of patients, though maybe not the majority)
- Outdoor (very important for a subset of patients, though maybe not the majority)
- Physical activity (very important for a subset of patients, though maybe not the majority)
- Individual psychotherapy weekly if desired by patient
- PT/OT if desired by patient
- Patients should be able to spend most of their time doing enjoyable activities
- Peer support
- Help people develop self-care
- Must offer meaningful treatment other than drugs, specifically for patient's condition

# Good care of physical health in hospitals

- Thorough high quality physical medical care
- Good nutrition, and individualized nutrition: hospitals must provide
- Gardening programs strongly encouraged (containers are fine)
- Physical activity
- Access to the outdoors
- Must check thoroughly for medical causes of psychiatric symptoms, and treat them

# Medically responsible approach to medications in hospitals

- Genetic testing before prescribing psych drugs
- Accurately inform patients about drugs and about other options, and offer choices informed consent
- Learn about the patient's health
  - don't prescribe a medication that is likely to worsen an existing medical problem
- Introduce or change the medication SLOWLY starting with a low dose

  makes akathisia less likely

  maybe a low dose will be effective enough

  Problems can be identified before the patient has consumed a lot of it
- Monitor medical and mental health effects of drug
- Frequent psychiatrist conversations that are two-way conversations
- Mandatory for hospitals to provide follow-up after discharge

# Ethical and philoshophical growth of hospitals

- Blue Knot Foundation principles of trauma-informed treatment
- Open Dialogue principles
- Develop the ability to treat conditions without drugs
  - Informed consent
  - Become capable of offering helpful treatment to patients who don't respond well to drugs (including those with genes for adverse reactions to drugs)
  - Treatment other than drugs is different from people just "not taking medication"- it's a real, effective treatment, just not a drug
  - Willingness to participate in treatment, and willingness to take medication, aren't the same thing- some people are very willing to participate in treatment, they just don't want to take drugs
  - Spare patients from the sometimes severe health consequences of medications
  - Protect patients from risk of harm in a system with too few outpatient psychiatrists available to monitor medication

# Hospital finance reform

- Prohibit hospitals from marking up drugs when charging insurance

- Limit CEO and administrator pay, to help hospitals afford good patient care

- Audit hospitals that aren’t able to afford good patient care

# Financial needs of hospitals

- More staff
- More training for staff
- Video equipment
- Training in specific non-drug therapies for specific mental health problems
- Training in new-to-them philosophical approaches, such as trauma-informed
- Better food
- Genetic testing to prevent at least some drug adverse reactions

# Transition to community from hospital

- Help finding housing
- build partially assisted housing (with resident staff in an apartment building) this model is used in Ottawa
- Require hospitals to provide or find follow-up outpatient mental health care for patient within 36 hours then weekly
- Prohibit requiring patients to see in-network therapist, to see psychiatrist
- Peer workers helping with life things
- Preview before release: meet follow-up treatment providers and peers, see housing, before release
- Reduce involuntary hospital admissions and readmissions by having enough outpatient mental health

# Criminal justice system mental health care

- Peer workers in probation and parole, and in prisons, and IPS taught in those situations

- Mental health care for all people in the criminal justice system

- Medication continuity when leaving prison

- After abstinence from opioids, people die of a lower dose of it, so it's important to offer treatment, not just forced abstinence (the latter is a death sentence because they're likely to use again, and die)

# Community mental health: lots of peer stuff

- Peer drop-in centers in all parts of the state
- Peer respites in all parts of the state
- Peer outreach workers in all parts of the state
- Peer practical life activities and self care assistants/coaches
- Alternatives to Suicide support groups in every part of the state and by computer
- Peer support groups having to do with other topics
- Peer warmlines, staffed from several places in the state
- Widespread IPS training for people who aren't paid to do it
- Bring back interactive WRAP trainings in the community
- Exercise and nutrition support in the context of peer support
- Trained peer support should be central to mental health care

# Community mental health: lots of high quality psychotherapists and social workers

- Subsidize education
- Prioritize people with lived experience
- Accommodate mental health disabilities
  - part-time and self-paced programs
- Work-as-you-get-your-degree programs like Washington state
  - have part-time and seasonal versions
- Goal- enough psychotherapists that everyone can have as much of that as they need
- Conflict resolution and problem solving help in the community, from trained social workers
- Pay for psychotherapists to get training in trauma
- Pay for and require brain injury rehab professionals to get training about emotional trauma.
- Pay for psychotherapists to get training about brain injuries
- Brain injury rehab professionals and trauma psychotherapists could meet

# Community mental health: diversify treatment (examples, not a complete list)

- Medicaid paying for a wide range of psychotherapy services
  - Somatic, movement, Arts based
    - Create licensing equivalent to other psychotherapy licensing
- TMS treatment access, without first having to try and fail at psychiatric drugs
- Professional-moderated support groups for some issues
- Pedophile psychotherapy, perhaps copying Germany's model
- Voluntary agreements that allow others to initiate in one's direction
- A system where people can propose a treatment and apply for a grant
- Make sure people have primary care providers
- "assertive" intensive outpatient treatment as an option people can voluntarily sign up for, or be connected to by clinicians or police or courts (Maine, NY)

# Community Mental Health: Medications

- Education for how to help taper off of psych drugs, for psychiatrists and primary care providers
- Continuity of medication access after Jail or Hospital
- Monthly appointments with medical tracking, including O2 sensor
- Informed consent-
  - full information and honest advising
  - access to other treatments
  - stable access to prescription refills
  - access to safe, assisted withdrawal If desired
  - choice
- Ways to help people make wise, stable, voluntary choices about medication
  - Nurse delivery, doctors office pickup

# Community Mental Health: Ethics

- Make mental health system less coercive for all
  - Use skills, education, and connection, instead of force, whenever possible
- Improve some community mental health organizations (Pay is not the only problem)
  - Honest, safe-from-retaliation feed back process- maybe anonymous
    - Clients
    - Employees
  - Make changes
    - Resources and support
    - Accountability
- Trauma informed treatment
- Use the concepts of Open Dialogue in many areas of the mental health system
- Examine and eliminate racism in the mental health system- peer work group
- focus on building quality of life
- Better community mental health care leads to less reliance on hospitals

# A guide to trauma informed approaches

- https://www.childabuseroyalcommission.gov.au/sites/default/files/IND.0521.001.0001.pdf

- P 38 individual treatment
- P 44 organizations

# Other things that can happen in community, that would help

- Mediation programs
- Parenting help, alternatives to spanking
- Use CDC's violence prevention guidance in our communities
- Aris moderate needs workers can help people with Independent Living, self care
- Less-coercive approach to foster kids, model mutuality
- Help schools stop school bullying
- Help for people trying not to DUI

# Medical reforms that would help

- Providers who prescribe opioids, should taper them
  - Not cut patients off cold-turkey
    - The patient gets forced to buy street drugs to prevent withdrawal
- Medical providers should investigate pain, do appropriate tests,

  Even if they think the patient is drug-seeking
- Grievance process at the state level
    - Medical providers that are doing bad stuff sometimes don't take grievances
      - Or even retaliate at the patient by "firing" them
- Patient being turned away from physical or mental health care should not be arrested
    - The crisis team should go meet the patient being turned away, and help them figure out what to do

# Law stuff that would help

- A way for a judge to catch it when defendants are so incompetent to stand trial that they're representing themselves because they don't understand how to get a lawyer (even though they were probably told)

- A way to stop harassment of people with disabilities and mental health challenges
  - Harassment in the community, in housing
  - Create a process to address instances when a person in an apartment building is harassing another resident, or someone harasses a person in a wheelchair on the street, by not letting them go where they're trying to go, things like that (prevent situations that can escalate)

# Leadership

There should be psychiatric survivors on the boards of all the mental health organizations, inpatient and outpatient

# Justice Across the Mental Health System

- Access to adequate and least-restrictive mental health care for all, without making committing a crime a requirement or an advantage for getting access to mental health care and least-restrictive mental health care
- Adequate voluntary outpatient mental health care
  - Prevents worse problems
  - Goes a long way toward justice across systems, in access to care

# Summary

- 64 prioritize optimal treatment;  trauma treatment
- 65 how process starts
- 66 if found incompetent
- 67 treatment for incompetent to stand trial defendants
- 68 competency- fair trial; victim counseling
- 69 no forensic hospital; causes of our problems
- 70 solutions
- 71 other means of reducing stress in our community
- 72 medical, legal, and leadership reforms; justice across our mental health system

# Summary: some principles

## “Prioritize optimal treatment”

(a concrete, actionable version of “not taking a punitive approach to mental health”)

**Trauma** Treating trauma could be central to mental health care

reduces recidivism, even in people with no mental health diagnosis

# Summary: How it starts

- Court diversion programs are good.  Small tweaks that seem to be happening.  Include restorative justice.  Improve treatment court.  Honor confidentiality of peer support.  More diversion programs.
- Grand jury process before competency eval, might not need to do competency eval if jury finds insufficient evidence the person did the thing or overwhelming evidence of insanity and no counterevidence
- Competency eval should not compel medical records because the same judge does the hospitalization hearing.  VT could write our own standards.

# Summary: if found incompetent

- **If found Incompetent to stand trial:**
- Act 248 for DAIL defendants.  Improve treatment for those who also have trauma or mental illness.
- Other defendants, DMH, or an agency created for that purpose, makes conditions of release for public safety and maybe competency restoration
- Competency restoration
- Takes place where defendant is
- Cognitive rehab and court education, no drugs
- Need for re-evaluation means we need to clear the backlog first
- More evaluators
- Fewer new people needing it if we improve community mental health
- Mental health treatment is separate from conditions of release
- Treatment team only reports on genuine danger posed by defendant

  Less pressure to force treatment, more room for the treatment to be voluntary or collaborative

# Summary: treatment for defendants

- **Treatment for defendants found incompetent to stand trial**
- Structure: Voluntary or collaborative is less restrictive than ONH; hospital is a possibility
- If Crime was violent: appropriate safety precautions
- Dissociation: emphasize consent
- Substance abuse: keep treatment confidential and let DOC do testing if they want
- Restorative Justice can help defendant buy in to goals about how they affect others
- Something voluntary for all defendants, especially peer support
- Responsible approach to medication, using informed consent if possible
- Accountability is to DMH or an agency created for that purpose, for their conditions of release
- Relationship to treatment doesn't really have to take the form of "accountability", though it can
- Adjustments to DOC's conditions of release if needed

# Summary: competency; victim counseling

- Competency:
- If still not competent after 2x the sentence if convicted, dismiss charge
- Make competency less of a disadvantage
  - Fair trial if competent
  - Add an in-between category similar to GBMI
  - Treatment-focused sentencing
- Mental health care for everyone in Department of Corrections

- Victim counseling

# No forensic hospital; causes of our problems

- No forensic hospital
    - History: community mental health wasn't adequately funded in deinstitutionalization
- Need money for solving the causes of our problems
- Don't need a hospital for competency restoration
- Involuntary hospitalization traumatizes and increases suicide risk
    - Prioritize optimal treatment
- Causes of our problems:
- Increase in people committing crimes and being incompetent to stand trial
        - inadequate community mental health
    - Increase in people committing crimes soon after release from hospital
        - People traumatized in hospitals
        - Meds administered or changed too fast or given to patients who don't respond well to them- increases risk of violence
        - People not given any treatment after released from hospital
- Over-reliance on drugs, under-delivery of other services
- Drugs don't work as well as we'd like, and can cause violence
- The treatments that really work are people-intensive

# Summary: solutions

- Solutions:
    Hospital: Less traumatizing, better treatment, finance reform
- Transition to community: services right away, continuity of meds, psychotherapy, housing
- Mental health care in prison and when leaving prison
- Community mental health:
    - Lots more peer stuff
    - Lots more psychotherapists and social workers, wider diversity
    - Medication help, including help going off of them if desired
    - Trauma informed approaches

# Summary: stress reduction in community

- Other ways of reducing stress in community
  - Mediation programs
  - Parenting help, alternatives to spanking
  - CDC's violence prevention
  - Aris moderate needs
    - Less-coercive approach to foster kids, model mutuality
  - stop school bullying
  - Help for people trying not to DUI

# Summary: reforms, justice across the system

- Medical reforms
  - Taper patients back off of opioids if prescribe them opioids
  - treat patients who are in pain, for their medical condition
- Legal reforms
- Judge catching it if self-representing defendant is of questionable competence to stand trial
  - stop harassment in the community
- Leadership
- Psychiatric survivors on boards of all mental health organizations

- Justice across the mental health system:
  - Access to adequate and least-restrictive mental health care for all, without making committing a crime a requirement or an advantage for getting access to mental health care

# Thank you

- Questions/Comments