Testimony 4.20.23
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Recent examples where obtaining an affidavit would have inhibited our ability to get individuals to safety or keep others safe in a timely manner…

In each of these examples, there were multiple witnesses/shift changes, multiple jurisdictions, and no way to collect affidavits from everyone in very dangerous situations, involving weapons.

Challenges and unintended consequences based on recent events and examples:

- Many police officers are off duty by the time we interact for collateral (eyewitness, first person information), and we are unable to speak with them directly let alone get signatures. This is the same for providers, outreach team members, etc.

- While we inform contacts that their name will be listed on legal documents as witnesses, we believe this would be a deterrent for community members/family to contact us when there is someone who needs our help as a signed affidavit feels more formal and may suggest a greater likelihood of being called upon in court. Family members share concerns regarding relationship conflict reasons or because they are the ones that are willing to support and often house the individual after hospitalization, when they are no longer a danger to themselves or others. If the client removes them from their lives or endangers their ability to remain in the home, this could mean losing the only natural supports that they may have.

- Some individuals want to be anonymous on record due to not wishing to be affiliated with law enforcement or the involuntary process.

- Individuals that are fleeing domestic violence/intimate partner violence situations who need to remain anonymous for their own safety.

- Clinician safety – we already have to expose ourselves to significant possibilities that reduce our safety, asking us to go to countless other sites/homes to obtain signatures furthers our risk.

- Clinician vacancies – our field suffers extensively from vacant positions and if we are going to be able to maintain the safety and risk of all of our community members, we need to use our resources wisely. We have already vet our witnesses and if we have concerns regarding reliability, we will not use the report and will gather as much additional information from other witnesses as possible.

- When there is a safety concern when responding in person, we need to rely on reliable persons reports, especially if law enforcement is unable to respond with us. Due to high acuity safety risks that are more prominent now vs historically volume wise, further delays could be catastrophic.

- Inability to get people to the hospital when they are experiencing a mental health episode can and likely will result in an increase of deaths, harm to self or others and legal implications.

- Qualified Mental Health Professional's (QMHP's) go through extensive training to gain this criteria. We do not take this role lightly and we believe that individuals being voluntary for their care is best practice. However, if someone's mental illness is impeding on their decisions to make safe choices for themselves or others, we are responsible for ensuring that they receive the necessary treatment, which includes being assessed by a psychiatrist. The number of warrants in proportion to the overall number of individuals that we assess is small in comparison. Also, the volume data shared correlates to Chittenden County only, the number of warrants across the state are less than those in Chittenden County due to population size and geographic area.

Speaking on behalf of First Call for Chittenden County's current experiences

	FY21	FY22	FY23 so far
Total Assessments	4524	5355	8878
*Reassessments (including in total assessments)	1146	1793	2643
Warrants		69	229
EE's		229	417
Combined Warrants/EE's	289		

*Reassessments are often completed when an individual is waiting for inpatient hospitalization, voluntarily or involuntarily.

In addition, the prevalence of high acuity presenting concerns over the past 2 fiscal years has also risen, which speaks to the rise of warrants/EE's in general; substance use within 7 days of assessment went from 32% to 60%, Suicidal ideation/intent/plan from 57% to 58%, violence ideation/intent/plan/physical aggressions have risen from 20% to 27th and active psychosis has risen from 23% to 28% over the past two fiscal years. Data for 2023 will be available following July 1st. The continued trend of higher acuity cases, along with the changes in availability of preventative care and use of force, means that more individuals are not only in crisis, but are meeting the threshold of a danger to themselves or others.

It was requested that I share an outline of the warrant process as well as the criteria/training necessary to become a QMHP. As you can see, the mental health warrant process is extensive and not only requires current events, but ultimately as much information as possible (see below).

Mental Health Warrants Process Outline

A. Review of Criteria:

Do they meet the criteria for "a person in need of treatment" as outlined in the QMHP Standards?

- Defined as "a person who has a mental illness and, as a result of that mental illness, their capacity to exercise self-control, judgement, or discretion in the conduct of their affairs and social relations is so lessened that they pose a danger of harm to others or themselves."
    - Do they have a historical mental illness ***or symptoms that are likely due to a mental illness*** **(not an intellectual disability).**
    - Danger to others:
        - Inflict or attempt to inflict bodily harm on another?
        - Threats or actions have placed others in reasonable fear of physical harm to themselves?
        - Actions or inactions present a danger to those in their care?
    - Danger to themselves:
        - Threatened or attempted suicide or serious bodily harm?
        - Behaved in such a manner as to indicate that they are unable, without supervision and assistance of others, to satisfy his or her need for nourishment, personal or medical care, shelter, or self protection and safety so that it is probable that death, substantial physical bodily injury, serious mental deterioration, or serious physical debilitation or disease will ensue unless adequate treatment is afforded.
- Are they willing to accept an appropriate/recommended level of care and/or
- Less restrictive alternatives are unavailable
- For Warrants: it must be determined that a physician (on an outpatient basis) is not available to evaluate the patient without serious and unreasonable delay and
- It must be determined that the client presents an immediate risk of serious injury to themselves or others if not restrained

<u>Mental Health Warrant procedure summary:</u>

- <u>Evaluate the client</u>
    - As above
    - If a circumstance involves such risk that the clinician does not feel they can evaluate the client in person, the clinician should consult with a supervisor or clinical backup to determine that a warrant can be completed without an in-person evaluation. The clinician and supervisor should review other strategies to perform the evaluation (such as calling the client, telehealth, etc.).
    - Complete the mental health warrant legal documentation. Questions included on the document:
        1. Personal Information (*Proposed patient's age, gender, marital status, residence, ethnicity, race, nationality, employment information, and any other relevant personal information.*)
        2. Location of Assessment (Where did the applicant meet and interview the proposed patient.)

3. Familiarity with Proposed Patient and Other Relevant Information (Include information on alternatives to hospitalization, etc.)
4. Mental Status Examination (Include information about the proposed patient's appearance, attitude, behavior, mood, affect, speech, thought process and content, cognition, insight, judgment, neuro-vegetative symptoms, and any other relevant information about the proposed patient's mental status. Quote proposed patient if possible.)
5. Threatening or Dangerous Behavior (Provide details, including time, place, witnesses, surrounding circumstances, and any other relevant information. Quote proposed patient if possible.)
6. Eyewitnesses (Provide names and contact information for anyone else who saw the threatening or dangerous behavior.)
7. Other Neurological Issues (List other neurological or developmental issues that affect the proposed patient's mood or mental status, including brain injury, disease, or developmental disability.)
8. Substance Use (If known, list all substances recently used by the proposed patient prior to this application and provide a general summary of current and past substance abuse.)
9. Criminal History (List any known past criminal behaviors where charges were brought, including any current criminal charges pending against the proposed patient.)
10. Unavailability of Physicians Certificate (Describe the emergency circumstances which lead you to believe that a certification by a physician is not available without serious and unreasonable delay.)
11. Need for Hospitalization (Provide a recommendation for disposition. Explain why the proposed patient needs hospitalization and cannot receive adequate treatment in the community.)
12. Clinician signs "under the penalties of perjury pursuant to 18 V.S.A. Section 7612(d)(2)"

- Contact the judge (there is a single judge on for each region, 24/7)
    - During the daytime hours, you will email your warrant as an encrypted file to designated court staff (their email addresses are listed on the white board). They will then present the warrant to a judge. Then they will email the signed warrant form back to the clinician or notify the clinician that the warrant was not signed (not accepted). The clinician may also try to fax the warrant to the court.
    - After hours, starting at 5pm, call the On-Call Judge at 741-1674. Judges may have different procedures they will want you to follow.
        - Some judges will ask you to report the narrative and will give you verbal permission to sign the warrant in their stead.
        - Others will want you to email them the completed and signed warrant for them to complete and sign. Judges do not have the ability to open encrypted documents.

        - If the clinician cannot reach the judge after hours, they should use the Region 1 After Hours Mental Health Emergencies list to try to reach another judge.
- Once the clinician reaches the judge, they may agree to "sign" it.
    - The warrant can be emailed to the Judge if they request this, please encrypt
- If the clinician is signing the warrant for the judge, they must note they are signing for the judge, print their initials and print the judge's name. For example: Write or type the judge's name, then place a * under the name and write "This clinician received verbal consent from judge to sign" with the clinician's initials.
- If the clinician does not have a way to email or fax the warrant to the court, they will have to go to the courthouse on Cherry Street, go up to the second floor and ask a court staff to present the warrant to a judge to review and sign.
- Contact the police using their non-emergency number, ask for their fax number
    - They will typically want the warrant to be faxed and not accept email
    - Emailed warrants should be sent with encryption
    - If the police ask the clinician to mee them at a location when they take custody of a client, the clinician may consult with clinical backup or a supervisor if they feel they are unable to assist the police
    - If the police are delayed for more than a day serving the warrant, the clinician or triage should designate the warrant as "unresolved" on the White Board and enter daily phone checks for FCCC to follow up with the police to determine if they are going to serve the warrant and/or if they need support
- Once a clinician is aware that the police are taking custody of the client, the warrant should be faxed to the ER with confirmation that they have received it.
    - A clinician should then contact the ER attending Psychiatrist and update them about the warrant as well as request that they evaluate the patient as soon as possible once they arrive at the ED.
- Warrant documentation need to be emailed to VPCH.

Becoming a Commissioner-Designated QMHP

By agreement with Vermont Psychiatric Care Hospital (VPCH) and Designated Hospitals (DHs), only QMHPs who are designated by the Department of Mental Health (DMH) Commissioner, or designee, and either employed by a Designated Agency (DA) or by the Department of Corrections (DOC), can screen and serve as the applicant for involuntary psychiatric admissions.

Qualifications

Education and Experience

1. Master's degree in human services field (licensure preferred) and:

a. Clinical work with individuals diagnosed major mental illness, and

b. One year of experience in providing services for people with at least two of the following: mental illness, substance abuse, or serious emotional disorders; and

c. Appropriate experience and training in crisis evaluation and intervention as determined by the DA Emergency Services Director or designee, or DOC designee.

or

2. Bachelor's degree in related human services field and:

a. Clinical work with individuals diagnosed with major mental illness, and

b. Two years of experience providing services for people with at least two of the following: mental illness, substance abuse, or serious emotional disorders, and

c. Appropriate experience and training in crisis evaluation and intervention as determined by the DA Emergency Services Director or designee, or DOC designee.

or

3. Bachelor's degree in a field unrelated to human services and:

a. Clinical work with individuals diagnosed with major mental illness, and

b. Three years of experience providing services for people with at least two of the following: mental illness, substance abuse, or serious emotional disorders, and

c. Appropriate experience and training in crisis evaluation and intervention as determined by the DA Emergency Services Director or designee, or DOC designee.

or

4. If an applicant does not meet the qualifications, but meets other criteria and has experience in providing crisis services to severely mentally ill individuals, an application may be submitted for designation consideration. The application should include information that explains the reason(s) for the exception, and a letter by the applicant's supervisor endorsing the applicant's ability and

knowledge to become a QMHP. This supervisor must also be a QMHP.

Demonstrated Knowledge of and Training

1. Vermont Mental Health Statutes
2. Emergency exam, warrant (process, observation, and documentation)
3. Emergency exam admission criteria and procedures
4. QMHP-specific training provided by DMH.
5. Familiarity with community resources (i.e., crisis beds, respite options, general hospitals, or other options for voluntary treatment)
6. Special needs and services of populations being served
7. Court screening process

Letter from a clinician shared with some members of the legislature:

Hello,

My name is Kelsey Carpenter and I am a crisis clinician and QMHP. I'm writing to share my individual experience with the Vermont warrant process and my concerns about the impact of proposed language in S47.

I am concerned about language adding the requirement of witness affidavits to the process for a mental health warrant. Currently, when a person is in need of treatment, there are many steps to obtain a signed warrant to enable us to get them to the hospital. This process takes hours to complete; giving people the opportunity to do great harm. When I pursue a warrant, after determining someone is a danger to self/others, I am normally forced to leave individuals in our community without supervision for many hours while I complete the process. For example, last week, someone showed me lethal means in their possession, and told me directly that they intended to use them. It took me five to six hours to obtain a warrant during which they could have harmed themselves and others. Obtaining a warrant is a time-consuming logistical process, which would be worsened by adding the requirement of signed affidavits.

I think the intent of requiring signed witness affidavits is to preserve an individual's rights, but the actual consequence would be to increase their risk of death. We are trained by and accountable to the Department of Mental Health to go above and beyond in due diligence in carefully screening the reports of direct witnesses. We do not pursue a warrant based on a few statements from a random person. We carefully engage with as many direct witnesses as possible, considering their credibility, and review the case based on the entire context. The logistical steps of obtaining a signed affidavit would substantially add to an already lengthy process, when we will already have carefully reviewed witnesses' account and credibility prior to considering a warrant. Keep in mind, we already list witnesses on the warrant form and make them aware they may be required to testify in court regarding the warrant.

Please consider striking this language. I am happy to speak further on this and discuss how the warrant process plays out in real life as I am actively doing this work. I am so grateful to have shared with Representatives Black and Houghton already.

Thank you so much for your careful examination and consideration of this critical issue.

Thank you,

Kelsey Carpenter, MA, QMHP

Crisis Clinician - First Call for Chittenden County