Report of the Act 33 Study Committee on Providing Community Supports for Persons with Serious Functional Impairments December 2013

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I. Executive Summary

During the summer and fall of 2013, the Act 33 Study Committee on Providing Community Supports for Persons with Serious Functional Impairments (Committee) met four times to discuss services in the community for individuals with a mental or functional impairment or with a developmental disability who pose a risk to public safety. The Committee recommends the following for the 2014 adjourned session:

- Passage of a legislative amendment specifying that use of an SFI designation end once an inmate leaves a correctional facility;
- Use of assessment tools measuring functional ability and impairments in addition to clinical diagnoses and level of risk during reentry planning for individuals with an SFI designation to better support successful reentry;
- Adoption of validated, evidence-based risk assessment tools that include both static and dynamic factors for use consistently across the Agency of Human Services to assess public safety and criminiogenic risk among members of the designated population;
- Consistent use statewide of the Sequential Intercept Model within the criminal justice system;
- Exploration of ways to implement consistently and uniformly the treatment court programs statewide;
- Training for all Vermont law enforcement officers in recognizing and responding to mental health issues;
- Assessment of the designated agencies to ensure that all counties are equipped with appropriately trained staff and risk management tools to provide the appropriate, necessary, and effective services to members of the designated population living in the community;
- Use of performance-based contracts that establish targeted treatment strategies and measureable outcomes for lowering rates of criminal justice contacts, including use of measurable goals and benchmarks for reducing the intensity of services;
- Continuation of ongoing discussions on the appropriate number of secure residential recovery beds in the State and the judicial route for placement in such a facility;
- Use of in-state health care providers within Vermont's correctional facilities in order to ensure continuity of care upon reentry to the community;
- Spending priority given to interventions that reduce public safety risks required by persons with the highest criminogenic thinking;
- Analysis of the design and constraints of TBI services by the Agency of Human Services to determine whether funding opportunities for this group may be expanded;
- Exploration of intensive multidisciplinary case management models similar to FACT and ACT that may be successfully used in rural communities as is done under the Blueprint for Health throughout Vermont; and
- Exploration as to whether payments to designated agencies for participation in reentry planning are eligible for use of MCO investment funds.

II. Background

The formation of the Committee was prompted by the rapidly growing budget for community supports benefiting a few individuals with very high-cost plans related to their mental or functional impairments or developmental disabilities who were either reentering the community after incarceration or who were not facing current charges. The Committee was surprised to learn that in these highest-cost plans ($200,000 plus) the vast majority of spending was related to 1:1 or 2:1 supervision associated with public safety risks versus treatment. In response to this increasing budget pressure, the Secretary of Human Services established a moratorium on individualized budgets, meaning that existing plans were continued until the end of their contractual terms with providers, but no new plans were subsequently approved. Consequently, some inmates with the correctional designation "serious functional impairment" (SFI) were held past their minimum sentence due to a lack of suitable placements in the community.[1] In response to these issues, the General Assembly passed 2013 Acts and Resolves No. 33, An act relating to community supports for persons with serious functional impairments.

The Committee, established pursuant to Act 33, found over the course of its work that the heart of its mission was to identify ways to reduce the number of individuals in prison who have mental health or other behavioral challenges while simultaneously protecting public safety. One of the most significant challenges faced by the Committee is the expansive scope of the population it was tasked with studying. Act 33's "designated population" includes individuals in correctional facilities with an SFI designation, individuals categorized as complex community cases, and individuals in the public safety group.[2] Each of these populations has unique legal rights, funding silos, and treatment opportunities, which adds layers of complexity to the work of the Committee.

For the purposes of this report, the Committee equates individuals who pose a risk to public safety with those engaging in criminogenic behavior as opposed to those whose criminal actions are primarily a result of illness. The Committee further acknowledges that having a diagnosis related to a mental health condition, functional impairment, or developmental disability does not make one more likely to be violent or commit criminal acts.

Across the nation, the percentage of prison inmates with a mental health diagnosis exceeds the percentage of individuals in the general population who have a mental health diagnosis.[3] In addition, such individuals stay in prison longer, both as detainees and after sentencing.[4] Testimony presented to the Committee indicated that up to one-third of inmates with a mental health diagnosis probably do not belong in prison at all. That is, they do not demonstrate the

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[1] *See* Appendix 3: Glossary of Terms for the definition of "serious functional impairment."
[2] *Id.* for the definitions of "designated population," "complex community case," and "public safety group."
[3] *See generally* Fred Osher et al., *Adults with Behavioral Health Needs Under Correctional Supervision: A Shared Framework for Reducing Recidivism and Promoting Recovery*, Council of State Governments Justice Center and Criminal Justice/Mental Health Census Project (2012). The U.S. Department of Justice's Survey on Inmates in State and Federal Correctional Facilities, as reported by the National Institute of Mental Health, indicates that over 56 percent of inmates in state prisons have a clinical mental diagnosis or receive treatment by a mental health professional. "Inmate Mental Health," National Institute of Mental Health, *available at* http://www.nimh.nih.gov/statistics/1DOJ.shtml.
[4] *See supra* note 3, Fred Osher et al., at 6.

criminogenic thinking that underlies the societal need for punishment; rather the primary driver of their behavior is mental illness. Although the treatment of inmates with mental illness and other behavioral challenges within Vermont's prison facilities is of concern to many, the Committee's charge focused on improving supports in the community, and therefore the scope of this report is limited to that area.

The Committee believes that one promising approach to reducing the incarceration of individuals with mental or functional impairments or developmental disabilities and other similar challenges is the Sequential Intercept Model. Under this approach, each point of contact with the criminal justice system is seen as an opportunity for diversion into appropriate treatment and case management services. While there are several successful programs across the State using portions of the Sequential Intercept Model, there is not a consistent network in all parts of the State or at all points along the criminal justice system. (*See* section V(D) for a discussion of the Sequential Intercept Model.)

In analyzing the needs of individuals with mental health or other behavioral challenges who pose a risk to public safety, the Committee believes it is necessary to consider their criminogenic risk prior to deciding appropriate placement and treatment. Tools for such analysis are becoming increasingly more sophisticated and key to determining how the State's treatment dollars should be targeted.

III. Statutory Authority and Responsibilities of the Committee

The General Assembly established the Committee in 2013 to address the needs of and public safety concerns related to the "designated population," meaning "those Vermont residents regardless of whether they are in the custody of the Commissioner of Corrections, with mental and functional impairments or developmental disorders so severe that they cannot live in the community without substantial supports and who have committed, been charged with, or have been identified as being at risk of committing a criminal offense that renders them a threat to public safety or who pose a risk to their own physical safety, or both." (2013 Acts and Resolves No. 33.) The Committee's charge includes consideration of appropriate treatments and legal protections for the designated population, as well as approaches for managing the related public safety risk. (*See* Appendix 1: 2013 Acts and Resolves No. 33.)

The Study Committee on Providing Community Supports for Persons with Serious Functional Impairments is a legislative committee composed of senators who serve on the Committees on Appropriations, on Health and Welfare, and on Judiciary, as well as one senator selected from "at large," and representatives who serve on the Committees on Appropriations, on Corrections and Institutions, on Human Services, and on Judiciary. Act 33 requires the Committee to submit a written report to the Senate Committees on Appropriations, on Health and Welfare, and on Judiciary, and to the House Committees on Appropriations, on Corrections and Institutions, on Human Services, and on Judiciary by December 15, 2013.

IV. Summary of Committee Activities

While the General Assembly was adjourned, the Committee convened four times in 2013 to hear testimony from a diverse array of stakeholders on a number of issues within its jurisdiction. (*See* Appendix 2: Witness List.) The Committee took testimony on the following subjects:

- Identifying and classifying members of the designated population;
- Funding streams associated with each classification in the designated population;
- Due process considerations for individuals in need of intensive community supports that may limit their personal freedom;
- Resources available to members of the designated population in both correctional and community settings;
- Service models and risk assessment tools used or piloted in other states; and
- Budgetary impacts of and opportunities for serving the designated population

The Committee's activities were focused on making recommendations to the General Assembly for consideration and action during the 2014 legislative session.

V. Findings and Recommendations

A. SFI Designation

The term "serious functional impairment" is a designation created by the General Assembly to confer specialized services upon inmates who experience a mental, functional, or similar challenge that impairs their ability to function solely in a correctional setting. The Committee recognizes that the SFI designation represents a heterogeneous population with great variation in clinical diagnosis, severity of diagnosis, criminogenic risk, functional impairment, and need. This designation is not a clinical diagnosis and was not intended for use outside correctional facilities. However, the Committee heard anecdotal testimony that inmates often carry the stigma of the SFI designation upon reentering the community, consequently making them less desirable clients to some providers.

Recommendation: The Committee recommends a legislative amendment specifying that use of an SFI designation end once an inmate leaves a correctional facility.

B. Public Safety

a. Functionality, Diagnosis, and Risk to Offend

One of the most important tasks before the Committee is to ensure that any recommendations resulting from its work account for public safety risks related to serving members of the designated population in the community. Historically, public safety decisions pertaining to residential placement and treatment have been based on individuals' clinical diagnosis. It is the belief of the Committee that the designated population needs to be assessed in a new way.

It is the Committee's belief that analyzing individuals' functional limitations will result in community supports better tailored to the needs of the individual, consequently reducing the likelihood of criminal behavior. Greater sophistication is needed in the identification and stratification of this population in order to match appropriate services effectively to each person's functionality and assessed risk.

Recommendation: The Committee recommends that individuals with an SFI designation be assessed for functional ability and impairments in addition to clinical diagnoses and level of risk when planning for reentry.

b. Risk Assessment Tools

Over the course of its four meetings, the Committee heard testimony from providers in both the community and the criminal justice system that a diverse array of risk assessment tools is used with the designated population. This has led to the inconsistent identification and treatment of criminogenic factors.

Recommendations: To ameliorate this problem, the Committee recommends the adoption of validated, evidence-based risk assessment tools that include both static and dynamic factors for use consistently across the Agency of Human Services to assess public safety and criminiogenic risk among members of the designated population. The Committee further recommends that any community providers giving around the clock supervision to a member of the designated population use a validated criminogenic risk assessment tool to determine continued need for this level of supervision, and applauds those already so doing.

C. LEGAL RIGHTS

Absent a court order, the Committee does not believe that any community placements should be made or treatments used without the consent of members of the designated population.[5]

Recommendation: Accordingly, the Committee favors a continuation of current practices.

D. TREATMENT, SUPPORTS, AND SERVICES IN THE COMMUNITY

a. Early Intervention

While various services and supports contribute to the success of members of the designated population reentering the community after incarceration, the Committee believes it would be even more beneficial to divert members of the population from the criminal justice system when few criminogenic indicators exist. Instead, resources aimed at early interventions and accepted on a voluntary basis by members of the designated population would better serve both the designated population and the public at large. The Committee heard testimony describing the Sequential Intercept Model, and is cautiously optimistic that the intercept

[5] "Court order" references involuntary mental health commitment pursuant to 18 V.S.A. chapter 181, further treatment at a secure residential recovery facility pursuant to 18 V.S.A. § 7621, and commitment to the Commissioner of Disabilities, Aging, and Independent Living pursuant to 18 V.S.A. chapter 206.

points identified in this Model could be used more frequently and more consistently to divert members of the designated population statewide.[6]

In brief, the Sequential Intercept Model is divided into five stages. (*See* Appendix 4: Criminal Justice Capable System of Care.) The first interception point occurs before an alleged offender is charged, where the police take the initiative to consult mental health professionals. The second point is before arraignment where screening and diversion is possible. The third interception point occurs between arraignment and disposition with referrals for treatment or case management. Fourth, interception can occur as part of the sentencing order using special dockets or treatment mandated as a condition of probation. And the last point occurs when an individual is released from prison and treatment is integrated as part of the reentry plan. Although this last step is important, far greater success could be achieved by maximizing the effectiveness of interventions earlier in the criminal justice process.

Recommendation: The Committee recommends consistent use of the Sequential Intercept Model statewide.

b. Pretrial Services and Court Treatment Programs[7]

Diversion from the criminal justice system is achieved in several counties through robust coordination between law enforcement officers and mental health providers. In Windham County, social workers participate in calls and rides with law enforcement officers. In Chittenden County, there are dedicated mental health staff members within the Burlington Police Department who do rounds in the community and check on individuals known to have mental or functional disabilities. While these initiatives have proven successful in diverting individuals from the criminal justice system, their impact could be much more significant if administered consistently across the State. Mandatory statewide mental health training for law enforcement personnel would be a first step in that direction.

There are several counties that successfully use various pretrial services. For example, Chittenden County has implemented the Rapid Intervention Program, which uses risk assessment tools and makes referrals to the community justice center and other community providers for the purpose of diverting offenders prior to the filing of criminal charges. Chittenden County also has the Rapid Referral Program, which serves people facing charges at the time of their arraignment. The Sparrow Program in Windsor County uses risk assessment, clinical assessment, and case management services with offenders from the time of arraignment through sentencing. Expanding programs such as these to address the needs of members of the designated population at various interception points has the potential to keep individuals out of prison when society is not served by their incarceration.

Vermont currently has adult treatment court dockets in Chittenden, Rutland, and Washington Counties that serve participants with either a primary substance abuse diagnosis or with a

[6] See Appendix 3: Glossary of Terms for the definition of "Sequential Intercept Model."

[7] Several of these programs have been evaluated by the Vermont Center for Justice Research. For more information visit www.vcjr.org.

primary mental health diagnosis. If it is determined that a defendant is an appropriate candidate for a treatment court program, he or she is provided information with which to make an informed decision about participation. The length of the program from referral through graduation is approximately 18–24 months and includes weekly judicial monitoring, team meetings to review participants' progress, two weekly drug tests, and intensive case management and behavior modification strategies. The treatment court programs occur in three stages, and graduation takes places once a defendant has met all necessary requirements.

Recommendations: Due to the success of these programs, the Committee recommends that the committees of jurisdiction explore ways to implement consistently and uniformly the programs statewide. Possible expansions include developing regional or mobile treatment court programs. The Committee further recommends that all persons in Vermont law enforcement at the local, county, and State levels have regular and appropriate training in recognizing and responding to mental health issues.

c. Assessment of Designated Agency Capacity

During the course of the Committee's proceedings, it came to light that although all designated agencies have the same core capacities, there is an inconsistency in their ability to provide for the designated population. Some designated agencies have specialized programs for this population, while others do not. All designated agencies have services to address individuals with co-occurring mental health and substance abuse challenges.

Recommendations: The Committee recommends that the Agency of Human Services conduct an assessment of the designated agencies to ensure that all counties are equipped with appropriately trained staff and risk management tools to provide appropriate, necessary, and effective services to members of the designated population who are living the community.

The Committee also recommends that the Agency of Human Services, in collaboration with community providers, assess and better define the liability and risks associated with serving members of the designated population in the community. In addition, the Agency should explore performance-based contracts that establish targeted treatment strategies and measurable outcomes for lowering rates of criminal justice contacts by individuals receiving services who have been determined to be at risk for initial or repeat criminal justice contacts.

d. Secure Residential Recovery Facility

In its charge, the Committee was asked to address the extent to which one or more secure residential recovery facilities are within the appropriate continuum of treatment alternatives for the designated population. However, the Committee did not reach a conclusion on this matter because it determined that the State should instead put resources into interventions at the front end of the system and evaluate the impacts and outcomes of those investments. Until the State provides more comprehensive services at the front end, the Committee believes that it is premature to make a decision as to the need for additional secure residential recovery facilities to serve members of the designated population.

Recommendation: The Committee recommends that the committees of jurisdiction continue ongoing discussions on the appropriate number of secure residential recovery beds in the State and the judicial route for placement in such a facility.

E. REDUCING RECIDIVISM

Many members of the designated population have committed a criminal offense; oftentimes this offense is what initially brings individuals to the attention of one or more departments within the Agency of Human Services. Once a member of the designated population is known, efforts are made to prevent the individual from reoffending. This is true regardless of whether the individual serves time in prison or receives services in the community. The Committee believes that programming both in and outside correctional facilities must be tailored to the needs of the individual being served. It further finds that more collaborative reentry planning involving both the inmate and community providers would serve to reduce recidivism among members of the designated population.[8]

The Committee understands that the Department of Corrections is in the process of renegotiating its contract for the provision of mental and physical health care services to inmates. It hopes that the Department chooses to contract with local health care providers versus maintaining its existing relationship with an out-of-state corporation.

Recommendation: The Committee believes that using in-state health care providers within Vermont's correctional facilities will ensure greater continuity throughout the system and foster more effective discharge planning.

F. PRIORITIZING APPROPRIATIONS AND SPENDING

a. Prioritize Spending on Evidence-Based Practices and High Criminogenic Risks

The Committee believes that it is essential to assess where and how money is currently being spent on the designated population, and to rearrange spending priorities in a manner that delivers the most cost-effective results.

Recommendation: Evidence-based practices with a demonstrated record of preventing incarceration should be prioritized ahead of other expenditures. In addition, priority should be given to interventions that reduce public safety risks required by persons with the highest criminogenic thinking. As part of the annual budget process, the Agency of Human Services should report on the actual outcomes of its expenditures for the designated population.

b. Braided Funding Streams

Many distinct funding silos are established in response to legislatively created definitions. Testimony before the Committee explored the concept of moving from distinct funding silos toward combined funding streams to provide more comprehensive services and supports to members of the designated population. Commissioner Larson of the Department of Vermont

[8] *See* section V(H)(b) for a discussion of reentry planning.

Health Access explained that blended funding should go hand in hand with blended services. One possible result of combining funding streams could be the formation of community care teams, in which clinical services are complemented by case management services. Use of a multidisciplinary team approach recognizes the importance of both health care and social services in supporting members of the designated population and keeps both types of providers accountable to each other for the well-being of members of the designated population living in the community.

Recommendation: The Committee recommends that the Agency of Human Services explore the feasibility of using multidisciplinary teams to support members of the designated population in the community.

G. FUNDING STREAMS AND OTHER OPPORTUNITIES

a. Funding Opportunities

In October of this year, the Department of Corrections was awarded a grant of $750,000.00 in federal funds under the Second Chance Act. The grant monies awarded to the Department were designated to assist more than 200 offenders reintegrate into the community and for the expansion of statewide reentry efforts aimed at reducing recidivism. Although the award is not specifically targeted to members of the designated population, it will certainly benefit some members as they transition from correctional facilities to community settings.

Also of interest to the Committee was whether any funding opportunities involving traumatic brain injury (TBI) services under the Global Commitment waiver exist. While the Committee did not have an opportunity to look at this issue in depth, it remains concerned how appropriate services can be woven together for some members of the designated population with a TBI. Even if better risk assessment tools and earlier interventions are used, these advances will be of no benefit to members of the designated population with a TBI unless funding for services is available.

Recommendation: The Committee recommends that the standing committees of jurisdiction analyze the design and constraints of TBI services to determine whether funding opportunities for this group may be expanded.

b. Other State Models

One of the Committee's many charges was to explore models used successfully in other states to address their equivalent of Vermont's designated population. Connecticut was highlighted by the Council of State Governments for its coordination between courts and mental health providers as part of its jail diversion program. Connecticut's courts distribute a list of individuals arrested each day to the Connecticut Mental Health Center.[9] The Center's staff then cross-references that list with its own database.[10] Where there is a match, the Center's

[9] *See* Counsel of State Governments, *Justice Center and Criminal Justice/Mental Health Census Project*, 91 (2002), *available at* http://csgjusticecenter.org/mental-health-projects/report-of-the-consensus-project/.
[10] *Id.*

staff, in conjunction with the public defender and pretrial services office, interviews the defendant and develops a plan for release, which is subsequently submitted to the court.[11] The only information submitted to the court is the proposed treatment plan; a defendant's diagnosis is not shared unless the defendant waives confidentiality.[12]

Connecticut also employs two community-based programs aimed at reducing recidivism in urban areas: the Forensic Assertive Community Treatment (FACT) Model and the Assertive Community Treatment (ACT) Model. These programs generally provide between 45 to 90 days of intensive multidisciplinary case management services focusing on meeting basic needs such as securing benefits, job placement, and stable housing. Services taper at the conclusion of this time-limited period. The Committee is especially interested in how these models could work in more rural environments because they have a record of success in providing individuals like members of the designated population with the tools they need to achieve stability in the community, which ultimately lowers the risk of recidivism.

Recommendations: The Agency of Human Services should explore intensive multidisciplinary case management models similar to FACT and ACT that may be successfully used in rural communities throughout Vermont. The Committee understands that some designated agencies have used a modified ACT model, and recommends that the Agency of Human Services assess the effectiveness of this modification to determine whether it is appropriate for statewide use.

The Committee further recommends that any plans for members of the designated population involving intensive supervision include measurable goals and benchmarks for reducing the intensity of services with the aim of achieving functionality, independence, and reduced criminogenic risk.

H. CORRECTIONS ISSUES

a. Forensics Unit

Whether appropriate correctional facilities are available to incarcerated members of the designated population was raised several times by witnesses, as well as during Committee discussion. Specific proposals included designating a separate facility or unit of an existing correctional facility for forensics purposes. A separate facility or unit would require staffing by employees with greater clinical expertise and training. Support for such a proposal was expressed in the unreleased Department of Corrections' report entitled, "Raising the Bar: Improving resources for care and custody of the severely functionally impaired offender population in Vermont." Since the Committee did not have time to reach a conclusion on this proposal, it recommends that the standing committees of jurisdiction and the Corrections Oversight Committee examine this matter in greater detail.

Recommendation: In recognition of the growing complexities involved in providing programs, services, and care for the general corrections population and persons who may have serious

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[11] *See id*.
[12] *Id*. at 95.

functional impairments, the Committee recommends that additional, specialized training be considered for all Department of Corrections' staff. If a specialized psychiatric forensic unit can be established, the Department of Corrections should carefully evaluate the staffing mix, clinical expertise, and training of staff in that unit.

b. Reentry Planning

Testimony before the Committee repeatedly emphasized the correlation between thorough reentry planning in correctional facilities and individuals' success once back in the community. Heterogeneity is an important factor in reentry planning as not all inmates with an SFI designation will require extensive services. One specific barrier to successful reentry planning services relates to designated agencies' inability to receive payment for reentry planning while an inmate is still in a correctional facility. This undermines opportunities for providers to contribute to the reentry planning process, which typically starts months prior to an inmate's release.

Recommendations: Committees of jurisdiction are encouraged to explore whether payments to designated agencies for participation in reentry planning are eligible for use of MCO investment funds.

The Committee recommends that the Department of Corrections conduct prerelease assessments to determine clinical needs and appropriate diagnostic categories for inmates leaving a correctional facility. It further recommends that the committees of jurisdiction consider the formation of reentry teams analogous to community care teams in the Blueprint for Health, which would use an array of multidisciplinary providers to tailor reentry plans to the specific needs of each inmate.

Report of the Act 33 Study Committee on
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Senator Dick Sears	*Representative Ann Manwaring*
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Senator Diane Snelling	*Representative Linda J. Waite-Simpson*

Appendix 1: 2013 Acts and Resolves No. 33

No. 33. An act relating to community supports for persons with serious functional impairments.

It is hereby enacted by the General Assembly of the State of Vermont:

Sec. 1. STUDY AND REPORT ON PROVIDING COMMUNITY SUPPORTS TO PERSONS WITH SERIOUS FUNCTIONAL IMPAIRMENTS

(a) As used in this act, "designated population" shall mean those Vermont residents, regardless of whether they are in the custody of the Commissioner of Corrections, with mental and functional impairments or developmental disorders so severe that they cannot live in the community without substantial supports and who have committed, been charged with, or have been identified as being at risk of committing a criminal offense that renders them a threat to public safety or who pose a risk to their own physical safety, or both.

(b) A legislative study committee is established to identify and examine the needs of the designated population in community-based settings. The Study Committee shall also be charged with determining how to most effectively allocate funds for the designated population within the constraints of past appropriations made for the purpose of serving this population. The Study Committee shall consist of a member from the House Committees on Appropriations, on Corrections and Institutions, on Human Services, and on Judiciary, not all from the same party, appointed by the Speaker of the House, and a member from the Senate Committees on Appropriations, on Health and Welfare, on Judiciary, and one Senator selected at large, not all from the same party, appointed by the Committee on Committees. The Study Committee shall discuss and make recommendations on legislative and nonlegislative solutions for improving the quality and cost-effectiveness of treatment to the designated population while maintaining public safety, in collaboration with the following organizations and individuals or their designee:

(1) the Secretary of Human Services;
(2) the Commissioner of Health;
(3) the Commissioner of Disabilities, Aging, and Independent Living;
(4) the Commissioner of Mental Health;
(5) the Commissioner of Corrections;
(6) the Commissioner of Vermont Health Access;
(7) the Commissioner for Children and Families;
(8) the Office of the Attorney General;
(9) the Mental Health Care Ombudsman;
(10) the Court Administrator;
(11) the Vermont Council of Developmental and Mental Health Services;
(12) Vermont Legal Aid's Mental Health Law Project;
(13) the Executive Director of the Vermont Developmental Disabilities Council;
(14) the Executive Director of the Vermont Human Rights Commission;
(15) Disability Rights Vermont;
(16) Vermont Psychiatric Survivors;
(17) Vermont League of Cities and Towns;
(18) Office of the Defender General's Prisoners' Rights Office; and
(19) other interested stakeholders.

(c)(1) The first meeting of the Study Committee shall be held on or before August 1, 2013. At its first meeting, the Study Committee shall elect two legislative members to serve as co-chairs. The Study Committee shall not meet more than four times.

(2)(A) The Office of Legislative Council shall provide administrative, staff, and legislative drafting support to the Study Committee. The Joint Fiscal Office shall provide staff support to the Study Committee.

(B) Prior to the first meeting of the Study Committee, the Office of Legislative Council shall collect from the Agency of Human Services existing data and background materials relevant to the responsibilities of the Study Committee, including past appropriations used to serve the designated population.

(d) The Study Committee shall consider:

(1) the continuum of appropriate treatment and services and supports for members of the designated population living in the community;

(2) practices for lowering the incarceration rate among the designated population;

(3) how best to protect the legal rights of members of the designated population living in community settings;

(4) approaches for managing public safety risks of the designated population;

(5) cost-saving opportunities for treating members of the designated population outside a correctional facility;

(6) treatment approaches used in other states that cost-effectively manage the public safety risks posed by residents comparable to the designated population; and

(7) any other issues as the Study Committee deems necessary and appropriate.

(e) On or before December 15, 2013, the Study Committee shall provide a written report containing any proposed legislation and its findings and recommendations, including the need for future action, to the House Committees on Appropriations, on Corrections and Institutions, on Human Services, and on Judiciary and to the Senate Committees on Appropriations, on Health and Welfare, and on Judiciary. In addition to the Study Committee's findings and recommendations, the report shall:

(1) develop proposed guidelines specifying how an individual shall be assessed to determine if he or she is a member of the designated population and what benchmarks shall be achieved by the individual prior to declassification from the designated population;

(2) address the extent to which one or more secure residential recovery facilities are within the appropriate continuum of treatment alternatives for the designated population; and

(3) evaluate the cost of potential treatment opportunities found by the Study Committee to appropriately balance care, legal rights, and public safety.

(f) For physical participation at meetings, legislative members of the Study Committee shall be entitled to receive per diem compensation and reimbursement of expenses pursuant to 2 V.S.A. § 406.

Sec. 2. EFFECTIVE DATE

This act shall take effect on passage.

Appendix 2: Witness List

1. Robert Appel, Attorney, Kohn Rath Danon & Appel LLP
2. Lynn Boyle, Field Services Director, Agency of Human Services
3. Delores Burroughs-Biron, MD, Health Services Director, Department of Corrections
4. Kim Bushey, Program Services Director, Department of Corrections
5. Chuck Cacciatore, Lieutenant, Vermont State Police, Rutland
6. Keith Clark, President, Vermont Sheriffs Association
7. David D'Amora, Director of National Initiatives, Council of State Governments
8. Paul Dupre, Commissioner, Department of Mental Health
9. Karen Gennette, Esq., Programs Manager, Office of Court Administrator
10. Monica Hutt, Director of Policy and Planning, Agency of Human Services
11. Margaret Joyal, Director, Center for Counseling and Psychological Services, Washington County Mental Health Services
12. Bram Kranichfeld, Executive Director, Vermont State's Attorneys and Sheriffs Association
13. Mark Larson, Commissioner, Department of Vermont Health Access
14. Meredith Larson, Chief, Mental Health Services, Department of Corrections
15. Jack McCullough, Director, Mental Health Law Project, Vermont Legal Aid
16. Katie McLinn, Legislative Counsel, Office of Legislative Council
17. Andy Pallito, Commissioner, Department of Corrections
18. Barbara Prine, Attorney, Vermont Legal Aid
19. Doug Racine, Secretary, Agency of Human Services
20. Annie Ramniceau, Clinical Director, Spectrum Youth and Family Services
21. Ed Riddell, Public Safety Specialist, Department of Disabilities, Aging and Independent Living
22. Michael Schirling, Chief, Burlington Police Department
23. Patricia Singer, MD, Director, Adult Services, Department of Mental Health
24. Julie Tessler, Director, Vermont Council of Developmental and Mental Health Services
25. Susan Wehry, Commissioner, Department of Disabilities, Aging and Independent Living
26. Mark Young, Coordinator, Sparrow Project

Appendix 3: Glossary of Terms

Community Rehabilitation and Treatment (CRT): CRT is an assortment of services provided in the community to adults with severe and persistent mental illness. The Department of Mental Health contracts with designated agencies to provide direct CRT services to eligible individuals. CRT clients are entitled to core services that are clinically appropriate to each individual's mental health needs. Core services include clinical assessment; service planning and coordination; community supports; individual, group, and family therapy; medication evaluation, management, and consultation with primary care; diagnosis-specific practices; emergency care and crisis stabilization; private practitioner behavioral services; and inpatient behavioral services.

Complex Community Case (CCC): Individuals categorized as "CCC" have a similar clinical profile to those individuals with a serious functional impairment. However, individuals designated as CCC have not been incarcerated and therefore have not received the SFI correctional designation.

Criminogenic**:** With regard to behavior or thinking patterns, refers to producing or tending to produce crime or criminality.

Designated Population: Those Vermont residents regardless of whether they are in the custody of the Commissioner of Corrections, with mental and functional impairments or developmental disorders so severe that they cannot live in the community without substantial supports and who have committed, been charged with, or have been identified as being at risk of committing a criminal offense that renders them a threat to public safety or who pose a risk to their own physical safety, or both.

Public Safety Group: This group has two categories: (1) persons committed to the custody of the Commissioner of Disabilities, Aging, and Independent Living because they have been found unable to stand trial and the court has found that they are in need of custody, care, and habilitation (per 1988 Acts and Resolves No. 248, Sec. 9); and (2) individuals who have not been adjudicated, but because of their known history, present a public safety risk.

Sequential Intercept Model: This model identifies five interception points in the criminal justice process—from arrest through community reentry—which provide opportunities to divert offenders from incarceration to treatment services and other supports.

Serious Functional Impairment (SFI): This term is a statutory designation versus a clinical diagnosis. It is defined at 28 V.S.A. § 906(1) to mean either "a disorder of thought, mood, perception, orientation, or memory as diagnosed by a qualified mental health professional, which substantially impairs judgment, behavior, capacity to recognize reality, or ability to meet the ordinary demands of life and which substantially impairs the ability to function within the correctional setting" or "a developmental disability, traumatic brain injury or other organic brain disorder, or various forms of dementia or other neurological disorders, as diagnosed by a qualified mental health professional, which substantially impairs the ability to function in the correctional setting."

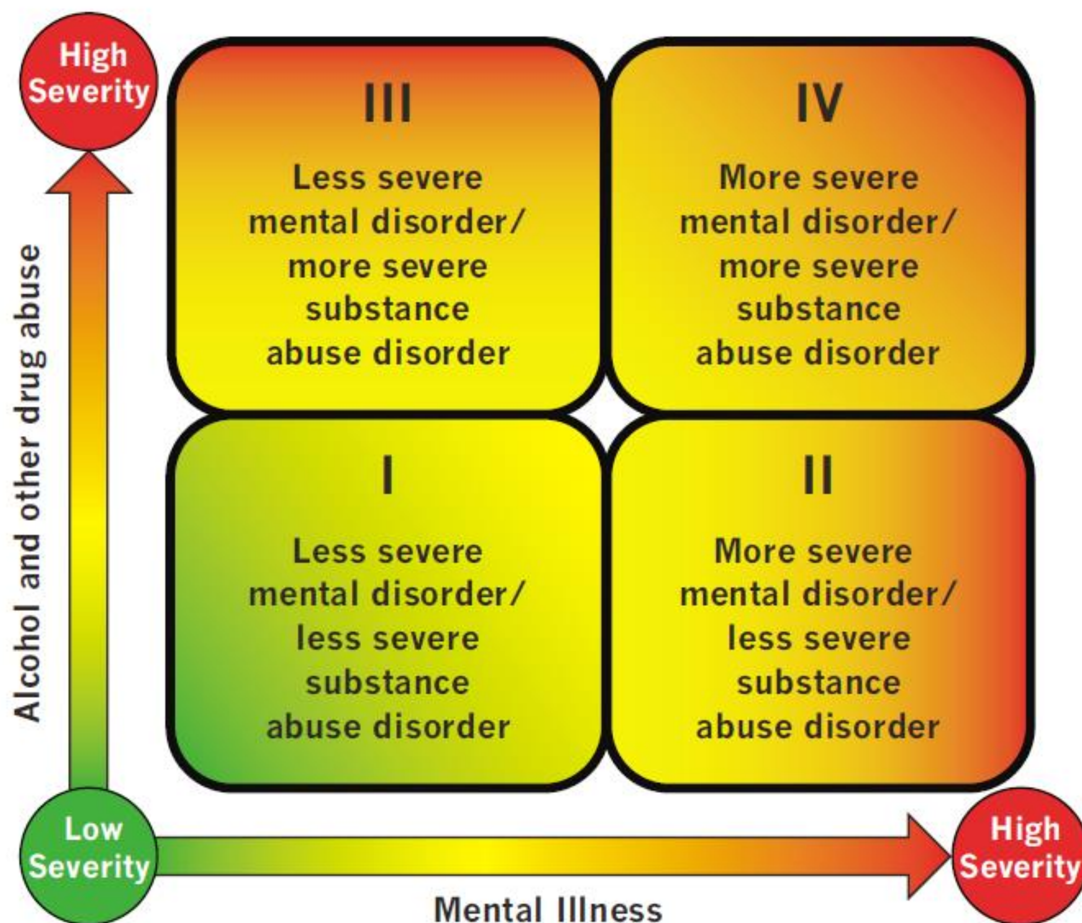
Appendix 4: Criminal Justice Capable System of Care

1 Pre Charge	2 Post Arrest	3 Pre-Trial Services	4 Disposition	5 Re-entry / Community Supports
Population Based Approach Before Seeing Prosecutor	Pre-Arraignment Initial Detention Initial Hearing Before Seeing the Judge	Post-Arraignment (prior to accepting responsibility / still presumed innocent while case is pending) Judges Decision	Judicial / Court Based Outcomes Corrections Based Outcomes	Transitioning back to the community
CJC Pre-charge (direct referrals) Emergency Services Law Enforcement Diversion incl. Team Two Training for LE & MH workers Mobile Crisis Teams	Court Diversion (Statewide) Rapid Intervention (Chittenden)	Rapid Referral (Chittenden) Sparrow Program (Windsor) Combo of RR & RI (Franklin)	Treatment Courts: Rutland, Washington & Chittenden MH Court: Chittenden Probation Furloughs Home Confinement	Conditional Re-entry Re-entry programs (COSA / CJC) Reintegration Furlough LIT & SIT

Robust Mental Health and Substance Abuse Programs
To Include: TBI, DS and Recovery Services

Courtesy of Karen Gennette, Office of Court Administrator

Appendix 5: Co-Occurring Disorders by Severity



Fred Osher et al., *Adults with Behavioral Health Needs Under Correctional Supervision: A Shared Framework for Reducing Recidivism and Promoting Recovery*, Council of State Governments Justice Center and Criminal Justice/Mental Health Census Project, 30 (2012).

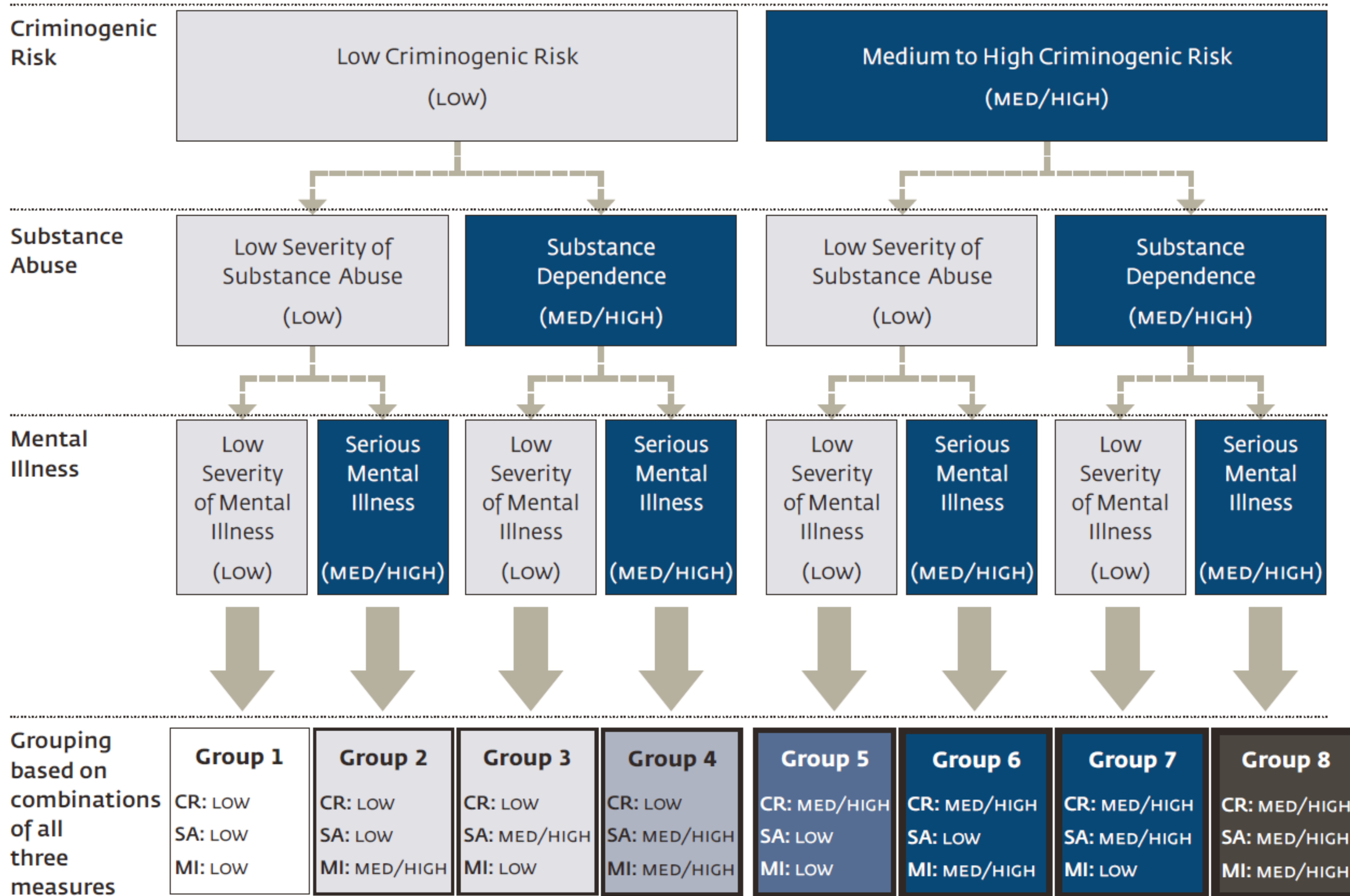
Appendix 6: Major Risk/Need Factors Associated with Committing Future Crimes (Criminogenic Risk)

Risk Factor	Description
1. Presence of Antisocial Behavior	Early and continuing involvement in a number and variety of antisocial acts in a variety of settings
2. Antisocial Personality Pattern	Adventurous, pleasure-seeking, weak self-control, restlessly aggressive
3. Antisocial Cognition	Attitudes, values, beliefs, and rationalizations supportive of crime; displays of anger, resentment, and defiance; and negative attitudes toward the law and justice systems
4. Antisocial Associates	Close association with criminals and relative isolation from law-abiding individuals; positive and immediate reinforcement for criminal behavior
5. Family and/or Marital	Poor relationship quality with little mutual caring or respect; poor nurturance and caring for children; and few expectations that family members will avoid criminal behavior
6. School and/or Work	Poor interpersonal relationships within school or work setting. Low levels of performance and satisfaction in school and/or work
7. Leisure and/or Recreation	Low levels of involvement and satisfactions in anticriminal leisure pursuits
8. Substance Abuse	Abuse of alcohol and/or other drugs (tobacco excluded)

Source: This table was adapted from Andrews, D. A., James Bonta, and Robert D. Hoge, "Classification for Effective Rehabilitation: Rediscovering Psychology," *Criminal Justice and Behavior* 17, no. 1 (1990): 19–52.

Fred Osher et al., *Adults with Behavioral Health Needs Under Correctional Supervision: A Shared Framework for Reducing Recidivism and Promoting Recovery*, Council of State Governments Justice Center and Criminal Justice/Mental Health Census Project, 23 (2012).

Appendix 7: Criminogenic Risk and Behavioral Health Needs Framework



Fred Osher et al., *Adults with Behavioral Health Needs Under Correctional Supervision: A Shared Framework for Reducing Recidivism and Promoting Recovery*, Council of State Governments Justice Center and Criminal Justice/Mental Health Census Project, 33 (2012).