Act 158 Study

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Report submitted to:

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Commissioner
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Executive Summary

In 2014, the Vermont legislature passed Act No. 158, an act relating to the commitment of a criminal defendant who is incompetent to stand trial because of a traumatic brain injury. The statute directs the Department of Disabilities, Aging, and Independent Living (DAIL) to "*evaluate best practices for treatment of persons with traumatic brain injuries who are unable to conform their behavior to the requirements of the law, and in identifying appropriate programs and services to provide treatment to enable those persons to be fully reintegrated into the community consistent with public safety.* "

In response to this legislative mandate, DAIL contracted with Brain Injury Association of Vermont (BIA- VT) and Flint Springs Associates (FSA) to conduct a study of best practices. The goal was to identify appropriate programs and services to provide treatment to persons with TBI found not guilty due to insanity (NGI) or incompetent to stand trial to be fully reintegrated into the community consistent with public safety.

Findings

- Vermont needs data on the number of persons with brain injuries who are engaged in criminal behavior, including individuals who are found NGI or incompetent to stand trial because of a brain injury. The data that does exist suggests that it can be expected that the numbers of individuals found NGI or incompetent to stand trial due to TBI, is likely to be small.

- No model exists to address community safety and community reintegration for persons found NGI or incompetent to stand trial due to a TBI.

- At this point research focuses on screening for and identifying TBI only among convicted offenders, it does not include persons found NGI or incompetent to stand trial. Vermont is not currently screening or identifying TBI among persons in the corrections system.

- National TBI experts felt that restoring competence to stand trial would require some degree of cognitive rehabilitation to attain the ability to participate in one's own defense. The experts believe if a person experiences a TBI more than two years prior to being found incompetent, the probability of restoring competence to stand trial is low.

- Programming and interventions should be tailored to the individual and based on information gained through neuropsychological evaluations and other information (i.e., criminogenic risk and needs assessment, medical history, medication history, co-morbidity issues, pre-morbid history, and any other psycho-social information).

Recommendations:

The expectation going into this study was that best practices exist, and could be identified, for addressing reintegration and community safety for persons who present a danger of harm to others and found NGI or incompetent to stand trial due to a TBI. However, the research found to the contrary that no best practices exist. As a result, the research did not lead to a clear programming recommendation. Rather, the researchers, in consultation with the Act 158 Work Group, recommend that further work take place through an expanded group of stakeholders to flesh out Vermont's strategy for responding to this population (detailed in

Recommendation 10). The expanded study group should address issues identified through the research to develop responses for persons with TBI who have been found NGI or incompetent to stand trial. (Note: Recommendations #1 through #9 progressively build on one another.)

1. Competency evaluations should identify the primary reason for incompetence. As part of this assessment, anyone identified as incompetent to stand trial should be screened with a brain injury screening tool.
2. If a person has screened positive for a TBI, then actuarial criminogenic risk and need assessments should be conducted by forensic psychologists trained in use of these tools to determine the level of risk the individual poses to public safety.
3. If an individual with TBI is also found to pose a high risk to public safety, then a full neuropsychological evaluation should be completed.
4. In order to develop a proposal to serve an individual with TBI who poses a risk to public safety, providers should receive detailed information about the individual. This will require cooperative agreements and collaboration across systems to provide the following types of information.
5. A range of options should be available in order to provide programming that is tailored to the individual. Interventions employed with individuals will be responsive to the nature of the brain injury, the risk to public safety, criminogenic needs, and one's willingness to participate in programming.
6. To provide appropriate assessments and interventions:
    - Evaluations and assessments should be conducted by individuals who possess both TBI and forensic expertise.
    - Medical professionals should receive brain injury training.
    - Provider staff should possess the same qualifications required of TBI Waiver Provider staff. In addition, training to address criminogenic needs through programming should be developed and implemented for TBI provider staff
    - Staff training on how to address criminogenic needs in order to reduce risk should be provided by the same organization as the Department of Corrections uses to build its staff capacity.
7. The statute should be revised to include language requiring regular reassessments of competence and Court review if a reassessment demonstrates competence to stand trial has been restored.
8. Regular reassessments of competency, TBI and community safety risk should take place to help determine when services should stop or change.
9. Administration of services and interventions should be delivered by administrators and providers with expertise in brain injury, such as the TBI Program currently in DAIL. However, any services and interventions should be separate and distinct from the current TBI Waiver Program, and will require new appropriation to support staffing.
10. Convene a broad group of key stakeholders to resolve a number of outstanding questions on how best to treat persons with TBI found NGI or incompetent to stand trial, due to their TBI. The group should include representatives of DAIL, DMH, Department of Corrections (DOC), Alcohol and Drug Abuse Program (ADAP) at the Department of Health, Agency of Human Services, Judiciary, Prosecutors, and the Defense Bar.

Costs: The report does not provide a set price tag for programming and services. First, insufficient data exists to calculate the number of individuals who might fall into the target group. Second, without assessments of treatment needs and risk to public safety it is difficult to estimate on the range and costs of required programming. Therefore, a cost estimate for programming is not possible at this point.

Introduction

In 2014, the Vermont legislature passed Act No. 158, an act relating to the commitment of a criminal defendant who is incompetent to stand trial because of a traumatic brain injury: http://www.leg.state.vt.us/docs/2014/Acts/ACT158.pdf

As part of Act 158, 13 V.S.A. § 4823 Section 10 was amended to say that "*If the Court finds that the person is a person in need of custody, care, and habilitation as defined in 18 V.S.A. § 8839, the Court shall issue an order of commitment directed to the Commissioner of Disabilities, Aging, and Independent Living for care and habilitation of such person for an indefinite or limited period in a designated program…and persons committed under the order shall have the same status, and the same rights, including the right to receive care and habilitation, to be examined and discharged, and to apply for and obtain judicial review of their cases.*" Person in need of custody, care and habilitation is defined as "*a person with an intellectual disability or a person with a traumatic brain injury; who presents a danger of harm to others; and, for whom appropriate custody, care, and habilitation can be provided by the Commissioner in a designated program*."

The statute directs the Department of Disabilities, Aging, and Independent Living (DAIL) to "*evaluate b e s t practices for treatment of persons with traumatic brain injuries who are unable to conform their behavior to the requirements of the law, and in identifying appropriate programs and services to provide treatment to enable those persons to be fully reintegrated into the community consistent with public safety.* " DAIL is also charged with designing "*the programs and services needed to treat persons with traumatic brain injuries who have been found not guilty by reason of insanity or incompetent to stand trial as required by this act*" and to request legislative approval and funding for DAIL's plan to implement the act.

In response to this legislative directive, DAIL contracted with the Brain Injury Association of Vermont (BIA-VT) and Flint Springs Associates (FSA) to conduct a study of best practices for treatment of persons with traumatic brain injuries who are found not guilty by reason of insanity or not competent to stand trial due to a brain injury, and identify appropriate programs and services to provide treatment to enable those persons to be fully reintegrated into the community consistent with public safety.

BIA-VT and FSA were charged with providing:

- Review of best practices
- Practice recommendations for effective treatment practices in Vermont
- Review of existing programs and services that adhere to those treatment practices
- Program and service recommendations for implementation in Vermont
- Initial cost estimates of implementing recommended programs and services in Vermont

BIA-VT and FSA consulted with the Act 158 Work Group composed of staff from DAIL and the Department of Mental Health (DMH) in designing the study, reviewing findings, and developing recommendations.

This report summarizes the methods and findings of the study, and concludes with recommendations.

Background: Individuals with Traumatic Brain Injury and Criminal Behavior

In January 2014, legislators heard testimony from a Vermont woman whose son had been sexually assaulted by a relative who had a TBI. The Court held that the offender was incompetent to stand trial, charges were dropped and the offender was released to the community. The woman reported that subsequent to his release, the offender resided next door to the victim's family. This led Rep. Warren Van Wyck to propose legislation intended to address circumstances in which a person with a TBI is found not guilty by reason of insanity or incompetent to stand trial, but poses a public safety risk. The statute defines an individual posing a public safety risk as someone "who presents a danger of harm to others."

As part of Act 158, legislators directed the Court Administrator to "*report on the number of cases from July 1, 2011 through June 30, 2013 in which the Court ordered the Department of Mental Health to examine a defendant…to determine if he or she was insane at the time of the offense or is incompetent to stand trial. The report shall include a breakdown indicating how many orders were based on mental illness, developmental disability, and traumatic brain injury, and shall include the number of persons who were found to be in need of custody, care, and habilitation.*"

In addition the Department of State's Attorneys and Sheriffs' Association were directed to report on the charging practices of State's Attorneys for persons with traumatic brain injury. Using the same time period as the Court Administrator, the report was to describe the number of cases, broken down by criminal charge, in which "*a person with traumatic brain injury was: charged with a criminal offense, including the disposition of the offense; charged with a criminal offense and the charges were dismissed because the person was suffering from a traumatic brain injury; and arrested for, or otherwise believed to be responsible for, a crime and criminal charges were not brought because the person was suffering from a traumatic brain injury*."

The Department of State's Attorneys and Sheriffs' Association collaborated with the Court Administrators Office, the Department of Mental Health, and the Department of Disabilities, Aging and Independent Living to develop a method for collecting the requested information. Time and resource limitations resulted in a decision to collect data from Chittenden County, as it represents one third of criminal filings statewide and from Franklin County, as a proxy for rural counties in the state.

The study reviewed 242 cases in which either the prosecutor, defense attorney or the court ordered a competency or sanity evaluation for the defendant. Of these 242 cases, nine (3.7%) involved three individuals with a TBI; of those, one individual accounted for seven of the nine cases. That person faced numerous charges including domestic assault, retail theft, and disorderly conduct. One of the two remaining individuals had a retail theft misdemeanor charge and the other was charged with a misdemeanor simple assault. The data collection method apparently prevented tracking of individuals, but it seems to imply that the one individual with seven dockets was found competent and sane in each case, while the remaining two individuals were found not competent due to a TBI.

The Court Administrator's report concludes, "It is clear that the diagnosis of TBI as a result of a competency/sanity evaluation pursuant to 13 V.S.A. § 4823 is a relatively rare occurrence."

The Department of State's Attorneys and Sheriffs' Association conclude, "Given the small number of cases with a TBI diagnosis, there is not enough data to extrapolate to predict with any degree of accuracy the potential number of TBI cases in the State. "

As demonstrated by the Court Administrator and Department of State's Attorneys and Sheriff's Association, Vermont needs data on the number of persons with brain injuries who are engaged in criminal behavior, including individuals who are found NGI or incompetent to stand trial because of a brain injury.

The data that does exist suggests that it can be expected that the numbers of individuals in the target population, that is persons found NGI or incompetent to stand trial due to TBI, is likely to be small.

Treatment and Intervention

BIA-VT and FSA used a multi-tiered approach to identify best practices for treatment of persons with a traumatic brain injury (TBI) found not guilty by reason of insanity (NGI) or incompetent to stand trial, due to their TBI. The intended goal was to find best practice models that would rehabilitate and reintegrate these individuals into the community and maintain public safety.

Information was gathered through:

- Requests to relevant list serves
- Key informant interviews
- Review of literature

BIA-VT and FSA developed a set of 12 questions to be used in interviews, and to guide the literature review. The Act 158 workgroup reviewed and provided input which resulted in a final set of questions. (See Appendix A for a list of information sources.)

Research revealed the following key findings (supporting details can be found in Appendix B):

- No model exists to address community safety and community reintegration for persons found NGI or incompetent to stand trial due to a TBI.

- Criminal justice systems in some states are beginning to recognize, and in a few cases document, the high prevalence of TBI among the populations of individuals who have been charged, convicted and sentenced to some form of corrections custody or supervision. At this point research focuses on screening for and identifying TBI only among convicted offenders, and therefore does not include persons found NGI or incompetent to stand trial. Vermont currently does not screen or seek to identify the prevalence of TBI in its corrections population.

- Restoration of competence is addressed in the literature for persons with ID/DD and mental illness, with only occasional mention of TBI.

During the Act 158 Work Group review of these findings, there was extended discussion of restoration of competence and a restorative justice, community-based model known as Circles of Support and Accountability (COSA). At the conclusion of this discussion, the Work Group requested that the research team convene a panel of experts from around the country, or lacking time, conduct individual interviews with experts to:

- Identify promising practices that might be tested for effectiveness with this population – including restoration of competence as well as services to enable reintegration into the community consistent with public safety

- Explore whether the COSA model could be used effectively with this population

Additionally, it was agreed that the initial research proposal to learn about practices currently in place through site visits with Vermont providers of TBI Waiver services go forward.

The following summarizes findings from phone interviews with national experts and in-person and phone visits with Vermont TBI waiver providers.

Restoration of Competence

In addition to seeking models for "treatment to enable (the target population) to be fully reintegrated into the community consistent with public safety" the Work Group wanted information on approaches intended to restore competence to stand trial. TBI experts interviewed suggested that restoring competence to stand trial requires a level of cognitive rehabilitation to enable an individual to participate in his or her defense and understand legal proceedings. Although regaining competence to stand trial may not represent a level of recovery from brain injury equal to cognitive rehabilitation, the two are closely related according to experts.

Experts agreed that if a person experiences a TBI more than two years prior to being found incompetent, the probability of restoring competence to stand trial is low. In addition, depending on the location of the injury, (e.g., the prefrontal cortex), restoration of competence could be limited. Ultimately, no uniform standard to identify restoration of competence exists across the states. Information Needed to Design Programming

When asked what information is needed about individuals found incompetent to stand trial or NGI in order to develop appropriate programming, experts noted the importance of first determining whether a finding of incompetence or NGI is due to a brain injury. Once a link to TBI is established an evaluator with TBI and forensic competence should:

- Conduct a full neuropsychological evaluation to provide critical information on the nature of the injury
- Gather complete pre-injury and post-injury medical history
- Gather information on co-occurring issues including substance abuse and mental illness
- Gather information on current medications, and history of medications

To determine one's probable risk to public safety, the experts acknowledged the importance of gathering criminal history information. One expert advocated the use of a psychological assessment to assess risk. Beyond these recommendations, none of the TBI experts interviewed were familiar with actuarial risk assessment tools used in criminal justice systems. These tools assess one's risk and criminogenic needs in order to predict the probability of that person re-offending and to develop a supervision and treatment plan intended to reduce that risk.

TBI Waiver providers were asked what assessment tools their programs use to determine the presence of a TBI. These include:

- Full neuropsychological assessment[1]
- Independent Living Assessment (ILA)
- Functional Behavior Assessment

In addition, providers identified information needed to provide services to the target population. Providers need:

- Criminal history
- Medical history, including pre and post injury
- Medication history and current medications
- Involvement with the mental health system
- Substance abuse history
- Family background
- Collateral information from family and friends

Providers noted that access to information across agencies is often challenging to obtain. While criminal history was identified as important, providers do not currently receive risk and criminogenic need assessment information.

Programming and Interventions

TBI experts recommended that programming and interventions should be tailored to the individual and based on information gained through neuropsychological evaluations and other information (i.e., medical history, medication history, co-morbidity issues, pre-morbid history, and any other psycho- social information). The experts noted that at present research on how to best address restoration of competence or community reintegration for persons found incompetent to stand trial or NGI due to TBI does not exist. In the absence of research, experts suggested that current forms of programming for brain injury which include cognitive rehabilitation, cognitive behavioral therapy, and pharmacology would be appropriate for the target population. In addition to these interventions, persons found NGI or incompetent to stand trial due to brain injury may require interventions to address their alleged offending behavior through emotional regulation and impulse control.

Site visits and interviews revealed that each of the four TBI Waiver providers involved in the study have experience providing services to individuals who have a TBI, have been justice- involved and have posed a public safety risk.

The TBI providers were asked how they develop programs to maintain public safety and provide rehabilitation services. All emphasized the importance of tapping into a wide range of options to develop individualized programs to meet the unique needs of each person. Key components of programming would focus on helping the individual set and achieve goals and negotiate how to manage risk. The range of available services could include case management, cognitive remediation, educational supports, or job training. As the target population of the legislation assumes individuals who pose a risk to public safety, providers felt initial programming likely might require one on one support 24 hours a day, 7 days a week. Providers suggested that at this initial stage, supervision could be accomplished most effectively through working with an individual in a residential setting where staff could get a thorough understanding of the individual, set a baseline, and learn how best to manage external negative influences. This level of supervision would be needed until such time as a new assessment finds that less restrictive programming would still provide effective community safety.

[1] The TBI Waiver does not cover the cost of a full neuropsychological assessment – a current assessment is most useful.

Circles of Support and Accountability (COSA)

The 158 Work Group asked the research team to explore the feasibility of adapting the COSA model to provide programming and intervention to the target population. The COSA model is built on the principles of restorative justice and applies to individuals who have been convicted of a crime and are released to the community after serving a sentence of incarceration. A central principle governing an offender's participation in a COSA is that s/he takes responsibility for the criminal behavior and commits to change that behavior. The COSA model was founded in Canada to work with convicted sex offenders returning to the community. Vermont has adapted the model to work with both sex offenders as well as other high risk offenders reentering the community. Offenders are typically individuals with a high risk profile based on the seriousness of their offense history coupled with their dynamic criminogenic needs.

Circles are administered by organizations (in Vermont Community Justice Centers fill this role) which are responsible for recruiting, training and supervising community volunteers who participate in a COSA around a "core member."

To gauge what aspects of a COSA might be applicable to the target population TBI experts were asked if they had any knowledge about COSA; none of the interviewees were familiar with the model. Next, the model was explained and the TBI experts were asked to give their opinion on how the COSA model might be applied to work with the target population toward restoration and rehabilitation. No one felt the COSA model could serve as a primary line of intervention with the target population for the following reasons:

- A foundational principle of COSA is offender accountability. As noted above, the core member (offender) must take responsibility for the criminal behavior for which s/he was charged and convicted. The person must understand the offense, understand what enabled that behavior (lack of insight is an issue for many individuals with TBI), and be able to self-monitor in order to prevent a reoccurrence – this principle cannot be addressed if a person is unable to stand trial due to a finding of incompetence or found NGI.

- The COSA process in which an offender is expected to take responsibility for his or her behavior may pose two challenges to being an effective intervention for the target population. First, participation in a COSA can be confrontational. Persons with a TBI often lack emotional regulation; a confrontational process may lead to overreactions on the part of person with TBI. Second, COSA's dependence on the ability to take responsibility for one's actions and to engage intentionally in changing thinking and behavior requires insight. Persons with a brain injury may have difficulty being insightful about their offending behavior, presenting a challenge to their meaningful participation in the COSA model and achievement of identified goals related to public safety outcomes.

- Persons with a TBI require assessments and services that are administered by competent professionals. Understanding the nature of a brain injury and how it impacts an individual are central to effective treatment and interventions for persons with a TBI. Individualized service plans should be implemented by trained professionals.

Some TBI experts expressed the idea that later in treatment, community volunteer support may be a helpful part of a service plan for individuals with TBI. In order to develop a meaningful community support system some entity would have to administer activities to recruit volunteers, provide training to meet the needs of

the specific individual, and supervise volunteers. While TBI Waiver programs do engage volunteers and community resources, they do not follow a COSA model.

COSA experts shed a different light on the question by noting that from a victim perspective persons who have perpetrated criminal behavior:

- Should be held accountable for their acts – again, understand the behavior and commit to changing that behavior
- Should engage in conditions of supervision which may include restrictions on behavior and participation in treatment and interventions provided by trained professional staff

The research leads to the conclusion that the COSA model does not fit for individuals with TBI found incompetent to stand trial or NGI and a public safety risk.

Refusal to Participate in Programming

National TBI experts were asked to recommend approaches to dealing with individuals who refuse to participate in programming. The majority of those interviewed expressed the opinion that "no good solutions" exist. Some suggested the need to rely on the presence of secure settings such as state hospitals, while noting that this was "not a good option." Other experts recommended exercising continued patience in working with an individual if there is not an ongoing safety risk to staff.

Conversations with providers and other stakeholders in Vermont revealed no strategies for dealing with individuals in the target population refusing to participate in prescribed programming.

The Work Group pointed out that while Civil Commitment of an individual to the custody of DAIL would give the Commissioner the authority to require participation, an individual still could decide not to comply. Therefore Vermont is aligned with conditions across the nation in which, according to the TBI experts interviewed, no recognized options exist for addressing non-compliance.

Changes in Programming

Interviews with brain injury specialists included questions about how to determine if and when interventions and services should change or stop. Responses pointed to the complexity of this question since decisions involve the individual's status with regard to restoration of competence, risk to community safety, and progress in TBI specific programming.

Brain injury experts said that in order to determine competence to stand trial, competency reassessments should be conducted. To ensure consistency the same criteria and assessment tools should be used throughout the reassessment process. If competency is restored, changes in programming for that individual become a legal question. Similarly, ongoing criminogenic needs and risk assessments are needed to determine public safety risks posed by individuals.

TBI providers were asked to describe conditions needed to determine one's eligibility to graduate from TBI specific programming. In Vermont's TBI Waiver Program individuals may reach graduation determined by the benchmarks articulated in one's Individual Service Plan (ISP) and TBI evaluation, thus the need for regular TBI evaluations. However, traumatic brain injury is increasingly seen as a chronic condition that requires ongoing

long term services and supports. The TBI Waiver Providers and many of the experts interviewed believe that there will continue to be a need for some level of support in an individual's community setting.

A tension may arise as it is conceivable that an individual in the target population may complete their brain injury program, but continue to pose a risk to public safety. In this case an assessment would be needed to determine what ongoing supports will be required to address their long term issues with TBI and the public safety component.

Programming Challenges

TBI Waiver providers identified the following challenges to serving the target population (i.e., individuals found NGI or incompetent to stand trial due to TBI):

- Funding to cover:
  - Full neuropsychological evaluations
  - Residential resources
  - Staffing
  - Case management

- Not everyone in the target population will meet the eligibility requirements for services provided through the TBI Waiver program

- Limited understanding within professions and the public that TBI can be a chronic disease requiring long-term services and supports.

- The difficulty of accessing needed information about individuals across agencies and departments.

Program and Service Recommendations and Cost Estimates

The expectation going into this study was that best practices exist and could be identified for addressing reintegration and community safety for persons who present a danger of harm to others and found NGI or incompetent to stand trial due to a TBI. The research found to the contrary that no best practices exist. A handful of states are beginning to study the prevalence of TBI within their corrections populations. However, there is no research on the prevalence of persons with TBI found NGI or incompetent to stand trial.

The research did not lead to a clear programming recommendation. Rather, the researchers, in consultation with the Act 158 Work Group, recommend that further work take place through an expanded group of stakeholders to flesh out Vermont's strategy for responding to this population (detailed in Recommendation 10). The expanded study group should address issues identified through the research to develop responses for persons with TBI who have been found NGI or incompetent to stand trial.

The following recommendations offered by BIA-VT and FSA are based on the research findings. Recommendations #1 through #9 progressively build on one another.

1. Recommendation: Competency evaluations should identify the primary reason for incompetence. As part of this assessment, anyone identified as incompetent to stand trial should be screened

with a brain injury screening tool (e.g., HELPS TBI screening instrument, Ohio State TBI Identification Method (OSU TBI-ID or Repeatable Battery for the Assessment of Neurological Status (RBANS)).

Rationale: In order to determine appropriate interventions and departmental responsibilities, it is important to understand what factors contribute to an individual's incompetence to stand trial. At present, competency assessments in Vermont include a review of medical records and other information to determine the reason for the incompetence, but the assessments do not include formal screening for brain injury. Co-morbidity of TBI with mental health issues and/or substance abuse is common, thus it is important to identify the full range of factors impacting the behavior that has brought an individual to court with a finding of NGI or incompetence to stand trial.

Estimated Cost: Average cost is $2,000 per competency evaluation. Source: Vermont Department of Mental Health.

2. Recommendation: If a person has screened positive for a TBI, then actuarial criminogenic risk and need assessments should be conducted by forensic psychologists trained in use of these tools to determine the level of risk the individual poses to public safety. The forensic psychologist should use the findings of the assessment to identify appropriate programming needed to address criminogenic needs and reduce the risk of future offending behavior.

Rationale: Evidence-based, validated criminogenic risk/needs assessments provide information needed to determine appropriate levels of supervision and types of programming intended to reduce one's risk of re-offending by addressing the criminogenic factors that lead to criminal behavior.

The Department of Corrections maintains a small pool of private forensic psychologists qualified to conduct risk/needs assessments with individuals posing complex situations, such as TBI.

Estimated Cost: $2,200 per assessment. Source: Vermont Department of Corrections.

3. Recommendation: If an individual with TBI is assessed as posing a high risk to public safety, then a full neuropsychological evaluation should be completed. The evaluation should be conducted under the supervision of a neuropsychologist with expertise in brain injury.

Rationale: If a person does not pose a public safety risk, than it may be appropriate to release that individual into the community without any further programming. However, if the person does pose a high risk, than programming should be identified that addresses both criminogenic needs and the brain injury. A full neuropsychological evaluation is needed to understand the impact of the injury on behavior and competence, and to develop appropriate programming.

Estimated Cost: $1500 - $2000 per neuropsychological evaluation. Source: Average cost based on the Brain Injury Association of Vermont's experience and feedback from neuropsychologists.

4. Recommendation: In order to develop a proposal to serve an individual with TBI who poses a risk to public safety, providers should receive detailed information about the individual. This will require cooperative agreements and collaboration across systems to provide the following types of information:
    a. Criminogenic Risk and Need Assessment

b. Neuropsychological evaluation
c. Medical history, including pre and post injury
d. Medication history and current medications
e. Information on co-occurring issues including substance abuse and mental illness
f. Employment history
g. Family background and collateral information from family and friends
h. Programming recommendations from qualified forensic psychologist or psychiatrist

Rationale: In order to develop a proposed intervention and service plan, a provider will need complete information about the individual, including criminogenic risk/needs assessment and recommended programming as well as information and needs based on the brain injury and co- occurring disorders such as mental illness and substance abuse.

Estimated Cost: Costs should be minimal; this recommendation is to share existing information.

5. Recommendation: A range of options should be available in order to provide programming that is tailored to the individual (based on complete information, see Recommendation #4). Interventions employed with individuals will be responsive to the nature of the brain injury, the risk to public safety, criminogenic needs, and one's willingness to participate in programming. Programming may include any or all of the following:
    a. Case management (which includes developing and updating Individual Service Plans (ISP); conducting TBI Evaluations as needed)
    b. TBI programming such as cognitive rehabilitation, emotional regulation, pharmacology
    c. Public safety programming such as Cognitive Behavioral Therapy (CBT), substance abuse treatment, and other interventions to address criminogenic needs
    d. Programming to reach individualized goals (e.g., employment, housing, education, social)
    e. Ratio of staff to individual that is appropriate to address public safety risk and compliance based on regular assessments

Rationale: In order to work with persons with TBI who pose a risk to public safety and are NGI or incompetent to stand trial, a range of options must be available to deliver interventions and services that work toward maintaining public safety, restoring competence, treating brain injury, and reintegrating people into the community. Several of Vermont's TBI Waiver providers have experience working with "difficult" individuals that are or have been involved in the criminal justice system. Based on this experience with the target population, Vermont TBI providers note that each individual will present a unique set of needs and challenges. Vermont's TBI Providers believe that for higher risk individuals one-on-one supervision initially may be needed for community safety reasons. TBI Waiver providers reported that intense levels of supervision are most effectively provided in a residential setting which allows close supervision along with assessment of the individual's current behavior and management of their environment to eliminate social contacts that negatively impact behavior.

Estimated Cost: Difficult to estimate due to the individualized nature of interventions and services. One-on-one 24 hour supervision would cost approximately $150,000 per year, per individual. Source: Feedback from interviewed Vermont TBI Waiver providers, understanding that co-morbidity issues would probably influence costs.

6. Recommendation: To provide appropriate assessments and interventions:
    a. Evaluations and assessments should be conducted by individuals who possess both TBI and forensic expertise.
    b. Medical professionals should receive brain injury training.
    c. Provider staff should possess the same qualifications required of TBI Waiver Provider staff. In addition, training to address criminogenic needs through programming should be developed and implemented for TBI provider staff. Programs for this population should engage staff or contractors with behavioral health background who have competence in Motivational Interviewing, Cognitive Behavioral Therapy (CBT) and other strategies deemed appropriate to meet individual programming needs.
    d. Staff training on how to address criminogenic needs in order to reduce risk should be provided by the same organization the Department of Corrections uses to build its staff capacity (i.e., Corrections Institute, University of Cincinnati). Ongoing coaching is an essential element of training, thus one individual should be identified and trained to provide ongoing coaching.

Rationale: Additional training and education is needed to ensure that all staff involved in working with the target population have the knowledge and skills to provide appropriate programming and address public safety concerns.

Estimated Cost: Training costs for medical professionals working for TBI providers and TBI provider staff will be driven based on the amount and type of training needed, and the number of staff that require training.

7. Recommendation: The statute should be revised to include language requiring regular reassessments of competence and a Court review of a case when the reassessment demonstrates competence to stand trial has been restored.

Rationale: If one goal of programming is to restore competence to stand trial, then a mechanism is needed to assess whether or not competence to stand trial has been restored. It is appropriate to conduct regular reassessments to determine competency status to determine i f it is appropriate to conduct a hearing on competency to stand trial. The reassessments should be done in a way consistent with the initial assessment of competency.

Estimated Cost: $2,000 per assessment. Source: Noted above.

8. Recommendation: Regular reassessments of competency, TBI and community safety risk should take place to help determine when services should stop or change under the following circumstances:
    a. When competence is restored (as determined by assessment) and criminal charges go forward, programming may be terminated depending on the outcome of the trial.
    b. When competence is restored and risk is lowered or reaches acceptable levels, programming should end or continue with community-based supports.
    c. When competence is not restored, or the person is NGI, and his/her risk is lowered/acceptable, an assessment should be done to determine if the person can be served by the TBI waiver program. Alternatively, the person may complete the TBI program and receive continued supports.
    d. When competence is not restored, or the person is NGI, and risk remains high, programming may continue over the long-term with regular reassessments.

Rationale: Determining whether and when interventions and services can be terminated should be based on assessment findings for each individual - findings related to the person's competence to stand trial and current risk to community safety. Assessments should be conducted at regular intervals in order to guide changes in programming and interventions. In the case where restoration of competence to stand trial is demonstrated the Court would be responsible for holding a hearing (as noted above in Recommendation #7).

Estimated Cost: Cost is a function of the number of assessments required, including Competency Assessment ($2,000); TBI Evaluation ($250); TBI Service Plan Update ($200); and Criminogenic needs/risk assessment ($2200). Sources: Competency Assessment and Criminogenic needs/risk assessment addressed above. TBI Evaluation and TBI Service Plan update costs obtained from Vermont TBI Waiver Providers.

9. Recommendation: Administering Services and Interventions:
    a. Services and interventions should be provided by providers with expertise in brain injury and experience with public safety issues. Several Vermont TBI Waiver Providers fit this description.
    b. Services could be administered by the TBI Program currently in DAIL since TBI Waiver Providers already under their administration would likely be the best organizations to work with this population. However, lack of data makes it difficult to predict the number of individuals that might make up this population and the number of administration staffing that might be required to support them.
    c. Services and interventions should be separate and distinct from the current TBI Waiver Program for the purposes of administration, and funding should not come from current waiver program funding but funds specifically earmarked for this program. This would require new appropriation to support staffing, and to address the fact that some people with TBI who are NGI or incompetent to stand trial will not be Medicaid or Waiver eligible.
    d. Approaches to working with this population will need to include programming and interventions to address brain injury as well as programming and interventions to address public safety concerns posed by each individual. Two manuals provide guidance on these issues - the "TBI Provider Manual", revised in 2011, and the "Protocols for Evaluating Less Restrictive Placement and Supports for People with Intellectual / Developmental Disabilities Who Pose a Risk to Public Safety" manual. Each manual should be carefully reviewed and updated to provide meaningful guidance to providers working with brain injured persons found incompetent to stand trial or NGI who pose a risk to public safety.
    e. When persons found NGI or incompetent to stand trial due to TBI and determined to be a public safety risk have been remanded to the custody of DAIL, as per Act 158, TBI Waiver Providers would then have the opportunity to present a proposal to DAIL for programming and interventions. It is important that the providers have all the information noted in Recommendation #4 above and an interview of the individuals before submitting a proposal. The Administrator of the State's program will determine the review process.

10. Recommendation: Convene a broad group of key stakeholders to resolve a number of outstanding questions on how best to treat persons with TBI found NGI or incompetent to stand trial, due to their TBI. The group should include representatives of DAIL, DMH, Department of Corrections (DOC), Alcohol and Drug Abuse Program (ADAP) at the Department of Health, Agency of Human Services, Judiciary, Prosecutors, and the Defense Bar.

Rationale: The Act 158 Work Group formed around this study did not include the full range of stakeholders who may impact, have expertise about and/or have responsibility for intervening with this population. An effective response to the target population and the goals of this study will require collaboration between the AHS departments and the courts, prosecution and defense bar. One of the group's activities might include convening (through teleconferencing) a panel of national experts to identify strategies for restoration of competency and mitigation of public safety risk.

Outstanding questions that require resolution include:

a. How should services and interventions be administered and staffed?
    i. Should there be a new program established?
    ii. Given the apparently small number of individuals in the target population, is a separate program appropriate?
    iii. Should the state use a Request for Proposal (RFP) process to identify one provider that will serve all persons who are found NGI or incompetent to stand trial due to TBI, whether through one program or individually?
b. What might we learn from other models, such as COSA, that can inform the development of practices for the target population?
c. Since there are no currently available actuarial risk/needs assessment tools validated and normed for persons with TBI, what assessment tools should be used?
    i. Should existing tools be normed and validated for the target population?
    ii. Should a new assessment tool be developed?
d. What is the level of risk that determines eligibility for services under the statute?
e. What is the level of risk that determines when a person has successfully completed programming?
f. What strategies can be employed if individuals are not willing to participate in prescribed programming?
g. What specific elements of completion or "exit" should be included in the statute?
h. What criteria deem a person no longer a public safety risk requiring services and interventions?
i. How are assessments, interventions and services delivered when there are co-occurring conditions? Who is responsible? How are matters coordinated?
j. What are the potential costs for each element of the selected approach?
k. What sources can provide funding?

Estimated Cost: $25,000 to contract with consultant to facilitate the group, gather needed information, and handle logistics for expert panel and group meetings

This report has not provided a specific, set cost for providing interventions and services to individuals with TBI who pose a risk of harm to others and have been found NGI or incompetent to stand trial. Nor, have the recommendations identified specific funding sources to cover the costs of services and interventions. Our reasons for these omissions are based on the following:

1. Each individual in the target population will present a unique set of needs and challenges. Interventions and services must be tailored to those individual needs. As a result it is difficult to estimate the cost of service without detailed information about the persons being served.

2. Vermont does not have sufficient data to determine how many individuals in any one year would be in the target population.

3. There are no existing evidence-based or best practice models from which to build a clearly described program for Vermont.

Significantly more information will be needed to provide cost estimates beyond what has been offered in this report and, as follow-up to determine the funding sources to cover those costs.

Appendix A

Sources of Information for Information on Best Practices

- Listserves
  - Requests for information were sent to the following listserves:
    - the Brain Injury Association
    - The Brain Injury Alliance
    - The National Institutes of Health,
    - The National Association of State Head Injury Administrations
    - Justice Research and Statistics Association
  - Received 23 responses from listserve inquiries

- Key informant interviews were conducted with the following: :
  - Seven TBI experts including a psychologist who serves as an expert witness on TBI, Directors of TBI organizations, and the Director of South Carolina's Head and Spinal Cord Injury Division, Department of Disabilities and Special Needs.
  - Five legal experts including the Disability Law Project Legal Director and members of DAIL's legal staff
  - Two judges, with experience in specialized courts including Veteran's and Mental Health Courts
  - Three individuals associated with criminal justice related organizations including the GAINS Center, Vermont's Department of Corrections
  - Two individuals with expertise in mental health and criminal justice

- Literature Review and Internet Search -- BIA-VT has a collection of articles regarding persons with TBI charged with criminal offenses. Consequently the literature review began with these articles and expanded based on input from listserve responses, interview responses, and extensive internet searches. A list of resources gathered and reviewed follows:

Restoration of Competency - nothing found specific to persons with TBI

1. "Standardizing Protocols to Restore Competency to Stand Trial: Intervention and Clinically Appropriate Time Periods", Washington State Institute for Public Policy, January 2013. - the report conducted by the Washington State Institute for Public Policy reviewed literature on five types of treatment protocols to restore competency. Persons with a TBI were not identified specifically. The report grouped together "persons with a low IQ, or who have brain injury or developmental disability" in a study of the impact of Educational Treatment Programs on restoration of competence. The study also identified the National Judicial Colleges Best Practices Models for Competency Restoration and for Length of Time for Competency Restoration. http://www.wsipp.wa.gov/ReportFile/1121/Wsipp_Standardizing-Protocols-for-Treatment-to-Restore-Competency-to-Stand-Trial-Interventions-and-Clinically-Appropriate-Time-Periods_Full-Report.pdf
2. Search - Restoring Legal Competency in Persons with TBI - https://www.google.com/?gws_rd=ssl#q=restoring+legal+competency+in+persons+with+TBI

3. Hearne, Beth. Competency and Brain Injury: An Interview with Robert Denny, PsyD. Brainline.org. 2009

"If there is no particular treatment that is going to make them competent, as would commonly occur in neurological disease, the judge then has to make a decision as to whether this defendant is un-restorable." http://www.brainline.org/content/2009/05/competency-and-brain-injury-an-interview-with- robert-denney-psyd_pageall.html

4. Justice Policy Institute. When Treatment is Punishment: The Effects of Maryland's incompetency to stand trial policies and practices. Justice Policy Institute. 2011 http://www.justicepolicy.org/uploads/justicepolicy/documents/when_treatment_is_punishmen t-full_report.pdf
5. Musgrave, Jane. Bill would expand treatment options for those in justice system with traumatic brain injuries. Sun Sentinel. 2011

http://articles.sun-sentinel.com/2011-02-06/news/fl-brain-injury-bill-20110206_1_traumatic- brain-injuries-ryan-crofutt-s-justice-system

6. Roskes, Erik. When the Defendant has TBI. The Crime Report. 2010 http://www.thecrimereport.org/news/inside-criminal-justice/when-the-defendant-has-tbi

Courts - no models focused specifically on issues related to persons with TBI. Most searches brought up information about Veteran's Courts, Veteran's issues and also information about Mental Health and Drug Treatment Courts

7. *Center for Court Innovation* - search - no specific information about TBI or about Incompetence/Restoration of Competence for persons w/TBI. Most information mentioned TBI in the context of Veteran's Courts or other Treatment Courts. http://www.courtinnovation.org/search-results/Traumatic%20Brain%20Injury
    a. Orange County Community Court

Types of cases: A single judge presides over a range of problem-solving court dockets, including adult drug court for non-violent felony drug offenders; DUI (driving under the influence) court for repeat-offense drunk drivers; three separate mental health courts; veterans court for combat veterans with Post Traumatic Stress Disorder, traumatic brain injury, or addiction resulting from their service; and homeless outreach court to clear up the infractions and low-level misdemeanors of homeless people.

    b. Contact information: Orange County Community Court, 700 Civic Center Drive West, Santa Ana, CA 92701

Paul Shapiro, Collaborative Courts Officer; Judge Wendy Lindley

    c. "The Brooklyn Mental Health Court Evaluation"
        i. They take felony cases
        ii. Evaluation said nothing about TBI
        iii. http://www.courtinnovation.org/sites/default/files/BMHCevaluation.pdf
    d. Recommended Practices in New York State Adult Treatment Courts - http://www.courtinnovation.org/sites/default/files/Recommended_Practices_10.pdf
8. "A Structured Evidence Review to Identify Treatment Needs of Justice-Involved Veterans and Associated Psychological Interventions" http://www.ncdsv.org/images/VA_Structured-Evidence-Review-to-identify-treatment-needs-of-justice-involved-veterans_2013.pdf
    a. Little acknowledgement of TBI - no mention of assessment tools
    b. Major focus on mental health and criminogenic risk assessment
    c. Resources for TBI named on page 26 and listed in bibliography
    d. Extensive list of assessment instruments for Mental Health/Substance Abuse/Criminogenic Risk and Need
        i. Citations from GAINS Center for Behavioral Health and Justice Transformation and the Washington State Institute for Public Policy (WSIPP)

9. *Bureau of Justice Assistance (BJA)* - Buffalo Veteran's Treatment Court - this was the first Veteran's Treatment Court established in the country. https://www.bja.gov/SuccessStoryDetail.aspx?ssid=11
10. *National Institute of Corrections* - Veteran's Treatment Courts - ANNOTATION: "The first veteran's court opened in Buffalo, N.Y. in 2008. The veteran's court model is based on drug treatment and/or mental health treatment courts. Substance abuse or mental health treatment is offered as an alternative to incarceration. Typically, veteran mentors assist with the programs. An important issue that has to be addressed is the eligibility for veteran's courts in terms of whether charges involving felonies or crimes of violence will be allowed. The inclusion of offenders charged with inter-family violence is also of grave concern to policy makers. Links to related online resources are listed below.

Searches led to more reports on Veterans with minimal focus on TBI population and none pertinent to the focus of this project

11. "A Structure Evidence Review to Identify Treatment Needs of Justice-Involved Veterans and Associated Psychological Interventions" - Prepared for: Veterans Health Administration, Homeless Programs, Veterans Justice Programs - http://dn2vfhykblonm.cloudfront.net/sites/default/files/justice-involved_veterans_structured_evidence_review_final.pdf
12. From An Achievable Vision: Report of the Department of Defense Task Force on Mental Health. Department of Defense - 100 page report from a task force to examine matters relating to mental health and the Armed Forces" and produce "a report containing an assessment of, and recommendations for improving, the efficacy of mental health services provided to members of the Armed Forces by the Department of Defense." - 1.5 pages on TBI
    a. P. 60 **"**Researchers are working to develop a reliable, valid screening tool for TBI that would trigger a more thorough evaluation. At present, however, there is no well- validated screening tool, and any efforts to carry out such assessment must address the fact that there will be a large number of false positive and/or false negative results. "

http://justiceforvets.org/sites/default/files/files/Dept%20of%20Defense%2C%20mental%20health%20report.pdf

Criminal Justice Search Results - the search results highlighted information about persons with TBI who are already under criminal justice supervision, thus having been adjudicated, found guilty a n d placed in corrections custody.

13. *Council of State Governments Justice Center* - primarily information on incidence of persons with TBI in the criminal justice population - references to mental health courts, nothing specific to the study population http://csgjusticecenter.org/search/TBI"
14. Dettmer, Judy. Brain Injury, The Hidden Epidemic: The Importance of Screening and Identification. Report by Brain Injury Program, Division of Vocational Rehabilitation, Colorado Department of Human Services. 2013
15. Ferguson, Pamela, et.al. Prevalence of Traumatic Brain Injury Among Prisoners in South Carolina. Journal of Head Trauma Rehabilitation. 2012. Vol. 27, No. 3, pp. E11-E20

This study has shown a high prevalence of TBI in state inmates, both those being released and those remaining in prison. These results are generally in concordance with those of other studies, where comparable, but this study also provides prevalence for subgroups of TBI and a lifetime history of TBI. Not only is TBI common among inmates, but early TBI, repeat TBI, and ongoing TBI symptoms are also quite prevalent.

Treatment of TBI in the inmate population, as well as prevention in the next generation, would most likely not only be cost-effective but also beneficial to both individuals with TBI and society.

16. Harmon, Katherine. Brain Injury Rate 7 Times Greater among U.S. Prisoners. Scientific American. 2012
http://www.scientificamerican.com/article/traumatic-brain-injury-prison/
17. Health Resources and Services Administration. Traumatic Brain Injury and the U.S. Criminal Justice System. 2011
http://www.disabilityrightsohio.org/sites/default/files/ux/hrsa-criminal-justice-fact-sheet.pdf
18. Shiroma, Eric, et.al. Prevalence of Traumatic Brain Injury in an Offender Population: A Meta-Analysis. Journal of Head Trauma Rehabilitation. 2010. Vol. 27, No 3, pp E1-E10

This study has combined epidemiological studies in a meta-analysis to estimate the prevalence of TBI in offender populations. The overall estimated prevalence of TBI in the overall offender population was 60.25% (95% CI: 48.08 to 72.41), which is narrower than the commonly reported range of 25% to 87%.
This study makes the case that an understanding of the true prevalence of TBI in offending populations would inform public policies nationally that could improve the social functioning of incarcerated persons with TBI, inform correctional policies that lead to better resource allocation for screening and treatment, and improve the management of offenders.
Development of partnerships with community health providers would further assure continuity of care and case management for offenders with TBI returning to the community and could lead to increased benefit to society.

19. Slaughter B, Fann JR, Ehde D. Traumatic brain injury in a county jail population: prevalence, neuropsychological functioning and psychiatric disorders. Brain Injury 2003; 17(9):731-41
20. Spearman, Russell. TBI Training for Law Enforcement and Corrections. 2007 http://www.tbiwashington.org/professionals/documents/TBITrainingforLawEnforcementandCorrections.pdf
21. *The Arc, National Center on Criminal Justice and Disability*, funded by the Bureau of Justice Assistance - new organization, no experience with the population at hand, asked us to send them information on TBI - http://www.thearc.org/what-we-do/programs-and-services/NCCJD and http://www.thearc.org/NCCJD
22. "Traumatic Brain Injury - A Guide for Criminal Justice Professionals" - discusses signs, what to look for, impact on other inmates, encourages screening for TBI, for co-occurring issues, more in-depth evaluation, provides recommendations for interventions post-release/reentry - http://www.brainline.org/content/2010/03/traumatic-brain-injury-a-guide-for-criminal-justice-professionals_pageall.html
23. "Traumatic Brain Injury in Prisons and Jails: An Unrecognized Problem". Centers for Disease Control. http://www.cdc.gov/traumaticbraininjury/pdf/Prisoner_Crim_Justice_Prof-a.pdf
24. Virginia Policy Summit Report on Brian Injury and Juvenile Justice. 2013

Along with Virginia, four other states serving youth with traumatic brain injury (TBI) in the juvenile justice system were invited to participate in the Policy Summit: Minnesota, Nebraska, Texas, and Utah (Minnesota's project involved adults, not juveniles). The two-day Policy Summit provided an opportunity for representatives from these states to engage in in-depth discussions on project outcomes, policy implications and recommendations, as well as suggestions for project sustainability and future study.
http://www.vadrs.org/cbs/downloads/VirginiaCollaborativePolicySummitProceedingsReport.pdf

25. Wald, Marlena, et. al. Traumatic Brain Injury Among Prisoners. Brain Injury Professional. 2008, pp. 22-25

TBI Assessment Tools - have found no sources pointing to the use of these with persons found Incompetent to Stand Trial or Not Guilty by Reason of Insanity due to a TBI.

26. HELPS Screening Tool - http://www.dsf.health.state.pa.us/health/lib/health/schoolhealth/HELPSScreeningTool.pdf

27. Ohio State University Traumatic Brain Injury Identification Method (OSU TBI-ID)

Used extensively by researchers working in criminal justice systems regarding individuals with TBI. http://ohiovalley.org/tbi-id-method/

28. The Montreal Cognitive Assessment (MoCA) - a cognitive screening test designed to assist Health Professionals for detection of mild cognitive impairment. The MoCA is used by Vermont DOC as one measure to identify persons deemed Seriously Functionally Impaired (SFI). www.**moca**test.org

Additional legal perspectives.

29. Johnson, Mark. Guilty or Innocent? Just Take a Look at my Brain – Analyzing the Nexus Between Traumatic Brain Injury and Criminal Responsibility. 37 Stanford Law Review. 2009. Rev. 25
30. Kitchenman, Andrew. Link between Crime and Brain Injuries Prompts Push for Legislation. NJSpotlight. 2014.

http://www.njspotlight.com/stories/14/11/09/links-between-crime-and-brain-injuries-prompts- push-for-legislation/

31. Lamparello, Adam. Using Cognitive Neuroscience to Predict Future Dangerousness. Columbia Human Rights Law Review. 2011. 42:481 http://www3.law.columbia.edu/hrlr/hrlr_journal/42.2/Lamparello.pdf

Appendix B

Findings from Best Practices Search

- A model for addressing community safety and community reintegration for persons found not guilty by reason of insanity or incompetent to stand trial due to TBI appears not to exist in the United States and thus there are no best practice models to study.
  - "You are really breaking new ground in an important issue that no one else has been focusing on," noted Steven D. Wade, Executive Director, Brain Injury Association of New Hampshire.
  - There have been a few bills introduced in other states addressing competence and TBI within criminal justice, none of the bills have passed, nor did any address programming.
  - National centers have not been able to identify models or individuals with expertise on this issue. For example, the National Center on Criminal Justice and Disability responded to a request for information by saying, "We are looking into it. Traditionally, The Arc focuses on ID/DD. However, we are more than open to incorporating TBI information on our website. We would love to include your legislation in the model legislation database we are developing and include any of the resources you find on our state by state map."

- Criminal justice systems throughout the nation are beginning to recognize TBI as an important issue.
  - The focus is on persons already involved in the criminal justice system – not persons who have been kept out of the system due to incompetence or insanity caused by TBI.
  - A current focus in criminal justice seeks to identify TBI, institute TBI screening, raise awareness about its impact on behavior, and identify appropriate interventions and treatment for persons with TBI who are incarcerated and who have been released back into the community.
  - The Ohio State University TBI Identification tool and the HELPS Brain Injury Screening Tool have been used for screening in criminal justice settings.
  - The Vermont Department of Corrections (DOC) uses the Montreal Clinical Assessment Tool (MoCA) as a screening tool for offenders within the system. *"Overall, I think I'd characterize the MoCA as a blunt instrument at this point… DOC doesn't have the resources to do more extensive neuro-cognitive testing but often we can piece together an understanding of the patient from prior records. When the sources, including our own observations, strongly suggest that someone's safe functioning within the prison environment is compromised by TBI we can designate the person as Seriously Functionally Impaired."* (Meredith A. Larson, Psy.D., Chief of Mental Health Services, Vermont DOC)

- The search often found the suggestion that approaches for restoring competence, rehabilitating and reintegrating persons with intellectual disabilities/developmental disabilities (ID/DD) could provide models for addressing persons with TBI.
  - The literature makes a clear distinction between ID/DD and mental health issues, generally including TBI in the same category as ID/DD not mental illness. For example, in South Carolina the assessment of competence assesses ID/DD and "related disability."
  - It is important to recognize that TBI often co-occurs in persons with mental health and substance abuse issues.
  - In Vermont, Act 248 allows civil commitment for individuals with ID/DD found incompetent to stand trial. Act 248 jurisdiction applies only to persons evaluated to have a DD and who have committed a criminal act defined as "danger of harm to others." The civil commitment places the individual in the custody of the Commissioner of DAIL to provide supervision and community-based services that address public safety and the individual's needs.

- Restoration of competence is addressed in the literature for persons with ID/DD and mental illness, with only occasional mention of TBI.
    - The Washington State Institute for Public Policy has published a review of protocols for restoring competence to stand trial. While there are best practice models for restoration of competency, none of them address persons with TBI. The review studied the impact of using an educational approach with persons with low intellectual functioning and/or brain injury, and found that persons in this category were least likely to be restored to competency to stand trial. The report also described the National Judicial College's Best Practices Models for Restoring Competency, none of which referenced persons with TBI.
    - Judge Brian Grearson, Vermont's Administrative Trial Court Judge and former presiding Judge of the Substance Abuse Courts and Mental Health Courts in Washington and Chittenden Counties provided the following information. Currently Vermont's special courts do not screen, nor treat participants for TBI. In terms of restoration of legal competence, one might see more than one evaluation for competency ordered throughout the stage of a person's involvement in the court process. Often, when competency is restored, charges are dismissed.
    - Robert Denney, PsyD, notes that when a judge rules that a person is not competent, the person may be ordered into treatment with the goal of restoring competency. "*If there is no particular treatment that is going to make them competent, as would commonly occur in neurological disease, the judge then has to make a decision as to whether this defendant is unrestorable.*

Every jurisdiction is a little bit different about this, but in general, once a judge has determined a person is unrestorable, then the question of public safety comes to the forefront. The question is, 'Can the person be safely released?', and if so, the charges can be dropped and the person can go back to whatever setting they need. Often, when you've got somebody with significant difficulties like this and they get caught up in the criminal justice system, it's because possibly they were living independently and shouldn't have been …So if the person is not competent and not restorable, the court is going to try and do what's right. That might be facilitating placement of this person in a setting where they do have appropriate supervision and can get their needs met."

    - Assessment of competency to stand trial due to TBI requires specific knowledge and skills. In Vermont, the lack of qualified specialists to assess DD has impacted the accuracy of forensic evaluations with regard to Act 248, according to the 2010 DAIL *Report to Representative William Lippert and Representative Michael Marcotte on Individuals with Developmental Disabilities Who Pose a Public Safety Risk.*

Appendix C
Experts Consulted

Expertise on Brain Injury

Ashley Bridwell, LMSW - Arizona
Rehabilitation Program Coordinator Adult
Neurological Program
St. Joseph's Hospital and Medical Center Outpatient Rehabilitation, AZ Consultant/Trainer at
the ASU Center for Applied Behavioral Health Policy

John Corrigan, PhD, ABPP - Ohio
Professor - Department of Physical Medicine and Rehabilitation at Ohio State University Director - Ohio Valley
Center for Brain Injury Prevention and Rehabilitation
Project Director - Ohio Regional Traumatic Brain Injury Model System Executive
Committee of the TBI Model Systems Project Directors

Wayne Gordon, PhD, ABPP/Cn – New York
Dept. of Rehab. Psychology & Neuropsychology – School of Medicine at Mt. Sinai Diplomat in
Clinical Neuropsychology
Fellow – Academy of Behavioral Medicine Research

Kim Gorgens, PhD - Colorado
Professor – Graduate School of Psychology – University of Denver (GSSP/DU) Neuropsychologist
w/forensics background

Neal Gowensmith, PhD – Colorado
Professor – Graduate School of Psychology – University of Denver (GSSP/DU) Director –
Denver First (focus on psychology and forensics)

Harvey E. Jacobs, PhD, CLCP – Virginia
Board of Directors – North America Brain Injury Society Board
of Trustees – United States Brain Injury Alliance Partner – Lash
Associates Publishing/Training

Anne McDonnell M.P.A., OTR/L, CBIST - Virginia
Executive Director – Brain Injury Association of Virginia
Clinical faculty position in the School of Occupational Therapy at VCU Virginia
Brain Injury Council
Chair of the VCU Traumatic Brain Injury Model Systems Grant Advisory Board

Adam Piccolino, Psy.D., L.P., ABN – Minnesota
MN corrections – involved in screening and assessment
Minnesota Department of Corrections – Behavioral Medicine Practitioner
The Impact of Traumatic Brain Injury on Prison Health Services and Offender Management
Journal of Corrections Health Care

Jonelle K. Sandel, PhD, CLCP – Colorado
Neurological Services – Div. of Youth Corrections
Colorado Office of Children, Youth, and Families

Ron Savage, Ed.D - Vermont
President - Sarah Jane Brain Foundation
Chairman and Co-Founder of the International Pediatric Brain Injury Society (IPBIS) Past
Chair of Chairman of the North American Brain Injury Society (NABIS)
Editor of Brain Injury Professional
Board of Governors for the International Brain Injury Association (IBIA)

Linda Veldheer, Ph.D. – South Carolina
Director – Head and Spinal Cord Injury Division
South Carolina Dept. of Disabilities and Special Needs

Expertise on Circles of Support and Accountability

Heather Allen
Office of the Public Guardian Regional Supervisor
Vermont Department of Disabilities, Aging and Independent Living

Derek Miodownik
Restorative System Administrator Vermont
Department of Corrections

Lori Baker Executive
Director
Greater Barre Community Justice Center

Linda Murphy
Volunteer COSA member
Greater Barrie Community Justice Center

Expertise in TBI Programming (VT TBI Waiver Providers)

CHOICE Services and Supports – Linda Ormsbee & Nicole Pierce (owners)

Eagle Eye Farm – Bill Cobb (Executive Director), Earl Whitmore (Case Manager), Sarah Alexander (Director of Operations), Jennifer Whitmore (Administrator)

Lenny Burke Farm – Kevin Burke (Director)

PRIDE Services and Supports – Michele Corrow, Kim Daniels (owners), and Laura Martin (Director of Operations)

Other Expertise

Robert T. Russell
Veteran's Treatment Court Judge
Buffalo City Court
Buffalo, NY

Ed Riddell
Public Safety Specialist
Vermont Department of Disabilities, Aging and Independent Living