Report to
The Vermont Legislature

Legislative Report on Implementation of Act 158 of 2014 Criminal Defendants with Traumatic Brain Injury

In Accordance with H.875
Act 172. Sec.E.300.3: ***An act relating to making appropriations for the support of government***

Submitted to:
Health Reform Oversight Committee
Joint Legislative Justice Oversight Committee

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Report Charge from Legislature Regarding Act 158

On or before November 30, 2016, the Department of Mental Health (DMH), the Department of Disabilities, Aging and Independent Living (DAIL) and the Department of Corrections (DOC) shall report to the Health Oversight Committee and the Joint Legislative Oversight Committee on the departments' examination of the implications of this act and the departments' proposals for strengthening the act to help ensure its successful implementation. The report shall include recommendations for defining traumatic brain injury (TBI) for purposes of determining when one may challenge a defendant's sanity at the time of the alleged offense or a defendant's mental competency to stand trial for the alleged offense. The report shall also identify appropriate treatment options and venues for this population, and shall assess the funding that would be required to implement the legislation as drafted or, in the alternative, to develop and support the report's recommendations.

Introduction and Relevant History

On April 5, 2016, the Agency of Human Services (AHS) submitted a memo to Senators Kitchell and Sears, and Representatives Johnson and Grad detailing our concerns with the implementation of Act 158 as written. The act was scheduled to go into effect on July 1, 2017. The Agency is concerned that the treatment, financial and legal impacts of the act as written create an unsustainable burden on the State of Vermont and requested that the Senators and Representatives consider three options:

1. **If Act 158 is to be implemented as written:**
    - Reconsider the law's disproportionate impact on any single department with AHS and develop a team approach, with respect to competency examinations and post-examination treatment that utilizes currently available resources and draws on the expertise of various departments.
    - Provide funding to create a state owned inpatient facility specialized in providing a safe environment and treatment services for persons with a TBI while appropriate, community based care can be developed.
    - Appropriate adequate funding for community based, individualized, long-term supports for individuals with a TBI that fall under the jurisdiction of Act 158.
    - Support the development of a no-refusal, designated system of TBI providers through an RFP and potentially a master grant process.
2. **If Act 158 is to be revised before implementation:**
    - Revise the act to address the necessary issues around eligibility, funding, and adequate support systems.
    - Delay implementation of the act until the concerns raised above can be addressed.
3. **If it is not feasible to implement Act 158:**
    - Repeal the act.

In response to the AHS memo, the Senators and Representatives agreed that a revision to the act might be necessary. They issued a legislative charge to the Departments of Mental Health (DMH), Disabilities, Aging and Independent Living (DAIL), and Corrections (DOC) requiring them to:

- consider an appropriate definition of TBI to be used in implementing Act 158;
- identify appropriate treatment options, systems and venues for that treatment;
- and detail realistic costs.

This report will provide the General Assembly with recommendations concerning clarification of the act, recommendations relating to the programmatic and fiscal implications of implementing Act 158, and an identification of challenges and concerns regarding implementation.

Strengthening Act 158: Proposed Approach

Strengthening Act 158 requires a clear definition of TBI and a clarification of the criteria to identify individuals who may be subject to commitment under the act. It also requires a meaningful discussion around the act's potential adverse impact on Vermont's mental health system of care, including the use of acute inpatient psychiatric beds for persons who do not have acute psychiatric conditions, as well as the legal (custody) status applied to individuals throughout the various stages of the process.

a. **<u>Defining TBI</u>**

As currently written, Act 158 does not recognize the nuances of the TBI's severity, timing or degree of impact on an individual's criminogenic behavior, and does not establish any framework for Act 158 commitments or program eligibility. Without a framework, any TBI (at any time or at any level of severity), could arguably be brought to bear as a reason for the person's incompetence and/or insanity. Without a more nuanced definition of what level of TBI falls into this act, AHS is concerned that use of the incompetency and/or sanity defense in this context may be abused.

As written, implementation of Act158 would significantly expand DAIL's current mandate around TBI. DAIL's current program eligibility is built on an occurrence of moderate-to-severe TBI within five years, the reasonable window for rehabilitation based on evidence. This eligibility is already more expansive than what occurs in other states. Vermont does not have a stand-alone, long-term TBI program.

While there is already a generally accepted definition of developmental disability as well as professional and systemic capacity to evaluate and diagnose individuals who might be subject to Act 248 supervision, no clear parallel exists for individuals with a TBI. A TBI can vary in severity, ranging from a mild deficit to one that is severely incapacitating. The outcome of a TBI is hard to predict. The trauma that leads to the injury's severity alone does not determine the extent of the deficit. This is still a field of active study without definitive answers. It appears that the most predictive aspect of a TBI is the time taken from loss of consciousness to time when basic cognitive functions, such as following a command, resume. Many people who have already experienced a TBI might not have clarity about this part of their own history and might not have received medical care immediately afterwards. It is imperative that we craft a definition and related eligibility criteria which will not result in too many or too few being civilly committed. For the original Act 158 report, the consultants hired by DAIL interviewed many experts around the country and identified no specific tools to assess competency or sanity specifically for TBI.

The competency evaluation is a functional assessment of whether a person can reasonably work with their attorney in their defense.
For someone whose TBI and after care was well-documented and available, it may be relatively simple to access that information to determine level of severity. In other situations, a cognitive exam may be required to understand the impact of the TBI on executive functioning. For that purpose, standardized tests for executive functioning should be used in determining the severity of the TBI and the disability created by the TBI.

The recommended definitions for TBI severity are as follows:

- Mild TBI
    - Brief loss of consciousness, usually a few seconds or minutes
    - Post traumatic amnesia (PTA) for less than 1 hour of the TBI
    - Normal brain imaging results
- Moderate TBI
    - Loss of consciousness for 1 – 24 hours
    - PTA for 1 – 24 hours of the TBI
    - Abnormal brain imaging results
- Severe TBI
    - Loss of consciousness or coma for more than 24 hours
    - PTA for more than 24 hours of the TBI
    - Abnormal brain imaging results

The Departments recommend that TBI, for purposes of Act 158, be defined **as moderate-to-severe TBI** as described above. It is important to note that this definition is inconsistent with the current eligibility criteria for the Vermont TBI program and could result in inconsistent application of the criteria across the Act 158 program and the standard TBI program.[1]

b. Determining competency to stand trial and/or sanity at the time of the offense

Under the current system, statutory obligations unevenly rest with DMH. That imbalance would be exacerbated by implementation of Act 158 as currently written. Specifically, DMH is mandated to pay and arrange for psychiatrists to conduct psychiatric examinations of criminal defendants, as well as to provide temporary care and custody for these defendants (on either an outpatient or inpatient basis) throughout the competency/sanity determination process. This includes examinations for persons believed to have a developmental disability or TBI, even though these conditions are not considered mental illnesses.

Under the current provisions of Act 158, this practice, at least with respect to the initial placement of individuals determined to require inpatient care, would continue because Vermont does not have any non-psychiatric, inpatient facilities to serve this population. Persons ordered to

[1] The eligibility criteria for the Vermont TBI program requires a moderate to severe TBI that has occurred within the last 5 years because the TBI program is designed with a focus on rehabilitation from a more recent injury. The creation of a different eligibility criteria will create confusion as our Vermont program doesn't have a long-term care component as envisioned in Act 158.

undergo inpatient examinations would be held at the Vermont Psychiatric Care Hospital (VPCH) or one of the two designated psychiatric hospitals able to provide a safe environment for these assessments. Depending on availability, a person may wait in Corrections until a bed is available. Guaranteeing the timely transfer of such persons to appropriate alternative placements after completion of these examinations, as well as the transfer of temporary custody from the Commissioner of Mental Health once an individual's incompetency/insanity is determined to be based on a developmental disability or TBI, will be critical to making sure that Vermont's limited resource of psychiatric hospital beds is used only by those who require acute psychiatric treatment.

The current process for determining competency and/or sanity relies on the court calling a screener from the local Designated Agency (DA) to assist in determining the person's level of care need. The screener helps the court in determining whether the psychiatric evaluation can be conducted as an inpatient or in an outpatient setting. The court takes the recommendation of the screener and issues an order for the evaluation, to include setting. An outpatient evaluation *may* mean use of a correctional facility, depending on the charges and the public safety risk.

The evaluations, whether conducted on an inpatient or outpatient basis, are conducted by DMH contracted forensic psychiatrists. In instances where it is believed that a defendant suffers from a developmental disability (including an intellectual disability or autism) or a TBI, the court will require input from a psychologist or other appropriate medical professional skilled in assessing individuals with those conditions. **There is no available group of evaluators with the expertise to evaluate TBI severity.**

If Act 158 is to be implemented effectively, this infrastructure will need to be developed. At present, there is not an adequate provider system available to conduct the necessary examinations in a timely fashion. To appropriately diagnose a TBI, a magnetic resonance imaging test (MRI) must occur and a neurologist and a neuropsychologist are required for initial diagnosis and assessment. Vermont has a limited provider pool qualified to diagnose TBI so timeliness and expense are significant issues. Moreover, unlike a radiological exam, neuropsychological testing requires active participation by the individual to get accurate results. This is something that may be complicated when associated with a criminal defendant who might be non-cooperative.

- **Timeframes and custody**

As no other viable options exist, AHS acknowledges that we would need to maintain the existing process to determine competency with the understanding that the limited pool of qualified assessors and appropriate settings may result in extended timelines and use of psychiatric hospital beds while competency is determined.

The expectation under the current statute is that an inpatient examination for competency will be completed within 30 days. If necessary, additional time, in increments of 15 days, may be provided by court order. Upon the court's determination that the individual's incompetency and/or insanity is the result of a TBI, a commitment hearing shall be scheduled. The hearing shall occur within 15 days, during which the individual may be "confined in jail or some other suitable

place." 13 V.S.A. § 4820. Without appropriate modifications to resources and statutes, AHS remains concerned that prison and hospitalization will be over utilized.

Because it is likely that the basis for an individual's incompetency/insanity will be determined before a determination of that person's eligibility for the TBI program, the General Assembly and AHS will need to:

- consider timely discharge alternatives to hospitalization for those ordered to have an inpatient evaluation who are later determined to no longer need inpatient care.
- determine alternatives to DMH custody (DOC/DAIL or some other appropriate entity) after incompetency/insanity due to a TBI has been determined,
- create the legal framework to assign that interim custody,
- revise the evaluative timeline to address more complex evaluations,
- revise the evaluative timelines included in existing statute to address the scarcity of human resources available to conduct evaluations
- provide additional funding for the increased number of evaluations as well as the increased complexity of the evaluations (which may include tests like MRIs).

c. Proposed criteria for civil commitment under Act 158

We would suggest that for a person to be committed to DAIL's custody and thereby be served under Act 158, the following eligibility criteria be established and that individuals be required to meet all of the criteria.

1. Clinical Criteria:
    - The individual is not competent to stand trial.
    - The individual's incompetence is the result of significant impairment caused by a TBI.
2. The individual's TBI is classified as moderate-to-severe TBI
3. Public Safety Criteria:
    - The individual has been charged with a serious crime as follows: inflicted or attempted to inflict serious bodily injury on another; or has committed an act that would constitute a sexual assault; lewd and lascivious conduct with a child.
4. Programmatic Criteria:
    - The individual must be a person for whom appropriate custody, care, and habilitation can be provided by the DAIL Commissioner in a designated program.[2] System of care ramifications need to be carefully considered. VPCH and other Level I facilities as well as DOC facilities that accept forensic patients, (those who were hospitalized pursuant to an order for inpatient psychiatric examination), already experience delays in discharge related to court procedures and adjudication of criminal charges. Some of these patients may have a TBI or a co-occurring diagnosis. Increasing the number of defendants who may use the

[2] If appropriate care cannot be provided, it is critical that the individual not revert to DMH custody.

"incompetent or insane due to TBI defense" has the potential for creating a significant burden on inpatient capacity and backup in emergency rooms. Since the persons will be in the Act 158 TBI program involuntarily, the capacity needed to manage the population is still uncertain as there is no locked facility in the community (non-hospital setting) suitable to care for a person with a TBI.

To review, implementing an evaluative process consistent with the mandate in Act 158 will require:

<u>Statutory Change</u>

- Statutory revision of Act 158 to define a TBI as moderate-to-severe.
- Statutory revisions to define the full complement of eligibility criteria to be met to be civilly committed under Act 158.
- Statutory revision to allow for lengthier confinement pending evaluations if additional funding for evaluations are appropriated.
- Statutory revision to allow sufficient time for completing the severity determinations within a realistic timeframe if evaluation funding is appropriated.
- Statutory determination of appropriate, interim custody options while awaiting competency/sanity and program eligibility determinations under Act 158.
- Expand statutory authority to include a new, alternative option to hold individuals with TBI during an evaluation.

<u>System of Care Development</u>

- Growth in the number of providers available to conduct evaluations.
- Development of options for evaluations such as out-of-state providers, in-state providers, or via telemedicine.
- Additional funding to increase capacity for a higher volume of screenings/screeners.
- Additional funding to increase capacity for contracted psychiatrists to conduct competency evaluations.
- Additional funding resources to contract with TBI specialists to assist in the competency determination.
- Identification or creation of alternatives to placement at VPCH, DOC, and alternative level 1 facilities.
- Development and funding of a new version of a secure residential option for Vermont.

DMH is presently developing and plans to issue an RFP for the next iteration of the secure residential program that is cited temporarily in Middlesex. Current program structure cannot serve as a step-down option from inpatient care for eligible individuals under Act 158 who are involuntarily held and who no longer need a hospital level of care as the program is technically unable to hold residents who request discharge due to Medicaid funding restraints. Replacement bed capacity will likely require either a Certificate of Need review or Certificate of Approval

review depending on the entity operating the facility. The facility will not be operational by 7/1/2018, the current effective date of Act 158.

Treatment Options and Systems: Creating a designated TBI program

Currently, AHS does not have a provider network that is prepared to serve this population. Our current TBI community based system is designed to address rehabilitation for recent injuries. In order to meet the mandate of Act 158, AHS would need to establish a network of providers or a single provider that could not refuse to serve individuals. AHS would need to identify and contract with some provider/providers willing to engage at this level.

Once the court has reviewed the comprehensive evaluation and found an individual incompetent to stand trial and/or insane and eligible for Act 158 civil commitment, it is critical to assess the appropriate support and supervision needs for the individual prior to placement in a community support program. In order to do this most effectively, an individual should have access to professionals with expertise in TBI evaluation, assessment of the impact of a TBI on the brain, and rehabilitation and support plan development. Currently, Vermont does not have any program or facility skilled in those arenas that also offers a secure and safe environment. Until such an environment is available in Vermont, we would recommend that Vermont draft an agreement with appropriate, neuro-rehabilitative facilities in bordering states to develop capacity for Vermonters under Act 158. Individuals may be placed in these facilities to enable further assessment and the development of an appropriate support plan with a Vermont, community-based provider.

This contractual arrangement will require that financial resources for care be dedicated to this population, the costs of which will be detailed in the financial section of this report. Use of out-of-state facilities may require statutory revision to provide legal authority to transport to, and place an individual at, an out-of-state facility for a transitional period.

Following the development of an appropriate support plan by the neuro-rehabilitative facility, DAIL would need to work in concert with its TBI community provider network to facilitate a transition for the individual back to Vermont for longer-term services and supports. There is no statewide provider network for persons with a TBI that is comparable to the system of care available to persons with a developmental/intellectual disability who are committed under Act 248. For that reason, it will be necessary to establish an agreement with one or more TBI providers to serve this Act 158 population. It will be critical to create the expectation that those providers cannot reject Act 158 participants and that the state can adequately fund those participants based on the recommendations from the neuro-rehabilitative facilities and any court expectations.

AHS is concerned that the original cost estimates for services for five potential individuals are extremely low[3]. A more accurate estimate would be $250,000 for each person needing 1:1 supervision and $500,000 for each person needing 2:1 supervision, in addition to a 1.0 FTE DAIL staff person at $50,000 or more per annum would be necessary. An assessment of final costs and an estimate of potential participation across the next 3-5 years will be detailed in the

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[3] Act 158 Report (2014)

financial section of this report. It is important to note that Act 158 does not specify whether persons being served must be eligible for Medicaid. Currently, DAIL's TBI program is available only to those who are Medicaid eligible. If that were not the case, the possible impact on the state general fund could be significant.

The costs of the program would represent a substantial investment in the increased public safety focus demonstrated by the act. The act represents a shift from the Departments' focus on core human services and expands DAIL's responsibility related to public safety. AHS services are generally focused on rehabilitation or habilitation and the provision of long term supports. AHS questions whether expanded civil commitment for the purpose of public safety is an appropriate use of our community-based system of care.

If public safety is indeed the focus, necessary resources and legal mechanisms must exist to ensure community services can be provided. Without such resources and legal mechanisms, courts will default to the only available options for involuntary containment in Vermont: psychiatric hospitals or correctional facilities.

Ongoing training and consultation for Vermont TBI providers will need to be developed and supported to ensure adherence to appropriate rehabilitative programming and assurance of public safety. Additionally, we will need to consider what an appropriate emergency response system will look like for those individuals served under Act 158. Training, consultation and emergency response capacity costs will be detailed in the financial section of this report. Given the scarcity of in-state TBI providers, statutory authority to transfer people out of state for treatment on an involuntary basis will be necessary.

To review, implementing a designated TBI program consistent with the mandate in Act 158 will require:

Statutory Change

- Statutory authority for the Commissioner of DAIL to utilize out of state facilities.
- If we pursue partnerships with other states for placement of the target population, Vermont will need to provide statutory authority for the transfer of persons out-of-state and the receiving state may also need to allow for individuals to be transferred in and out of that state.
- Statutory revision to provide legal authority to transport to, and place an individual at, an out-of-state facility for a transitional period and to return them to Vermont when appropriate.
- Statutory revision to hold individuals in community-based treatment programs unless clinical criteria for admission to hospital are met and hospitalization is the least restrictive option.

System of Care Development

- Drafting an agreement with out-of-state providers to accept, support and develop treatment plans for Vermonters eligible for Act 158 civil commitment while community based placements are being developed.
- Identifying a TBI provider or provider network.
- Designating and licensing TBI programs and providers.
- Promulgation of regulations concerning the operation of TBI program.
- Enrolling TBI providers as Medicaid providers
- Development of training and consultation capacity to support TBI providers addressing both treatment and public safety concerns.
- Development of secure, crisis capacity for individuals in TBI community-based services to be used in the event of individual or staffing crises.

Recommendations and Funding Considerations
Below are statistics comparing the prevalence of TBIs nationally to Vermont. This assumes a total Vermont population of 600,000.

Description	National Statistic	Vermont Based on National Statistic
TBI Prevalence	824 per 100,000	4,120
Prevalence of TBI with long-term disability (LTD)	1.1% - 1.7%	45 - 70
Rate of incarceration	743 per 100,000	3,715
Actual average DOC Population	67% of national number	2,500
Rate of TBI in DOC	1.19% males .93 % female	

The following chart details projected costs of TBIs assuming a Vermont DOC population of approx. 2,500. Please note that this chart does not include additional necessary costs such as MRIs (required to make severity determination) or the supervision and transportation of individuals during the evaluation period.

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Description	Data	Estimate
Estimated DOC Population with Long Term Disability (LTD) from a TBI	1.1% - 1.7% of average Vermont DOC population of 2,500	28 – 43 individuals (average 35.5)

Cost of TBI with LTD based on average of 35.5 individuals	Assumes average cost of TBI w/LTD $265,000 ($30,000–$500,000 based on severity)	$9,407,500
Cost of hospitalization until evaluation can be completed based on 30 day hospitalization	$1,375 - $2,200/day	$1,464,375 – $2,343,000
Estimate of incarcerated individuals who have experienced a head injury	According to the CDC 25% - 87% of DOC population	625 – 2175 individuals
Cost of evaluations to determine any level of disability	$1,750 per evaluation	$1,093,750 – $3,806,250
Cost of DAIL Position	Pay Grade 27	$90,000

Summary and Legislative Requests

In summary, we ask that the General Assembly consider the statutory, system of care and financial considerations detailed above. Implementation of Act 158 will require significant strengthening of the act and a significant allocation of resources to address the necessary system of care development in addition to statutory changes to allow for an expansion of our current civil commitment statute.

In order to move forward with implementation, we must:

1) support recommended changes to the act as detailed above and fund adequately with a new appropriation and,
   a. Define TBI for purposes of this act as moderate to severe TBI;
   b. Authorize and fund DAIL programs capable of meeting the needs of this population as defined in (a);
   c. Appropriately and adequately fund the cost of these programs as well as required staffing and training
2) adopt necessary statutory/regulatory changes to support the recommended changes,
   a. Create statutory authority to involuntarily hold individuals, both prior to and after competency determination, who do not meet inpatient level of care criteria but need care and will not voluntarily consent to that care;
   b. Extend the July 1, 2017 effective date for Act 158 implementation to allow for sufficient time to develop and implement the system of care as described

OR

3) Repeal Act 158 as passed.