

Community Competency Restoration Task Force

Wednesday, August 19, 2020 | 12:00 PM – 1:30 PM

WebEx 415-655-0003 | Access Code: 964 924 079

Meeting Minutes

Workgroup C = Members Present		
Carli Stark Elliot Butay Ian Heath Kelsey Shirkey Krystynna Majerus KyleeAnn Stevens	Laura Lane Leah Kaiser Lydia Ly Michael Trangle Rick Lee Ryan Fralich	Sarah Steenhoek Sharon Mahowald-Horner Sue Abderholden Tarryl Clark Tim Carey

Workgroup C: Recommend Alternative or Expanded Competency Restoration Programming Meeting Minutes

Timeline for CCRTF-Work Group C	Timeline for CCRTF (Big Group)
<ul style="list-style-type: none"> Aug. 12, 2020, 12:00-1:30 Sept. 9, 2020, 12:00-1:30 Oct. 7, 2020, 12:00-1:30 	<ul style="list-style-type: none"> Oct. 28, 2020, 11:00-1:00 Nov. 9, 2020, 11:00-1:00 Dec. 2, 2020, 10:00-1:00

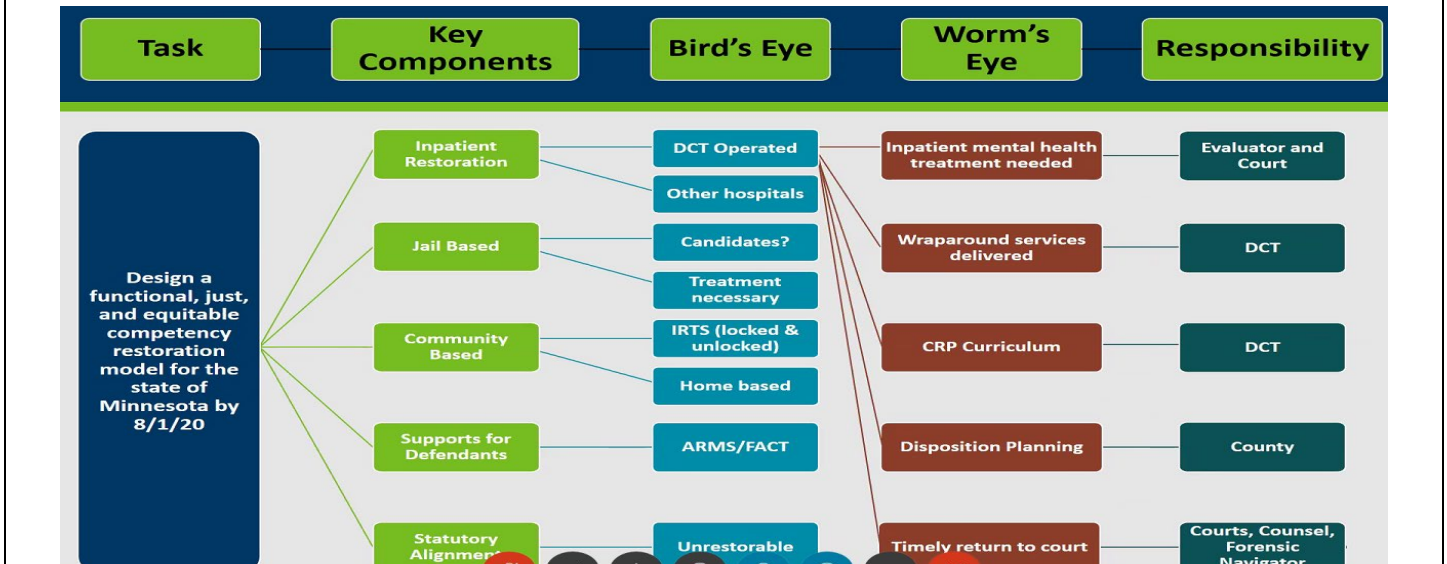
Objective

Minnesota law is silent regarding the provision of competency restoration services. No state law requires any state agency or local unit of government to provide competency restoration services. Additionally, no state statute requires individuals to undergo competency restoration.

This workgroup will focus on addressing how competency restoration should be provided in Minnesota and clarifying the roles and responsibilities of entities in providing this service.

Recommendations (from the Interim Report)

- 1.) Clarify the roles and responsibilities of state and county entities relating to competency restoration.
- 2.) Explore ways to provide responsive competency restoration services at multiple levels to meet individual needs.
- 3.) Ascertain funding needs for community-based competency restoration services across continuums of care and secure resources.
- 4.) Expand current pilot outpatient competency restoration programs in Minnesota.



Inpatient Competency Restoration: - Hospital level of care

- Inpatient treatment is needed
- Needs to be a curriculum for staff to follow
- An array of services provided for the individual on an inpatient basis
- Disposition planning is important when closing out episode

Inpatient Treatment Discussion

- Tim Carey asked if the disposition planning needs to be specific with being presumed with the county case manager or to keep it general.
- Dr. Stevens shared that from a high level we need collaboration between partners both with inpatient, courts, evaluators, hospitals, sheriffs, discharge. It helps when the hospital is able to say when the patient is ready to go as opposed to waiting for a court date which will create a lag in discharge for those who should no longer be in inpatient.
- For the bird's eye view would be regular assessment either at specific intervals and trigger based. So the treatment provider can say that the patient is doing very well and may be ready for their competency even though it may not be scheduled for another 30 days.
- This would be a shared responsibility among the treatment team, social worker, psychiatric evaluator, forensic evaluator, and psychologist or clinicians who are facilitating some of the curriculum. Should be an ongoing process on admission.
- Sharon said to add ongoing screening and assessment of their competency status while inpatient. This can be an ongoing process.
 - ✓ Add a green box for ongoing forensic assessment.
- Michael ask if it's assumed that involvement of family is appropriate for standard of treatment for both inpatient treatment and disposition planning.
 - ✓ Add this to the Key Supports for Defendants
- Kelsey asked if we would contract with hospitals for beds
 - ✓ Laura will reach out to Behavioral Health division on contracted beds.

Competency Restoration Curriculum Discussion

- It would be important to have a standardized approach to the curriculum and individual needs
- A sub group of stake holders can come together to put the curriculum together and distributed broadly
- Kristynna said there are a lot of good standardized material being used by hospitals now. So a good idea to work off of what we already have.
- The stake holders would bring in different perspectives whether on county attorney side or defense attorney side. It would help with the standardization.
 - ✓ Kristynna would like to be part of the stakeholders group to put the curriculum together.
- Person Centered Treatment Planning
- Discharge planning – There would be stake holders involved that needs to be incorporated. Put some definition around it. Leah to look at Collaboration between partners and list out the stakeholders specifically

Jail Based Competency Restoration

- Appropriation Population
- CRP Curriculum
- Mental Health Treatment
- Disposition Planning

Appropriate Population Discussion

- Leah recommended to ask someone from public defender to weigh in on this one.
- Inpatient Mental Health Treatment Not Needed – referring to population that does not meet hospital level of care that will be staying in jail and needs treatment.
- Sharon shared going back to the language used in jail for full scale or time limited. The full scale is restoration occurring in the jail and the person is not waiting for an inpatient bed, where time limited it temporarily in jail before inpatient bed. Maybe define which model or model type and use that language.
- Recommend that if the number warrants it, the jails designates a space.
- Michael shared the potential for telehealth treatment
- Having a perspective of a jail administrator to make recommendations that is reasonable during the meeting
 - ✓ Invite or get feedback for next meeting from a jail administrator

Responsibility for Jail Based Restoration Discussion

- Currently have judges for public risk.
- Recommendation is an examiner who is familiar with both individuals can make an assessment whether or not hospitalization is required.
- Tim shared that in criminal court they have the public defender fighting with the county attorney with someone being charged sitting in jail with mental health issues, they are released and back in two days with a new charge and it's hard for the lawyer to provide a coherent answer as to why the individual is back. A dedicated forensic examiner can help give the clear description of where the individual can be maintained in the community. This can help avoid jail, hospital, or new charges.
- Sharon shared that before involving an examiner there could be a screening from jail psychologist and forensic coordinator, and try it on outpatient and send someone immediately to do that evaluation. The examiner can come back and say if the patient needs inpatient or not. It does create a bit of diversion and moves the individual along faster. This is for inpatient examination not someone found incompetent.
- Kelsey asked who would be responsible in this jail process to be re-evaluating, if the individual doesn't need inpatient care anymore, but they have to go back to jail and they are doing some curriculum that is jail based, but the next forensic evaluation isn't until another 6 months and they are sitting around waiting for this evaluation to see if they are competent anymore. This is in regards to another population who has received inpatient care but are now in the jail and what happens to them there. Kelsey said in their community the individual just sits in the jail.
- Krystynna shared that in Olmstead County they continue to deliver educational information and they do the McArthur assessment, and then make that request for early evaluations. They are under the "Whatever It Takes" in Human Services.

Mental Health Treatment Discussion

- If indicated should be provided in that jails and is the responsibility of the jails
- Michael shared that we may have to provide Mental Health Treatment through telehealth in the jails.
- Sue shared that jails are already required to provide treatment, but the length of it has limits.
- Leah said she is unsure who's responsibility to provide treatment in the jail
- Sue recommended having a centralized coordination
- Rick said the Mental Health centers are likely to develop expertise for their county jails. Centralize would be last resort, but it's important to develop relationships with community health centers. Suggest to have training available to develop the expertise locally and if it's available and have funding source for it, the mental health center and private practitioners can be mobilized quickly to do commitment evaluations.
- Leah agreed with Rick that the language needs to be written to allow flexibility due to the different areas and be careful not to assign it to an entity.
- Dr. Stevens shared that the suggestions for the CRP curriculum for everyone to use then train everyone to use it.
- Sharon shared that the technology among various jails is challenging in doing evaluations in jails for telehealth.
- Sue said there needs to be a responsibility belonging to someone to make sure it's happening in jails. Even if we give a curriculum and train them, there's still a cost and there needs to be some organized way to address this.
- Dr. Stevens suggested addressing in the statute that a jail of a certain size require this capability within their program and need to figure out how to provide CRP within their jail.
- Carli Stark shared that health care is one of the biggest cost of running the jails which is why there are less treatment services that is adequate to run the jails. There are some counties that just can't afford quality care services. There are geographic disparities.
- Tarryl said we put in dedicated funding at least of what we think it would take, and have discussions what it means when these recommendations go forward and funding does exist then can come back for another discussion.
- Elliot to take a look at states that are already doing competency restoration in the jails, see how they are being funded.

Next time

Sharon share her presentation and Elliot's research and see how it's funded.

Community Based

Key Supports

Statute

Feedback on Jail based

Sharon to share statute that they worked on to Sara Steenhoek to do any updating