

Corrections Inpatient Work Group
March 19, 2007 3:30 p.m. – 5:00 p.m.
DOC Small Conference Room, State Office Complex, Waterbury, Vermont

Next meeting: April 23, 2007 DOC Small Conference Room

Present: Ron Smith, DOC; Beth Tanzman, VDH/DMH; Mary Moulton, WCMHS; Larry Lewack, NAMI; Linda Corey, VPS (by phone); Ed Paquin, VP&A; Sue Ransom-Kelley, DOC Springfield; Kathy Astemborski, DOC Windsor.

Staff: Judy Rosenstreich, VDH/DMH; Jessica Oski, AAG/DMH

Co-chairs Beth Tanzman and Ron Smith convened the first meeting of the Corrections Inpatient Work Group. People introduced themselves, presenting the diversity of backgrounds represented on the work group. As a Futures workgroup, meetings will be publicly noticed and will be posted on the VDH/DMH website. The Mental Health Weekly Update will be distributed to everyone on the work group.

Overview of Futures Planning Process

Beth summarized the statutory framework and planning guidelines adopted by the Vermont legislature in May 2004 in response to recognition of the need to replace VSH. Work began about 18 months prior to this legislation. Historically, Vermont pursued the goal of downsizing the state hospital, shifting emphasis from VSH to community mental health services. This policy direction has led to a robust community system. Vermont's spending per capita on community mental health is fourth in the nation. In other states, many consumers served by Vermont's CRT programs would be served in institutions.

The process of downsizing the state hospital also had the effect of reducing the clinical and administrative infrastructure even while patient acuity became higher and concentrated across a smaller population. As of 2003, we had two suicides at VSH and subsequently lost certification. The hospital regained certification in 2004, however, it lost it again in 2005.

The Futures planning process was never envisioned to include children's mental health.

The 2004 legislation created a Futures Advisory Committee reflecting the diversity of the mental health community. The committee was to be consulted on all aspects of planning and implementation, operating within guidelines, principles and thirteen specific points outlined by the legislature.

The Advisory Committee has referred major areas of study to work groups, twelve in all to date. The work groups develop recommendations, bring them to the Advisory Committee, which advises the Secretary of Human Services on specific topics. The

conclusions of work groups do not need to be unanimous as it is useful to the Advisory Committee and to the Secretary to understand and consider different points of view.

After two years of deliberation, the Advisory Committee voted in support of a Futures plan. In 2006, the legislature's Joint Mental Health Oversight Committee and the Joint Fiscal Committee voted to approve this Futures plan. The state's regulatory approval process for a Certificate of Need required a new level of planning, a *conceptual* or Phase I CON, prior to detailed planning for replacement of the state hospital that will require a significant expenditure of public funds. BISHCA ruled the Phase I application submitted last August complete and the Public Oversight Commission (POC) held a hearing in December. BISHCA will issue a decision by mid-April. The Department of Health cannot contract for any planning services until the conceptual CON is granted.

Discussion

Beth offered work group members the opportunity to add their observations about the Futures planning process.

Linda stated the fact that many peers have participated in the Futures planning process.

Ed spoke of the leadership transitions in state government, commenting on the need for a philosophical coherence to fulfill the closing of VSH. While community resources serve consumers throughout the state, the limits, the potential, of treating people outside of hospitalization have yet to be realized. Ed described how important the policy consensus with regard to closing the Brandon Training School was to that initiative.

In comparing the closing of Brandon Training School in 1993 to the replacement of functions now provided at VSH, Beth described the state hospital as a dynamic situation, continuing to admit about 200 patients a year whereas Brandon curtailed admissions for five years before the institution closed.

Larry stated that the Futures project has been fueled by consensus, however, concerns have arisen about the length of time it is taking and the cost. Larry shared a copy of legislative testimony titled "Coalition for Appropriate Mental Health Services for Inmates with Serious Mental Illness." It offers comments from an *ad hoc* group of organizations concerning the delivery of services for mentally ill inmates. Copies will be distributed to the work group. Larry also referred to a bill in the legislature, S.97, a proposal relating to correctional facilities, including the mental health component of correctional needs.

Charge of Work Group

Beth opened discussion of the work group charge and passed out a proposed draft. Also relevant to consideration of the group's primary focus is the content of the Vermont State

Hospital Futures Plan from February 4, 2005, that the VDH/Division of Mental Health prepared for then-Secretary of AHS Charles Smith. She distributed excerpts of the plan. Discussion of the group's charge stimulated discussion around several issues:

- Given a number of different populations currently served at VSH, should we create multiple inpatient programs to address each population?
- How do we meet the needs of people in Department of Corrections custody?
- How would we estimate the inpatient capacity needed for Corrections?
 - The February 2005 Futures Plan reported the Department of Corrections' estimate of four to ten persons in DOC custody needing psychiatric hospitalization for whom no appropriate inpatient service site was available.
 - The inpatient mental health needs of Corrections is required for capacity planning for the Futures project.

Discussion

The group had a general discussion of Corrections' need for mental health services as many issues *in addition to* inpatient capacity are of concern. These issues tend to get tangled up with the core issue central to the work group's charge.

Linda observed that mental health issues may not be the primary diagnosis but are part of the reason why young people end up in Corrections.

How do we identify who needs what type of treatment?

Ron stated that Corrections finds it a challenge to place individuals at VSH even when admission is appropriate.

Beth offered that the current planned capacity is based primarily on past utilization; the concern is that those past trends may not fully reflect the need for psychiatric inpatient care. Advocates, stakeholders, and legislators are among those who have concluded that we have to look more closely at the core question of need for hospitalization.

Mary described some of the characteristic behaviors presented by persons Washington County Mental Health has to place at VSH---those whose lack of function places them at risk of harm to self or others, including generally a level of violence in their behaviors.

Sue offered to review the population at the Springfield facility over the past six months. She described some steps that the Corrections' psychiatrist might take to assess a possible admission to VSH.

- Beth suggested that for the next meeting she involve our attorneys to help lay out the statutory and legal considerations and current process for transfer from the Department of Corrections to the Vermont State Hospital.

Ed pointed out that individuals detained by Corrections have a legitimate range of needs although there may be an unwillingness to serve them at the state hospital. This does not mean that there is no need.

Larry explained that the Department of Corrections is required by statute to assess every client for mental health needs.

Sue responded that this screening happens at intake. [INS = initial screenings]

The work group struggled with the need to place some boundaries around the discussion (i.e., a more narrow focus on the need for psychiatric inpatient treatment) and the broad issues concerning appropriate treatment of inmates for a variety of mental health and other conditions. The group agreed to focus on the proposed charge, however, we will maintain a list of the broader issues regarding mental health treatment. As part of the work product, the work group will make recommendations about how the larger list of issues could be best addressed.

Questions/Issues

Of the total Corrections population, who is in treatment? Define what we mean by “treatment.”

How does Corrections identify people for mental health treatment?

How does Corrections move people through the mental health screening process?

In the Department of Corrections, if someone is detained and has a medical need, they are given access to appropriate medical treatment. Mental health should be no different.

When we have done counts before, we have looked at who is on a psychiatric roster, the number of admissions to VSH, who takes psychiatric medication. We also need to look at what *level of service* the person needs. What parameters? Offenders re-entering? Traumatic brain injury? How many need hospitalization for psychiatric care?

Mary emphasized the importance of good psychiatric care delivered on a consistent basis, citing the 32-bed Waterbury Inn as an example. They did not have one hospitalization in the past year!

Beth referred to the actuarial study commissioned by VDH/DMH in 2006. The study concluded that a key variable in determining inpatient capacity needs is the strength of the community system. Although the actuarial study considered the inpatient needs of Corrections, she stated that many legislators and stakeholders do not find the current working estimate of 4-10 people at any given time to be credible. Therefore, the key charge to this group is to develop a process for estimating the Corrections need for psychiatric inpatient care that could be widely viewed as accurate.

Ed suggested there may be literature that could inform our process. He also pointed to Vermonters' reluctance to incarcerate anyone who does not require it. Because of this, in his opinion, we may find more people in Vermont prisons that have a severe mental illness. Vermont could therefore differ as compared to national standards.

Ron also offered to discuss the SMI (Severely Mentally Ill) list maintained by Corrections. He also suggested that the group consider how inpatient psychiatric standards can be applied to a Corrections population in that it is not unusual for the Corrections environment to cause people to regress in terms of behavior and functioning.

Larry questioned the whether the content of psychiatric inpatient treatment for people who are forensic is different from the psychiatric inpatient treatment for the general population.

Work Group Process

For the next meeting...

1. How systems currently operate.
 - How does the DOC identify mental illness in the incarcerated population and what are the treatment services currently available? (Ron Smith)
 - What is the mental health screening and referral process for VSH and other psychiatric hospitals? (Mary Moulton)
 - What is the current referral and transfer process between Corrections and VSH? (Beth and legal representatives)

2. What do we mean by forensic? Create definitional clarity.

Next Two Meetings: April 23 3:00 to 4:30 Corrections Small Conference Room

May 21 3:00 to 4:30 Corrections Small Conference Room

ADDENDUM TO MINUTES: Bill McMains will join the work group.

The meeting adjourned at 5:15 p.m.

SUBMITTED BY: Judy Rosenstreich
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