

Corrections Inpatient Work Group
April 23, 2007 3:00 p.m. – 4:30 p.m.
DOC Small Conference Room, State Office Complex, Waterbury, Vermont

Next meeting: May 21, 2007 DOC Small Conference Room

Present: Ron Smith, DOC; Beth Tanzman, VDH/DMH; Mary Moulton, WCMHS;
Larry Lewack, NAMI; Ed Paquin, VP&A; Bill McMains, VDH/DMH;
Sue Ransom-Kelley, DOC Springfield; Kathy Astemborski, DOC Windsor;
Harlow Ballard, MHM Services.

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

Updates

1) Two more people with background pertinent to the group's charge will join us:

- Bill McMains, Medical Director, Division of Mental Health.
bmc mains@vdh.state.vt.us or 652- 2008; and
- Bob Wolford, Coordinator of Offender Services, Howard Center for Human Services, to bring his clinical work experience interfacing with individuals under supervision of Corrections. BobW@howardcenter.org or 865-6179.

2) Senate Bill 97 --- Larry has been following S.97, a bill that charges the Joint Legislative Corrections Oversight Committee with a study during the 2007 interim of the prevalence of serious mental illness among current and recent inmates. The study would include the number of mental health hospital beds needed, as required by

- inmates with acute mental health treatment needs;
- criminal defendants committed for pre-trial forensic evaluation in an inpatient setting;
- criminal defendants found incompetent to stand trial or insane at the time of the offense.

S.97 also asks the oversight committee to:

- a. review policies from other states that address issues of mental health in inmate populations;
- b. consider whether a separate inpatient psychiatric facility, administered by the Agency of Human Services, for inmates with severe mental illness would address the mental health needs of the inmate population; and
- c. consider whether the definition of serious mental illness in Vermont law should be changed to include all forms of developmental disabilities, including mental retardation, traumatic brain injury, autism, various forms of dementia, and other mental impairments that significantly and negatively impact daily functioning.

3) New Corrections Handbook --- Ron distributed a brand new handbook for families and friends of inmates. There is a section devoted to public health issues, identifying mental health problems and substance abuse among the illnesses that are prevalent in the inmate population. Facts and figures for FY 2006 are available online; these include daily census, crimes that have been committed, and much more. The total population in correctional facilities at any given point in time is 1,750.

Review of Group Charge

Beth reviewed the tasks before the work group:

1. Develop a method to estimate the number of individuals incarcerated or detained by the Department of Corrections for whom the Futures project must plan inpatient psychiatric capacity.

In order to fulfill this charge, the group will need to consider whether the current criteria used for admission to VSH from the community needs to be adjusted to reflect the incarcerative environment.

2. Make recommendations on how and in what forum(s) the broader issues of concern about the mental health treatment needs and accommodations of inmates might be addressed.

Agenda for Today's Meeting

1. DOC presentation on mental health services: capacity and organization
2. Process and standards for admission to VSH from the community
3. Current referral and transfer process between VSH and DOC

DOC Presentation: Mental Health Services in Corrections

Ron presented an overview chart detailing the mental health services process in Corrections by facility. In addition, he provided copies of all the screening, assessment, and treatment forms that DOC uses.

Screening and Assessment – There are generally 1,750 inmates at any given time. Upon admission, all inmates are given an “Initial Needs Survey” (INS) designed to identify health, mental health, and substance abuse issues.

Referrals – Individuals who screen positive at intake for mental health issues are referred to Mental Health, within 24 hours if the screening score is above a certain threshold. About 690 inmates are seen for mental health on a routine basis.

Services – 13 FTE clinicians and 3.5 FTE psychiatric physicians and nurse practitioners provide mental health services in eight different facilities. This is primarily assessment and individual and group services.

- During the month of January, 445 inmates received individual counseling and 187 participated in group sessions. In addition, there were 132 “short sessions” or brief contacts and phone consultation, treatment and discharge planning was provided on behalf of 394 inmates.
- Harlow gave the work group a sense of the numbers within the incarcerated population who need psychiatric treatment. During a 13-month period, Mental Health Management (MHM), the mental health services contractor for Corrections, deemed 4 people in need of psychiatric hospitalization. Ron added that the MHM list represents the clinical services paid for and provided.

The overview and materials presented by the Department of Corrections raised questions and issues among members of the work group. Several core issues came up for discussion:

- Staffing levels of psychiatrists and psychiatric nurse practitioners. Hours of service/month and numbers of FTE’s, and staffing levels by discipline, site (facility), and days of the week. Data will be included with the minutes.
- What happens over the weekend for an inmate who may be suicidal? Ron responded that the inmate can be put on a suicide or safety, mental health, or medical watch. Any one may make a referral or request that a clinician see an inmate. Referrals usually come from a Correctional Officer or a nurse.
- When an inmate has a MH incident, is s/he moved to a nursing area or remain in a cell? The inmate may already be in a crisis unit. Harlow advised that nurses are not psychiatrically trained. Mary added that prison may be a safe setting; we can’t force someone to engage in treatment so they may opt to sit there.
- Is Emergency Exam (EE) criteria open to being different for Corrections? Beth Responded that people who are incarcerated should have the same access to VSH as others in the community. Ron added that the process does not have to be different, however, the incarcerative environment itself may be precipitous to needing hospitalization; the prison environment can be triggering for certain types of disorders.
- Ed discussed the Milliman report numbers of the projected mental health inpatient capacity needs for Corrections’ inmates, commenting that the numbers rested heavily on what services will be provided elsewhere.
- Harlow explained that the number of inmates with serious mental health issues and the number being treated reflects a gap in services. The SMI list does not reflect services provided but the number of people who are entitled to certain protections such as notification before transferred from one facility to another.

- Ed stated that the Department of Corrections has chosen to define people as SMI in order to impose certain protections that others do not have such as the use of restraints. He discussed the statutory definition of SMI, which in his opinion is a clear functional definition. People who are becoming mentally ill should not be held down. These legal concepts have been put together by a civilian legislature to protect their constituents from people with mental illness.
- Ed asked if the current admission criteria for VSH make sense for Corrections.
- Bill advised that services that are not inpatient are outside the purview of this committee. Is there a forum to address that broader question.
- Larry suggested that the work group consider the screening process that has resulted in the decrease in VSH admissions among individuals who are incarcerated or detained by the Department of Corrections.

Bill summarized pending questions regarding VSH admission and discharge criteria for inmates and how the criteria may differ from the mental health services system.

Current Process for Admission to VSH from the Community

Mary Moulton gave an overview of the process by which individuals from the community are admitted to the Vermont State Hospital.

An Emergency Exam (EE) is the civil standard for involuntary admission to VSH or to other Designated Hospitals (DH's). An EE provides that a person be admitted to an inpatient setting for evaluation. After 72 hours the person may be discharged; convert to voluntary status; or, if they are clinically evaluated to be in need of further treatment, the hospital may seek a court order to continue the hospitalization. The standards for an EE are:

- 1) The person has mental illness and is in need of treatment
 - E.g. Acute substance use alone is not grounds for admission
- 2) There is a risk of harm to self or others
 - In some cases, this may involve a level of violence
 - Examples are the person is not able to function or take care of themselves; the person may go outside in subzero weather without adequate clothing
- 3) No less restrictive environment could be safe or appropriate
 - A lesser level of care would not suffice to take care of the person

Referrals for an EE come from homes, doctors' offices, schools, all over. We first see people in emergency departments of hospitals as they need to be medically cleared. A psychiatrist or mental health screener evaluates the person to determine if an EE is required. In Vermont, screeners are qualified mental health professionals, designated by the commissioner and work through the Designated Agency mental health programs. The EE is one of three civil admission paths to VSH. In the case of an EE, the person is hospitalized first and a court

hearing follows. There also is a *non-emergency* exam, which can take up to ten days. And, finally, there is revocation of an order of non-hospitalization (ONH).

Mary's presentation was short on time at the meeting; therefore the minutes provide this more detailed description of the three ways for a person to be admitted to VSH through a civil door:

1. EE is used in emergency situations. The mental health team, consisting of a medical doctor, a psychiatrist, and a screener, may order an EE.
2. Non EE is a request for a court hearing at which a judge can order a non-emergency exam. This can take up to ten days.
3. Revocation of an ONH. This could take weeks or months. It is another avenue to return to VSH if circumstances warrant hospitalization.

Plans for the Next Meeting

The work group will review progress to date and focus on the following:

- Current process for transfer between Corrections and VSH
- Continued discussion of the current system guiding VSH admissions from the community
- Review of subcommittee charges related to operationalizing EE standards in Corrections
- Understanding of the Corrections residential services

The meeting adjourned at 4:30 p.m.

SUBMITTED BY: Judy Rosenstreich
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