Corrections Inpatient Work Group

May 21, 2007 3:00 p.m. – 4:30 p.m.

DOC Small Conference Room, State Office Complex, Waterbury, Vermont

Next meeting: June 11, 2007 DOC Small Conference Room

Present: Ron Smith, DOC; Beth Tanzman, VDH/DMH; Larry Lewack, NAMI; Ed Paquin, VP&A; Sue Ransom-Kelley, DOC Springfield; Harlow Ballard, MHM Services; Ken Libertoff, VAMH.

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

The work group reviewed the minutes of April 23rd and made corrections.

Beth reviewed topics for the work group to address:

1. How people are admitted to VSH from the community.
   - Mary Moulton provided an overview at the last meeting, however, time constraints did not allow for a full discussion.
2. Alpha and Bravo mental health units at Southern State Correctional Facility
3. Current referral process from DOC to VSH
   - This will help inform the development of a methodology for estimating the inpatient bed capacity for Corrections.
4. A subcommittee, will look clinically at how admission standards from the community to VSH may need to be modified for an incarcerative environment.

Larry also asked that the group discuss the treatment issues for inmates who are incarcerated in out-of-state facilities.

Beth reviewed the work group's core charge—How can we estimate the inpatient psychiatric capacity that Vermont will need for people incarcerated or detained by the DOC in the years ahead when VSH is replaced by other facilities? In developing this, we will need to examine admission standards from the community to VSH and juxtapose these standards against an incarcerative environment to see how they need to be changed.

Ron agreed that our goal is to come up with a number, suggesting that we first must identify the factors that will lead to that number. The physical environment is one factor, according to Ed.

Concerns that relate to this core objective were noted:

- Restoring benefits to people who leave the Correctional system (Ken)
- Availability of affordable housing (Sue)

Larry discussed the challenge of caseloads within Corrections, giving the example of a caseload as high as 53 per 1 FTE mental health counselor, possibly compromising assessments. How do we know when a person is spiraling downward? What is the warning system?

Harlow identified the nursing staff as a good source as they have a good sense when someone is beginning to decompensate. The security staff (correctional officers) also observes behavior of inmates and many referrals for mental health services come from them.

Sue explained that correctional officers write an end-of-shift report, sharing that most of the referrals that she makes for mental health assessments originate from these reports.

Ron added that Corrections has a set of eyes on everyone, 24 hours/day. The system has been pretty reliable as there is a sensitivity to mental health issues.

There is a hierarchy of staff, the correctional officer, nurse and doctor, who in turn weigh in on an individual's need for a mental health assessment and referral to VSH, however, Harlow makes the decision to refer an inmate to VSH. It would be highly unusual for Harlow to be the first one to see an inmate.

Larry asked whether Corrections' contract with MHM Services is capitated. An issue is what may be built into the payment structure that provides an incentive (or not) to have an inmate transferred to another system of care. Are there economic drivers to push someone into another system? Ron described the MHM contract as quasi-capitated, including…

- A base fee for work performed consistent with the contract
- Billable services up to a certain amount
- Beyond that we don't pay for the services

Harlow commented that it is so rare that an inmate is admitted to VSH that it is not a big part of what we do week to week. He does not think there is an economic driver to move an inmate to VSH since his workload only increases if an inmate goes to VSH. Financial impact is measured in the extra time spent with an inmate who goes to VSH.

In response to Ken's question, Sue offered an educated guess of 10 as to how many referrals to Vermont State Hospital should have been made over the past year.. Not all 10 are at once so the number of beds needed is less than 10.

Ed stated that from P&A's perspective, there are people in segregated settings that should be in other, more appropriate settings for them. Among our inmates, Ed sees a larger number than 4 or 5 inmates who would benefit from a less restrictive setting than what we provide. In part this is because the current residential programs in Corrections have not had very strong treatment services.

Larry said that Susan Wehry provided testimony that 27 inmates have serious mental illness. The new definition of serious mental illness does not include people with personality disorders, post-traumatic stress disorder (PTSD), and other conditions. Ron added that 75 inmates would benefit from a secure dual diagnostic treatment program (MH/SA) in the community.

Ed supported the concept of heavily staffed residential programs, stating that for Corrections there needs to be something analogous to a residential program.

Harlow described the evolving Alpha and Bravo units at Southern State Correctional Facility in Springfield. The Alpha unit is a 10-bed stabilization unit for individuals having a psychiatric crisis or who have destabilized in some manner. It provides acute, short-term (3-5 days) stabilization services for inmates of Vermont's correctional facilities. Harlow acknowledged that the unit is not an ideal psychiatric stabilization program as conditions are deficient in some respects. DOC would be more able to self-manage this population with an improved unit. The Bravo unit is 24 beds and offers some additional supports beyond the general corrections environment.

In the discussion of design issues and physical space, Beth noted that the Futures planning process is working toward scalable clusters that would allow treatment to take place near the residential care. Architecturally and programmatically, treatment capability must be built in to the physical space.

Addressing the number of beds that may be needed at any given point in time, Ed recalled a time when mental health offered to take up to 5 DOC inmates concurrently. Beth referred to the actuarial study that reasoned 4 to 8 people at any given time, noting, however, that this estimate does not seem to be viewed as a credible range even though the actuarial study said it. Harlow felt that 4 beds would be inadequate relative to need, suggesting 10 beds. Sue saw 10 to 12 beds as a reasonable estimate.

Harlow suggested that before we can come up with a credible number, it would be helpful to identify what resources the DOC is going to have such as enhancements at the Southern State Correctional Facility where the mental health units are located. Another consideration is whether DOC may gain the capability under Act 114 for administration of involuntary medication or whether VSH will continue to be the only option. Given that DOC cannot provide involuntary psychiatric treatment, those who refuse medication are among the people for whom admission to VSH is sought. Beth pointed out that this is essentially the same population that goes to VSH from the community.

Beth offered her own personal view that the Alpha and Bravo units in Springfield should be made more robust in order to strengthen the treatment capability of DOC. Harlow agreed on the desirability to make the 10-bed Alpha unit more fully capable of treatment, not just stabilization. Also, he noted that if treatments were designated under Act 114 less hospital care would be required.

Larry asked what happens after an inmate is stabilized; does s/he go back to prison? Would it not be better for them to go to some kind of a residential setting where they could continue to be stabilized and reduce the possibility of an escalation of their illness?

Beth acknowledged the concern, pointing out that whole issue requires another discussion in a different forum. Under current procedures, inmates return to prison after medical or mental health treatment to complete their sentences.

The group decided to meet on June 11, 3:00 to 4:30, in the Small Corrections Conference Room. Judy will send out the subcommittee charge and confirm the meeting date.

The work group adjourned at 4:30 p.m.

SUBMITTED BY: Judy Rosenstreich
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