

Corrections Inpatient Work Group
June 11, 2007 3:00 – 4:30pm
DOC Small Conference Room, State Office Complex, Waterbury, Vermont

Next meetings: July 16 and August 13, 2007
3:00 4:30pm DOC Small Conference Room

Present:

Ron Smith, DOC; Beth Tanzman, VDH/DMH; Larry Lewack, NAMI; Ed Paquin, VP&A; Sue Ransom-Kelley, DOC Springfield; Kathy Astemborski, DOC Windsor; Harlow Ballard, MHM Services; Ken Liberto, VAMH; Mary Moulton, WCMHS; Bill McMains, VDH/DMH; Jessica Oski, AAG/DMH; Michelle Lavalley, Acute Care, DMH

Minutes:

The minutes from the May 21, 2007 meeting were reviewed and Ron suggested a change to language concerning the payment provisions for the mental health services contract. This change was made and the corrected minutes were posted to the VDH/DMH Website on June 22, 2007.

Sub Committee Charge:

The group reviewed the draft charge. The proposed membership for the subgroup is:

- Tom Simpatico, Medical Director VSH
- Harlow Ballard, Medical Director, MHM Services
- Ron Smith, Clinical Director, DOC
- Mary Moulton, WCMHS
- Bill McMains, Medical Director DMH.

The group is charged to produce a set of clinical guidelines for involuntary psychiatric inpatient admissions applicable to Corrections.

Ken asked that the sub group also provide this committee with a sense of how mental health treatment services “are going” in Corrections and “are there a lots of people there [in Corrections] who shouldn’t be there?” As a follow up, Ken asked this Futures work group to clarify its role vis a vis the Corrections Summer Study and also how the DOC and VDH are working on the activities outlined in the legislation for the summer study. Ron will update the group on this at the July meeting. The Corrections Oversight Committee is meeting on July 11 and will begin with a tour of the Springfield facility.

A general discussion followed of concerns that incarcerated individuals with mental illness are not receiving appropriate mental health treatment. Bill offered that one concrete step towards assuring appropriate treatment is to develop clinical guidelines for involuntary psychiatric inpatient admissions. Once this is established, the sub group could turn next to developing guidelines for voluntary inpatient psychiatric care. He

observed that lack of appropriate access to VSH is one of the concerns that many stakeholders express. Ken stated that at some point, someone is going to have to address the widely held perception among Corrections line-staff that there are many, many, people in Corrections who should be in mental health treatment facilities and not incarcerated.

Mary stated that it would be important to gain a better understanding of who seems to need hospital care and what the current capacity within Corrections is for addressing mental health issues. Case studies, she suggested could be helpful. Ron offered that Dr. Ballard will be able to provide this to the sub-committee.

Ron continued that while this sub committee will help address the population in Corrections who need inpatient care; there is a much larger group who requires treatment for mental illness short of a hospitalization. Fundamentally, Corrections is not a therapeutic environment and it is not intended to be so. The experience of incarceration can exacerbate symptoms of mental illness.

Larry raised the issue of Co-occurring mental illness and substance use issues. Clearly, many incarcerated individuals also have histories of substance abuse difficulties. Bill suggested that any treatment capacity that is created – both in and out of Corrections – needs to be designed to be capable of providing treatment services for people with dual diagnoses.

Ron pointed out that the goals of treatment may be different for people who are expected to remain incarcerated for long periods and those who are expected to rapidly return to the community. For people with longer sentences, DOC seeks to stabilize the mental condition while for people who will return more quickly transition and safe community participation are the targets of change.

Ken expressed skepticism that DOC provides mental health treatment citing the changes in the number of people on the list for serious mental illness (SMI) as an example. Ron stated emphatically that the list of people with “serious mental illness” does not represent the total group of people who may need, and who receive, mental health treatment in Corrections. Currently over 500 inmates receive psychiatric medications, and others may have counseling or consultation services. The list for **serious mental illness (SMI)** is created by specific criteria. These criteria include the diagnosis of a major mental illness (one of five conditions) **and** current functional impairments. Based on these specific criteria, approximately 27 individuals are on the list. Ron offered that a list reflecting need for mental health treatment would arguably be more useful and would likely include a larger group of people. The Department of Corrections, he stated “widely recognizes that there are more individuals who need, and receive, mental health supports than who are on the list for serious mental illness”. Also, Ron pointed out that the SMI list doesn’t reflect who needs hospitalization as it is not a proxy for acuity of mental illness.

Ed reminded that group that the legislative intention and statutory language for serious mental illness in Corrections was designed to reflect functional impairment and not only

diagnostic criteria. Furthermore, the list / definition was designed to assure that people who are functioning below a certain level are granted accommodations and protections that other incarcerated individuals do not need. Ed offered that Corrections may be too narrowly developing the SMI list by limiting to people who have one of five diagnostic categories in addition to functional impairments.

Beth stated that the criteria for the CRT (Community Rehabilitation and Treatment Programs) are based on the key factors: the diagnosis of major mental illness, functional impairment, and a long duration of functional impairment. Larry offered that that “best outcome” for a person with mental illness when they leave Corrections is that they are able to participate in community-based services.

Larry also asked how many people from Corrections who are referred for psychiatric inpatient care are turned away by the community hospitals. He expressed concern that the designated community hospitals may essentially refuse to treat an individual who is incarcerated even if they meet the clinical criteria appropriate for psychiatric hospitalization and that these people instead are referred to VSH. Bill observed that there does seem to be a feeling that the current designated community hospital psychiatric units lack the resources and programming to serve individuals incarcerated or detained in Corrections. Sue stated that tracking the number of referrals that are turned away from community hospitals may not be that informative because eventually people simply stop making such referrals.

Ken challenged, how can we be counting on the designated hospitals to play such a prominent role in the Futures project if they currently turn away referrals from Corrections? Beth clarified that the Futures plan calls for new inpatient services designed to appropriately treat the VSH-level patient and that any successor program to VSH will need to serve all eligible admissions, regardless of the referral source. But how, asked Ken, will we know? Mary stated that hospitals are pretty up-front in describing what they can manage or take.

Discussion to be continued at our next meeting!

Proposed agenda:

- 1) Corrections summer study – plans and relationship to this work group
- 2) Progress report from the sub committee
- 3) Discussion: who should be in Corrections or, should anyone who has a mental illness or cognitive impairment be incarcerated?

Minutes submitted by Beth Tanzman, 6/22/07