



Meeting #01
June 05, 2009

MEETING MINUTES

Waterbury
Secure Recovery Residence
Vermont State Hospital
0536 VSH^B1B

Name	Organization
Kitty Gallagher	Vermont Psychiatric Survivors
Linda Corey	Vermont Psychiatric Survivors
Jane Winterling	Vermont Psychiatric Survivors
Dave Gallagher	Consumer
Patrick Kinner	VHS
Tom Simpatico	VHS
Mary Moulton	Washington County Mental Health
Anne Donahue	Member, Vermont House of Representatives
Michael Hartman	Commissioner, DMH
Beth Tanzman	Deputy Commissioner, DMH
Norma Wasko	DMH
Bill McMains	DMH
Judy Rosenstreich	DMH
Wanda Minoli	BGS
Mike Kuhn	BGS
Frank Pitts	architecture +
Anthony Garner	architecture +

Initial Workshop: Secure Residential Program, Visions and Values

- Attendees introduced themselves and indicated their areas of interest and involvement in this project.
- Beth Tanzman reviewed:
 - A brief history of the project
 - Status of the legislation that enables this project
 - Upcoming planning processes and timelines (parallel and interconnected efforts):
 - Architectural programming and design
 - Programming, current
 - Optimal model, early August
 - Design development with Site Specificity, late August/Sept/Oct
 - Building systems with firm budget, late October/Nov
 - All leading to CON application submission and permitting
 - Recovery program planning
 - Site selection
 - Futures project

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3. Ms. Tanzman reviewed the population who might be eligible for residence here. This includes people who cannot be served in a less secure setting. There is no other "common" diagnosis. This may lead to significant discussion regarding development of the Recovery Program (needing to address possibly very disparate therapeutic needs) and the Architectural Program (needing to design for community, while also providing for possible secure separation of incompatible residents). The Recovery Program group is working to better define this.
4. Wanda Minoli and Mike Kuhn reviewed the role of BGS.
5. Representative Donahue expressed concern that the architectural model should be intimately linked to a specific site, and questioned how building design might proceed absent a specific site.
 - a. Discussion followed of how of site selection criteria and architectural design criteria will develop in parallel, progressing from general to specific, each informing the other at every step. Neither effort is independent or dominant.
 - b. General site selection criteria were issued for individual review. This document will be revised based on today's meeting, for further discussion at the next meeting.
6. Vision and Values for Recovery: (a brief synopsis)
 - a. Respect
 - b. Caring
 - c. Dignity
 - d. Sanctuary and Safety
 - e. Launching Platform for Success
 - f. Home
 - g. Personal Responsibility
7. Facilitated Discussion Notes; most of the meeting involved discussion and further explication of the various participants' understanding of the Visions and Values, as follows:
 - a. Today there are not other options. What happens to our mission when or if alternatives are in place or the current patient mix transitions?
 - i. It will be a fairly gradual progression. There are likely to be a progression of candidates as residents. This will be the secure community based alternative.
 - ii. These are people who don't need hospitalization but aren't ready to succeed in the community.
 - b. A beautiful setting is needed. What is beautiful?
 - i. Direct and personal experience of the outdoor via both immersion and observation
 - ii. Light
 - iii. Fresh air
 - iv. Colors
 - v. Things and places I can call my own
 - vi. Music
 - vii. Art
 - c. Exterior and Interior building expression and scale (residential vs. institutional). What can we do to make it seem like my home? How do we keep it from being sterile and ugly? The exterior should NOT look like a prison. The built environment should not generate adverse expectations and behaviors on the part of staff or residents.

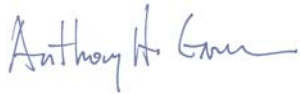
- d. Invoke people's human-ness
 - i. Stress the positive
 - ii. Work with individual's goals, dreams and hopes
 - iii. Encourage personal expression
- e. Within what is necessarily a safe and secure environment, how do we develop a recovery-based program that is self-regulating? Overt security can compromise recovery.
 - i. Provide Education: Skills acquisition, learning to share, learning to interact, role modeling, and adult education (library, computers, reading/writing).
 - ii. Experience and Working: Provide real jobs (for pay or stipend?) with real opportunities for work education (e.g. designing and printing menus for local restaurants, web design, baking bread, etc.)
 - iii. Empowerment and Development of Personal Responsibility: Peers coming into the program (choice?) development of an appropriate attitude toward work. Promote positive attitudes and experiences.
 - iv. Expansion and Community Exposure: Bring in teachers, peers (with success stories!) and community members who can offer learning opportunities. Develop links to the Community (local press, organizations, work camps, etc.).
 - v. Home and not-Home: Provide the ability to move among differently functioning places (possibly separate buildings), the ability to engage others in different cultural situations (residence vs. work). The Arizona State Hospital is an interesting example.
 - vi. Development of Shared and Personal Responsibility: My room, our house, our community ... involve residents in house maintenance and stewardship.
 - vii. Supportive and Intense Relationships: Foster and build relationships between and among residents and staff. Develop a place that delivers relationship based programming as well as educational programs.
 - viii. Activity: Provide opportunities for indoor and outdoor exercise/activity.
 - ix. Spirituality: Provide a chapel or other opportunities for personal reflection.
- f. How can we use the environment to encourage positive Staff behaviors? How can we develop a program and place that will keep staff here and decrease the amount of turnover? Provide education for Staff as well!!!
- g. What are the security risks and challenges that we need to anticipate and manage?
 - i. The adjacent Community feels safe when:
 - a) They do not experience problems.
 - b) They understand that the residence is secure.
 - ii. Managing leaving without leave:
 - a) People should not be able to climb over a perimeter barrier.
 - b) People should not be able to leave the building without leave, even if the site is barrier surrounded.
 - iii. The introduction of contraband must be controlled/eliminated.
 - iv. Confidentiality for residents must be provided.
- h. What is secure?
 - i. This is not correctional facility.

- ii. DMH has legal responsibility for the residents.
 - iii. The project must be intrinsically secure. We must not rely upon a local or state police presence to maintain or establish security.
 - iv. Insofar as possible, security should not be visible, obvious, and overt (to the extent possible).
 - v. Provide a range of options should be available. Everyone should be able to be in a place where THEY can be trusted.
 - vi. Provide a baseline high level of security for all with appropriate flex for those with less security need.
 - vii. Provide controlled access to the site, maybe embedded within a building.
 - viii. Provide security that is sure, allowing the staff and residents focus to be on treatment and freedom within the secure perimeter.
 - ix. There is a possibility for operable windows and penetrable walls if the site perimeter is strong and has two means of detecting motion. But do not allow complete freedom, i.e. avoid nuisance absences with limited opening windows.
 - x. No one is locked in their bedroom.
 - xi. Provide ability to lock off parts of the building, residential areas vs. work areas, etc.
 - i. How do we manage the mix of resident's security challenges?
 - i. Think flexibly
 - ii. Offer a range of solutions and levels of containment
 - iii. Treatment advancement involves risk
 - j. What are the safety risks we need to anticipate and manage?
 - i. Safety is personal and possibly different feeling for each resident.
 - ii. Personal safety is extremely important, allowing recovery to progress fearlessly.
 - iii. How do we achieve it?
 - a) Patients should be able to lock their own door, where clinically appropriate.
 - k. Growth must be accommodated. Planning of this project cannot rule out future possibility for facility growth.
 - i. 50% growth ability must be demonstrated.
 - ii. DMH does not desire the Residence to grow because beyond a certain size we no longer have a "residence", but an "institution".
 - iii. The requirement to demonstrate growth ability must focus on possible solutions that do not change the inherent initial residential character of the facility.
 - iv. Growth must also accommodate all program necessities, not just beds.
 - l. The Program should develop a Supportive Language, such as:
 - i. "moving in", not "admitting"
 - ii. "graduation", not "release"
 - iii. "residence", not "facility"
 - iv. "barrier", not "fence"
 - m. Animals (resident of visiting): Allow for the possibilities of engagement that can grow from relationships and assumptions of responsibility with and for domestic animals.
 - n. Long versus short term stays and programs. Is there a common core of intentions, or just a diversity of intensity? This requires additional discussion of other core groups.
8. Ideas:

- a. Build a new residential building and then use an existing Waterbury campus building as the work-space.
 - b. Be able to come back...not just hang out in the parking lot....but to come inside, to touch base with staff. This can be positive for the returnee, as well as for current residents.
 - c. Provide outside space with covered porches and wind protected patios that capture the sun.
 - d. Provide ceremonies for life transitions, such as "graduation" exercises.
9. Programming Discussion Notes:
- a. Discussion started to address architectural programming. A Draft Program was begun which will be developed for next meeting's discussion.
 - b. Provide all private bedrooms with en suite bathrooms
 - c. On average four to five people per cluster is best. Given the need for flexibility and the variability and diversity of patient needs (including some exclusivity of patient needs) participants ultimately recommended a 4 bed cluster, a 5 bed cluster and a 6 bed cluster with the latter being sub-dividable (3+3 or 2+4).
 - d. Some bedrooms need to feel very private and very close to supervision
 - e. Comfort rooms should be located in quiet common areas

These minutes reflect our understanding of the business transacted and the decisions made at this meeting. Please provide corrections or additions to our office within 14 days of the date indicated below. ***Note: Items italicized happened after the meeting and are included for clarification purposes.***

Recorded by,
architecture+



Anthony H. Garner, AIA
June 19, 2009

cc: Attendees