

Corrections Inpatient Work Group
August 13, 2007 3:00 p.m. – 4:30 p.m.
DOC Small Conference Room, State Office Complex, Waterbury, Vermont

Next meeting: September 26, 2007 1:00 – 2:30 DOC Small Conference Room

Present: Ron Smith, DOC; Bill McMains, DMH; Larry Lewack, NAMI-VT;
Ed Paquin, VP&A; Linda Corey, VPS; Harlow Ballard, MHM Services;
Mary Moulton, WCMH

Guests: Mary Fitzgerald, Dual Diagnosis Peer Coordinator, VPS; Anne Donahue,
Counterpoint

Staff: Judy Rosenstreich, DMH

Bill facilitated the meeting. He conveyed Beth's regret that she could not attend today. Judy will email members with alternate dates for the next meeting to accommodate as many members as possible.

Today's agenda---

1. Review "Psychiatric Hospitalization Criteria: Future's Bed Planning for DOC"
(*Ad Hoc* Subcommittee's draft clinical guidelines)
2. Discuss Larry's memo of 8/10/07

Review Draft Clinical Guidelines for Hospitalization

Bill reported that the subcommittee began by looking at mental health's clinical criteria for involuntary admission to VSH as well as voluntary admission to a hospital. While the involuntary criteria are set in law, we are aiming to make the language of the guidelines clear enough so a screener could read it, be guided by it, and make a decision.

Bill also discussed the role of attending physicians, stating that it is a clinical call of the attending physician to weigh options. Outpatient? Inpatient? Decisions are subject to utilization review.

DISCUSSION

Linda described the experience of people in her organization who have severe health issues and need to go to a hospital yet are told, "No." Their condition then becomes more severe. People with an existing medical condition generally know when they need to go into a hospital to get help. The system needs to listen to their need.

Harlow commented from the Corrections perspective. Inmates may want to be in a hospital, however, if they need medical help, they put in a sick slip. In all correctional

centers—except the work camp—inmates can see a clinician and, if urgent, within 24 hours. Ron agreed that if an inmate says s/he needs medical attention right now, that is listened to.

The subcommittee's draft involuntary hospitalization criteria refers to the Corrections environment as a *less restrictive environment* than a hospital in that there is no around-the-clock nursing coverage, no daily psychiatric coverage, and no mental health staff on weekends. Corrections is a lower level of **care** environment than VSH, stated Bill.

According to the subcommittee's draft, when this level of support is insufficient and the two criteria of mental illness and dangerousness are met, then hospitalization is appropriate. On the other hand, when the level of care in Corrections is sufficient to maintain safety and provide treatment, then hospitalization criteria are not met.

This draft language elicited comments from the work group. Ed stated his concern that solitary confinement for 22 hours/day to maintain safety is not an acceptable alternative to hospitalization. Larry also found the phrase *less restrictive environment* as it relates to the ability of an inmate to get his needs met in a Corrections environment problematical.

Anne discussed the terms *less intensive* and *less restrictive*, citing an example to illustrate her point. She compared a person in a correctional facility who is extremely depressed and meets the criteria for hospitalization. Another person with the same diagnosis in a nursing home does not meet hospitalization criteria. Whether or not the person in Corrections meets the hospitalization criteria depends on availability of service. If the level of support is ineffective in prison, then he is likely to require hospitalization. This was not the case for the person with the same diagnosis who is in a nursing home. For this reason, Anne suggested a clarification to the draft hospitalization criteria proposed by the *ad hoc* subcommittee: If the least intensive care that meets the needs of the person is in a hospital, then a hospital is the least restrictive. In other words, if the least intensive services are not available, then hospitalization may be indicated as the least intensive.

Ed questioned what environments there are in prison and which ones are therapeutically appropriate. If safety can be applied but no therapy, does that mean that hospitalization is not needed? Taking a child to the ER for an ear infection would be appropriate if no primary care is available. By the same token, if no reasonable alternative exists in prison that offers the treatment a person needs for his condition, then admitting him to a hospital is appropriate.

The discussion turned to the voluntary hospitalization criteria recommended by the subcommittee. Anne commented that the clinical rationale for hospitalization is the same for everyone.

Ed asked at what point does the State have a duty to evaluate. If an incarcerated person refuses treatment, s/he may never get out of segregation. Let's presume s/he has a violent history. If the person was not in prison, s/he would have gone through the EE process.

Ron emphasized that Corrections is not a therapeutic environment nor is there a goal to make it such. We need to work within the framework we have, stated Ron.

Ed responded that if a prisoner's issue was cancer and DOC could not treat it in a manner that would otherwise be provided in the community—chemotherapy, bed rest, etc—DOC would transfer the person to Fletcher Allen. In the mental health unit of DOC, how many people are segregated for up to 22 hours/day to ensure their safety and protection but not provided therapy while their condition worsens? Hospitalization may be appropriate.

Bill will re-work the Psychiatric Hospitalization Criteria based on today's discussion, ask the subcommittee for comment, and bring revisions back to the work group. Discussion at today's meeting, however, provides a clear sense of the needs identified by the work group to plan sufficient psychiatric inpatient capacity for Corrections. These needs will be added to the bed estimation process, which will continue.

Linda asked what happens to a person in Corrections who needs inpatient psychiatric care if a hospital says that they have no room? Mary offered that only VSH will take them.

Ed cited the example of the Caledonia Community Work Camp in St. Johnsbury, a program that the State created in response to an identified need. If there is a type of facility which presently does not exist in the context of mental health treatment for the Corrections population, then the State will need to create it.

Larry's Memo of August 10, 2007

Larry had written a memo to the work group and spoke to the issues he raised.

1. Is there a standard of care in the Department of Corrections that is in compliance with our policies? With national standards? And what are those standards?
2. Does the State's contract with MHM Correctional Services fully address DOC policies? National policies? Concerns arise over variance with those policies.
3. Citing a professional disincentive of state employees to find fault with current standards of service, Larry called for an analysis by independent consultants to look at quality benchmarks, specifically what the MHM contract requires and what is delivered.

DISCUSSION

Harlow shared with the work group that the National Commission on Correctional Health Care (NCCHC)¹ has reviewed and passed every Vermont DOC facility.

¹ NCCHC is a Chicago-based, not-for-profit organization that seeks to improve the quality of health care in jails, prisons and juvenile confinement facilities. NCCHC's *Standards for Health Services* cover the general areas of care and treatment, health records, administration, personnel and medical-legal issues. NCCHC offers programs, services and resources, including facility accreditation, technical assistance, quality reviews and clinical guidelines. For more information, see its Web site <http://www.ncchc.org>.

Ron responded to Larry's assertion about the disinclination of those on the state payroll to find fault with the system, stating his commitment and incentive to do the best job that he can to a professional and ethical standard.

Ron further commented that there are currently five almost parallel processes taking place now, all of which are going back to the legislature's Corrections Oversight Committee whose summer study encompasses mental health issues in Corrections. He urged support for the oversight committee's process, suggesting that the work group not reproduce what is being done.

Ed referenced a news analysis, pointing out that some of the worst prisons in the country get accreditation. He also would like to see the MHM Services contract. Responding to Ron's description of the oversight committee process, Ed stated that he would be satisfied to obtain information gathered in the context of another committee, and suggested that we get linked up with the process.

Ron further explored the issue of the work group's approach to addressing issues of concern. An important outcome of the work group, according to Ron, is to define what services DOC does not provide—the gap in services—and to make recommendations. Ron capsulated the mental health services that are or are not provided:

MHM is providing:

- a. crisis services
- b. assessment services
- c. stabilization services

MHM is NOT providing treatment services.

Larry offered that having the MHM contract on the table will help people understand what services are being provided and what are the gaps...in effect, what we are and aren't doing for people.

Meeting Plans

The work group agreed that Judy would follow up by email to schedule the next meeting.

The meeting adjourned at 4:30 p.m.

SUBMITTED BY: Judy Rosenstreich
jrosen@vdh.state.vt.us

