GOVERNOR'S ADVISORY COMMISSION ON MENTAL ILLNESS AND THE CORRECTIONS SYSTEM

MINUTES

October 8, 2019
2:00 p.m.

DEPARTMENT OF CORRECTIONS CONFERENCE ROOM
COMMISSIONER'S OFFICE
105 PLEASANT STREET
CONCORD, NH

Commissioner Helen E. Hanks called the Commission meeting to order at 2:05 pm.

Participants:

Helen E. Hanks, Commissioner NH Department of Corrections, Chairperson
Sarah Blodgett, Executive Director, NH Judicial Council
James Boffetti, Associate Attorney General
Robert Lynn, Chief Justice, NH Supreme Court (Retired)
Heather Moquin, Chief Operating Officer NH Hospital
Emily Rice, Solicitor, City of Manchester
Thomas Sherman, Senator
Robert Steigmeyer, President & CEO, Concord Hospital
Kenneth Norton, Executive Director, NAMI
Lois Monette, Administrative Assistant, Commissioner's Office

This Commission was formed to examine and make recommendations on issues facing individuals with mental illnesses in the corrections system. Executive Order 2019-02

Commissioner Hanks opened the meeting announcing that the report is due to the Governor before November 30 this year.

ICJJC committee discussion:

- Prior to incarceration is critical,
- Reform while incarcerated
- Post release safety nets

<u>Integrated Delivery System discussion</u>

Integrated delivery networks have made significant inroads, really lifting up programs throughout the state.

We really are underway with the creation of a high preforming Behavioral Health System with a strong community base.

Concord and Manchester are probably the most connected areas. Depending where you are sending someone as they leave your facility depending on the area and the set of services available to connect with in the region.

Supervision: tap into all resources available. How do we use case manager services in a way that is sustainable?

We can have case managers upon discharge and a great plan upon discharge but upon release things can fall apart very quickly. I can work to take vacant positions and put a case manager in each district office and I might still chose to do that but it's really about creating an envelope of resources offering support in avoiding recidivism around employment, housing.

Peer support - who better to help someone with the success of a transition then someone who has been successful transitioning themselves? Suicide rates are high at that point of change. Is there a way to come up with a model of peer support? I would imagine a conversation someone has with a peer is very different from a conversation with his or her PPO**.**

Currently I have three re-entry coordinators following people with substance use disorders on an opioid grant we received; it has been an interesting pilot. As we generate data, I will share it with this group. Research says it has supposed to help people stay out longer.

Healthcare and substance abuse
Incarceration - how do we work around setting up resources, number one driver to relapse in substance abuse?

IDN's funding and substance use disorder monies are all running out in the next two years. Long-term fiscal sustainability of the success already under way is a huge concern. 5-year journey to sustainability, less than 2 years left, is a worry. What we are trying to do here is a longer journey

Congress Women Kuster has a bill about Medicaid Coverage. The bill removes the exclusion of Medicaid coverage while incarcerated. . It is now a bill in Washington. Creates a standard of health care in Corrections that does not exist at this point. If this bill is approved, Medicare will become the base layer of insurance. There are still gaps around the dental side. We generally practice around a Medicaid platform in this state knowing that upon release that is generally the healthcare available to our people. It would create a financial share that is attractive to the state. 90/10

Senator Hassan has a bill to remove the X1 waiver process for Suboxone; the bill will remove the caseload maximum for the provider.

Unfortunately currently we are focused on the immediately crisis, have been reaching out to CMHC partners to advance collaboration. We need the infrastructures in place will give us the breathing room to continue to deepen the community investments.

Mobile Crisis Treatment Centers, currently 3 in the state, budget has either allowed for a Mobile Crisis Center or fixed unit. RFPR went out with no response. It has been re-released. Difficulty in staffing them. Second option – a fixed unit instead of mobile

Do we leverage Medicaid reimbursement model, IDN"S?

Just as Oxycodone has been abused, we need to be thoughtful about what is now being prescribed and be responsible. The amount of community procured strips of Suboxone is a problem.

Mental Health
Staffing issues in ER and not enough adequate beds. Emergency Rooms trying to divert to appropriate resources, Bill for next session possibly opening up the doors for tele- physiatrists to help fill the void in staffing. Not enough incentive for providers, no desire to serve the population. Economic driven

Field Services - On DOC side only one case manager in Nashua. My department and leadership would like to see a case manager in every office. A lot of case management services in the community. Can we create community partnerships that creates the safety net to hold people together?

The challenge I have with the concept is that if we are going to use integration, we should be truly cohesive and integrated and not rely on one agency. Does it matter what case manager they have if the case manager has the whole skill set?

DOC -We can open our doors and have Riverbend bring their case managers onsite at the facilities. Just starting to work on. Trying to move that area of the department forward with resources they have not had.

Many parallels with this discussion and hospital discharges, maybe not reinvent the wheel but use our resources and partnering with hospitals who have experience with readmission.

Is there a peer support model anywhere? We have just started a peer support training and coaching on the substance abuse side through a private vendor. Just on the cusp of learning about a program for peer-to-peer monitoring program for adults and for mentoring program for children of incarcerated adults. Cogent that I am state corrections, county jails also have opportunities that could benefit people.

First Step ACT of 2018 also calls attention to providing services for families, small grant we started two years ago through the DOJ that tackles that topic.

Transition Discussion
It is the transition point into the community that is where the gap is, when things can just fall apart, and how do we create a network of those supports? The 10-year plan works for any citizen whether it's mental health or substance abuse.

Does DOC case manager's assists with and what happens after the Resident is released and loses housing? Yes, the case manager inside the facility helps find housing before release, the Parole Officer goes out, and looks to make sure it is suitable housing. If housing is lost after release then that circles back around to Field Offices staff asking for case managers in every office. Nashua is the only office currently with a case manager. It boils down to who do they call? We have HUD restrictions on Felony Offenders. One third of the male population is incarcerated on sex offender

charges. How do we take the stigma out of the crime? We have barriers from both the Federal and State restrictions when it comes to housing.

Housing
Proposed contract coming before G & C for housing resources for those leaving jail and prisons. Housing contract is not out of DOC but DHHS and has not been approved as of yet so stayed tuned.

Case management, and housing, if any one thing falls apart like lack of housing, the whole thing crumbles. At the hospital, bail changes and they are released to the community if they qualify for an ACT team they will get case management or in the absence of qualifying for an ACT team what, do they have available?

Employment
Employment opportunities with DOT, currently four people working with them.

Sex Offenders
Are there any organization like AA or Narcotics Anonymous for sex offenders? Where people with shared life experiences can get and give support. The churches have offered a lot of support on the sex offender side.

Our grant funded Peer Recovery coaching has helped us understand that. Prior to that, we had created and taught Psychological First Aid in Corrections. We already had peers doing peer mentoring when people are under crisis watches. We have one person who has done this as a Resident, has met the certification requirements and is going for the certification and employment as a Peer Coach. Peer coaching is real and an employment opportunity.
It was an easy transition to start a dialogue about AA meetings in the facilities.

Diversion
How do we tap into resources when relapse starts to happen?

Appropriate points of diversion:
Arrests
Courts
Mental health centers
Prosecutors

LEED Program out in Seattle – to discuss in another meeting.

Bail reform -accustomed to using incarceration as a point to give services but with bail reform, we have lost that contact point.

Pre-trial services at the misdemeanor level or at the first psychotic episode,

20 to 23 year olds adults, parents no longer able to handle them. Ageing out of the system.

Build a system that can respond effectively to the diversity of those situations or realign systems and what is the gap in the health system.

Studies have shown that the rates of neurological trauma in people incarcerated can be as high as 80%, the rates of neurological testing is very low partially because it is expensive and a lot of states haven't recognized the issue. Do we have any testing done on intake?

We do physiological testing upon entry and physiatrist testing when it is called for. Everyone who comes in is asked about physical, sexual and emotional trauma, women self-report more than men do. We have a member of our group sitting on Senator Rosenwald commission looking at intellectual disabilities. We should learn a lot from that.

The one thing we have not talked about is adverse childhood experiences. We have to think about how we define family innocence.

Points for November Report:

3 main items:

Incarceration
Transition
Reintegration

Things to include in the report:

- items we have agreed upon in the communality of our dialogue
- Summary of what we discussed in prior meetings

Define integrated delivery systems to create seamless paths to services and untangle the webs of referral

Housing being a critical resource for people leaving county jails and state correction systems with mental illness inclusive of substance use disorder

Case Management **- clearly** is critical. Whether it is a combination of community, based resources and state corrections. Many county jails have case managers.
Medicaid makes a big difference

Peer support and Peer mentoring

Scope of our efforts: Does domestic violence cases fit in? Situations like the person has not had a criminal record or their criminal activity is the product of their mental illness. To have the person access services, leave the charges on file and give an opportunity for an intervention before we move forward to a disposition.

The meeting adjourned at 3:18 p.m.

The next meeting TBD

Respectfully submitted, Lois Monette