Forensic Interagency Task Force
July 28, 2015
Minutes

Those attending the meeting held in the DOC Training Academy on the above date were: **Carol Bamford** (Director of Emergency & Court Services); **Daniel Beauchamp** (Regional Forensic Liaison); **Chris Blough** (NHS Team Leader); **Patricia Brader** (Community Relations Specialist); **Tory Bright** (SE Reg. MH Services Coordinator); **Scott Buchanan** (Lic. Psychologist Mgr.); **Margaret Chapman** (NAMI President); **Lance Couturier** (Lic. Psychology Director, annuitant); **Hazel Dacus** (Forensic Liason-DOC); **Mary Jo Dickson** (Administrator, Adult MH Services); **David Dinich** (President FTAC); **Chris Fitz** (Executive Director, CCP); **James Fouts** (Dir. Forensic System Solutions); **Heidi Fuehrer** (Psychological Services Specialist); **G. Galentine** (Correctional Counselor II); **Jeff Geibel** (Treatment Supervisor); **Lawrence George** (Executive Director, LCBHDS); **Michael Gorzelic** (Case Manager**); Mary Jordan** (Director); **Michael Keefer** (MH Court Coordinator); **Susan King** (Psychological Services Specialist); **Marirosa Lamas** (Superintendent); **David Lopes** (MH Advocate); **Robert Marsh** (DOC Psychologist) ; **Kerri Miller** (SPORE Case Manager); **Smana Pamphile-Clerfe** (JRS State Support Specialist); **Lynn Patrone** (DOC MH Advocate); **Charles Van Ravenswaay** (Forensic Specialist); **Jessica Reichenba** (MH Program Representative); **Melissa Repsher** (Director); **Sandra Riggers-Vollrath** (Psychological Services Specialist); **Kelly Rodriguez** (Training Sergeant); **Emily Scordellis** (Regional MH Director); **Matthew Sheaffer** (Parole Agent 2); **Jill Shepler** (Deputy); **Deborah Shoemaker** (Executive Director); **Vivian Spiese** (FTAC); **S. Drew Taylor** (SPORE Director); **Stacy Tekely** (Supervisor, JRS State Support); **J. Warfield** (Court Coordinator); **Lloyd Wertz** (Vice President FTAC); **Katy Winckworth-Prejsnar** (Project Coordinator); **Chris Wysocki** (JVBDS Administrator); **Elaine Ziegler** (MH Manager); **David Zug** (Psychologist)

This was the first meeting of this resumption of the Forensic Interagency Task Force (FITF). Superintendent Marirosa Lamas welcomed the attendees and noted that she coordinates the CIT effort within the PA DOC. She stated that it is offered based on the Memphis CIT model. There is a CIT program run by the DOC every month with a duration of four-day or 32 hours for Correction Officers and other staff. This could eventually involve county staff who can designate a set of attendees to participate in that program. It is offered on the DOC training grounds. It has not been regionalized, due to the involvement of specialists who provide specific portions of the training and who would not be able to do so if they had to travel extended distances. There are currently 700 Corrections Officers trained with a goal, as specified in a court settlement, to number 1000 by January 1, 2017.

Dave Dinich was next and noted the presence of a Sign-In sheet asking all to add their names or check next to their names on that list. He gave a brief reference to some of the history of the

organization FTAC and FSS, who assisted in convening the group, as part of PMHCC, Inc. and based in the City of Philadelphia.

After a brief hiatus due to an unexpected fire alarm that was NOT a drill, we returned to the room provided for the meeting and moved on to the presentation by Dr. Bob Marsh of the DOC.

Dr. Marsh offered an extended presentation on Policy and Procedural Updates from the PA DOC. This was developed in response to a settlement agreed upon between the DOC and the PA Disabilities Rights Network in the context of segregation of those who exhibit symptoms of mental illness in the Prison setting. He introduced some of his staff who concentrate from a Regional Perspective on issues of BH Treatment in the correctional/institutional setting. He lauded his staff who, not only do good work as assigned, but also are very capable in providing data feedback as required in today's world of correctional settings.

He noted that there are 726 CO's who have been trained in CIT thus far with the full expectation that 1000 will be trained by January 2017, as agreed upon in the Settlement. He also noted that Mental Health First Aide Training has been completed with ALL staff in the DOC system. There are approximately 35 certified MHFA Trainers in the system to accomplish this feat. In addition the Hearing Examiners, who make decisions on misconduct or disciplinary matters as they might relate to individuals on the active mental health rosters in the inmate population, are trained to help them work with those who have those issues while in prison and are reported to have acted in a way that might require discipline. These Hearing Examiners have been trained in these issues related to working with those with Mental Illness in the prison setting.

There was a recent effort to consolidate those with mental illness into specialized settings which are specifically prepared to work with them into fourteen SCI sites across the Commonwealth. There are now Mental Health Units at SCI's PIT, ROC, MUN, and GRA. There is a Forensic Treatment Center at Waymart that continues in operation primarily for male offenders on a 304 Commitment. These beds at Waymart are all "open" beds and require special provisions for certain inmate patients. There is a planned expansion of the Intermediate Care Unit at SCI Waymart. There are Specialized Assessment Units at Waymart and at Camp Hill for those that have confusing diagnoses and need to be further understood and assessed. Finally, he noted that there are Behavioral Management Units at SCI FRA and MUN. These units are intended to serve those with Personality Disorders who also have shown tendencies to have other behavioral manifestations, such as suicide attempts; or self-harm, such as cutting.

There are certified peer specialists at every SCI in the Commonwealth. These have lived through serious mental illness and are specially trained to become CPS's. These CPS's are trained based on the same requirements as stipulated by OMHSAS so that they are employable as CPS's upon release to the community. Lynn Patrone noted that OMHSAS is working on a grant to offer CPS in Forensic settings and might be able to enroll and train additional CPS's. There will be CPR training offered in addition in order to be able to serve those who might be more likely to attempt

suicide in that setting and are under special watch. It was suggested that this should be added to CPS training in the Commonwealth, in addition to MHFA, if possible.

Peers who are incarcerated and who are interested in this training and these positions can approach staff in the facility. There has been some learning from the VERA Institute of Justice Segregation Reduction Projects. The purpose of this is to learn more about how to better manage these types of efforts in the PA-DOC. Dr. Marsh reported that there were certain aspects of services that were exemplary within the DOC at the current time.

Dr. Marsh noted that there were some incentives in the state-wide contract with the contractor for Mental Health Services in the DOC, Mental Health Management (MHM). One of the matters for these incentives is medication compliance. This is currently between 80% to 90%, a relatively high level of compliance in the prison setting.

This effort is entirely focused on the issue of mental illness services and not on those with Substance Use issues.

There was a question about continuity of care for those entering counties from the DOC system. This issue was referred to the "Parking Lot" to be addressed at a later time, and could be one of the issues to be addressed by the FITF itself in future meetings.

Dr. Marsh also stated that the PA-DOC performed a Sequential Intercept Mapping Study to better help in the understanding of processes in the handling of inmates.

Dr. Marsh related the fact that there has been an established set of nine diagnoses which will result in an inmate's being placed on the "D Roster" There were about 900 on that roster previously, but now that has risen to about 4000, based, on that change. In response to a question, he noted that the agreed upon nine diagnoses seems to have been developed from other states and other previously agreed upon settlements. There are some issues that might suggest there are needy individuals who have signs and symptoms of serious mental illnesses, but who might not have one of the nine Dx's.

There might be others who have functional impairment who do not have one of the nine Dx's who might be specially included on the "D Roster." These are folks who are also to be considered as having serious mental illness. There was a question as whether those who meet the requirements for services in the community, such as an "NOS" diagnostics, but who might not meet the requirements for the "D Roster" in the prison setting. This might raise the question of whether there is a genuine intention to create a Recovery oriented environment, even though it is a prison setting, given the reliance on diagnostics to determine the level of the participation on the part of the inmate. It seems that re-entry was not part of the DRN Settlement as it was agreed upon. This was among other issues that will be relegated to the "Parking Lot" for discussion later in the meeting and, perhaps, for other meetings.

There was a question about improved outcomes based upon these new efforts. Dr. Marsh note that some seem to have been achieved, but that data have not been developed to prove it. He also noted that the DOC's method of "Goal Planning" has become far more inmate-centered and developed more as a Recovery Plan as opposed to one generated by the DOC professionals, as was the process in the past. This will result in differential Treatment Group participation and others.

Some inmates with Sexual Offense convictions might be on the "D Roster" if they may not if they do not also have one of the diagnoses. There was a request to have the Rosters shared with counties, which had been a prior practice.

Dr. Marsh then moved on to discuss the Disciplinary Process involving Hearing Examiners. Anytime a misconduct notice comes to a Shift Commander, a referral is made to Psychology to assure there is an assessment before the issue moves on through the disciplinary process. He posited that one in every ten of these reach the level of an Involuntary Commitment for Mental Health Treatment, these number approximately 25 to 30 per month. There are a total of 70 "inpatient beds" with that number being studied on a regular basis to assess its sufficiency. There is also Voluntary Commitment for Mental Health Treatment options which are offered regularly, and whenever possible. It was also noted that certain misconduct sanctions could result in up to 90 days in a more restrictive prison setting. Now, if there is a decision to make a disciplinary referral of greater than 30 days, the decision is forwarded to Dr. Marsh and his staff to assure that the best options are being followed. This places the Commonwealth in a small minority of States which have taken this forward step in decision-making.

In response to a question, we learned that there are residential care units which provide specialized care in 2000 DOC beds across the State. Most are in 256-bed settings which house those who have clinical indications for remaining there. These are in a generalized housing unit referred to as a Residential Housing Unit.

PA has determined that there will not disciplinary misconducts for self-injury or cutting or taking actions toward suicide, being referred to treatment instead.

There are Diversionary Treatment Units in each SCI that has "D Roster" inmates for placement of individuals who appear before a Hearing Examiner and are found to be in need of treatment. These folks get 20 hours "out of cell time" per week at a minimum to assist in their recovery. They are seen out of their cells weekly with daily rounds. There is one out-of-cell activity weekly by the Program Review Committee and the Psychiatric Review Team on a monthly basis.

Those in "Administrative Custody" are reviewed by the Regional Deputy Secretary and Licensed Psychologist Director and need to have a plan for release or referral after 30 days. There are about 160 inmates in Diversionary Units, due to a recent spike from 130 to 150. There is also involvement of CPS's on these Units as well.

There have been Suicide Prevention Committees developed at each SCI. These are multi-disciplinary committees which monitor training compliance among staff, administration of suicide prevention screenings and other activities intended to address this issue. These teams also do attempted suicide drills to address an "in progress" suicide if it were to be found.

There are Clinical Reviews which occur to determine what defines a serious suicide attempt, based on any medical procedure which results form a suicidal act—EG. "Had to be cut down" and others. All of these result a Clinical Review. Should lesser events occur on a very frequent basis they will eventually result in a Clinical Review as well.

There was a slide representation which shows that there have been reductions in suicide completions and that frequency is now below those found throughout the Commonwealth.

There are Recovery Plans in place that address assets and challenges for individuals in treatment in the prison setting.

Secure Residential Treatment Units (SRTU) are intended to serve those with mental illnesses who have also demonstrated a high level of risk for violent behaviors. These folks are offered a minimum of 20 hours per week out of cell activities, ten of which are structured and ten of which can be unstructured. There have been incentives introduced to this program. There is encouragement of being out of cell without violent outbursts which can result in rewards for individuals for some basic things such as an additional shower, certain food treat, etc. There was a recent suggestion to have a change in the color of garb, from orange to blue, for the prisoners in the setting. This was accomplished to help in identifying the need for treatment versus those in other units. It was noted that all Diversionary Units have been differently painted and with murals, and other positive additions to the environment to assist with treatment and not reflect only the incarceration setting. Folks come out of this type of restrictive housing after successfully completing a specified number of days and can returned to the Residential Treatment Units.

A question was offered about the individual's return to general population and how they are received upon that return. This is a corollary to those who intentionally act out to get the increased out-of-cell time that is offered in the Specialized Unit.

A break was called and the presentation then resumed.

Dr. Marsh first reflected on the use of Trauma Screenings at SCI MUN, housing females in the system. The one used is the PCL Screening.

High results on the Trauma Screening might then result in referral to attending relevant groups in the Diagnostic Center for the individuals identified in that manner.

He noted that the DOC requested a "tiered budget" in last fiscal year. There were an additional 98 positions approved, 68 of which are for Qualified Mental Health Professionals (QMHP's).

The Mental Health Contractor, MHM has been willing to move available psychiatric hours to accommodate needs in these settings.

SMI Segregation Safeguards/Restrictive Housing Safeguards. There is access to structured MH Services and Treatment. There are pre-and post-placement screening and evaluations. There are IRP's developed with the inmate and the multi-disciplinary team. There is communication for all transfers of inmates with serious mental illness. The waiting lists for SRTU, SAU, ICU, and BMU are reviewed at least weekly and, perhaps, daily. MH input in housing decisions is NOT always overridden. There are trends recognized with a Central Office Review Team which reviews monthly data and identify trends for which there are then resources addressed.

He then offered a listing of the "Right Things" that the PA DOC is now doing.

1. Restructured for better oversight and tracking.
2. The training initiatives have directly influenced culture.
3. Expansion and realignment efforts and planning to improve service through specialization.
4. CPS's VERA. NAMI, Suicide Prevention committees, Clinical Review improvements have been achieved.
5. Recovery Base Treatment Model adoption.
6. Trauma Screening at MUN.
7. Improved identification and institutional placement of SMI Offenders.
8. Continual evaluation of staffing considering needs of the given population.
9. The constant review of policy within the Prison setting.

The result is that the Seriously Mentally Ill inmates are no longer, necessarily, segregated. The Disciplinary process encourages informal resolution for non-violent misconducts. The driving principle has become: "Is the person a threat in a less secure status?" If that answer is "Yes" then divert to DTU, SRTU, or BMU without cell time.

A question regarding continuity of care was offered. Dr. Marsh noted that Allegheny and the five county Philadelphia area seem to be able to offer good levels of continuity, based upon the available services in those areas. For others, there might be greater struggles to find the services necessary services and there is a need for greater coordination among the Counties and the PA-DOC.

There was another question about SSI and benefits continuity with scheduled interviews with the SSA in the home communities. It was suggested that there should be some sharing and a return to the beginning of the process to better move it along.

Another was offered as to the need to work with the individual county representatives to assist with continuity across the entire Commonwealth to assure cooperation and consistency across the institutional settings and the counties themselves.

Dave Dinich offered closure to this meeting, noting that it was the first re-convening of the Task Force in quite a while. He stated that a goal is to have a significant level of sharing of current practices across PA and that the future Agendas for the FITF will include these types of topics.

How often and where should we meet? As to frequency of meetings the consensus was every other month. **The meetings are to begin at 10:00AM and go to 12:00noon. The next meeting was scheduled for September 22 at the DOC Training Academy in Elizabethtown**.

Respectfully Submitted,

Lloyd G. Wertz, FTAC/FSS.