Forensic Interagency Task Force
January 26, 2015
Meeting Narrative

Those attending the meeting held in the DOC Training Academy on the above date were: **Tricia Baffa** (Forensic Case Mgmt Supervisor); **Carol Bamford** (Director of Emergency & Court Services); **Daniel Beauchamp** (Regional Forensic Liaison); **Dana Benn** (D&A Treatment Specialist); **Tory Bright** (SE Reg. MH Services Coordinator); **Margaret Chapman** (NAMI President); **Janeen Christ (**Regional Reentry Administrator**); Lance Couturier** (Lic. Psychology Director, annuitant); **Hazel Dacus** (Forensic Coordinator); **David Dinich** (President FTAC); **Charles Folks** (Dir. Counseling/Community Integration); **James Fouts** (Dir. Forensic System Solutions); **Heidi Fuehrer** (Psychological Services Specialist); **Laurie Hess** (Forensic Corrections Counselor); **Mary Jordan** (Director); **Alissa Kachel** (Community Relations Specialist); **Faith Kroggel** (Social Worker II); **Marirosa Lamas** (Superintendent); **Robert Marsh** (DOC Psychologist); **Robert Nichols** (Prime Care); **Emily Scordellis** (Prime Care); **Cheryl Scott** (Acting Chief of Treatment); **Deborah Shoemaker** (Executive Director); **Renea Snyder** (D&A Program Magr); **Jack Sommers** (Superintendent Waymart); **Vivian Spiese** (FTAC); **Gary Tennis** (Secretary D&A Dept); **Tammy Twombly** (Social Worker II); **Charles Van Ravenswaay** (Forensic Specialist); **Lloyd Wertz** (Vice President FTAC); **Nancy Wieman** (Consultant); **Jenn Williams** (C-M-P Mental Health); **Elaine Ziegler** (Mental Health Manager);

This is the fourth meeting of this resumption of the Forensic Interagency Task Force (FITF) convened by FTAC/FSS with 33 attendees.

Facilitator, Dave Dinich of FTAC, welcomed the group and asked attendees for self-introductions and to relate new things that are happening in the Commonwealth from their varied perspectives. Dave noted that Secretary Wetzel is coming to Schuylkill County to celebrate the 10th anniversary of that county's operation of a Forensic Task Force with representation from multiple service agencies as well as the forensic system.

Dave then turned to Tory Bright to discuss the most recent meeting of the RE-Entry Committee last month. Tory gave a brief background to the Re-Entry

Committee, noting that there are now approximately 22 members of that Committee. The group has met a total of two times. The sharing in that venue has demonstrated the fact that all participants in the "system" do seem to have the same interests and intentions, while the methods employed are quite varied across the Commonwealth.

She then went on to note the creation of a survey to be used to get an idea of the varied processes that exist within this same area of specialty. Furthermore, there was a suggestion that there might be a mapping project which could further highlight areas of effective relationships and those which might create more friction or heat. The areas of challenges were identified by the Committee nearly immediately. The survey questions intended to address these areas, nine of them, were developed by a Sub-Committee tasked with this particular job. It was distributed and there were 185 responses from about 45 counties and 17 SCI's. Most of the questions were open-ended allowing for anecdotal reports and suggestions. The information shared in that process, will take this Sub-Committee several weeks to sort through in detail to be useful to the larger Committee.

There seemed to be several themes that were shown in the survey responses to this point. Tory noted that there is an effort by her office to bring on a consultant to further understand the information received through the survey.

Several themes have seemed to develop thus far:

- The DOC is proud of the work that is being accomplished in its offering of high levels of treatment, especially to specific populations of people with serious and persistent mental illness (SMI). The clinical capacities of the DOC have shown itself as being quite impressive.
- It seems that there is a great deal of information existing within the county and DOC systems. However, the methods of communicating that information across the lines of these systems are nebulous and not clearly defined. Thus the information is seldom effectively and consistently shared across the Commonwealth.

- It was also clearly defined that the greatest need from both perspectives is housing and the lack of that resource for those who come out of the DOC system. There was a great deal of commentary in the survey responses directed toward a method of matching housing to the needs of the individuals who are being released. Tory noted that Housing is not one of the County MH mandates, and thus is not an entitlement from the Counties' perspectives. One Task Force member noted that OMHSAS has a "Housing Plan" and her belief that community reinvestment funds should be directed toward that need. It was shared that there are 120 returning inmates in the Southeast Counties alone, without counting Philadelphia, which might need this service. There does not appear to be a prioritization at the OMHSAS level directed toward these needs. There was also a suggestion that Long Term Structured Residences (LTSR) located in the Commonwealth might also be able to address some of these needs. It was also clarified that there are a number of inmates who would not choose to live in congregate settings upon release from the Prison system. There was a reference to the Olmstead Plan and the fact that there is a direction away from institutional levels of housing services. It was added that the difficulty in placing individuals with a forensic history and SMI is further compounded when Substance Use and sex offenses are also involved. One participant noted the presence of a housing developmental effort within the DOC to create leasing arrangements that might be more likely to serve those folks with SMI upon release. Other issues with that development are the complexity of needs among those reaching release. Tory summarized that there seems to be a need for an "array" of services, given that we are dealing with folks in the community system with multiple needs and requirements, which are often unique to the individual, for these types of housing services. The Housing Contractors with the DOC might not be as aware of the need for such a broad array of housing services.

- There is also a need for a high level of clinical assessment of both the mental health needs as well as significant physical health needs of individuals upon release, especially for the older inmate being prepared for release. These can include wheelchair dependence, highly volatile blood sugar levels, etc.

- There might be a need for recommendations recognizing the types of needs and risks involved in dealing with them. Specifically, the sex offender presents high levels of risk in the public and community from the County MH side of the equation. That has been primarily dealt with in the forensic system. That needs to change with support provided in doing so. The highly complex medical issues noted above also need to be addressed as part of the array of housing options. In comparison, folks with histories of trauma seem to have risen to a higher level of awareness in both the community and forensic systems. This type of highlighting and resulting raised awareness need to occur for other specialty populations within the forensic system.

- Connection to Benefits and demonstrating eligibility for them for the inmate upon release is another issue pointed out in the survey. Shortening the delay between release and the eligibility for MA and social security income benefit needs to be addressed in order to allow the released inmate to survive in the community. Current delays are between three to six months to get an individual eligible for and receiving SSI in the Community. Often some of that delay can be the assigning of an address to the applicant.

There was discussion about whether that Re-Entry Committee is too large to function effectively. Thus, there was a suggestion that there might a need to create other, specifically tasked, groups that can be created to work concurrently on these additional topics.

There was another Sub-Committee of the Re-Entry Committee created to develop a "Best Practice" protocol about the documentation necessary to effect a smooth transition to the community for an inmate with SMI to be released. This group is working on this type of document assembly and the types of information necessary to effectively prepare for transition from the DOC system into the county. There is a "Level 1" type of information exchange that includes a release of information, the completing of an Intake form at the county level, and a recent, within the past twelve months, Psychiatric evaluation from the DOC on the individual involved. It was suggested that specifically asking for a Psychiatric Evaluation might be the wrong term to use, as that requires a court order to be released. The real purpose of this type of evaluation is to substantiate that the individual has SMI. Rather the Progress Notes from the psychiatrist might meet these needs, as they consistently

have reference to the working diagnosis which is being addressed by the psychiatrist in the session with the inmate. This Sub-Committee might be ready to issue some suggestions to be considered by the larger Task Force for the creation of a state-wide standard for this process in developing of a consistent methodology to effect this type of information exchange.

The continuing of the Re-Entry Committee was brought into the discussion, noting that the next meeting of the RE-Entry Committee is Monday, February 1, 2016 at 1:00 in Linglestown at the County Commissioners Association of Pennsylvania (C-CAP) Offices.

Dave Dinich noted the great deal of work being done by the Re-entry Committee and the forward, progressive movement that might result from those efforts. He also highlighted the difficulty in creating effective methods of communication both within the systems and outside of them to interact with others. Might there be some capacity to create staff positions in both the Community and Corrections systems created and tasked with the sole responsibility of better coordination and communication?

Marirosa noted the approach by the Commonwealth in merging the DOC and the Pennsylvania Board of Probation and Parole will be very important in moving forward in any effort prescribed by this Committee and the larger task force.

At this point, Gary Tennis, Secretary of the Department of Drug and Alcohol Programs entered the Task Force Meeting and was asked to take the podium. Dave Dinich addressed the prior discussions of the group to Mr. Tennis to give him some context to the Task Force and its most recent efforts and today's discussions.

Mr. Tennis then began to offer a brief background on him and the work he is doing, with his staff and the Governor and his Administration, in addressing the issue of drug problems in the community. He noted that his work in policy at the state and national levels did result in required sentencing for drug crimes, which has resulted in increased prison populations, but no reduction in use nor arrest rates in the Community. He went on to note that the delivery of drug and alcohol clinical services, if delivered with integrity, can result in a 70% reduction rate in recidivism.

He noted the contracting of a study by Rutgers University, "Socioeconomic Evaluations of Drug and Alcohol Addictions Treatment" which actually showed that treatment of a longer duration resulted in greater savings than a shorter. He noted that there was a $7 to $1 return for each dollar spent on treatment in savings to the overall system.

Our current system has led us down a road to a fundamentally flawed D&A Treatment system. Studies currently indicate that the need of funding for D&A Treatment services is funded at the 10% of need levels. Specifically, he addressed the very limited funding of residential D&A Rehabilitative services at fewer than 15 days per stay. Rather, these folks end up relapsing and committing crimes resulting in imprisonment, or overdose and death. He characterized the Forensic System as doing "clean up" work for a failed and flawed D&A treatment system which is "barbaric and inhumane."

He referred to a study with a focus on assessment and treatment and the resulting behavioral changes that have been found to have a "success rate" of 86% in participants who do not show back up in the forensic system. Obviously, treating these individuals with integrity is a remarkably successful method of improving lives and reducing overuse of the forensic system. Furthermore, he noted that cuts to funding over the past several years, have resulted in the current opioid crisis and the casualties that have resulted. Medicaid Expansion has reversed this trend since our new Administration has taken over.

The Secretary then went on to speak about the current efforts of Naloxone treatment for opioid overdose in the Commonwealth. He referred to the current efforts in forwarding this initiative in PA and the rebuttals to any arguments which are lifted from certain municipalities and counties which are resistant to the implementation of Naloxone use. He noted that there are 1000 police forces in PA and that the efforts of his Department and other individuals in gaining their cooperation. He related that there are 600 individuals who have been saved in the first year of implementation. Finally, he asked the members of the FITF, should they know anyone who is addicted to opioids or those who take opioid-based prescriptions, to encourage them to have a prescription of Naloxone in the home for their loved ones use or anyone else. He also stressed the need to call 911 in any

case of use of Naloxone, as the medication can wear off and the overdose process can resume.

He also suggested that we re-frame the discussions we have with individuals in need of D&A Treatment from a "suggestion" that they seek treatment to escalate to simply taking and engaging the person in the treatment setting, not unlike someone who is in dire need of cardiac care.

A question from a Task Force member was directed to the issue of the shortage of beds in the Commonwealth to provide facility-based treatment, given the recent influx of financial resources into that system through Medicaid Expansion. The potential of using hospital beds which are currently idle to serve as inpatient detox. This carries a high level of risk, and the recognition that MA funding is so low that it cannot be accomplished in a fiscally feasible manner. The issue of interesting the BMHCO's in allowing for that resource development in their own regions has been addressed by the Secretary to a number of these executives who seem to be very interested in addressing this issue.

There was another question about the issue of Medicaid enrollment for those in the prison system on the day of release. He related success in this process in specific counties in PA. There was a plan to have the person assessed by a Certified Specialist and a communication with the local County Assistance Office is what has been effective. He believes to have expanded to over 50 counties in PA. He further noted that this needs to be effected within the DOC with its inmates prepared for release as well. There was a belief expressed that there is a 30-day period during which the released inmate will be without federally-matched MA and in a Fee for Service MA plan. Angela Episale, of the DDAP, will be recommended for membership on the Task Force to continue to discuss this effort and others, as she has a background in Income Maintenance in the DHS. The potential of effecting a "suspension" of MA benefits during incarceration at the county level with reinstatement upon release might be a method of address but also needs to expand to address those with SMI in addition to D&A issues.

Secretary Tennis wrapped up with a reference to the need for high a quality assessment for D&A issues as being paramount. In addition it needs to focus on triggers and the existence of trauma in the individual's past. Medication assisted

treatment needs to be a part of the accepted regime. Community Treatment needs to follow facility based in order to be optimally effective. The optimal for folks with SU issues in prison shows that an effective treatment program in the prison needs to be followed up with a strong outpatient program in the community. He referred to the Keycrest Study as demonstrating this.

There was a question about the issue of county of residence for a released inmate as to the type of inpatient rehabilitative services provided in the areas served by different BMHCO's. Varied insurance coverages present a problem across the Commonwealth. The Secretary referred to the Mental Health and Addiction Services Parity Act, and its applicability in these cases. Act 106 establishes 90 day minimums for inpatient rehabilitation with an accompanying MD order. The issue of the released inmate in identifying a MCO which might be a difficult decision based on the determination as it relates to the residence to which the former inmate might live. There was commentary from a Task Force member regarding the varying allowance of types and lengths of stay by the BMHCO's as to how those decisions are made as to funding for the stay.

Secretary Tennis ended his presentation with his story of Benjamin Rush, the father of modern day psychiatry. He referred to these early days in our country when water was often not potable and the development of a tendency to drink alcoholic beverages as a replacement. To address the addictive behaviors that resulted, Benjamin Rush stated, "These folks need to be treated as they have a disease, and not (a choice) or addiction."

Dave Dinich ended noting that there was a paper being distributed to solicit folks interested in forming Committees to address the Benefits Instatement issue and the Housing issue as noted earlier in this Meeting.

**The next meeting of the Forensic Interagency Task Force is scheduled for Tuesday, March 22, 2016 from 10:00 to 12:00 at the DOC Training Academy in Elizabethtown.**

Respectfully Submitted,

Lloyd G. Wertz, FTAC