COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF CORRECTIONS

Good Morning Chairman Vance, Chairman Kitchen and all the members of the Senate Public Health and Welfare Committee,

My name is Lynn Patrone. I am the Mental Health Advocate for the Department of Corrections (DOC).
Without reservation, the Pennsylvania Department of Corrections has established a commitment to enhance our mental health system. Considering the systemic changes to mental health policies, procedures, and training initiatives, this evolution represents a time of change for Pennsylvania. With the support and direction of Secretary Wetzel, the Pennsylvania Department of Corrections is dedicated to executing this transformation as one team. The Department is proud of the reputation as a leader in corrections and will continue to embody positive change, especially with the delivery of our mental health services. We have implemented significant policy changes to improve what we offer to inmates struggling with mental illness, co-occurring drug and alcohol disorders, and intellectual disability.

Before I share what the state of our behavioral healthcare system within the Department of Corrections is, I would like to take a moment to paint a picture of the populations incarcerated within our Institutions. DOC serves 50,000 inmates of which 15,000 have a diagnosable mental illness, 8%,

over 1, 200, of which have a serious and persistent mental illness, such as major clinical depression, schizophrenia and bipolar. Initially, every inmate entering the Diagnostic and Classification Center is given a psychological evaluation and if results warrant, a Personality Assessment Inventory will be conducted by psychology.

DOC operates mental health communities with access to almost every type of programming that can be found in the community. All programming is delivered based on the recovery principles of choice, hope, empowerment, person centered, respect, dignity and individually driven. Our goal is to ensure that inmates with a mental illness are placed in the level of care that is commensurate with their behavioral health needs. A few examples of treatment units that we have include: Secure Residential Treatment Units, Behavioral Management Units, Residential Treatment Units and Diversionary Treatment Units (DTUs). These are units specifically designed to provide inmates that have identified mental health issues and numerous restricted housing placements a diversionary program, with multidisciplinary teams that will help him /her return to the general population when appropriate. They have a different look and feel that other units-you will see murals painted by the inmates, inspirational quotes and a more therapeutic environment to promote recovery. A few of our therapeutic approaches in the MH programs include: Cognitive Behavioral Therapy and Dialectical Behavioral Therapy. We also operate Mental Units (MHUs) currently at: Graterford, Rockview, Pittsburgh, Muncy (all women prison), and Waymart (Forensic Treatment Center-Long term mental health care). The process for admission to one of the MHUs is the need for a commitment, which would occur just as it does within the

community. Just as in the community, SCIs are bound by the Mental Health Procedure's Act.

What has struck me in the facilities that I have visited has been the level of commitment by the staff from the Correctional Officers to the clinical teams that work in the specialized mental health units. Many of the inmates with a Serious Mental Illness (SMI) do not receive visitors and are serving their time and trying to recover from a mental illness with no family support. The Correctional Officers and other mental health staff have become their support system.

Other systemic and cultural improvements include, Suicide Prevention Committees in every SCI, and suicide companion watch. The Committees consist of multidisciplinary professionals who meet monthly, review critical incidents, recommend policy changes, and evaluate facility processes and procedures as they relate to suicide prevention. Additionally, the department has drastically enhanced the requirements and procedures for clinical reviews of self-injurious behaviors, suicide attempts, and completed suicides. One other monumental change department has executed is the implementation of recovery-based Individual Treatment Plans (ITP). Every individual completes an ITP with their own goals stated in their own words.

The Department also recognizes the need for system wide training initiatives. A few examples of changes implemented in this area include Mental Health 1st Aid. Ninety-nine percent of staff have been trained in MH 1st Aid and every facility has staff who have receive Crisis Intervention Training. Additionally, we have trained and introduced Certified Peer Specialists (Peers) in every facility and are realizing significant positive

outcomes from this investment. It's important to note that this is an investment in our inmates who are trained as Peers and in the inmates who receive the service. Inmates that are employed as Peers receive the highest pay grade and personal reward. This has been a very successful program as the Peers can be used in situations to deescalate someone who may be struggling emotionally as well as part of the trauma care teams at our female State Correctional Institutions (SCI) or for an inmate that may be incarcerated for the first time.

With the expansion of Medical Assistance (MA), we have an initiative underway with the Department of Human Services to ensure that inmates are enrolled in MA upon release. I mentioned earlier, DOC releases 1200 inmates monthly. The daily batch file transfer between Departments begins well before the release date, with an effective date for eligibility being the date of release. This process enhances our opportunity to do reentry planning early enough to coordinate community treatment services because of the accessibility of MA. This process will result in continuity of care and cost effectiveness and allows resources to be better spent on developing strong home plans and other needs. We anticipate that we will see less recidivism with this process.

It's important to discuss the point of entry to the correctional system and diversions that can be implemented. We need to have an increase in Crisis Intervention Training (CIT) to local first responders and law enforcement, mental health courts and specialized crisis emergency services where individuals that are in a crisis can go for a very short term stabilization period with the linkage to appropriate levels of treatment. If an individual is

exhibiting symptoms of his/her mental illness and encounter law enforcement that may not have specialized training, the outcome can be very different than if an officer is trained in CIT. There is also the issue of homelessness and poverty. Many of the inmates with SMI were homeless prior to incarceration. Too often, individuals with mental illness exhibit symptoms of their illness that may lead to an arrest which may be diverted if front end interventions and access to treatments were readily available. The Commonwealth has a shortage of psychiatrists and there can be a wait period of months in accessing a psychiatrist. There are models of social and therapeutic approaches that are promising which could be considered such as the Fairweather Lodge Model. This is a program that is inclusive in rooted in independence through providing individuals the tools to be contributing members of our communities. It helps people reintegrate themselves into the community through an environment that is built on emotional support, a place to live, and employment for its members. The program was developed by Dr. George Fairweather in California in 1963 as a result of extensive experimental research. In his studies, Dr. Fairweather found that people with serious mental illness are less likely to return to the hospital when they live and work together as a group, rather than live and work individually as well as helping people stay in the community longer.

It’s also critical to address the housing issues both on the front end as an intercept and on the back end as a step down. If we cannot ensure that individuals with a serious mental illness do not have access to the basics, we are not fixing the problem but rather putting a Band-Aid on it. We need to think of this continuum for success from incarceration as Maslow’s Hierarchy of Needs - meet the basics first. These are individuals with very

complex care needs for specialized treatment approaches and much like the success of the Community Hospital Integration Project Program (CHIPP), we need a similar approach for those at risk for incarceration or being released. As we strive to create successful transition planning for those with mental illness, I am very excited to share an innovative program.

We are creating a Community Correction Center in Wernersville to serve inmates who have a mental illness and are eligible for parole. This facility will be a step down but only for those with a mental illness. This is the first in the Commonwealth. The purpose is to create a transitional reintegration program where the individual continues intensive programming to set the foundation toward successful independent living upon release from the program. This will only be for inmates being paroled that need a structured treatment that consists of life skills, psychiatric rehabilitation, psychotherapy, vocational rehabilitation and others programs. The goal of this structured treatment is to work toward creating a strong home plan. We anticipate that this will need to be expanded across the state. Our intent is to create a model that is a transitional reintegration that serves Berks and the contiguous 5 counties.

DOC has committed to many additional culture-change initiatives that involve relationships with community mental health and criminal justice experts. These initiative include assistance from the National Alliance of Mental Illness to review and improve mental health related policies. Similarly, the department has partnered with the VERA Institute to assess our segregation policies and practices. The collaboration with the VERA institute will also facilitate the ongoing systemic reduction of inmates

confined to segregation. DOC also consulted with the Pennsylvania Mental Health and Justice Center of Excellence to complete a sequential intercept mapping of our correctional mental health system, from reception to reentry. This system-wide mapping assisted the DOC with the identification of gaps in our mental health procedures and ultimately enhanced the placement, identification, treatment planning, and reentry of inmates with mental illness to the community. To this end, the department has refined the definition of serious mental illness with the intent of enabling improved tracking and identification of inmates involved with the departmental disciplinary process. The departmental disciplinary process, as it relates to inmates with mental illness and serious mental illness, has also been greatly augmented. Our hearing examiners received a specialized training on the amendments and new provisions to the disciplinary process. These provisions include enhanced out-of-cell services for inmates in segregation as well as informed sanctioning practices for inmates with mental illness and serious mental illness.

And lastly, the newest innovation that has occurred is the creation of the Office I oversee. The Secretary's Office of Mental Health Advocacy has been created to ensure that mentally ill inmates are receiving care while incarcerated as well as having access to mental health treatment upon release. Working independently of the Psychology Office, this Office directly reports to the Secretary and offers an opportunity to advocate for the behavioral health needs of the inmates while working with the psychology department to review policies and implement changes that guide recovery focused outcomes for the individual. A few examples that we are looking at implementing include a quality assessment survey with

the inmates, which would provide an opportunity for their input on how their treatment is helping with their illness so that we can use this information to improve our care. In the event of a suicide, which we hope to be very rare, the Office will be part of the after suicide clinical analysis to ensure the analysis looks at the suicide from a non-clinical approach and from a certified suicide prevention background. The Office will also enhance the training needs of the staff that work with the mental health population and consider other therapeutic approaches to complement existing programs where appropriate.

Where Do We Go From Here: We average about 5 individuals with a mental illness per month that are maxing out that need housing, services, and other supports. We have a major shortage of placements for them and have particular issues when we encounter the Good Neighbor Rules around placement of offenders with certain crimes. Without increased programs that are available and accessible, we hit brick walls and the likelihood for recidivism is very high. It is critical to implement and increase the use of the early interventions and diversionary programs mentioned earlier. It is our goal to offer the tools, skills, and mental wellness stability and recovery that will begin the journey of success for an inmate being released so that they may successfully reintegrate and have a quality of life that includes employment, social skills, and a mental health foundation with access to health care so that they become and remain law abiding citizens. Thank you for the opportunity to stand before you today.