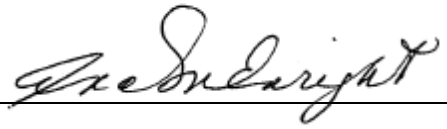
NEW YORK STATE Corrections and Community Supervision **DIRECTIVE**	TITLE **Mental Health Specialized Supervision Standards**		NO. 9230 DATE 10/14/2020
SUPERSEDES DIR #9230 Dtd. 09/26/19	DISTRIBUTION A B	PAGES PAGE 1 OF 8	DATE LAST REVISED
REFERENCES (Include but are not limited to) ACA Expected Practices 4-APPFS-2A-02, 4-APPFS-2A-03, 4-APPFS-2A-07, 4-APPFS-2A-11; Directives #8500, #9025, #9030, #9210, #9301, #9432, #9504	APPROVING AUTHORITY 		

I. PURPOSE: The purpose of this directive is to establish a system of supervision standards for certain eligible individuals with mental illness, and to successfully manage this population's reintegration into society and transition to community supervision.

II. POLICY: It is the policy of the Department of Corrections and Community Supervision (DOCCS) to provide a community reintegration program to eligible persons with mental illness on parole, conditional release and post-release supervision. The Mental Health Community Reintegration Program (MHCRP) will provide specialized supervision in order to enhance public safety, quickly engage parolees, and connect them with appropriate services in the community so as to address case risks and needs.

The Parole Officers (PO) will supervise parolees assigned to the MHCRP as set forth in this directive and will make all contacts as necessary to assist these parolees in the successful completion of parole, conditional release or post-release supervision.

Persons supervised as an MHCRP case are subject to the directives, policy, procedures, and guidelines of DOCCS, except as otherwise noted in this directive.

III. DEFINITIONS

A. OMH Level 1: Seriously mentally ill individual and/or requires on-site, dedicated staff from an outpatient clinic with the highest level of mental health services available (e.g., residential crisis treatment program, special programs, residential treatment, etc.).

B. OMH Level 2: Stable individuals who may or may not be Seriously Mentally Ill (SMI), who are compliant with mental health treatment, may require medication and can be maintained with outpatient clinic services with dedicated staff on-site (no crisis or special programs). Parolees designated an OMH Level 2 without the "S" indicator are to be supervised upon their release from prison as a COMPAS Level 1 case assigned to regular supervision and are not considered MHCRP cases. After 12 months of uninterrupted supervision, the Case Supervision Review instrument will be utilized to determine if the parolee supervision level should be lowered or maintained.

OMH Level 1S or 2S (Prison "S" Designated): Individuals who have been designated SMI due to possessing one or more of the following diagnoses: Schizophrenia (all sub types); Delusional Disorder; Schizophreniform Disorder; Schizoaffective Disorder; Brief Psychotic Disorder; Substance/Medication Induced Psychotic Disorder (excluding intoxication and withdrawal); Unspecified Schizophrenia Spectrum Disorder; Major Depressive Disorder; Bipolar Disorder I and II, Unspecified Bipolar Disorder; Severe Personality Disorder (if functionally impaired); actively suicidal or has engaged in a recent serious suicide attempt (requires to be deemed a suicide attempt by OMH);

Diagnosed with a mental condition that is characterized by breaks with reality resulting in functional impairments involving acts of self-harm or other behavior that have a serious adverse effect on life, mental and physical health; Organic brain syndrome that results in significant functional impairment; Deteriorating in segregated confinement and experiencing significant functional impairment.

D. SMI V- Indicator: The "V" designation was developed by OMH to indicate known patterns of violence. Two or more violent felony offenses or one homicide in the community will generate a "V" designation. Institutional violence is addressed through treatment but is not factored into a "V" indicator. The "V" mental health service level designation can be found on the Security Classification screen on the DOCCS computer system (FPMS).

E. Serious Mental Illness - Community Standard: Individuals who have been designated Seriously Mentally Ill due to possessing one or more of the following diagnoses: Schizophrenia (all sub-types), Delusional Disorder, Schizophreniform Disorder, Schizoaffective Disorder, Brief Psychotic Disorder, Unspecified Schizophrenia Spectrum Disorder, Major Depressive Disorder, Bipolar Disorder I and II, Unspecified Bipolar Disorder, Borderline Personality Disorder (if functionally impaired), Post Traumatic Stress Disorder (PTSD) (if functionally impaired).

F. Assisted Outpatient Treatment (AOT): Court-ordered treatment to ensure that individuals with mental illness and a history of hospitalizations or violence comply with community-based mental health treatment.

G. Intensive Case Manager (ICM): Many ICM programs are designed to offer 24-hour/7 days per week intensive individual support through a case manager to eligible recipients who may have demonstrated risk factors and/or a history of not successfully being able to manage community living.

H. Assertive Community Treatment (ACT): Provides recipients with an integrated set of evidence-based treatment, rehabilitation, case management and support services delivered by a mobile, multi-disciplinary mental health treatment team.

IV. PROCEDURE

A. Parole Officer Responsibility

1. New Releases, Re-releases and Transfers

   a. POs will prepare for the release of MHCRP cases from DOCCS custody. PO's will review all information and documents available relative to the case, including any discharge plan developed by the NYS Office of Mental Health (OMH). If a discharge plan has not been received within a month of the proposed release date, the PO will contact the Offender Rehabilitation Coordinator (ORC) assigned to the inmate and request a copy of the discharge plan, who will in turn contact OMH. The PO should request assistance from Re-entry Services whenever difficulties arise with obtaining a discharge plan.

   b. MHCRP 15:1 cases will be those SMI individuals released from incarceration who also possess the "V" indicator due to having been determined to have a propensity for violence.

These cases will be supervised as a MHCRP 15:1 case for the first 24 months of unrevoked supervision, then automatically convert to a MHCRP 25:1 case (unless approved by an Assistant Commissioner to remain as a MH 15:1 case, see Section V-E). After 12 additional months of unrevoked supervision as a MHCRP 25:1 case, a Case Supervision Review (CSR) will be completed, at which time staff will follow established CSR protocols.

NOTE: If the CSR instrument recommends raising the Supervision Level, and staff are in agreement, the parolee will then remain a MHCRP 25:1 case (will not revert back to a MHCRP 15:1 designation).

c. MHCRP 25:1 cases will be those SMI individuals released from incarceration who do not possess the "V" indicator; OMH Level 1 cases; and those parolees who were initially identified as a MHCRP 15:1 case who have completed 24 months of supervision. After 12 months of uninterrupted supervision, the CSR will be utilized to assess whether the individual's supervision level should be changed. If the CSR recommends raising or maintaining the current supervision level, the parolee will remain as a MHCRP 25:1 case and will require another CSR assessment after 12 months of uninterrupted supervision thereafter. If the CSR instrument recommends lowering the supervision level, the parolee will then be designated a COMPAS Level 2 case, and subsequent CSR assessments will be completed in accordance with Directive #9030, "COMPAS Case Supervision Review."

d. POs will coordinate with Reentry Operations Managers to develop community-based resources as needed.

e. The assigned PO will confirm that appropriate transportation plans, when applicable, are in place for MHCRP cases, in conjunction with DOCCS Classification and Movement. If the parolee is undomiciled, staff may be required to provide direct transportation from the releasing facility to a shelter, DSS intake location or emergency housing location. Alternative transportation plans to be conducted by other agency professionals must be identified and submitted to the Bureau Chief or Senior Parole Officer (SPO) for approval.

NOTE: POs are not to place MHCRP parolees, who are not in custody, in restraints during transports, unless the releasing facility indicates safety concerns, or the parolee demonstrates behavior that threatens their own safety or that of the PO. If restraints are deemed appropriate and are utilized, the PO will document it in CMS.

f. The arrival report with the assigned PO or designee is to occur on or within one business day of release. The arrival report will focus on parolee concerns, a review of the conditions of supervision, and review of initial treatment plans. Release of information forms, as required, will be reviewed with the parolee, signed, and copied to the case file.

g. The PO will confirm that the parolee has been released with any prescribed medications, prescriptions, and a Medication Grant Program (MGP) card, if applicable.

Any issues of parolees released from prison without the prescribed medication/scripts will be brought to the attention of facility staff for assistance in problem-solving.

h. The PO of record will review any Assisted Outpatient Treatment (AOT) order in the case and will confirm with the parolee the requirements of any such order.

i. If an Intensive Case Manager (ICM) or Assertive Community Treatment (ACT) provider is assigned to the case, the PO will engage with these professionals to ensure coordination and cooperation as required in the case. The PO will ensure all required release of information forms have been obtained, as required by all parties, and that copies of these forms are filed in the case folder. Special conditions will be imposed requiring the parolee to comply with all treatment services and medication regimens as appropriate.

j. The PO will complete the Individualized Supervision Plan (Case Plan) within 10 business days of release. The PO will engage the parolee in this process and obtain the parolee's feedback in case assessment and setting case goals and objectives. Acute needs and issues of immediacy (e.g., medical, mental health, medication, residence, etc.) must be identified and addressed as soon as possible.

k. The PO will conduct a home visit on all new MHCRP releases, re-releases, or transfers to their caseload within 3 business days of the release or re-release to supervision, or first report to the receiving officer in transfer cases.

l. The PO will review the Individualized Supervision Plan (Case Plan) with any treatment provider included in the treatment plan, the Intensive Case Manager (ICM) if applicable, and any other person(s) deemed significant in the successful supervision of the case.

2. MHCRP 15:1 Cases (Individuals who have been designated as SMI with the "V" indicator) - POs must conduct contacts as follows (see attachment A):

a. POs will conduct one office report each week for the first three months of supervision, followed by no less than two office reports each month thereafter, unless modified after a case conference with the SPO and approved by the Bureau Chief;

b. POs will conduct a minimum of two positive home visits each month;

c. POs will conduct a minimum of two other contacts, one of which must be positive;

d. One curfew visit will be conducted each month. A curfew visit may also count as a mandated monthly home visit;

e. If the parolee is participating in a mental health treatment program, one program visit must be conducted each month.

For treatment programs other than mental health, one program verification must be conducted each month, with a program visit conducted at least bi-monthly;

f. If the parolee is employed, employment verification will be conducted each month;

g. The case plan must address the criminogenic and/or stabilization needs as identified by the COMPAS Assessment Instrument, the PO, and parolee. The Case Plan will first prioritize a parolee's need for a stable residence as well as address the mental health need;

h. When addressing a criminogenic and/or stabilization need, staff will use the designated activity codes and provide detail in the contact narrative of CMS; and

i. The PO will contact Re-entry staff in the event of an outstanding service need.

3. MHCRP 25:1 Cases (Individuals who have been designated as SMI without a "V" indicator; OMH Level 1 cases; and those SMI-V cases who have completed 24 unrevoked months in the community) – Parole Officers must conduct contacts as follows:

   a. POs will conduct a minimum of two office reports each month;

   b. POs will conduct a minimum of one POSITIVE home visit each month;

   c. POs will conduct a minimum of two other contacts per month, one of which must be positive;

   d. One curfew visit will be conducted each month. A curfew visit may also count as a mandated monthly home visit;

   e. If the parolee is participating in a mental health treatment program, one program visit must be conducted each month. For treatment programs other than mental health, one program verification must be conducted each month, with a program visit conducted at least bi-monthly;

   f. If the parolee is employed, employment verification will be conducted each month;

   g. The case plan must address the criminogenic and/or stabilization needs as identified by the COMPAS Assessment Instrument, the PO, and parolee. The Supervision Plan will first prioritize a parolee's need for a stable residence as well as address their mental health need;

   h. When addressing a criminogenic and/or stabilization need, staff will use the designated activity codes and provide detail in the contact narrative of CMS; and

   i. The PO will contact Re-entry staff in the event of an outstanding service need.

4. Supervision Standards Conference (SSC): The SPO will meet with the PO on a monthly basis to conference all MHCRP cases. The SPO will ensure during the SSC that any identified criminogenic and/or stabilization needs are being addressed adequately. Upon completion of the review and assessment, the SPO will advise the assigned PO of any issues requiring attention and document accordingly in CMS. Supervision Standards Conferences will be entered in CMS using Contact Code "SSC" – Supervision Standards Conference.

5. Pre-delinquent Behavior Mandatory Case Conference (CC): For all supervision levels, in the event an individual exhibits any pre-delinquent behavior, such as but not limited to a failure to report, a positive drug test or curfew violation, the Parole Officer must case conference with the Senior Parole Officer or higher rank within 24 hours of the pre-delinquent behavior. The case conference must be entered in CMS using Contact Code "CC
6. Substance Abuse Testing: In all cases where there is a COMPAS identified substance abuse need, the PO will administer Department approved substance abuse testing in compliance with the testing frequency as outlined in Directive #9432, "Substance Abuse Testing."
7. Failure to Report: Upon the parolee's failure to report as directed, the PO must attempt to re-engage the parolee within 24 hours. Failing to make contact with the parolee by any means within 24 hours will necessitate a home visit being conducted by the PO, to the approved residence, within 48 hours.
8. The PO will work closely with the ICM/service provider and DOCCS Re-entry Services to secure emergency/crisis psychiatric evaluation assistance for any parolee who appears to have decompensated in the community.

NOTE: For any MHCRP parolees who are hospitalized, the PO will make contact on a weekly basis with a hospital representative (i.e. doctor, case manager, social worker, etc.) to confirm the location and status of the parolee. At minimum, confirmation by way of a visit will be conducted on a monthly basis.

B. Interagency Team Approach: In addition to case supervision practices, PO's will establish working relationships with those professionals providing case services (i.e., mental health treatment providers, ICM, ACT provider, substance abuse provider), DOCCS Bureau of Mental Health staff, staff in local psychiatric hospitals to which parolees may be psychiatrically committed and from which they may be discharged back to the community, and also family members or other individuals who provide significant support to the parolee.

C. Training: SPOs and POs supervising MHCRP cases will participate in ongoing trainings as they become available to expand their knowledge and expertise in areas regarding mental illness such as: psychiatric diagnosis and serious mental illness; psychotropic medications and side effects; community resources for housing, treatment, emergency services, and other program interventions; recognizing signs and symptoms of psychiatric decompensation; handling challenging parolees; and openly discussing mental health issues with parolees, etc..

D. Senior Parole Officer (SPO) Responsibility: The SPO is responsible for ensuring that the PO provides the necessary level of supervision to foster public safety and assist the parolee's successful completion of community supervision.

1. At a minimum, the SPO will meet with the PO to conference cases on a monthly basis. Cases will be reviewed to determine if the PO has developed a structured Case Plan for the parolee and is adequately managing the caseload.
2. The SPO will observe the PO and parolee interactions, both in the field and in the office. This type of case supervision affords the SPO an opportunity to personally assess a parolee's adjustment.

3. The SPO will assist POs in the establishment of working relationships with professionals who provide services to the MHCRP cases.
4. The SPO will routinely review CMS to ensure that the PO is providing the case-specific level of supervision required.

E. Bureau Chief Responsibility: Bureau Chiefs will ensure that SPOs and POs are in compliance with this policy and are assisting parolees with treatment, and with the successful completion of community supervision.

1. The Bureau Chief will ensure that all MHCRP 15:1 and 25:1 parolees have the required COMPAS Level 1 supervision status.
2. The Bureau Chief has the discretion to submit an email to Quality and Control requesting MHCRP 25:1 designation for any case released to the community who was not identified as SMI while incarcerated, but who displays serious mental health needs while in the community requiring a heightened level of supervision.

F. Regional Director/Assistant Regional Director Responsibility: The Regional Director/Assistant Regional Director will ensure that all MHCRP cases in the region are supervised appropriately at all times, focusing on assisting the parolee's successful completion of community supervision. The Regional Director/Assistant Regional Director has the discretion to adjust supervision standards, if needed, to assist parolees in the successful completion of community supervision and treatment. All adjustments to supervision standards must be documented and detailed in CMS.

G. Assistant Commissioner Responsibility: The Assistant Commissioner will have the sole authority to override the automatic changeover of a MHCRP 15:1 case to a MHCRP 25:1 case. The Assistant Commissioner will review such requests received from staff through their Chain of Command. If the Assistant Commissioner agrees to the override request, an email will then be sent to Quality and Control approving the override.

H. Quality and Control: Upon receiving an email from the Assistant Commissioner approving an override of the automatic changeover of a MHCRP 15:1 case to a MHCRP 25:1, Quality and Control staff will enter a Miscellaneous Data record noting "MH Override" in the "Type" field, and in the "Detail" field enter "15 To 1."

I. Re-entry Services Responsibility: The Mental Health Assistant Re-entry Managers (MHAREM) are expected to work closely with the POs who supervise the MHCRP cases and assist staff with other parolees who may have mental health issues and possess complex discharge planning needs.

1. At a minimum, on a monthly basis the MHAREM will review on CMS all of the MHCRP cases assigned to the Region to ensure that services are in place and determine if the required minimum supervision standards are being met. Any noted deficiencies will be brought to the attention of the Re-entry Manager (REM), who will in turn notify the Assistant Regional Director/Regional Director.
2. The MHAREM will assist POs who supervise MHCRP cases with obtaining the OMH discharge plans as needed.

SUPERVISION STANDARDS: MENTAL HEALTH COMMUNITY REINTEGRATION PROGRAM		
MHCRP 15:1 Case	Monthly (5 Face-to-Face Contacts Required)*	Supervision Duration
	2 Office Reports (Weekly for first three months) 2 Home Visits Positive 2 Other Contacts (1 must be positive) 1 Program (Mental Health) Visit 1 Program (Non-Metal Health) Verification 1 Employment Verification 1 Curfew Visit Required 1 Supervision Standards Conference	- MHCRP 15:1 cases (SMI-V) will retain this Supervision Status for the first 24 months of unrevoked supervision. - After 24 months of unrevoked supervision will automatically convert to a MHCRP 25:1 case (unless overridden by an AC). - A CSR will then be completed after 12 months of unrevoked supervision as a MHCRP 25:1 case.
MHCRP 25:1 Case	Monthly (4 Face-to-Face Contacts Required)	Supervision Duration
	2 Office Reports 1 Home Visit Positive 2 Other Contacts (1 must be positive) 1 Program (Mental Health) Visit 1 Program (Non-Mental Health) Verification 1 Employment Verification 1 Curfew Visit Required 1 Supervision Standards Conference	- MHCRP 25:1 cases (OMH 1, SMI Non-V, and SMI-V cases who have completed 24 months as a 15:1 case) will retain this Supervision Status for the first 12 months of unrevoked supervision. - A CSR will be completed after 12 months of unrevoked supervision, and every 12 months thereafter with Supervision Level changes made in accordance with the CSR directive.

*NOTE: For MHCRP 15:1 cases, for the first three months of supervision, a monthly total of seven face-to-face contacts are required due to the weekly office reports; this transitions to the required five face-to-face contacts after three months of supervision. All pre-delinquent behavior will require a Case Conference (CC) with a SPO or person of higher rank within 24 hours and must be documented in CMS.