Study of the Treatment of Persons with Mental Illness in the Criminal Justice System

Report to the

COLORADO

GENERAL ASSEMBLY

Colorado Legislative Council
Research Publication No. 457
November 1999

RECOMMENDATIONS FOR 2000

STUDY OF THE TREATMENT OF PERSONS WITH MENTAL ILLNESS IN THE CRIMINAL JUSTICE SYSTEM

Report to the
Colorado General Assembly

Research Publication No. 457
November 1999

COLORADO GENERAL ASSEMBLY

EXECUTIVE COMMITTEE
Sen. Ray Powers, Chairman
Rep. Russell George, Vice Chairman
Sen. Tom Blickensderfer
Sen. Michael Feeley
Rep. Doug Dean
Rep. Ken Gordon

STAFF
Charles S. Brown, Director
David Hite, Deputy Director

COMMITTEE
Sen. Ken Chlouber
Sen. Gigi Dennis
Sen. Rob Hernandez
Sen. Doug Lamborn
Sen. Pat Pascoe
Sen. Bill Thiebaut
Rep. Bob Bacon
Rep. Dorothy Gotlieb
Rep. Dan Grossman
Rep. Steve Johnson
Rep. Shawn Mitchell
Rep. Lola Spradley

LEGISLATIVE COUNCIL

ROOM 029 STATE CAPITOL
DENVER, COLORADO 80203-1784
E-mail: lcs.ga@state.co.us
303-866-3521 FAX: 303-866-3855 TDD: 303-866-3472

November 1999

To Members of the Sixty-second General Assembly:

Submitted herewith is the final report of the Study of The Treatment of Persons with Mental Illness in the Criminal Justice System. The interim study was created pursuant to House Joint Resolution 99-1042.

At its meeting on November 15, 1999, the Legislative Council reviewed the report of this committee. A motion to forward this report and the bills therein for consideration in the 2000 session was approved.

Respectfully submitted,

/s/
Senator Ray Powers
Chairman
Legislative Council

RP/CB/rm

TABLE OF CONTENTS

RECOMMENDED BILLS AND FISCAL NOTES

Study of
The Treatment of Persons With Mental Illness in the Criminal Justice System

Members of the Committee

Representative Steve Tool
Chairman
Representative Kenneth Kester
Representative Gloria Leyba

Senator Norma Anderson
Vice Chairman
Senator Bob Martinez
Senator Dottie Wham

Legislative Council Staff

Cynthia Bihms
Research Associate

Carl Jarrett
Senior Analyst

Office of Legislative Legal Services

Julie Pelegrin
Senior Staff Attorney

Beth Braby
Staff Attorney

Advisory Task Force on the Study of The Treatment of Persons With Mental Illness in the Criminal Justice System

Mr. Ray Slaughter, Chairman
Division of Criminal Justice

Ms. Barbara McDonnell, Vice-Chairman
Department of Law

Dr. Tom Barrett
Department of Human Services

Mr. John Befus
Department of Human Services

Ms. Nita Bradford
Family Member of Mentally Ill

Sheriff George Epp
County Sheriffs of Colorado

Chief Bruce Goodman
Colorado Chiefs of Police

Ms. Kim Jensen
Mental Health Institute at Pueblo

Dr. Dennis Kleinsasser
Department of Corrections

Ms. Beth Krulewitch
Colorado Criminal Defense Bar

Judge John Leopold, Alternate
Judicial Department

Judge John Popovich, Alternate
Judicial Department

Ms. Niki Moore
Community Corrections

Mr. Eric Philp
Judicial Department

Ms. Kathy Sasak
Colorado District Attorneys Council

Ms. Susan Spinicken
Family Member of Mentally Ill

Ms. Lisa Sullivan
Mental Health Professional

Dr. Mary West
Department of Corrections

Mr. Maurice Williams
Mental Health Professional

Mr. Doug Wilson
Colorado Criminal Defense Bar

Executive Summary

Committee Charge

House Joint Resolution 99-1042 directed a six-member legislative committee and a 19-member advisory task force to study the treatment of mentally ill persons in the criminal justice system. The charge included a study of prosecution, sentencing, diagnosis, housing, placement, on-going treatment and medication monitoring for mentally ill adult and juvenile offenders.

Committee Activities

The interim committee met six times during the interim session. The committee was briefed by its advisory task force *(members listed on page 2)* and discussed numerous issues concerning offenders with mental illnesses. The advisory task force met seven times and formed three subgroups that met on numerous occasions to study issues as directed by the interim committee. A summary of recommendations by the advisory task force are included as Appendix A.

Committee Recommendations

As a result of committee discussion and deliberation, the committee recommends four bills for consideration in the 2000 legislative session.

Bill A — Concerning Continued Examination of the Treatment of Persons with Mental Illness who are Involved in the Criminal Justice System and Making an Appropriation Therefor. This bill authorizes a three-year continued examination of mentally ill persons in the criminal justice system. It establishes a six-member legislative oversight committee and a 27-member advisory task force to examine broad issues related to treating mentally ill persons in the criminal justice system.

Bill B — Concerning Creation of Community-Based Management Pilot Programs for Persons with Mental Illness Who Have Been Charged with a Criminal Offense. This bill authorizes the Department of Human Services (DHS) to issue a request for proposals and select two entities, one in a rural community and one in an urban community, to operate an adult offender community-based intensive treatment management pilot program. It also authorizes the DHS to select two entities, one in a rural community and one in an urban community, to operate similar pilot programs for juveniles.

Bill C — Concerning Eligibility of Institutionalized Persons for Aid to the Needy Disabled. This bill allows persons who are diagnosed with a mental illness, disease, or psychosis, and who are in public institutions (correctional facilities and mental health hospitals) to apply for "Aid to the Needy Disabled" benefits 90 days prior to release from the public institution to expedite the receipt of benefits in order to continue on-going medical treatment after release.

Bill D — Concerning the Development of a Standardized Screening Process for Mentally Ill Persons in the Criminal Justice System. This bill authorizes the Judicial Department, the Department of Corrections, the State Parole Board, the Division of Criminal Justice in the Department of Public Safety, the Alcohol and Drug Abuse Division and the Division of Mental Health Services in the Department of Human Services, to develop a standardized inter-agency screening process to detect mental illness in persons in the criminal justice system.

STATUTORY AUTHORITY AND RESPONSIBILITIES

The study of the treatment of persons with mental illness in the criminal justice system was precipitated by a 1998 report by a multi-agency task group formed by the Colorado Department of Corrections (DOC) at the request of the Joint Budget Committee.[1] The Joint Budget Committee requested a report because of the unexpected shift in institutional placements and the increased number of offenders with serious mental illnesses. The findings of the multi-agency task group prompted the adoption of House Joint Resolution 99-1042.

House Joint Resolution 99-1042 directed the Speaker of the House of Representatives to appoint three members, the President of the Senate to appoint two members, and the Senate Minority Leader to appoint one member to the Interim Committee on the Study of the Treatment of Persons with Mental Illness in the Criminal Justice System. The Speaker of the House appointed the chairman and the President of the Senate appointed the vice-chairman of the interim committee.

The committee's charge included, but was not limited to, a study of:

- early identification, diagnosis, and treatment of adults and juveniles with a mental illness who are charged with a criminal offense;
- prosecution and sentencing alternatives for persons with mental illness that may involve treatment and ongoing supervision;
- diagnosis, treatment, and housing of mentally ill persons who are convicted of crimes or plead guilty, nolo contendere, or not guilty by reason of insanity or who are found incompetent to stand trial;
- civil commitment of persons with mental illness who are criminally convicted, found not guilty by reason of insanity, or found incompetent to stand trial;
- ongoing treatment and supervision of mentally ill adults and juveniles, especially with regard to medication, who are convicted or adjudicated and housed within the community, or are on probation or parole;
- ongoing supervision with regard to medication after discharge from a sentence; and

1. *Offenders with Serious Mental Illness: Appendices.* Colorado Department of Corrections. Multi-agency Task Group. November 1998. (The multi-agency task group included representatives of the Department of Corrections, the Judicial Department, the Divisions of Youth Corrections and Mental Health Services in the Department of Human Services, the Division of Criminal Justice in the Department of Public Safety, the Division of Probation in the Judicial Department, and the University of Colorado Health Sciences Center forensic psychiatry unit.)

- other issues concerning persons with a mental illness who are involved with the criminal justice system.

The chairman and vice-chairman of the interim committee were authorized to appoint a 19-member advisory task force as specified in HJR 99-1042 to assist the committee in its study. The state departments, divisions, and private agencies represented on the advisory task force are listed below, followed by the name of the individual representing the state department, division, or private agency.

Department of Public Safety **Division of Criminal Justice**	—	Mr. Ray Slaughter, Director, Division of Criminal Justice
Judicial Department	—	Judge John Leopold, 18th Judicial District, *rotated* with Judge John Popovich, 17th Judicial District
Probation Division	—	Mr. Eric Philp, Director, Probation Services
Department of Corrections	—	Dr. Dennis Kleinsasser, Director, Correctional Programs
Division of Parole	—	Dr. Mary West, Deputy Director Special Operations and Community Services
Department of Human Services **Division of Youth Corrections**	—	Mr. John Befus, Director of Medical and Psychological Services
Division Mental Health Services	—	Dr. Tom Barrett, Director of Mental Health Services
Mental Health Institute at Pueblo	—	Ms. Kim Jensen, Associate Manager, Office of Direct Services
Department of Law	—	Ms. Barbara McDonnell, Chief Deputy Attorney General
Community Corrections	—	Ms. Niki Moore, Executive Director, Colorado Community Corrections Coalition
Local Law Enforcement	—	Sheriff George Epp, Boulder County Chief Bruce Goodman, Louisville Police Department
District Attorney's Council	—	Ms. Kathy Sasak, Assistant District Attorney, Jefferson County
Criminal Defense Bar	—	Ms. Beth Krulewitch, Levanthal Law Firm Mr. Doug Wilson, Pueblo Public Defender
Practicing Mental Health Professionals	—	Ms. Lisa Sullivan, Executive Director, Independence House Mr. Maurice Williams, Denver Regional Director, Division of Youth Corrections
Family Members of Mentally Ill Persons Who Have Been Involved in Colorado's Criminal Justice System	—	Ms. Nita Bradford , NAMI [2] Ms. Susan Spincken, Guardians Support Alliance for Families of Mentally Ill Children

2. National Alliance for the Mentally Ill

Committee Activities

In order to learn about the scope of issues surrounding mentally ill persons in the criminal justice system, the interim committee heard public testimony from members of the advisory task force and representatives from the Social Security Administration, therapeutic mental health communities, community corrections agencies, and community mental health service agencies. Representatives from the Department of Education, housing advocates, community mental health service providers, and consumers of correctional and mental health services also participated in deliberations of the advisory task force. The interim committee and advisory task force toured the San Carlos Correctional facility and the Colorado Mental Health Institute at Pueblo.

Prevalence of Mentally Ill Persons in the Criminal Justice System

This section discusses national and state statistics regarding the number of incarcerated mentally ill offenders. The interim committee found that the rise in the number of incarcerated mentally ill offenders is not unique to Colorado. The rising number of incarcerated mentally ill offenders is reported to be the result of the lack of availability of community mental health treatment services and the deinstitutionalization of the mentally ill. The National Alliance for the Mentally Ill (NAMI) and other advocates for mentally ill claim that prisons have become the mental hospitals of the 1990s.[3]

National statistics. A study published in July 1999 by the U.S. Department of Justice, indicated that at mid-year 1998, an estimated 283,800 mentally ill offenders were incarcerated in the nation's prisons and jails.[4] The study indicates that a U.S. Bureau of Justice Statistics survey found that 16 percent of state prison inmates, 16 percent of local jail inmates, and seven percent of federal prison inmates reported having a mental condition or an overnight stay in a mental hospital at some point in their life prior to incarceration. In addition, 61 percent of state prison inmates and 41 percent of local jail inmates had received counseling, medication, or other mental health services prior to their current incarceration.

Colorado statistics. In October 1999, the Colorado Department of Corrections (DOC) reported that approximately 11 percent of state prison inmates have a serious mental

---

3. *NAMI Calls for Congressional Hearings Following Justice Department Report Lack of Treatment Cited as Cause of Criminalization of Mental Illness: Executive Actions Also Proposed.* Press Release via NewsEdge Corporation, Arlington, VA. July 13, 1999

4. *Mental Health and Treatment of Inmates and Probationers.* U.S. Department of Justice, Bureau of Justice Statistics, Special Report. Washington, DC. July 1999

illness.[5] The DOC reported that the number of inmates with a major mental illness is twice the number identified in 1996, and five to six times higher than the number identified in 1988. The DOC further reported that prior to incarceration, most of the inmates who were diagnosed as having a mental illness were homeless, substance abusers, reported physical or sexual abuse, had several medical problems, or had been treated for or diagnosed with a mental illness during childhood.

In October 1999, the Division of Youth Corrections (DYC) reported that approximately 22 percent of juveniles in its legal custody have moderate to severe mental health problems requiring psychiatric treatment. The DYC reported that mentally ill youths present different mental health problems than mentally ill adults. The DYC defines youths with mental disorders as those with attention deficit hyperactivity disorder, depression, learning disabilities, anxiety, impaired thinking, and eating disorders in addition to the major types of mental illnesses.

Defining Mental Illness

This section provides basic definitions of major mental illnesses. The following definitions were obtained from the Colorado Behavioral Healthcare Council:

- **panic disorder** - sudden intense and overwhelming fear for no apparent reason;
- **bipolar disorder** - fluctuating episodes of extreme depression and mania;
- **major depression** - severe and continuous feelings of sadness that may result in decreased activity, loss of appetite, sleeplessness, and senses of guilt and hopelessness;
- **schizophrenia** - confused thoughts, communication problems and sudden mood swings; and
- **obsessive-compulsive disorder** - continuous interruption by unwanted thoughts and the constant performing of specific actions.

Statutory definitions. Colorado has statutory definitions for: 1) mentally ill person, 2) biologically-based mental illness, and 3) major mental illness. The definitions follow:

- Section 27-10-102 (7), C.R.S., governing care and treatment of mentally ill persons defines **mentally ill person** as *"a person with a substantial disorder of the cognitive, volitional, or emotional process that grossly impairs judgement or capacity to recognize reality or to control behavior."*

5. Offender Programs Report. *Offenders with Serious Mental Illness: A Multi-agency Task Force Report to the Colorado Legislature.* Civic Research Institute, Inc., Kingston, NJ. September/October 1999

- Section 10-16-104 (5.5) (a) (II), C.R.S., governing mandated health insurance coverage (commonly referred to as the parity bill), defines **biologically-based mental illness** as *"schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder, and panic disorder."*
- Section 26-4-673 (1) (a), C.R.S., governs eligibility for home- and community-based services for persons with **major mental illnesses.** The statute includes *schizophrenic, paranoid, major affective, schizoaffective disorders, and atypical psychosis* as major mental illnesses. The statute also specifies that major mental illness includes primary diagnoses as such terms are defined in the Diagnostic and Statistical Manual of Mental Disorders used by the mental health profession.

Diagnostic and Statistical Manual (DSM). The Diagnostic and Statistical Manual of Mental Disorders (DSM) is a manual prepared by the American Psychiatric Association in Washington, DC. The DSM IV (1994) is the current edition which is used by mental health professionals in Colorado. The manual contains sets of diagnostic criteria regarding mental disorders and is used to improve the reliability of mental health diagnoses. The diagnostic criteria for each mental disorder serves as a guideline for making a diagnosis and enhances agreement among clinicians and investigators. Proper use of criteria in the DSM IV requires specialized clinical training.

Overview of Colorado's Mental Health System

This section provides an overview of Colorado's mental health system. It also discusses the Institute for Forensic Psychiatry (IFP) at the Mental Health Institute at Pueblo, and Colorado's Medicaid Mental Health Capitation and Managed Care Program.

Overview

The interim committee learned that Colorado has 17 community mental health centers, 61 residential treatment centers, 52 mental health facilities, seven mental health assessment and service agencies (MHASAs), six speciality clinics, and two mental health institutes. The goals of Colorado's mental health system are to:

- provide quality services and outcomes to mentally ill persons through a comprehensive system of care by utilizing a consumer, family and community-based treatment approach;
- promote collaboration and coordinate services among providers, agencies, and communities; and
- provide equitable services to Medicaid and non-Medicaid eligible recipients.

Community mental health centers. Colorado's community mental health centers are statutorily required to provide certain minimum prevention and treatment services which include: inpatient, outpatient, partial hospitalization, residential treatment, emergency, consultation, and educational services.[6] However, Colorado's mental health centers provide core services that extend beyond the statutory requirements and include:

- ✓ assessment;
- ✓ prevention;
- ✓ early intervention;
- ✓ crisis;
- ✓ vocational;
- ✓ day treatment;
- ✓ case management;
- ✓ family support;
- ✓ interagency consultation;
- ✓ medication management;
- ✓ rehabilitation;
- ✓ school-, home- and intensive-based services;
- ✓ clinical treatment;
- ✓ consumer advocacy;
- ✓ residential support; and
- ✓ peer counseling.

Mental health assessment and service agencies. Section 26-4-528, C.R.S., establishes mental health assessment and service agencies (MHASAs). MHASAs provide services to targeted Medicaid-eligible populations. Targeted groups are considered to be persons who most need mental health services. Targeted groups under the MHASA system include:

- adults (age 21 and over) and older adults (age 65 and older) with serious and persistent mental illness (SPMI). Persons in this category have a mental illness which seriously impairs their ability to be self-sufficient, and who have been persistently ill for more than one year or have been hospitalized for intensive mental health treatment;
- adults and older adults with serious mental illness (SMI). Persons in this category have schizophrenia or severe affective disorders but do not meet the definition of persistent because of the duration of their illness, or have had less intensive mental health treatment or levels of dysfunction; and
- children and adolescents (0 to 17 years of age) with serious emotional disturbances (SED). Persons in this category have emotional or mental health problems that significantly impair their ability to function and place them at-risk for out-of-home placement.

MHASAs must also provide court-ordered mental health services to clients, including inpatient hospitalization for clients under age 21 and clients age 65 and over at the State Mental Health Institutes at Pueblo and Fort Logan. MHASAs are responsible for the costs of mental health services for involuntarily committed persons who commit crimes and are on conditional releases. Other MHASA services include outpatient, residential, physician, rehabilitation, psychosocial rehabilitation, medication management, emergency, and case management services.

---

6. Section 27-10.3-103 (2), C.R.S.

Residential treatment centers. Residential Treatment Centers serve persons of all ages who need 24-hour supervised care due to a mental illness. The centers serve as an alternative to inpatient hospitalization. The Child Mental Health Act (House Bill 99-1116) requires that residential treatment services be provided to mentally ill children without going through the dependency and neglect process as well as children in the child welfare system. The act authorizes care for children who are covered under Medicaid and who are at-risk of an out-of-home placement. Residential services are available in varying degrees of intensity.

Mental health facilities. Of Colorado's 52 mental health facilities, approximately 23 are authorized to conduct mental health evaluations and hold mentally ill persons for up to 72 hours. These facilities are commonly called "27-10" facilities, which term refers to the section of Colorado's law (Section 27-10-105, C.R.S.) that authorizes the Colorado Department of Human Services (DHS) to designate certain mental health facilities to conduct mental health evaluations and treat mentally ill persons up to 72 hours.

Speciality clinics. Colorado law authorizes the DHS to designate unlicenced hospitals, residential child care facilities, and community mental health centers as speciality clinics in order to promote expansion of community mental health services and integrate community mental health services with state mental health services.[7] State agencies are authorized to purchase services from speciality clinics which may be designated as 72-hour treatment and evaluation clinics, short-term treatment facilities, or long-term treatment facilities.

Mental health institutes and the Institute for Forensic Psychiatry. Colorado has two state-run mental health institutes and a forensic psychiatry unit at the Mental Health Institute at Pueblo (CMHIP). Colorado's Mental Health Institute at Pueblo is a 552-bed facility with a psychiatric unit called the Institute for Forensic Psychiatry (IFP). The IFP is an inpatient psychiatric treatment facility with a bed capacity of 278, but representatives from the IFP reported that it houses an average of 300 patients. The DOC is allocated 21 beds to house offenders who exhibit severe mental disorders or suicidal tendencies. The remaining IFP unit caseload consists of patients who are:

- ✓ found not guilty by reason of insanity (NGRI);
- ✓ adjudicated incompetent to proceed (ITP);
- ✓ civil commitment transfer cases;
- ✓ mental health evaluation cases; and
- ✓ behavioral management transfer cases.

The Colorado Mental Health Institute at Fort Logan (CMHIFL) is located in Denver. The CMHIFL is a 220-bed facility. Of the 220 beds, none are allocated to the DOC and the DYC is allocated 47 beds for its most severely mentally ill juveniles.

---

7. Section 27-1-203, C.R.S. and 27-1-204, C.R.S.

Colorado Medicaid Mental Health Capitation and Managed Care Program

In 1992, the Colorado General Assembly adopted legislation authorizing the Departments of Human Services (DHS) and Health Care Policy and Financing to implement a pilot program to provide comprehensive mental health services to Medicaid recipients. The DHS reported that approximately 44 percent of the consumers of Colorado's mental health services are Medicaid recipients. The DHS also reported that the mental health capitation program is a contributing factor to the lengthy waiting lists for non-Medicaid eligible persons to obtain mental health services.

Special Needs Mentally Ill Offenders

The committee found that some mentally ill offenders have special needs. This section discusses dually-diagnosed, female, and minority mentally ill offenders that were identified by the advisory task force as having special needs.

Dually-diagnosed offenders. Dually-diagnosed offenders are offenders who are diagnosed with a mental illness and a substance abuse disorder. Dually-diagnosed offenders are also referred to as offenders with co-occurring disorders or mentally ill chemical abusers (MICAs). The DOC and community mental health providers report that many mentally ill persons who are on psychotropic medications begin taking alcohol or drugs to combat side effects caused by the psychotropic medications.

A person with a dual-diagnosis of mental illness and substance abuse presents special problems regarding eligibility for disability benefits and placement in community corrections facilities. While a mental illness may qualify an individual for Social Security and Medicaid eligibility, the use of alcohol or drugs prohibits the individual from being eligible to receive benefits. In addition, many local community corrections boards will not accept mentally ill offenders in community corrections facilities if the mentally ill offender is on psychotropic medications.

Female offenders. The DOC reported that mentally ill female offenders have special needs because many have experienced physical or sexual abuse and are sentenced to the DOC for drug or child abuse convictions. Female offenders tend to need specialized therapy regarding issues of awareness, self-esteem, stress and anger management, supportive therapy for child abusers, parenting classes, and sex abuse survivorship.

Minority offenders. The DYC, Department of Human Services, reported that nearly 50 percent of juveniles in its detention, commitment, and client assessment and orientation programs are minorities. The DOC also reported that a significant number of its inmates are minorities. However, few minorities receive mental health services from these agencies because mental health problems go undiagnosed in minority offenders.

The DOC and DYC believe that this is because minorities are unlikely to reveal mental health problems during screening and assessment since minorities are reluctant to talk about problems with someone to whom they can not relate. The DYC and DOC report that the agencies have a shortage of professional minority mental health staff and experience difficulty recruiting minority mental health professionals.

Arrest and Diversion of Mentally Ill Offenders in Colorado

This section discusses how mentally ill offenders are treated from the point of entry into the criminal justice system (arrest) and reviews a jail diversion program which diverts mentally ill misdemeanants from jail into mental health treatment programs.

Arrest. The interim committee heard testimony about how law enforcement officers process mentally ill offenders after an arrest. The interim committee also heard testimony that most mentally ill offenders will not end up in state correctional facilities if appropriate intervention is given at the time of arrest since jails are the starting point for persons entering the criminal justice system.

Representatives of law enforcement reported that most calls to law enforcement agencies involving mentally ill persons are for minor offenses. Law enforcement officers must determine whether to take a mentally ill person to a mental health facility for a mental health evaluation or take them to jail for detainment. Law enforcement officers usually take mentally ill offenders to jail because the threshold to place a mentally ill offender in jail is low compared to the threshold to have a mentally ill offender placed on a mental health hold *(see section on civil commitment, page 11)*.

Representatives of law enforcement also reported that mentally ill offenders have a better chance of being evaluated and admitted in a hospital if they have health insurance and are not under the influence of drugs or alcohol. It was reported that hospital personnel usually direct law enforcement officers to take mentally ill offenders to a detoxification center if the mentally ill person is under the influence of drugs or alcohol. Law enforcement officers in rural areas reported that officers usually take mentally ill offenders to jail because rural communities lack mental health services. In these cases, a mental health professional is called to the jail to conduct a mental health evaluation.

The interim committee found that jail staff are limited in terms of accessing confidential information regarding an offender's mental health history. Local jailers must keep mentally ill offenders from the general population because they do not know whether a mentally ill person will be a danger to others. As a cautionary measure, mentally ill offenders are usually separated from the general jail population for their own safety and protection.

Jail diversion. The committee heard testimony about the jail diversion program in Jefferson County (House Bill 96-1196). The program has been operating since January 1997 and allows class 2 and class 3 mentally ill misdemeanants to be diverted from jail and

into mental health treatment programs. Mentally ill defendants must agree to receive mental health treatment at a local mental health center before a deferred sentence is granted.

The jail diversion treatment team in Jefferson County consists of jail staff, pre-trial services personnel, a probation officer, drug and alcohol treatment providers, and a local mental health provider. Officials of the jail diversion program in Jefferson County reported that mentally ill offenders who are diverted are not receiving needed services such as medication supply and monitoring, on-going treatment, and temporary shelter. The interim committee found that the jail diversion program in Jefferson County has not been successful and identified the following problems:

- ✓ many mentally ill offenders are homeless, resourceless, and are committed to jail on minor infractions which are not class 2 or class 3 misdemeanors;
- ✓ there is no definition of "serious mentally ill" and officials report that progress is nearly impossible without standardized definitions;
- ✓ the statutory definition for mental illness does not include the majority of mentally illnesses from which mentally ill persons suffer and therefore, prohibits them from benefitting from the jail diversion program;
- ✓ there is no entity to ensure compliance by the mentally ill offender and that the mentally ill offender is receiving appropriate treatment;
- ✓ many mentally ill offenders who are eligible for the jail diversion program are released from jail before the treatment teams can give them a mental health evaluation; and
- ✓ pending charges frequently change or there are multiple charges which make it difficult to categorize the types of crimes that could be diverted.

Officials of the Jefferson County Jail Diversion Team submitted recommendations regarding the jail diversion program including:

- ✓ requiring, identifying, and enforcing treatment for seriously mentally ill offenders from the pre-trial stage until the final disposition of the case;
- ✓ creating an authority to assume responsibility for treatment and follow-up services provided to mentally ill offenders; and
- ✓ granting that authority access to an offender's mental health information and standing authority with the court.

The interim committee and advisory task force agreed that some of the recommendations pertaining to the jail diversion program could be implemented without statutory changes. The interim committee suggested that the jail diversion program be further evaluated but recommended that a standardized screening process be developed which could be used to assist jail personnel in identifying offenders with mentally illnesses (see Bill D).

Civil Commitment, Prosecution and Sentencing

Civil commitment. The committee heard testimony from the Office of Legislative Legal Services regarding Supreme Court rulings and constitutional standards pertaining to civil and involuntary commitment of mentally ill persons.

In *O'Conner v. Donaldson*, 422 U.S. 563, the Supreme Court ruled a person cannot be involuntarily civilly committed without due process. The court also found that it is not sufficient to civilly commit persons solely for having mental illnesses. The court ruled that a mentally ill person must present a danger to self or others or be gravely disabled. In *Addington v. Texas*, 441 U.S. 418, the court ruled that clear and convincing evidence that a person presents a danger to self or others or is gravely disabled is necessary to establish a need for an involuntary commitment. However, a preponderance of the evidence, meaning that the issue of mental illness is over 50 percent likely, is necessary for a civil commitment.

Not guilty by reason of insanity. When an offender is found not guilty by reason of insanity (NGRI) the offender bears no criminal responsibility because he or she is determined to be insane. NGRI cases must be proven beyond a reasonable doubt because they are criminal cases. Persons convicted as NGRI are immediately involuntarily (criminally) committed upon acquittal.

Colorado's statute governing "not guilty by reason of insanity" does not prohibit mentally ill offenders from serving longer periods of involuntary commitment than they would serve if they had been convicted of the crime. [8] If an offender pleads NGRI, he or she can also serve a shorter period of involuntary civil commitment than if he or she would have been sentenced to incarceration. The Office of Legislative Legal Services reported that courts may order NGRI defendants released if the court determines that defendants are no longer a threat to self or others. If the treating facility recommends continued commitment, the defendant has the burden of proof to show otherwise.

Statistics from the Colorado Mental Health Institute at Pueblo (CMHIP) indicate that offenders convicted under a NGRI verdict for criminal trespass serve an average of 23.5 years in the Colorado Mental Health Institute and offenders convicted of murder under NGRI serve an average of 8 years in the CMHIP.

Incompetent to proceed. The U.S. Supreme Court also considered standards for commitment in cases where persons have been found incompetent to proceed (ITP) or incompetent to stand trial, and have not yet been convicted of a crime. Colorado's "incompetent to proceed" statute prohibits persons who are found ITP from being held in civil commitment longer than the maximum sentence the person could have received if they

8. Sections 16-8-115 (1) and 16-8-116 (1), C.R.S.

had been convicted of the crime.[9] In other states, mentally ill ITP offenders may be held in involuntary commitment longer than someone who is convicted for a similar crime and sentenced to a correctional facility. Advocates for mentally ill persons say that civil commitment of ITP offenders, like NGRI cases, is seen as a potential life sentence because some mentally ill people are never restored to competency.

Guilty but mentally ill verdict. The interim committee directed the advisory task force to study the feasibility of establishing a guilty but mentally ill (GBMI) verdict in Colorado. States that have a GBMI verdict resolve the question of criminal culpability by legally holding mentally ill offenders responsible for their crimes while acknowledging that mentally ill offenders need mental health treatment. Under the GBMI verdict, an offender convicted of an offense serves the same sentence as an offender who is not mentally ill and is still required to serve a period of mandatory parole.

The advisory task force reported that in GBMI cases, jurors are first instructed to look at whether the insanity standard has been met under statutory definitions of insanity. If a jury finds a defendant insane, the defendant goes to the state mental health institution for treatment. If a jury finds the defendant sane, the jury is instructed to consider a verdict of GBMI. If the GBMI verdict is rejected, the jury considers a verdict of guilty or not guilty.

The advisory task force also reported that the rationale for a GBMI verdict is that there is a population of offenders who are mentally ill but do not meet the statutory definition of insanity.[10] The committee heard testimony about how the definition of "mentally ill" under a GBMI verdict is critical to how a GBMI law works and said definitions must encompass mental illnesses and insanity.

A GBMI offender may or may not receive mental health treatment as part of the sentence. The advisory task force reported that GBMI statutes in some states mislead jurors into believing that offenders will get mental health treatment. The state of Michigan guarantees mental health treatment for offenders found GBMI while Pennsylvania and Georgia allow treatment as the state determines necessary and to the extent that state funds permit. The states of Illinois, New Mexico, South Dakota, and Utah vest discretion with the state agency having custody of the offender to provide treatment as deemed necessary. The advisory task force also reported that most states with a GBMI verdict sentence offenders to the Department of Corrections.

---

9. Section 16-8-114.5, C.R.S.

10. Section 16-8-101.5, C.R.S., defines insanity as "persons who are diseased or defective in mind at the time of committing the crime which rendered the person incapable of distinguishing right from wrong, or persons who suffer from a condition of mind caused by a mental disease or defect that prevented the person from forming a culpable mental state that is an essential element of the crime charged."

The advisory task force reported that the GMBI verdict withstands legal and constitutional muster and that judicial systems across the country have, so far, been unwilling to strike down GBMI laws as unconstitutional. An offender found GBMI in the state of New Mexico challenged the verdict and appealed the case to the 10th Circuit Court of Appeals (Colorado is in the 10th Circuit).[11] The court decided that New Mexico's GBMI statute was constitutional because the law permitted a jury to return a verdict of GBMI if the defendant was found: 1) guilty of the offense; 2) not insane; and 3) mentally ill.

The advisory task force also noted an Illinois case in which, despite mixed reviews, an appellate court ruled that offenders do not receive due process under GBMI.[12] However, the decision did not apply widely in Illinois since that state does not have a unified court system.

The advisory task force reported that a Michigan study identified major criticisms of GBMI verdicts in 13 states: [13]

- ✓ the GBMI verdict has a minimal effect on the acquittal rate;
- ✓ there is no decrease in the number of people found NGRI;
- ✓ many offenders' mental illnesses are not treated; and
- ✓ there is the possibility that the availability of the GBMI verdict may encourage compromise pleas and lessen chances of a guilty verdict.

The Michigan study also indicated that in states' with both GBMI and NGRI verdicts:

- ✓ the number of NGRI cases remained steady;
- ✓ the availability of the GBMI verdict did not result in an increase in the number of NGRI verdicts; and
- ✓ 60 percent of the GBMI cases resulted from plea bargains.

The advisory task force reported there may be necessary reasons for the high percentage of plea bargains and said the issue warrants further study.

The advisory task force reported that a GBMI verdict could be used in Colorado as an alternative to the NGRI verdict for certain mentally ill offenders. However, the advisory task force noted that the GBMI verdict should not replace the NGRI verdict but rather, supplement NGRI, because it addresses a separate group of mentally ill offenders. The advisory task force also reported that a NGRI verdict in Colorado would help bridge the gap between the Colorado's criminal justice and mental health systems.

---

11. *Neeley v. Newton*, 149 F.3d 1074 (1998)

12. *People v. Robles*, 682 N.E.2d 194 and *Robles v. People*, 686 N.E.2d. 1170 (1997)

13. *A Pleasant Surprise: The Guilty But Mentally Ill has both Succeeded in its own Right and Successfully Preserved the Traditional Role of the Insanity Defense.* 55 U.Cinc. Law Rev. 943, 988-992 (1987) Mickenberg, Ira.

The advisory task force recommended that a further study of the GBMI verdict include a study of insanity pleas, financial implications, and reallocation of personnel to provide mental health treatment. The advisory task force suggested that if the legislature adopts a GBMI statute, the statute also require mental health treatment as some states have done. The committee found that there are huge costs associated with treating persons convicted as GBMI when courts order treatment for mentally ill offenders as part of the sentence. The advisory task force recommended against drafting an interim committee bill until a comprehensive examination of the GBMI verdict is conducted.

Assessment of Mentally Ill Adult and Juvenile Offenders

This section discusses assessment for adult and juvenile offenders.

Adult assessment. The Division of Parole in the Department of Corrections reported that nine to eleven percent of the total parole population has a mental illness. Inmates are assessed while in prison and the assessment follows the inmate when they are released from prison. Inmates and parolees with mental illnesses are placed in one of the following mental health needs categories:

- ✓ P5 - inmates who are diagnosed as acutely disturbed and are unable to function in the general prison population;
- ✓ P4 - inmates who are diagnosed with a major mental illness requiring special mental health services but are able to function in the general prison population; or
- ✓ P3 - inmates who are diagnosed with a major mental illness but are able to function in the general prison population for one year with no significant difficulties.[14]

Juvenile assessment. The DYC reported that juveniles receive mental health assessment/discharge (A/D) screening, which is called the Colorado Client Assessment Record (CCAR). The CCAR is used to measures a juvenile's:

- ✓ severity of mental health problems;
- ✓ strengths and resources; and
- ✓ level of functioning.

Dimensional subsets of the CCAR measure security needs, assault risk, behavioral problems, self care, thought disorders, suicidial thoughts, affect disorders, interpersonal, and family problems.

14. The letter "P" denotes a psychiatric needs level.

Parole and Probation Services for Mentally Ill Adult and Juvenile Offenders

This section discusses parole and probation services for mentally ill adult and juvenile offenders. It also identifies problems regarding supervision of mentally ill parolees and probationers.

Parole

The interim committee learned that many mentally ill parolees were homeless prior to their incarceration and tend to remain homeless after their release from correctional facilities. The DOC reported that many shelters will not accept mentally ill persons because shelters require that residents have the ability to be employed and transition out of the shelter.

The DOC reported that case managers and parole officers assist parolees in obtaining public assistance benefits prior to their release from prison. The DOC reported that obtaining benefits does not occur in a timely manner and that the agency is trying to accelerate the process. The DOC identified benefit eligibility and medication monitoring services and as extremely important for mentally ill parolees who need psychotropic medications. The DOC reported that a high number of parole revocations tend to be mentally ill offenders who commit violent crimes after the mentally ill parolee has stopped taking medications.

Parole officers identified the lack of housing and financial resources as the main concerns with which parole officers struggle when supervising mentally ill parolees. The parole division also expressed concerns about the high recidivism rate among mentally ill parolees and the lack of judicial funds to assist parolees who are violent, substance abusers, or on psychotropic medications with rehabilitation.

Juvenile parolees. The Division of Youth Corrections reported that in FY 1997-98, 725 committed juveniles received parole services. [15] The average daily caseload was 255 juveniles with an average length of stay on parole being over six months. The DYC also reported that the impact of the 1996 mandatory parole legislation will significantly increase the average daily caseload and length of stay over the next decade.

Probation

The Division of Probation Services in the Colorado Judicial Department did not begin to identify probationers who are receiving mental health services until July 1999. The Division is in the process of entering a code in its Integrated Colorado Online Network

15. Committed juveniles are juveniles in the legal custody of the Department of Human Services who are adjudicated by courts and held on charges of delinquent acts.

(ICON) database to identify all probationers who receive mental health services. The Division estimated that approximately 35,513 adults and 8,722 juveniles were on probation as of June 30, 1999. The division also estimated that approximately 17,493 adult probationers and 9,112 juvenile probationers have a serious mental illness and need intensive mental health services. The division further estimated that an additional 2,400 to 2,800 probationers need less intensive mental health services.

The Judicial Department reported that approximately $750,000 per year is appropriated to the Offender Services Fund which is derived from 20 percent of probation supervision fees. Moneys from the fund are used to assist probationers in purchasing services that will assist the probationer in his or her rehabilitation.

The Division of Probation Services reported that 57 percent of probationers are on active levels of supervision (required to have face-to-face contact with probation officers) and 43 percent of probationers are on administrative levels of supervision (not required to have face-to-face contact with probation officers). Probationers on active levels of supervision may receive assistance from the offender services fund while probationers on administrative levels of supervision most likely will not receive offender services funds. Most offenders must obtain their own financial resources.

Specialized probation officers. The Judicial Department reported that there is one probation officer for the Intensive Supervision Program (ISP) who also supervises probationers in the Denver Drug Court. Two other specially trained probation officers supervise probationers with special needs, including mental health needs. Community mental health centers provide almost all of the mental health services for adult and juvenile offenders.

Denver District Court Project. The Denver District Court provides specialized mental health services to persons on probation. The District Court Project was established in 1994 to provide intensive supervision to seriously mentally ill adult offenders. There are two staff psychologists in the Denver District Court who perform court-ordered assessments. Upon stabilization of ISP and Denver Drug Court probationers, cases are transferred to a regular probation officer. The success rate for the ISP and Denver Drug Court probationers is reported to be between 55 and 65 percent.

The Judicial Department also reported that its current budget provides approximately $80 per officer for training and it needs to increase levels of training for specialized and regular probation officers.

Correctional Facilities and Housing of Mentally Ill Adults

This section discusses correctional facilities for adults that have programs specifically designed to address needs of mentally ill inmates.

Adults

The DOC reported that mentally ill adults are present throughout the state's correctional facilities. However, the facilities that house most of Colorado's mentally ill inmates will be discussed.

San Carlos Correctional Facility. The San Carlos Correctional facility is a 250-bed facility that houses Colorado's most serious mentally ill and developmentally disabled adult prison population. Males account for 226 of the beds while 24 are reserved for female inmates. The facility provides mental health assessment, medication management, and psychosocial treatment interventions. Services are provided by psychiatrists, psychologists, social workers, registered nurses, substance abuse counselors, and clinical therapists who work with program, housing, and security staff to provide a multi-dimensional approach to integrating treatment and correctional management of inmates.

Fremont Correctional Facility. Fremont Correctional facility is a 1,181 bed facility for male inmates. The facility houses most of Colorado's sex offenders and runs an intensive therapeutic program for sex offenders. The committee learned that sex offenders are not automatically considered mentally ill unless they are diagnosed as having one of the major mental illnesses. In August 1999, the DOC reported that 157 inmates were identified as chronically mentally ill (CMI), 72 of which were also sex offenders.

Arrowhead Correctional Center. Arrowhead Correctional Center is a 480-bed facility for male inmates. The Center has specialized programs for sex offenders and educates inmates about the impact of crime on crime victims. It also has a drug and alcohol program and is a therapeutic community that emphasizes work skills.

Housing and Detention Programs for Mentally Ill Juveniles

Juveniles

The Division of Youth Corrections (DYC) also reported that mentally ill youths are present throughout DYC facilities. The DYC also reported that juveniles present a host of different and multiple mental health needs than adult populations. Juvenile commitment and detention populations, the Lookout Mountain Youth Services Center and its Cypress Unit, and pilot detention and post-detention programs designed to meet the needs of mentally ill juveniles will be discussed.

Commitment population. The DYC reported that between 1994 and 1996, the number of committed juveniles with moderate to extreme mental health needs nearly doubled to 86 percent. In 1996, 42 percent of the juvenile commitment population required psychotropic medications and 41 percent had a history of psychiatric hospitalization. In FY 1998-99, the DYC reported a total of 2,269 committed juveniles, including 878 new commitments. The average daily residential population was 1,112 juveniles with a 16-

month average length of stay. The DYC reported that committed juveniles range in age from 12 to 19 years and the average age at commitment is also 16 years of age.

Detention population. The DYC reported that in FY 1998-99, there were 15,212 admissions to the detention population. Eighty-two percent were males and 18 percent were females. The average daily population was 602 with a five-day average length of stay. The DYC reported that the average age of juveniles at the time of detention is16 years old.

A 1997 sample of 189 youths in DYCs detention population was assessed with the CCAR to determine the severity of mental health needs. The DYC sample was compared to detainees of the public mental health institutions and the sample matched the profiles of 91 percent of the public institutionalized population. The DYC survey indicated that:

- ✓ 24 percent had severe to extreme needs;
- ✓ 65 percent had moderate to severe needs; and
- ✓ 11 percent had none to moderate needs.

The survey further indicated:

- ✓ 91 percent had family problems;
- ✓ 75 percent had substance abuse problems,
- ✓ 70 percent had depression problems;
- ✓ 57 percent had violent tendencies; and
- ✓ 44 percent had a history of abuse.

Lookout Mountain Youth Services Center and the Cypress Unit. Lookout Mountain Youth Services Center is a 152-bed facility in Golden, CO. The DYC is funded to provide intensive secure, and residential mental health treatment services to 60 juveniles, 24 of which are located in the Cypress unit and serve males with severe to extreme mental health needs. These youths are not able to function in the general population. The DYC reported that it works with staff from the University of Colorado Health Sciences Center to provide clinical services to the youths. The other 36 beds serve youths who are able to function in the general population.

The DYC also reported that all beds at the Lookout Mountain facility could possibly be used for the mental health needs of juveniles due to the lack of community mental health services. However, the DYC reports that some juveniles could be safely managed in the community if appropriate mental health resources existed.

Detention and Post-Detention Pilot Programs for Mentally Ill Juveniles. In FY 1998-99, two statewide pilot programs were funded to provide crisis intervention services to juveniles detained by the DYC. The DYC formed partnerships with the Colorado West Regional Mental Health and Center and the Jefferson Center for Mental Health to design and implement pilot programs in their respective areas. The Colorado West Regional Mental Health Center operates the Grand Mesa Youth Services Center which is a 20-bed

detention facility. The Jefferson Center for Mental Health operates the Mount View Youth Services Center which is a 72-bed facility. Both pilot programs are designed to address the mental health and substance abuse needs of detained juveniles.

Key components of the pilot programs include the Colorado Client Assessment Record (CCAR) screening, case management, crisis intervention and community referral. Components of the post-detention program include comprehensive community-based individual, group, and family intervention for up to three months after release from detention. Community mental health centers provide services beyond three months if necessary.

The DYC identified the following concerns about its detention programs:

- ✓ six other detention sites have limited crisis intervention services and must form agreements with community mental health centers to address the needs of DYCs detention population;
- ✓ large numbers of youth admitted to detention facilities for short stays result in inefficient service delivery;
- ✓ exchange of information across systems and service providers is inconsistent; and
- ✓ existing models of care rely on deficit-based individual and group models, rather than on strength-based family and community empowerment programs.

The DYC reported that the Department of Human Services has contracted with the Alcohol and Drug Abuse Division (ADAD) to provide substance abuse education and services to juveniles for the past 15 years. The department is negotiating services with Mental Health Assessment and Service Agencies (MHASAs) to increase mental health services provided to Medicaid-eligible juveniles.

The DYC informed the committee that more transition services for youths are needed because youths re-enter communities sooner than adults re-enter communities.

Community Corrections

This section provides an overview of community corrections programs and the authority of local oversight boards. Concerns expressed by representatives of community corrections' agencies are also discussed.

Community corrections. Section 17-27-101, *et seq.*, C.R.S., authorizes community corrections programs to be operated by units of local government, the Department of Corrections, private individuals, partnerships, corporations, or associations. Community corrections providers report that it costs an average of $55 per day to house a mentally ill person in a correctional facility versus $35 per day to place an offender in a community

corrections facility. Community corrections providers are authorized to supervise offenders and must offer programs and services that provide:

- ✓ residential or non-residential services;
- ✓ monitoring of activities;
- ✓ oversight of victim restitution and community service;
- ✓ aid to offenders in obtaining and holding regular employment;
- ✓ aid to offenders in enrolling in and maintaining academic courses or vocational training programs;
- ✓ aid to offenders in utilizing community resources to meet the personal and family needs of offenders;
- ✓ aid to offenders in participating in specialized programs with the community, including day reporting centers; and
- ✓ aid to offenders in obtaining other services and programs that may be appropriate for the rehabilitation of the offender.

The Division of Criminal Justice in the Colorado Department of Public Safety is responsible for oversight of community corrections programs including supervision, monitoring, counseling, and therapeutic programs. The Division also:

- ✓ establishes health and safety standards;
- ✓ prescribes minimum levels of supervision and services;
- ✓ conducts compliance audits of community corrections programs;
- ✓ allocates state funds to community corrections programs; and
- ✓ provides technical assistance to community corrections programs.

Community Corrections' Local Oversight Boards

Local oversight boards of community corrections programs are comprised of a local board of county commissioners or may be appointed by such. The oversight boards are authorized to enter into contracts with the State of Colorado to provide services to offenders. The oversight boards may approve or disapprove the establishment of a community corrections facility and may accept or reject offenders into community corrections programs.

The committee learned that some oversight boards routinely deny seriously mentally ill persons and violent offenders placement in community corrections programs due to liability concerns even though the community corrections facility may be able to provide services to such offenders. The committee also learned that approximately eight percent of mentally ill persons are on psychotropic medications and are automatically disqualified from being accepted into a community corrections program. In addition, to be placed in a community corrections facility, an individual must be employable but many mentally ill

persons are unemployable. Community corrections programs often do not have funds or staff to meet the needs of seriously mentally ill offenders.

Concerns of community corrections facilities. The Governor's Advisory Council to the Division of Criminal Justice looked at how to increase the per diem rate paid to community corrections providers. The Advisory Council focused on five specific offender populations: 1) substance abusers; 2) sex offenders; 3) seriously mentally ill; 4) women; and 5) high-risk offenders. These special needs offender groups increase per-day housing costs in community corrections facilities. Other issues of concern include:

- ✓ local board review;
- ✓ liability and public safety concerns;
- ✓ payment of restitution (offenders in community corrections are required to pay restitution but many special needs offenders are unemployable);
- ✓ funding for medications (psychotropic medications were reported to cost between $300 - $800 per month); and
- ✓ per diem rate ($35 is not enough reimbursement for special needs offenders).

Medication Administration and Monitoring

This section discusses involuntary administration of medication and identifies some of the problems associated with administering and monitoring medication for incarcerated and released mentally ill offenders. The committee recommended establishing pilot community-based intensive treatment programs to address on-going treatment, supervision, and medication monitoring for mentally ill offenders (see Bill B). The committee also recommended that inmates and patients of mental health hospitals be eligible to apply for "Aid to the Needy Disabled" benefits 90 days prior to their release from public institutions in order to continue on-going treatment with medications (see Bill C).

Involuntary administration of medication. The Office of Legislative Legal Services reported that involuntarily committed patients have the right to refuse medication. Courts require states to consider the following four factors in determining whether to administer medications to an involuntarily committed adult:

- ✓ competency of the person;
- ✓ whether medication is necessary to prevent deterioration of the individual or for the safety of other persons;
- ✓ availability of less intrusive measures; and
- ✓ compelling need to override the patient's interest.

Medication monitoring. Representatives of the Department of Corrections reported that monthly costs for psychotropic medications ranges from $300 to $800 per offender. The Department of Human Services reported that the DYC experienced a more than 700 percent increase in the number of medications administered to detained and committed juveniles. The advisory task force also reported that most offenders do not have private health insurance and local mental health centers are reluctant to treat offenders if they do not have financial resources or are not receiving Medicaid.

The advisory task force found that county jails often will not give psychotropic medications to inmates. The advisory task force also reported that offenders coming out of the county jail after being accepted in a community corrections program must routinely have their medication changed. Many of the offenders have not been diagnosed, and when offenders are diagnosed, medications do not follow the offender to the community corrections facility.

The advisory task force also reported that medication for offenders moving into the community often gets lost because the offenders are transferred between facilities upon their release from the Department of Corrections. The committee learned that medications must be obtained by the offender and probation officer but this usually does not occur.

Successful Prevention and Intervention Programs

This section discusses two programs which have documented success for treating and monitoring seriously mentally ill adults and juveniles. The interim committee recommended that pilot community-based intensive treatment programs (Bill B) have components of the assertive community treatment and multisystemic therapy programs described below *(both programs are described in more detail in Appendix A, page 38).*

Assertive community treatment for adults. Assertive community treatment (ACT) programs are nationally recognized treatment approaches with demonstrated effectiveness in treating and monitoring individuals with serious and persistent mental illnesses. Assertive community treatment clients include mentally ill persons who are at high risk for psychiatric deterioration, have poor social functioning, impaired ability to function in the community, substance abuse problems, and criminal behavior.

Treatment teams are multi-disciplinary and include psychiatrists, nurses, case managers, vocational, and substance abuse counselors. Assertive community treatment teams provide case management services, individualized supportive therapy, crisis intervention and hospitalization services. Research indicates that ACT teams reduce hospitalizations, decrease symptoms of mental illness, increase independent living, promote employment successes, and promote more positive social relationships among mentally ill program participants.

Most ACT services are provided in the community and the treatment teams maintain frequent contact with clientele. Services include money management, housing, transportation assistance, appointment setting and reminding, medication monitoring, community integration, and focusing on the client's strengths. Assertive community treatment programs also promote new anti-psychotic and antidepressant medications and provide substance abuse treatment. The programs are behaviorally oriented and ACT treatment teams collaborate with family members of mentally ill persons.

Multi-systemic therapy for juveniles. Multi-systemic therapy (MST) programs provide intensive family and community-based treatment that addresses multiple determinants of serious antisocial behavior in juvenile offenders. Multiple determinants may include a youth's values, social skills, social network, family relations, school, peer groups, and neighborhood. Multi-systemic therapy is based on assumptions that there are multiple causes for criminal behavior and rather than focus limited aspects of a youth's social ecology, MST addresses a broad range of determinants.

Multi-systemic therapy programs define success in terms of reduced recidivism, improved family and peer relations, decreased behavioral problems, and decreased rates of out-of-home placement. Research indicates that follow-up studies on the effects of MST programs are long lasting and reduce rates of sexual and criminal offenses. Strengths of MST programs are its cost-effectiveness, proven success in treating difficult clinical populations, and relative ease of implementation across geographic location and community agencies.[16]

Collaborative Efforts Between Criminal Justice and Mental Health Agencies

The advisory task force identified programs in other states where criminal justice and mental health agencies work together. Colorado does not operate any of the programs described below on a statewide level.

Mental health courts. Mental health courts are a relatively new concept and were specifically designed to hear cases of mentally ill misdemeanant offenders and divert them from jail and into treatment programs. The courts have specially-trained court teams that may consist of judges, prosecutors, defense attorneys, treatment providers, correctional staff, and case managers. The team works with mentally ill offenders and the courts have procedures that allow pre-sentenced and incarcerated mentally ill offenders to have their pending cases transferred to the mental health court.

The Division of Criminal Justice reported that mental health courts provide therapeutic jurisprudence. Therapeutic jurisprudence allows mental health and legal disciplines to explore knowledge and develop theories and insights that will make laws work

16. *Treating Serious Anti-Social Behavior in Youth: The MST Approach.* U.S. Department of Justice. Office of Juvenile Justice and Delinquency Prevention. Washington, DC. May 1997.

for all offenders and remain consistent with principles of justice. It requires immediate intervention, non-adversarial adjudication, hands-on judicial involvement, treatment programs with structured goals, and a team approach.

Colorado does not have a mental health court to deal with mentally ill offenders though Denver's drug court operates on principles similar to therapeutic jurisprudence in that necessary treatment is provided to offenders. In 1997, the state of Florida established the country's first known mental health court in Broward County. In March 1999, Washington established a mental health court in King County. In June 1999, Alaska established a mental health court. None of these mental health courts operate on a statewide basis. In November 1999, the District Court in Utah authorized a judge and court administrative personnel to travel to King County Washington to observe its mental health court.

The advisory task force spoke with the Chief Justice of Colorado's Supreme Court who indicated that the Judicial Department would like to be involved and kept abreast of efforts to establish a mental health court in Colorado. The advisory task force, interim committee, and Chief Justice would like to see documented success from other states operating mental health courts before establishing a mental health court in Colorado.

Community mental health and criminal justice programs. The state of Maryland instituted a multi-agency collaboration program called the Maryland Community Criminal Justice Treatment Program (MCCJTP) in the early 1990s. The MCCJTP is a partnership between its health, mental health, social service and criminal justice systems. The goal of the program is to reduce recidivism and cycling of mentally ill offenders who repeatedly use these systems and improve identification and treatment of mentally ill offenders to increase their chances of living independently.

The agencies work together to screen mentally ill offenders, prepare treatment and aftercare plans, and provide post-release and follow up services. Services are also extended to mentally ill offenders who are on probation or parole, and who are homeless or have substance abuse needs. Key features of the program are:

- ✓ agencies receive state government support;
- ✓ local partnerships provide assistance to mentally ill offenders;
- ✓ a broad range of case management services are provided to incarcerated and released mentally ill offenders;
- ✓ diversion strategies are incorporated in case plans;
- ✓ homeless mentally ill and/or dually-diagnosed offenders receive enhanced services;
- ✓ criminal justice and mental health treatment professionals receive specialized training; and
- ✓ agencies receive program evaluations.[17]

---

17. *Coordinating Community Services for Mentally Ill Offenders: Maryland's Community Criminal Justice Treatment Program.* U.S. Department of Justice. National Institute of Justice. Program Focus. April 1999

Milwaukee's municipal court intervention and community support programs. The Correctional Services program in Wisconsin operates a central intake unit and municipal court intervention program, both of which are located in its court system. The central intake unit is a pretrial diversion service that provides comprehensive services including intensive pretrial supervision and a drug testing program. The municipal court intervention program aims to keep convicted persons who are in need of mental health and/or substance abuse treatment in the community and link them to needed services. The objectives of both programs are to keep mentally ill offenders out of jails and mental health hospitals and assist them to live independently.

Services provided by the community support program include:

- ✓ medical and therapeutic services;
- ✓ money management;
- ✓ housing assistance; and
- ✓ day reporting and monitoring services.[18]

Crisis intervention teams. The interim committee learned about crisis intervention teams (CITs) which consist of volunteer law enforcement officers and mental health professionals. Crisis intervention teams respond to police calls involving mentally ill persons. The teams promote community efforts by enjoining law enforcement and community mental health professionals to provide services to mentally ill persons and their families.

Crisis intervention teams also promote education, sensitivity, understanding about mental illness, and building of community partnerships. Officers use verbal de-escalation techniques in crisis situations and most mentally ill persons are taken to medical facilities without injury or charges filed. Family members of mentally ill persons and consumers may request CIT officers to respond to their calls. The partnerships between CIT officers and mental health professionals often provides solutions to mental health crisis situations.

The city of Memphis formed a CIT in 1988 to respond to the downsizing of mental health facilities. The Memphis CIT partners with the National Alliance for the Mentally Ill, mental health consumers and providers, and two local universities to develop and implement safe, proactive, and preventive methods of containing emotional situations involving mentally ill persons that could lead to violence. Memphis CIT officers receive free specialized training about mental illnesses from mental health professionals, advocates, and family members of mentally ill persons. The training enables officers to understand that mental illness is not a crime, but rather a disease.

---

18. *Managing Mentally Ill Offenders in the Community: Milwaukee's Community Support Program.* U.S. Department of Justice. National Institute of Justice. Program Focus. March 1994

SUMMARY OF RECOMMENDATIONS

As a result of the committee's activities, the following bills are recommended to the Colorado General Assembly.

Bill A — Continued Examination of Mentally Ill Offenders

The bill establishes a six-member legislative oversight committee and a 27-member advisory task force. The bill expands current membership of the advisory task force from 19 to 27 members. The 27-member advisory task force will consist of representatives of the following state departments and agencies, followed by the number of representatives from each department or agency. The new membership represents expertise that was lacking on the current advisory task force and appears in **bold** print:

- ✓ Department of Human Services, Division of Youth Corrections (1), Division of Mental Health Services (1), the Colorado Mental Health Institute at Pueblo (1); **the Division of Alcohol and Drug Abuse (1), and the Division of Child Welfare Services (1);**
- ✓ **Department of Education (1)**;
- ✓ a **private community mental health provider (1)**;
- ✓ a **person with knowledge of public housing or public benefits (1)**;
- ✓ a **forensic professional (1)**;
- ✓ Judicial Department (1), adult probation, (1) **juvenile probation (1)**;
- ✓ mentally ill person *or* family member of mentally ill person who has been involved in the criminal justice system. The bill now specifies that a **person who has a mental illness and has been involved in the criminal justice system (1)** must be appointed to the advisory task force, in addition to a family member of a mentally ill adult (1), and a family member of a mentally ill juvenile (1);
- ✓ Department of Corrections (1) and the Division of Parole (1);
- ✓ Department of Law (1);
- ✓ Department of Public Safety, Division of Criminal Justice (1);
- ✓ law enforcement (2);
- ✓ community corrections (1);
- ✓ district attorney (1);
- ✓ Colorado Criminal Defense Bar (2); and
- ✓ mental health professional (2).

The bill requires a continued examination, but is not limited to, a study of prosecution, sentencing, diagnosis, housing, placement, on-going treatment and medication monitoring for mentally ill adults and juveniles. The advisory task force identified specific issues that require further examination and concern persons with mental illness who are involved in the criminal justice system. Some of the issues include:

- ✓ developing a joint comprehensive community mental health and criminal justice proposal;
- ✓ examining the feasibility of mental health courts;
- ✓ examining the feasibility of a "guilty but mentally ill" verdict;
- ✓ expanding research on special needs mentally ill populations, including females, minorities, and persons with co-occurring disorders (mental illness and substance abuse);
- ✓ examining community corrections' liability issues with mentally ill clients;
- ✓ expanding successful early intervention programs;
- ✓ increasing inter-agency coordination and cross-training about mental illness among mental health professionals, judges, district attorneys, defense lawyers, probation, and parole officers who deal with mentally ill offenders;
- ✓ improving jail assessment, treatment, and transition services for mentally ill adults and juveniles;
- ✓ improving medication monitoring and supervision;
- ✓ expediting benefit acquisition for mentally ill offenders;
- ✓ detention and community placements for mentally ill offenders;
- ✓ identifying funding sources for family- and home-based services;
- ✓ reviewing insurance parity, jail diversion, and detention-based pilot programs;
- ✓ examining confidentiality concerns in order to ensure that a mentally ill offender's medical and clinical information are more accessible to persons who have a need to know;
- ✓ encouraging the development of crisis intervention programs; and
- ✓ expanding the use of specialized caseloads.

Bill B — Management for Mentally Ill Offenders

This bill is the primary recommendation of the advisory task force because it provides the most expeditious approach to treating and supervising mentally ill offenders.

The bill authorizes the Department of Human Services to issue a request for Proposals (RFP) and select two entities, one in a rural community and one in an urban community, to operate an adult offender community-based intensive treatment management

pilot program. It also authorizes the DHS to select two entities, one in a rural community and one in an urban community to operate similar pilot programs for juveniles. These pilot programs must provide intensive community management of mentally ill offenders and be based on programs that are proven to be effective in the treatment and oversight of serious and persistent mentally ill individuals. The pilot programs are intended to reduce hospitalization, incarceration, recidivism, and out-of-home placement of mentally ill offenders. The pilot programs are scheduled for repeal on July 1, 2007.

Bill C — Eligibility of Institutionalized Persons for Aid to the Needy Disabled

This bill allows persons who are diagnosed with a mental illness, disease, or psychosis, and who are in public institutions (correctional facilities and mental health hospitals) to apply for "Aid to the Needy Disabled" benefits 90 days prior to release from the public institution. The bill expedites eligibility for assistance in order for these individuals to continue their on-going medical treatment when released from public institutions.

Bill D — Standard Screening Process for Mentally Ill Offenders

This bill authorizes the Judicial Department, the Department of Corrections, the State Parole Board, the Division of Criminal Justice in the Department of Public Safety, and the Alcohol and Drug Abuse Division and the Division of Mental Health Services in the Department of Human Services, to develop a standardized inter-agency screening process to detect mental illness in persons in the criminal justice system. The bill allows the inter-agency group to study the feasibility of developing a definition of "serious mental illness." The bill requires that a report be submitted to the joint House and Senate Judiciary Committees on or before March 1, 2002, to determine if legislation is necessary to implement the standardized process.

RESOURCE MATERIALS

The resource materials listed below were provided to the committee or developed by Legislative Council Staff during the course of the study. The summaries of meetings and attachments are available at the Division of Archives, 1313 Sherman Street, Denver. For a limited period of time, the meeting summaries and materials developed by Legislative Council Staff are available on our web site at:

www.state.co.us/gov_dir/leg_dir /lcsstaff/1999/99interim.

Meeting Summaries	Topics Discussed
August 3, 1999	Selection of advisory task force members and advisory task force chairman; charge to the interim committee and advisory task force; findings of the Department of Correction's (DOC) Multi-agency task group; discussions of the number of mentally ill persons in the (DOC); DOC mental health screening and assessment instruments; minimum mental health services that correctional facilities must provide; and statutes pertaining to treating mentally ill persons.
August 17, 1999	Discussion of three subgroups of the advisory task force and what each subgroup will study; overview of Colorado's community mental health and community corrections systems; mental health resources for adults and juveniles; supervision and monitoring services for parolees and probationers; parole assessment system; mental health assessment instruments for juveniles; juvenile commitment and detention population; costs of psychotropic medications.
September 7, 1999	Discussion of case law and constitutional issues concerning treating and medicating mentally ill offenders and persons who are civilly committed; presentation by subgroup of the advisory task force on prevention, early identification, diagnosis and treatment; law enforcement and family member perspective of treatment of mentally ill adults and juveniles in the criminal justice system; jail diversion; and the Assertive Community Treatment Program.
September 22, 1999	Discussion of the former Colorado Criminal Justice Commission; "not guilty by reason of insanity" plea; "guilty but mentally ill verdict;" civil commitment; definitions for mental illness and impaired mental condition; case law regarding definitions of "insane" and "incompetent to

	proceed;" mentally ill juveniles; mental health courts; and task force priorities including crisis intervention teams, screening device for mental illness, a juvenile forensic unit, and pilot programs for intensive community treatment and supervision.
October 7, 1999	Discussion of family member perspective from the National Alliance for the Mentally Ill; Social Security Administration's Pre-release Prison Program; transition and continuum of care programs; institutions; and civil commitments.
November 3, 1999	Discussion of advisory task force recommendations; schematic chart depicting programs and intervention strategies; service gaps in Colorado's mental health system; and final approval of recommended legislation.

Memoranda and Reports

Legislative Council and Office of Legislative Legal Services staff memoranda:

July 19, 1999	*Committee Membership, Background Information, Committee Charge, and Proposed Topics of Discussion.* Legislative Council Staff.
August 3, 1999	*Summary of Existing Statutes Concerning Competence to Stand Trial and the Defense of Not Guilty By Reason of Insanity.* Office of Legislative Legal Services.
August 3, 1999	*Summary of Existing Statutes Concerning the Post-trial Treatment of Mentally Ill Offenders.* Office of Legislative Legal Services.
August 10, 1999	*Summary of Existing Case Law Regarding Constitutional Issues Related to the Treatment and Medication of Persons Charged With and Convicted of Crimes.* Office of Legislative Legal Services.
August 26, 1999	*Mental Health Courts in Florida and Washington.* Legislative Council Staff.
September 7, 1999	*Standards and Requirements for Civil Commitments.* Office of Legislative Legal Services.

Reports Provided to the Committee

Advisory Task Force Report to the Colorado Legislative Interim Committee on the Study of the Treatment of Persons with Mental Illness in the Criminal Justice System, Colorado Department of Public Safety, Division of Criminal Justice, Office of Research and Statistics. November 1999.

Offenders with Serious Mental Illness: Appendices (Executive Summary), Colorado Department of Corrections, Multi-agency Task Group. November 1999.

Offenders with Serious Mental Illness: A Multi-agency Task Force Report to the Colorado Legislature. Offender Programs Report. Civic Research Institute, Inc, Kingston, NJ. September/October 1999.

NAMI Calls for Congressional Hearings Following Justice Department Report, Lack of Treatment Cited as Cause of Criminalization of Mental Illness: Executive Actions Also Proposed. Press Release via NewsEdge Corporation, Arlington, VA. July 13, 1999.

Mental Health and Treatment of Inmates and Probationers. U.S. Department of Justice, Bureau of Justice Statistics, Special Report. Washington, DC. July 1999.

Offenders with Serious Mental Illness: A Qualitative Case Study, Executive Report to the Legislature. Colorado Department of Corrections, Multi-agency Task Group. February 1999.

Summary of Jefferson County's Experience in Attempting to Implement House Bill 96-1196, the Diversion of the Mentally Ill from the Criminal Justice System. Jefferson County Department of Corrections, Tom Giacinti. September 3, 1999.

Appendix A

Advisory Task Force
Summary Of
Recommendations to the Interim Committee
on the Study of the Treatment of Persons
With Mental Illness in the
Criminal Justice System

Prepared by the Division of Criminal Justice,
Colorado Department of Public Safety

APPENDIX A

November, 1999

Advisory Task Force Recommendations to the Interim Committee on Treatment of Persons with Mental Illness in the Criminal Justice System

PART ONE: The task force recommends that the legislature consider the following legislation in the 2000 legislative session.

1. Introduce legislation to continue the Advisory Task Force for three additional years, with annual reports to the legislature.

The Advisory Task Force needs to continue its work with statutory authority. Although members of the Task Force have presented substantial information on the current status of the persons with mental illness who enter the criminal justice system, additional information needs to be gathered on a number of issues. These issues include examination of the interaction between Mental Health Centers and corrections systems, the kinds of treatment provided for persons with mental illness, including medication monitoring, as well as a number of other topics cited in the bullets below.

- **Perform a comprehensive review of criminal insanity law and definitions, including Guilty But Mentally Ill (GBMI) and Not Guilty By Reason of Insanity, civil commitment, and juvenile commitment.**

The state has considered for some time allowing a Guilty But Mentally Ill verdict in criminal cases. If a defendant is found GBMI, he/she is ordered to serve a sentence of the same dimension as could otherwise have been imposed, along with mental health treatment. However, there has been no comprehensive examination of the GBMI verdict within the context of either criminal insanity law as a whole or of its potential advantages, financial implications, or commitments. A change of this magnitude should not be made precipitously, but only after thorough study of the issue. The Children's Code must also be included in this comprehensive review, as different statutes apply to youth.

In addition, the Task Force needs representation from additional agencies and disciplines. These include forensic professionals, community mental health centers, education, housing, child welfare, the Alcohol and Drug Abuse Division (ADAD), and additional consumer representation. Subcommittees should be formed for the study of legal

issues and for the study of special populations such as offenders with co-occurring disorders, juveniles, minorities, and women.

Some minimal resources would be needed to assist the Task Forces in studying the following areas:

- **Increase inter-agency coordination.**

Multi-agency coordination is critical to ensure continuity of care for offenders with mental illness. In some instances, it is difficult to access clinical information from other systems. Coordination efforts should include reaching a consensus on defined goals, delineating responsibilities, and initiating continuous program review. Mental health services that are provided through different agencies should be coordinated, and clinical information should follow the client. An integrated service model makes it possible to plan and manage mental health services for offenders in a manner that maximizes their benefit.

- **Improve transition services.**

The transition from an inpatient or correctional residential facility to the community can be very traumatic for people with serious mental illness. The steps to independent living are critical for the transition of offenders with serious mental illness. There are few facilities and services in the state for those coming out of prisons, jails, and inpatient facilities. In addition, better discharge planning is needed for both adult and juvenile offenders with mental illness. Increased cooperation between state Mental Health Services, some Community Mental Health Centers and Department of Corrections mental health staff has resulted in some progress in facilitating continuity of care for offenders with serious mental illnesses who are transitioning back to the community, but more needs to be done.

- **Improve housing and placement.**

The availability of housing is a significant factor in both short- and long-range success of offenders with mental illness living in the community. However, there is currently little housing available for either adults or juveniles with mental illness. One problem is public sentiment against such facilities. Offenders with co-occurring disorders are especially difficult to place; no one with an arrest record is eligible for HUD housing. Collaborative efforts between agencies are encouraged, but additional resources are desperately needed.

- **Examine the issue of insurance parity.**

Private health insurance companies are required to provide mental health services for people with certain mental illness diagnoses, but at present, only six diagnoses related to mental illness are covered. The Task Force encourages the expansion of covered diagnoses to other legitimate mental illness diagnosis.

- **Expand funding for family and home-based services.**

Family and community-based services have been shown to be very effective in ensuring that clients continue receiving necessary services. Family and community-based services should be the standard of care for offenders with mental illness rather than the traditional individual and group models of care because this population is typically difficult to maintain and engage in traditional treatment approaches. Although these community-based approaches may be more expensive on the front end, they are more effective in reducing the need for more intensive and costly services later on.

- **Improve access to and acquisition of benefits for offenders with mental illness.**

Offenders with mental illness often experience difficulties and delays in receiving benefits to which they are entitled, and those convicted of specific offenses are ineligible to receive certain benefits. Both in jails and juvenile detention centers, a case management approach would make resources available more quickly to offenders with mental illness. This and other possible solutions to this issue must be examined.

- **Improve medication provision and supervision.**

A large number of those with mental illness in the criminal justice system are on psychotropic medication. Providing medications and supervising offenders with mental illness to ensure that they take prescribed medications on a regular basis is an apparent problem throughout the criminal justice system, especially at transition points. Although representatives of all groups on the Task Force recognize the problem, there is little data to document it. More information needs to be gathered regarding where system improvements are needed in the continuity of medication provision and supervision and who should pay for them.

- **Resolve the conflict between improving confidentiality and making offenders' medial and clinical information more accessible.**

Confidentiality restrictions need to be uniformly interpreted and applied so that information about criminal and mental health history can be shared more easily among law

enforcement, courts, jails and mental health professionals. Courts now have inconsistent information with respect to offenders' mental health backgrounds and their true needs before a sentencing decision must be made. This is a problem throughout the system, as agencies are often reluctant to transfer confidential records and information, despite the importance of sharing such information with other agencies. Increased agreement and coordination are badly needed in this area. All improvements must be made with an eye toward the welfare of the client and to encourage continuity of services, and at the same time, the protection of the client's privacy.

- **Expand research on special populations—females, co-occurring disorders, ethnic populations.**

Additional information must be gathered on the growing number of offenders who have co-occurring mental health and substance use disorders. In addition, information is currently inadequate on other special populations, especially females and minorities, with mental illness who are involved in the criminal justice system. As noted above, the need to gather such additional information is one reason for continuation of the Task Force.

- **Examine the feasibility of establishing pilot mental health courts.**

The Task Force recommends the further study of Mental Health Courts (MHCs), which are a promising approach to diverting misdemeanants into the mental health system. At present, there are four Mental Health Courts across the country. MHCs typically provide misdemeanants with mental illness a single point of contact with the court system. Defendants may be referred to the Mental Health Court by jail psychiatric staff, law enforcement, attorneys, family members, probation officers, or another court. Participation is voluntary, as defendants must waive their rights to a trial on the merits of the case. Defendants receive court-ordered treatment in place of standard sentencing.

Mental Health Courts provide a liaison position to monitor compliance, individualized treatment plans, and case managers to strengthen the defendant's support system. To be successful, programs must be linked with aftercare, and release planning must occur well before release. It is important to put systems in place to ensure that relevant information follows the individual rather than being located in separate agency records. The Colorado Judicial Department has expressed in interest in being involved in discussions surrounding the issue of Mental Health Courts.

- **Expand juvenile transition services.**

The Division of Youth Corrections has great difficulty in transitioning youth with severe mental health needs into safe and effective community-based placements. Resources need to be provided to develop additional alternatives. Juvenile transition services and continuity should also be enhanced through increased integration, cross-training, and multi-agency coordination.

- **Expand successful early intervention programs.**

Programs designed to intervene early in the lives of at-risk children are successful in preventing a life cycle of violence and criminal justice involvement. Examples of early intervention programs are those that provide home visits and supported child care, partial-day treatment programs for preschool children with emotional disturbances, the Child Development Program in Boulder, and the Denver Project Parent Empowerment Alternatives with Resources and Learning (PEARL). The Task Force encourages adoption of such programs and others described in the section entitled "What Works?" (See report of Advisory Task Force, *Colorado Legislative Interim Committee on the Study of the Treatment of Persons with Mental Illness in the Criminal Justice System*, November 3, 1999). The Task Force recommends that additional resources be provided to expand the use of such programs statewide.

- **Address the issue of community corrections' liability.**

Those who supervise offenders in the community are concerned about their potential liability resulting from offenders with mental illness who commit additional crimes. The Task Force recommends that the legislature address this issue with an eye toward releasing community corrections from liability for those with mental illness.

- **Develop a comprehensive community mental health/criminal justice proposal.**

The Task Force recommends examining the feasibility of a pilot program that would ideally encompass all promising approaches addressing the needs of offenders with mental illness. Such a program would cut across usual agency lines and would incorporate many of the concepts described above. Crucial to such a comprehensive community mental health/criminal justice project would be collecting baseline data and evaluating the success of all elements of the pilot. A comprehensive project is a priority for the Task Force for next year.

2. Introduce legislation initiating inter-agency protocols to develop a standardized screening process.

Existing procedures and diagnostic tools are inadequate for identifying the level of impairment of offenders with mental illness. There is no standardized way to collect and share clinical information across the mental health and corrections systems. A standardized screening process to more accurately assess an offender's level of impairment is badly needed.

The Task Force encourages inter-agency development of a screening process designed to identify current mental health disorders. Research shows that interventions have a greater likelihood of success when the assessment and intervention are provided early. Therefore, screening should be done at the earliest possible point and should follow an individual in his/her movement through the criminal justice system. Issues of confidentiality must also be addressed as part of the effort to develop a standardized screening process.

3. Introduce legislation to expand intensive community management approaches (including ACT—Assertive Community Treatment) and Multi-Systemic Therapy Programs.

Intensive community management programs are community-based programs for offenders with mental illness. A well-known model, called Assertive Community Treatment (ACT), has been demonstrated to be effective in the treatment and oversight of individuals with serious and persistent mental illness. The program targets difficult to engage clients, those at high risk for psychiatric deterioration, and those with co-occurring substance abuse and criminal behavior. The Mental Health Corporation of Denver (MHCD) undertook a study to examine and document changes in offenders' involvement in the criminal justice system before and after the ACT (called High Intensity Treatment Teams in Denver). The study examined the records of clients three years prior to involvement with the High Intensity Treatment Teams and three years after. After removing four outliers representing numerous prostitution arrests, there was a 30% decrease in total arrests, and a 44% decrease in fresh arrests (that is, removing those arrests that were from earlier unresolved contacts with the legal system, many of which were found when a client attempted to secure housing). Drug and alcohol offenses decreased by 20% and fresh violent offenses decreased by 49%. The committee recommends that intensive community management approaches be expanded in additional sites in the state.

Multi-Systemic Therapy (MST) is an intensive family and community-based treatment that addresses the multiple determinants of serious anti-social behavior in juvenile offenders. The goal of the MST approach is to provide an integrative, cost-effective, family-based treatment that results in positive outcomes for adolescents who demonstrate serious anti-social behavior. MST interventions focus efforts on individuals and their families, peers, school and vocational performance, and neighborhood and community support systems. MST therapists carry small caseloads of 4-6 families and offer primarily home and family-based services. They focus on skill-building, strength-based and resource

development strategies. MST programs require intensive training, strict quality assurance, and continued accountability, and evaluation. MST programs remove cross-systems barriers. Evaluations of MST programs have demonstrated the following outcomes for serious juvenile offenders: reduced long-term rates of arrest by 25%-70% compared to control groups; reduced days in out-of-home placements by 47%-64%; extensive improvements in family functioning; and decreased mental health problems. The Task Force recommends expansion of MST programs for at-risk juveniles with serious mental illness.

4. Revise the Aid to the Needy Disabled statute to expedite access to benefits.

Modifications to current statutes are needed to enable those who are institutionalized to expedite access to benefits. To ease the transition from incarceration to community release, prohibitions against offenders with mental illness applying for Aid to the Needy Disabled several months prior to release should be lifted to enable these individuals to access funds immediately upon release from an institution. Additionally, under current law, offenders with mental illness must currently overcome significant obstacles to access Supplemental Security Income benefits. These barriers interfere with the ability of many offenders with mental illness to obtain the basic public assistance necessary to successfully transition from an institutional setting to community supervision.

PART TWO: The task force supports the following actions by the legislature in the 2000 Legislative Session.

1. Implement, through the state budget process, a differential daily rate of compensation for community corrections' agencies that will accept offenders with serious mental illness.

The differential daily rate is needed to cover the daily program cost not recoverable from an offender who is unable to work due to a serious mental illness. This may have the effect of increasing the number of offenders with serious mental illness who are accepted for transitional placement, which may help reduce the length-of-stay at the Department of Corrections (DOC) and delay future needs for special placement beds.

2. Support expanded specialized placements and forensics.

- The Task Force supports the Colorado DOC's request for an expansion of beds at the San Carlos Correctional Facility and other protected environments for offenders with mental illness. The San Carlos Correction Facility is a 250-bed facility that serves inmates with mental illness or developmental disabilities.

Inmates served by the program are those with the highest needs as determined by diagnosis, symptom severity, and disruptive behavior.

- Through a partnership between Youth Corrections and the Colorado Mental Health Institutes, the Division of Youth Corrections (DYC) proposes to construct a 20-bed (expandable to 40 beds) intensive, secure, highly specialized, and self-contained residential commitment facility for juveniles ages 16-20. The facility is needed to serve juveniles with severe mental health needs and felony offense histories who cannot safely function in existing Youth Corrections. The Task Force supports the DYC proposal.

- The Colorado Department of Human Services request for replacement and expansion of the Institute for Forensic Psychiatry's maximum and medium security units. The Institute for Forensic Psychiatry is charged with housing and treating persons with mental illness who have been found not guilty by reason of insanity, incompetent to proceed with their trial, or who require psychiatric competency or sanity evaluations. The maximum and medium security units serve the most dangerous and seriously mentally ill patients, and present numerous safety and security issues. Additionally, the units have chronically operated over capacity.

PART THREE: The following items can be acted upon immediately by the legislature or referred to the task force for future study.

1. Encourage the development of crisis intervention programs.

The Task Force recommends implementation of programs such as the Memphis Police Crisis Intervention Team (CIT) throughout the state. Programs like CIT could be modified to meet the needs of Colorado local communities. CIT is a partnership between the Memphis Police, the Memphis Chapter of the Alliance for the Mentally Ill, mental health providers, and two local universities. These groups have worked together to organize, train for, and implement a specialized unit to respond to crisis events involving persons with mental illness. Results have included a significant decrease in officer injury rates and increased access to mental health care by people with mental illness. The program keeps people with mental illness out of jail, minimizes law enforcement time spent on calls, and maintains community safety.

2. Increase cross-training for all those who deal with offenders with mental illness who are in the criminal justice system.

Cross-training is essential to ensure that mental health professionals understand the criminal justice system and that judges, district attorneys, defense lawyers and probation officers understand the mental health system. It is also essential to train law enforcement

officers, as they are often the "gatekeeper" of those with mental illness entering the criminal justice system. However, most officers lack the training to identify, manage, and refer persons with mental illness appropriately.

3. Expand the use of specialized caseloads.

Specialized probation staff handling limited caseloads have had the highest level of success with offenders with mental illness. Revocations and re-sentences to Colorado DOC have decreased when offenders are part of such limited, specialized caseloads. Structured team approaches between Mental Health and Probation, which involve interagency system training and coordination, facilitate success. Any expansion of specialized caseloads of offenders with serious mental illness would necessitate concomitant increases in mental health resources dedicated to addressing the needs of these offenders.

4. Provide support to evaluate the results of all proposed activities.

The Task Force recommends that adequate resources be provided to evaluate the success of ongoing and new projects designed to improve the treatment of persons with mental illness in the criminal justice system. Baseline data should be gathered, and research should be carried out to ensure that programs are both efficient and effective.

5. Review jail diversion programs.

County jails hold a large number of persons with mental illness. Estimates of the size of mentally ill jail populations vary, but a recent review by Boulder County Jail's medical staff determined that approximately 38% of those in custody suffered some form of mental illness.

Several larger counties have programs in place to divert persons with mental illness from jail. In these systems, the jail medical staff identifies inmates with serious mental illness and contacts mental health workers to conduct an assessment of the individual. If the assessment indicates that the individual needs hospitalization, the criminal charges are put on hold and the person is transferred to a Colorado State Mental Health Institute. The limitation is that existing programs are only able to remove a very small number of those with the *most* seriously mentally ill who have committed minor offenses. To continue and expand such diversion programs, additional resources are needed to provide treatment in the community.

In addition, probation officers and mental health caseworkers working out of the same office to facilitate case management should be explored. Day centers specifically for criminal defendants with mental illness could provide the structure needed to comply with conditions of supervision, maintain medication schedules, and coordinate case management.

Such a program could serve at the local level as a diversion from criminal charges, as a condition of pretrial release, or as a sentencing condition.

6. Improve jail assessment, treatment, and transition services.

Although early intervention and diversion efforts are encouraged, there is nevertheless a strong need for the availability of services for those in jail. Research indicates that those with mental illness spend more time in jail than a person without mental illness arrested for the same offense. However, very few resources are available in jails for proper screening and treatment. Only larger county jails have any staff available or trained to provide assessments, and the availability of treatment is limited.

Resources should be provided to develop additional specialized services for persons with mental illness who are in jail. Trained staff should provide assessments, treatment, and transition services.

7. Expand detention-based pilot projects.

The pilot project is a partnership between Youth Corrections and Community Mental Health Services. The program offers detention-based screening, assessment, case management, crisis intervention, and community-based referral. Local mental health services then provide comprehensive, community-based post-detention mental health services. The goal of the project is to decrease the mental health needs of the juvenile detention population and lower the number of readmissions. The Task Force recommends a review of the outcomes associated with this project, and, if effective, an expansion of such services to all DYC detentions site.

Bill A

BY REPRESENTATIVES Tool and Kester;
also SENATORS Anderson and Martinez.

A BILL FOR AN ACT

CONCERNING A CONTINUING EXAMINATION OF THE TREATMENT OF PERSONS WITH MENTAL ILLNESS WHO ARE INVOLVED IN THE CRIMINAL JUSTICE SYSTEM, AND MAKING AN APPROPRIATION THEREFOR.

Bill Summary

"Study Of Mentally Ill Offenders"

(Note: This summary applies to this bill as introduced and does not necessarily reflect any amendments that may be subsequently adopted.)

Interim Committee to Study the Treatment of Persons with Mental Illness Who are Involved in the Criminal Justice System. Establishes a legislative oversight committee to continue to examine the treatment of persons with mental illness who are involved in the criminal justice system. Requires the committee to report annually to the general assembly on the issues studied and to propose legislative changes based on the recommendations from the task force examining the treatment of persons with mental illness who are involved in the criminal justice system.

Creates a task force to continue examining study specific issues related to the treatment of mentally ill persons in the criminal justice system and to provide guidance and recommendations to the legislative oversight committee. Requires the task force to obtain input from groups in the state affected by the issues studied by the task force.

Repeals the oversight committee and the task force, effective July 1, 2004.

Be it enacted by the General Assembly of the State of Colorado:

SECTION 1. Title 18, Colorado Revised Statutes, is amended BY THE ADDITION OF A NEW ARTICLE to read:

ARTICLE 1.7

Continuing Examination of the Treatment of Persons with Mental Illness Who are Involved in the Criminal Justice System

18-1.7-101. Legislative declaration. (1) THE GENERAL ASSEMBLY HEREBY FINDS THAT:

(a) A STUDY BY THE COLORADO DEPARTMENT OF CORRECTIONS COMPLETED IN THE FALL OF 1998 IDENTIFIED APPROXIMATELY ONE THOUSAND TWO HUNDRED INMATES, NEARLY TEN PERCENT OF THE INMATE POPULATION OF THE DEPARTMENT OF CORRECTIONS, AS PERSONS WHO MEET THE DIAGNOSTIC CRITERIA FOR MAJOR MENTAL ILLNESSES;

(b) THE NUMBER OF INMATES IN THE CUSTODY OF THE DEPARTMENT OF CORRECTIONS IDENTIFIED IN 1998 AS MEETING THE DIAGNOSTIC CRITERIA FOR MAJOR MENTAL ILLNESSES IS TWICE THE NUMBER IDENTIFIED IN 1996 AND FIVE TO SIX TIMES THE NUMBER IDENTIFIED IN 1988;

(c) IN 1998, APPROXIMATELY TWENTY PERCENT OF THE JUVENILES IN THE LEGAL CUSTODY OF THE DIVISION OF YOUTH CORRECTIONS WITHIN THE DEPARTMENT OF HUMAN SERVICES WERE IDENTIFIED AS HAVING MODERATE TO SEVERE MENTAL HEALTH PROBLEMS REQUIRING PSYCHIATRIC TREATMENT;

(d) A STUDY CONDUCTED IN 1995 FOUND THAT APPROXIMATELY SIX PERCENT OF THE PERSONS HELD IN COUNTY JAILS AND IN COMMUNITY CORRECTIONS THROUGHOUT THE STATE HAD BEEN DIAGNOSED AS PERSONS WITH SEVERE OR CHRONIC MENTAL ILLNESS;

(e) IT IS ESTIMATED THAT CURRENTLY NEARLY NINE PERCENT OF ALL THE ADULTS AND JUVENILES ON PROBATION THROUGHOUT THE STATE OF

COLORADO HAVE BEEN IDENTIFIED AS HAVING SEVERE OR CHRONIC MENTAL ILLNESS;

(f) FOR THE 1998-99 FISCAL YEAR, APPROXIMATELY FORTY-FOUR PERCENT OF THE INPATIENT POPULATION AT THE COLORADO MENTAL HEALTH INSTITUTE IN PUEBLO HAD BEEN COMMITTED FOLLOWING THE RETURN OF A VERDICT OF NOT GUILTY BY REASON OF INSANITY OR A DETERMINATION BY THE COURT THAT THE PERSON WAS INCOMPETENT TO STAND TRIAL DUE TO MENTAL ILLNESS;

(g) PERSONS WITH MENTAL ILLNESS, AS A DIRECT OR INDIRECT RESULT OF THEIR CONDITION, ARE IN MANY INSTANCES MORE LIKELY THAN PERSONS WHO DO NOT HAVE MENTAL ILLNESS TO BE INVOLVED IN THE CRIMINAL JUSTICE SYSTEM OR THE JUVENILE JUSTICE SYSTEM;

(h) THE EXISTING PROCEDURES AND DIAGNOSTIC TOOLS USED BY PERSONS WORKING IN THE CRIMINAL JUSTICE SYSTEM MAY NOT BE SUFFICIENT TO IDENTIFY APPROPRIATELY AND DIAGNOSE PERSONS WITH MENTAL ILLNESS WHO ARE INVOLVED IN THE CRIMINAL JUSTICE SYSTEM;

(i) THE CRIMINAL JUSTICE SYSTEM AND THE JUVENILE JUSTICE SYSTEM CURRENTLY MAY NOT BE STRUCTURED IN SUCH A MANNER AS TO PROVIDE THE LEVEL OF TREATMENT AND CARE FOR PERSONS WITH MENTAL ILLNESS THAT IS NECESSARY TO ENSURE THE SAFETY OF THESE PERSONS, OF OTHER PERSONS IN THE CRIMINAL AND JUVENILE JUSTICE SYSTEMS, AND OF THE COMMUNITY AT LARGE; AND

(j) THE ONGOING SUPERVISION, CARE, AND MONITORING, ESPECIALLY WITH REGARD TO MEDICATION, OF PERSONS WITH MENTAL ILLNESS WHO ARE RELEASED FROM INCARCERATION ARE CRUCIAL TO ENSURING THE SAFETY OF THE COMMUNITY.

(2) THEREFORE, THE GENERAL ASSEMBLY DECLARES THAT IT IS NECESSARY TO CREATE A TASK FORCE TO CONTINUE TO EXAMINE THE IDENTIFICATION, DIAGNOSIS, AND TREATMENT OF PERSONS WITH MENTAL ILLNESS WHO ARE INVOLVED IN THE STATE CRIMINAL JUSTICE SYSTEM, INCLUDING THE JUVENILE JUSTICE SYSTEM, AND TO MAKE RECOMMENDATIONS TO A LEGISLATIVE OVERSIGHT COMMITTEE FOR THE DEVELOPMENT OF LEGISLATIVE PROPOSALS RELATED TO THIS ISSUE.

18-1.7-102. Definitions. AS USED IN THIS ARTICLE, UNLESS THE CONTEXT OTHERWISE REQUIRES:

(1) "COMMITTEE" MEANS THE LEGISLATIVE OVERSIGHT COMMITTEE ESTABLISHED PURSUANT TO SECTION 18-1.7-103.

(2) "CRIMINAL JUSTICE SYSTEM" MEANS THE ADULT CRIMINAL JUSTICE SYSTEM AND THE JUVENILE JUSTICE SYSTEM WITHIN THE STATE.

(3) "TASK FORCE" MEANS THE TASK FORCE FOR THE CONTINUING EXAMINATION OF THE TREATMENT OF PERSONS WITH MENTAL ILLNESS WHO ARE INVOLVED IN THE CRIMINAL JUSTICE SYSTEM ESTABLISHED PURSUANT TO SECTION 18-1.7-104.

18-1.7-103. Legislative oversight committee - creation - duties. (1) (a) THERE IS HEREBY CREATED A LEGISLATIVE OVERSIGHT COMMITTEE FOR THE CONTINUING EXAMINATION OF THE TREATMENT OF PERSONS WITH MENTAL ILLNESS WHO ARE INVOLVED IN THE CRIMINAL JUSTICE SYSTEM.

(b) THE COMMITTEE SHALL CONSIST OF SIX MEMBERS. THE PRESIDENT OF THE SENATE AND THE SPEAKER OF THE HOUSE OF REPRESENTATIVES SHALL APPOINT THE MEMBERS OF THE COMMITTEE, AS FOLLOWS:

(I) THE PRESIDENT OF THE SENATE SHALL APPOINT THREE SENATORS TO SERVE ON THE COMMITTEE, NO MORE THAN TWO OF WHOM SHALL BE MEMBERS OF THE SAME POLITICAL PARTY;

(II) THE SPEAKER OF THE HOUSE OF REPRESENTATIVES SHALL APPOINT THREE REPRESENTATIVES TO SERVE ON THE COMMITTEE, NO MORE THAN TWO OF WHOM SHALL BE MEMBERS OF THE SAME POLITICAL PARTY;

(c) THE PRESIDENT OF THE SENATE SHALL SELECT THE FIRST CHAIR OF THE COMMITTEE, AND THE SPEAKER OF THE HOUSE OF REPRESENTATIVES SHALL SELECT THE FIRST VICE-CHAIR. THE CHAIR AND VICE-CHAIR SHALL ALTERNATE ANNUALLY THEREAFTER BETWEEN THE TWO HOUSES. THE CHAIR AND VICE-CHAIR OF THE COMMITTEE MAY ESTABLISH SUCH ORGANIZATIONAL AND PROCEDURAL RULES AS ARE NECESSARY FOR THE OPERATION OF THE COMMITTEE.

(d) COMMITTEE MEMBERS SHALL BE REIMBURSED FOR ALL ACTUAL AND NECESSARY EXPENSES INCURRED IN THE PERFORMANCE OF THEIR DUTIES AND, IN ADDITION, SHALL BE PAID AS PROVIDED PURSUANT TO SECTION 2-2-307, C.R.S. FOR ATTENDANCE AT MEETINGS OF THE COMMITTEE.

(2) (a) THE COMMITTEE SHALL MEET ON OR BEFORE AUGUST 1, 2000, AND SHALL MEET AT LEAST THREE TIMES EACH YEAR THEREAFTER, AND AT SUCH OTHER TIMES AS IT DEEMS NECESSARY.

(b) THE COMMITTEE SHALL BE RESPONSIBLE FOR THE OVERSIGHT OF THE TASK FORCE AND SHALL SUBMIT ANNUAL REPORTS TO THE GENERAL ASSEMBLY REGARDING THE FINDINGS AND RECOMMENDATIONS OF THE TASK FORCE. IN ADDITION, THE COMMITTEE MAY RECOMMEND LEGISLATIVE CHANGES WHICH SHALL BE TREATED AS BILLS RECOMMENDED BY AN INTERIM LEGISLATIVE COMMITTEE FOR PURPOSES OF ANY INTRODUCTION DEADLINES OR BILL LIMITATIONS IMPOSED BY THE JOINT RULES OF THE GENERAL ASSEMBLY.

(c) THE COMMITTEE SHALL SUBMIT A REPORT TO THE GENERAL ASSEMBLY BY JANUARY 15, 2001, AND BY EACH JANUARY 15 THEREAFTER THROUGH JANUARY 15, 2004. THE ANNUAL REPORTS SHALL SUMMARIZE THE ISSUES ADDRESSING THE TREATMENT OF PERSONS WITH MENTAL ILLNESS WHO ARE INVOLVED IN THE CRIMINAL JUSTICE SYSTEM THAT HAVE BEEN CONSIDERED AND ANY RECOMMENDED LEGISLATIVE PROPOSALS.

18-1.7-104. Mentally ill offender task force - creation - membership - duties. (1) THERE IS HEREBY CREATED A TASK FORCE FOR THE CONTINUING EXAMINATION OF THE TREATMENT OF PERSONS WITH MENTAL ILLNESS WHO ARE INVOLVED IN THE CRIMINAL JUSTICE SYSTEM IN COLORADO. THE TASK FORCE SHALL CONSIST OF TWENTY-SEVEN MEMBERS AS FOLLOWS:

(a) THE CHIEF JUSTICE OF THE COLORADO SUPREME COURT SHALL APPOINT THREE MEMBERS WHO REPRESENT THE JUDICIAL DEPARTMENT, TWO OF WHOM REPRESENT THE DIVISION OF PROBATION WITHIN THE DEPARTMENT;

(b) THE CHAIR AND VICE-CHAIR OF THE COMMITTEE SHALL APPOINT TWENTY-FOUR MEMBERS AS FOLLOWS:

(I) ONE MEMBER WHO REPRESENTS THE DIVISION OF CRIMINAL JUSTICE WITHIN THE DEPARTMENT OF PUBLIC SAFETY;

(II) TWO MEMBERS WHO REPRESENT THE DEPARTMENT OF CORRECTIONS, ONE OF WHOM REPRESENTS THE DIVISION OF PAROLE WITHIN THE DEPARTMENT;

(III) ONE MEMBER WHO REPRESENTS COMMUNITY CORRECTIONS;

(IV) TWO MEMBERS WHO REPRESENT LOCAL LAW ENFORCEMENT AGENCIES;

(V) FIVE MEMBERS WHO REPRESENT THE DEPARTMENT OF HUMAN SERVICES, AS FOLLOWS:

(A) ONE MEMBER WHO REPRESENTS THE UNIT RESPONSIBLE FOR MENTAL HEALTH SERVICES WITHIN THE DEPARTMENT OF HUMAN SERVICES;

(B) ONE MEMBER WHO REPRESENTS THE DIVISION OF YOUTH CORRECTIONS;

(C) ONE MEMBER WHO REPRESENTS THE UNIT RESPONSIBLE FOR CHILD WELFARE SERVICES;

(D) ONE MEMBER WHO REPRESENTS THE ALCOHOL AND DRUG ABUSE DIVISION; AND

(E) ONE MEMBER WHO REPRESENTS THE COLORADO MENTAL HEALTH INSTITUTE AT PUEBLO;

(VI) ONE MEMBER WHO REPRESENTS THE DEPARTMENT OF EDUCATION;

(VII) ONE MEMBER WHO REPRESENTS THE STATE ATTORNEY GENERAL'S OFFICE;

(VIII) ONE MEMBER WHO REPRESENTS THE DISTRICT ATTORNEYS WITHIN THE STATE;

(IX) TWO MEMBERS WHO REPRESENT THE CRIMINAL DEFENSE BAR WITHIN THE STATE;

(X) TWO MEMBERS WHO ARE LICENSED MENTAL HEALTH PROFESSIONALS PRACTICING WITHIN THE STATE;

(XI) ONE MEMBER WHO REPRESENTS COMMUNITY MENTAL HEALTH CENTERS WITHIN THE STATE;

(XII) ONE MEMBER WHO IS A PERSON WITH KNOWLEDGE OF PUBLIC BENEFITS AND PUBLIC HOUSING WITHIN THE STATE;

(XIII) ONE MEMBER WHO IS A PRACTICING FORENSIC PROFESSIONAL WITHIN THE STATE;

(XIV) THREE MEMBERS OF THE PUBLIC AS FOLLOWS:

(A) ONE MEMBER WHO HAS MENTAL ILLNESS AND HAS BEEN INVOLVED WITH THE CRIMINAL JUSTICE SYSTEM IN THIS STATE;

(B) ONE MEMBER WHO HAS AN ADULT FAMILY MEMBER WHO HAS MENTAL ILLNESS AND HAS BEEN INVOLVED WITH THE CRIMINAL JUSTICE SYSTEM IN THIS STATE; AND

(C) ONE MEMBER WHO IS THE PARENT OF A CHILD WHO HAS MENTAL ILLNESS AND HAS BEEN INVOLVED WITH THE CRIMINAL JUSTICE SYSTEM IN THIS STATE.

(2) IN MAKING APPOINTMENTS TO THE TASK FORCE, THE APPOINTING AUTHORITIES SHALL ENSURE THAT THE MEMBERSHIP OF THE TASK FORCE REFLECTS THE ETHNIC, CULTURAL, AND GENDER DIVERSITY OF THE STATE AND INCLUDES REPRESENTATION OF ALL AREAS OF THE STATE.

(3) THE TASK FORCE SHALL EXAMINE THE IDENTIFICATION, DIAGNOSIS, AND TREATMENT OF PERSONS WITH MENTAL ILLNESS WHO ARE

INVOLVED IN THE STATE CRIMINAL JUSTICE SYSTEM. THE TASK FORCE SHALL SPECIFICALLY CONSIDER, BUT NEED NOT BE LIMITED TO, THE FOLLOWING ISSUES:

(a) THE EARLY IDENTIFICATION, DIAGNOSIS, AND TREATMENT OF ADULTS AND JUVENILES WITH MENTAL ILLNESS WHO ARE INVOLVED WITH THE CRIMINAL JUSTICE SYSTEM;

(b) THE PROSECUTION OF AND SENTENCING ALTERNATIVES FOR PERSONS WITH MENTAL ILLNESS THAT MAY INVOLVE TREATMENT AND ONGOING SUPERVISION;

(c) THE DIAGNOSIS, TREATMENT, AND HOUSING OF PERSONS WITH MENTAL ILLNESS WHO ARE CONVICTED OF CRIMES OR WHO PLEAD GUILTY, NOLO CONTENDERE, OR NOT GUILTY BY REASON OF INSANITY OR WHO ARE FOUND TO BE INCOMPETENT TO STAND TRIAL;

(d) THE DIAGNOSIS, TREATMENT, AND HOUSING OF JUVENILES WITH MENTAL ILLNESS WHO ARE ADJUDICATED FOR OFFENSES THAT WOULD CONSTITUTE CRIMES IF COMMITTED BY ADULTS OR WHO PLEAD GUILTY, NOLO CONTENDERE, OR NOT GUILTY BY REASON OF INSANITY OR WHO ARE FOUND TO BE INCOMPETENT TO STAND TRIAL;

(e) THE ONGOING TREATMENT, HOUSING, AND SUPERVISION, ESPECIALLY WITH REGARD TO MEDICATION, OF ADULTS AND JUVENILES WHO ARE CONVICTED OR ADJUDICATED AND HOUSED WITHIN THE COMMUNITY AND THE AVAILABILITY OF PUBLIC BENEFITS FOR SUCH PERSONS;

(f) THE ONGOING ASSISTANCE AND SUPERVISION, ESPECIALLY WITH REGARD TO MEDICATION, OF PERSONS WITH MENTAL ILLNESS AFTER DISCHARGE FROM SENTENCE;

(g) THE CIVIL COMMITMENT OF PERSONS WITH MENTAL ILLNESS WHO ARE CRIMINALLY CONVICTED, FOUND NOT GUILTY BY REASON OF INSANITY, OR FOUND TO BE INCOMPETENT TO STAND TRIAL;

(h) THE IDENTIFICATION, DIAGNOSIS, AND TREATMENT OF MINORITY PERSONS WITH MENTAL ILLNESS, WOMEN WITH MENTAL ILLNESS, AND PERSONS WITH CO-OCCURRING DISORDERS IN THE CRIMINAL JUSTICE SYSTEM;

(i) THE MODIFICATION OF THE CRIMINAL JUSTICE SYSTEM TO SERVE ADULTS AND JUVENILES WITH MENTAL ILLNESS WHO ARE CHARGED WITH OR CONVICTED OF A CRIMINAL OFFENSE;

(j) THE LIABILITY OF FACILITIES THAT HOUSE PERSONS WITH MENTAL ILLNESS AND THE LIABILITY OF THE STAFF WHO TREAT OR SUPERVISE PERSONS WITH MENTAL ILLNESS;

(k) THE SAFETY OF THE STAFF WHO TREAT OR SUPERVISE PERSONS WITH MENTAL ILLNESS AND THE USE OF FORCE AGAINST PERSONS WITH MENTAL ILLNESS;

(l) THE IMPLEMENTATION OF APPROPRIATE DIAGNOSTIC TOOLS TO IDENTIFY PERSONS IN THE CRIMINAL JUSTICE SYSTEM WITH MENTAL ILLNESS;

(m) ANY OTHER ISSUES CONCERNING PERSONS WITH MENTAL ILLNESS WHO ARE INVOLVED IN THE STATE CRIMINAL JUSTICE SYSTEM THAT ARISE DURING THE COURSE OF THE TASK FORCE STUDY.

(4) THE TASK FORCE SHALL PROVIDE GUIDANCE AND MAKE FINDINGS AND RECOMMENDATIONS TO THE COMMITTEE IN ITS DEVELOPMENT OF REPORTS AND LEGISLATIVE RECOMMENDATIONS FOR MODIFICATION OF THE CRIMINAL JUSTICE SYSTEM, WITH RESPECT TO PERSONS WITH MENTAL ILLNESS WITHIN THE CRIMINAL JUSTICE SYSTEM. IN SO DOING, THE TASK FORCE SHALL:

(a) SELECT A CHAIR AND A VICE-CHAIR FROM AMONG ITS MEMBERS;

(b) MEET AT LEAST TWICE EACH YEAR FROM THE DATE OF THE FIRST MEETING UNTIL JANUARY 1, 2004, OR AS OTHERWISE DIRECTED BY THE CHAIR OF THE COMMITTEE;

(c) COMMUNICATE WITH AND OBTAIN INPUT FROM GROUPS THROUGHOUT THE STATE AFFECTED BY THE ISSUES IDENTIFIED IN SUBSECTION (3) OF THIS SECTION;

(d) CREATE SUBCOMMITTEES AS NEEDED TO CARRY OUT THE DUTIES OF THE TASK FORCE. THE SUBCOMMITTEES MAY CONSIST, IN PART, OF PERSONS WHO ARE NOT MEMBERS OF THE TASK FORCE. SUCH PERSONS MAY VOTE ON ISSUES BEFORE SUCH SUBCOMMITTEE BUT SHALL NOT BE ENTITLED TO A VOTE AT MEETINGS OF THE TASK FORCE.

(e) SUBMIT A WRITTEN REPORT TO THE COMMITTEE BY OCTOBER 1, 2000 AND EACH OCTOBER 1 THEREAFTER THROUGH OCTOBER 1, 2003, AT A MINIMUM SPECIFYING THE FOLLOWING:

(I) ISSUES TO BE STUDIED IN UPCOMING TASK FORCE MEETINGS AND A PRIORITIZATION OF THOSE ISSUES;

(II) FINDINGS AND RECOMMENDATIONS REGARDING ISSUES OF PRIOR CONSIDERATION BY THE TASK FORCE;

(III) LEGISLATIVE PROPOSALS OF THE TASK FORCE THAT IDENTIFY THE POLICY ISSUES INVOLVED, THE AGENCIES RESPONSIBLE FOR THE IMPLEMENTATION OF THE CHANGES, AND THE FUNDING SOURCES REQUIRED FOR SUCH IMPLEMENTATION.

(5) MEMBERS OF THE TASK FORCE SHALL SERVE WITHOUT COMPENSATION.

18-1.7-105. Task force funding - staff support. (1) THE TASK FORCE IS AUTHORIZED TO RECEIVE CONTRIBUTIONS, GRANTS, SERVICES, AND IN-KIND DONATIONS FROM ANY PUBLIC OR PRIVATE ENTITY TO BE EXPENDED FOR ANY DIRECT OR INDIRECT COSTS ASSOCIATED WITH THE DUTIES OF THE TASK FORCE SET FORTH IN THIS ARTICLE.

(2) THE DIRECTOR OF RESEARCH OF THE LEGISLATIVE COUNCIL, THE DIRECTOR OF THE OFFICE OF LEGISLATIVE LEGAL SERVICES, THE DIRECTOR OF THE DIVISION OF CRIMINAL JUSTICE WITHIN THE DEPARTMENT OF PUBLIC SAFETY, AND THE EXECUTIVE DIRECTORS OF THE DEPARTMENTS REPRESENTED ON THE TASK FORCE SHALL SUPPLY STAFF ASSISTANCE TO THE COMMITTEE AS THEY DEEM APPROPRIATE. THE COMMITTEE MAY ALSO ACCEPT STAFF SUPPORT FROM THE PRIVATE SECTOR.

18-1.7-106. Repeal of article. THIS ARTICLE IS REPEALED, EFFECTIVE JULY 1, 2004.

SECTION 2. Appropriation. In addition to any other appropriation, there is hereby appropriated, out of any moneys in the general fund not otherwise appropriated, to the department of public safety, for allocation to the division of criminal justice, for the fiscal year beginning July 1, 2000, the sum of ___ dollars ($) and ___ FTE, or so much thereof as may be necessary, for the implementation of this act.

SECTION 3. Safety clause. The general assembly hereby finds, determines, and declares that this act is necessary for the immediate preservation of the public peace, health, and safety.

DRAFT

Colorado Legislative Council Staff

STATE FISCAL IMPACT

BILL A

Drafting Number:	LLS 00-0374	**Date:**	November 26, 1999
Prime Sponsor(s):	Rep. Tool Sen. Anderson	**Bill Status:**	Interim Committee on Mentally Ill in the Criminal Justice System
		Fiscal Analyst:	Geoff Barsch (866-4102)

TITLE: CONCERNING A CONTINUING EXAMINATION OF THE TREATMENT OF PERSONS WITH MENTAL ILLNESS WHO ARE INVOLVED IN THE CRIMINAL JUSTICE SYSTEM, AND MAKING AN APPROPRIATION THEREFOR.

Fiscal Impact Summary	FY 2000/2001	FY 2001/2002
State Revenues General Fund		
State Expenditures General Fund	$57,321	$57,321
FTE Position Change	1.0 FTE	1.0 FTE
Other State Impact:		
Effective Date: Upon signature of the Governor.		
Appropriation Summary for FY 2000-2001: $37,425 GF and 0.6 FTE to the Department of Public Safety and $19,896 GF and 0.4 FTE for the Legislative Department.		
Local Government Impact: None		

Summary of Legislation

This bill establishes a six-member legislative oversight committee to continue to examine the treatment of persons with mental illness who are involved in the criminal justice system. The bill requires the committee to report annually to the General Assembly on the issues studied and any recommended legislative changes.

The bill authorizes a 27-member task force to continue examining specific issues related to the treatment of mentally ill persons in the criminal justice system and to provide guidance and recommendations to the legislative oversight committee. The bill details the composition of the task force and requires the task force to obtain input from groups in the state affected by the issues it studies.

The legislative oversight committee and task force are repealed effective July 1, 2004.

State Expenditures

The bill directs the Division of Criminal Justice in the Department of Public Safety, the executive directors of the departments represented on the task force (the Departments of Public Safety, Corrections, Human Services, Education, and Law), the director of Legislative Council Research, and the director of Legislative Legal Services to provide staff support to the committee.

Expenditures related to oversight committee members and support from the legislative staff are based on the assumption that the committee will meet six times annually.

- Member costs would be $5,724 annually assuming members will be reimbursed at a rate of $159 per day ($99 per diem and $60 for expenses).
- Staff costs would be $14,172 and assume the committee would require 0.3 Senior Research Assistant FTE and 0.1 LLS Staff Attorney FTE. This includes PERA and Medicare but does not include health/life/dental or short term disability insurance.

Expenditures related to Task Force support provided by the Department of Public Safety are based on the assumption that the Task Force will meet 12 times annually.

- Operating costs associated with support of the Task Force total $13,483 and include phones, printing, postage, travel, supplies, and meeting expenses.
- Staff costs would be $23,942 and assume the task force would require 0.6 General Professional III FTE. This includes PERA and Medicare but does not include health/life/dental or short term disability insurance.

State Appropriations

This fiscal note indicates the Department of Public Safety will require an appropriation of $37,425 GF and 0.6 FTE, The Legislative Department will require an appropriation of $19,896 GF and 0.4 FTE for FY 2000-01.

Departments Contacted

Corrections
Human Services
Judicial
Legislative Department
Public Safety
Colorado District Attorney's Council

Bill B

BY REPRESENTATIVES Kester, Tool, and Leyba;
also SENATORS Wham, Anderson, and Martinez.

A BILL FOR AN ACT

CONCERNING THE CREATION OF COMMUNITY-BASED MANAGEMENT PILOT PROGRAMS FOR PERSONS WITH MENTAL ILLNESS WHO ARE INVOLVED IN THE CRIMINAL JUSTICE SYSTEM.

Bill Summary

"Mgmt For Mentally Ill Offenders"

(Note: This summary applies to this bill as introduced and does not necessarily reflect any amendments that may be subsequently adopted.)

Interim Committee to Study the Treatment of Persons with Mental Illness Who are Involved in the Criminal Justice System. Creates community-based intensive treatment management pilot programs to provide supervision and management services to mentally ill adults and juveniles who are involved in the criminal justice system.

Instructs the department of human services ("department") to issue a request for proposals and to select 2 entities, one in a rural community and one in an urban community, to operate an adult offender pilot program and 2 entities, one in a rural community and one in an urban community, to operate a juvenile offender pilot program. Identifies specific requirements of each proposal, including demonstration that the pilot program would operate as a collaborative effort among specified agencies. Authorizes the department to adopt guidelines as necessary to implement the act.

Specifies the services to be provided by the adult offender pilot program, including psychiatric services, medication supervision, crisis intervention services, services to promote employment of the offender, and services to teach daily living skills. Specifies the services to be provided by the juvenile offender pilot program, including psychiatric services, medication supervision, crisis intervention services, integrated family-based treatment, and services to promote the development of community support systems.

Requires each entity operating a pilot program to report annually to the department specified information concerning the operation of the program. Directs the department to submit an annual report to the general assembly.

Repeals the pilot programs, effective July 1, 2007.

Be it enacted by the General Assembly of the State of Colorado:

SECTION 1. Article 8 of title 16, Colorado Revised Statutes, is amended BY THE ADDITION OF A NEW PART to read:

PART 2

INTENSIVE TREATMENT MANAGEMENT

FOR PERSONS WITH MENTAL ILLNESS

16-8-201. Legislative declaration. (1) THE GENERAL ASSEMBLY HEREBY FINDS THAT:

(a) ADULTS AND JUVENILES WHO ARE INVOLVED IN THE CRIMINAL JUSTICE SYSTEM AND WHO ARE DIAGNOSED WITH SERIOUS MENTAL ILLNESS ARE MORE LIKELY THAN PERSONS WITHOUT MENTAL ILLNESS TO REOFFEND AND REQUIRE REPEATED INCARCERATION;

(b) ALTHOUGH SOME COMMUNITY-BASED INTENSIVE TREATMENT AND MANAGEMENT SERVICES ARE CURRENTLY AVAILABLE TO PERSONS WITH SERIOUS MENTAL ILLNESS WHO ARE INVOLVED IN THE CRIMINAL JUSTICE SYSTEM, THESE SERVICES ARE NOT AVAILABLE IN ALL AREAS OF THE STATE AND ARE NOT SUFFICIENTLY SUPPORTED IN ANY SINGLE COMMUNITY WITHIN THE STATE;

(c) PROVISION OF COMMUNITY-BASED INTENSIVE TREATMENT AND MANAGEMENT SERVICES FOR PERSONS WITH SERIOUS MENTAL ILLNESS HAS BEEN SHOWN TO DECREASE THE RATE OF RECIDIVISM AND THE NEED FOR MULTIPLE PERIODS OF INCARCERATION AND HOSPITALIZATION AND TO ENHANCE SIGNIFICANTLY THE ABILITY OF THESE PERSONS TO FUNCTION IN THE COMMUNITY;

(d) OVER THE LONG TERM, THE COST OF PROVIDING COMMUNITY-BASED INTENSIVE TREATMENT AND MANAGEMENT SERVICES IS MORE THAN OFFSET BY THE DECREASE IN INCARCERATION AND HOSPITALIZATION COSTS AND BY THE SOCIETAL BENEFITS REALIZED BY ENABLING THESE PERSONS TO FUNCTION SAFELY AND PRODUCTIVELY IN THE COMMUNITY.

(2) THE GENERAL ASSEMBLY THEREFORE FINDS THAT CREATION OF PILOT PROGRAMS TO PROVIDE COMMUNITY-BASED INTENSIVE TREATMENT AND MANAGEMENT SERVICES TO ADULTS AND JUVENILES WHO ARE DIAGNOSED WITH SERIOUS MENTAL ILLNESS AND WHO ARE INVOLVED IN THE CRIMINAL JUSTICE SYSTEM IS NECESSARY FOR THE PUBLIC WELFARE AND SAFETY.

16-8-202. Definitions. AS USED IN THIS PART 2, UNLESS THE CONTEXT OTHERWISE REQUIRES:

(1) "ADULT OFFENDER PILOT PROGRAM" MEANS THE INTENSIVE TREATMENT MANAGEMENT PILOT PROGRAM FOR ELIGIBLE ADULT OFFENDERS CREATED PURSUANT TO SECTION 16-8-203.

(2) "CRIMINAL JUSTICE SYSTEM" MEANS BOTH THE ADULT CRIMINAL JUSTICE SYSTEM AND THE JUVENILE JUSTICE SYSTEM.

(3) "DEPARTMENT" MEANS THE DEPARTMENT OF HUMAN SERVICES.

(4) "ELIGIBLE ADULT OFFENDER" MEANS A PERSON EIGHTEEN YEARS OF AGE OR OLDER WHO IS INVOLVED WITH THE CRIMINAL JUSTICE SYSTEM AND HAS BEEN DIAGNOSED BY A MENTAL HEALTH PROFESSIONAL AS HAVING SERIOUS MENTAL ILLNESS.

(5) "ELIGIBLE JUVENILE OFFENDER" MEANS A PERSON WHO HAS BEEN DIAGNOSED BY A MENTAL HEALTH PROFESSIONAL AS HAVING SERIOUS MENTAL ILLNESS AND WHO EITHER IS LESS THAN EIGHTEEN YEARS OF AGE AND INVOLVED WITH THE CRIMINAL JUSTICE SYSTEM OR HAS BEEN COMMITTED TO THE DEPARTMENT OF HUMAN SERVICES.

(6) "ENTITY" MEANS ANY PUBLIC OR PRIVATE NONPROFIT, NOT-FOR-PROFIT, OR FOR-PROFIT ORGANIZATION, ASSOCIATION, OR CORPORATION OR ANY GOVERNMENTAL ENTITY.

(7) "JUVENILE OFFENDER PILOT PROGRAM" MEANS THE INTENSIVE TREATMENT MANAGEMENT PILOT PROGRAM FOR ELIGIBLE JUVENILE OFFENDERS CREATED PURSUANT TO SECTION 16-8-204.

(8) "MENTAL HEALTH PROFESSIONAL" MEANS A PERSON LICENSED TO PRACTICE MEDICINE OR PSYCHOLOGY IN THIS STATE OR ANY PERSON ON THE STAFF OF A FACILITY DESIGNATED BY THE EXECUTIVE DIRECTOR OF THE DEPARTMENT FOR SEVENTY-TWO-HOUR TREATMENT AND EVALUATION AUTHORIZED BY THE FACILITY TO DO MENTAL HEALTH PRESCREENINGS AND UNDER THE SUPERVISION OF A PERSON LICENSED TO PRACTICE MEDICINE OR PSYCHOLOGY IN THIS STATE.

16-8-203. Intensive treatment management pilot program for adult offenders - creation - request for proposals - parameters. (1) THERE IS HEREBY CREATED THE INTENSIVE TREATMENT MANAGEMENT PILOT PROGRAM FOR ADULT OFFENDERS TO PROVIDE SUPERVISION AND MANAGEMENT SERVICES TO ELIGIBLE ADULT OFFENDERS WHO ARE CHARGED WITH OR CONVICTED OF A CRIME OR WHO ARE FOUND NOT GUILTY BY REASON OF INSANITY. ON OR BEFORE OCTOBER 1, 2000, THE DEPARTMENT, IN CONSULTATION WITH THE DEPARTMENT OF CORRECTIONS AND THE JUDICIAL DEPARTMENT, SHALL ISSUE A REQUEST FOR PROPOSALS FROM ENTITIES THAT ARE INTERESTED IN

PARTICIPATING IN THE ADULT OFFENDER PILOT PROGRAM. ON OR BEFORE MARCH 1, 2001, THE DEPARTMENT, IN CONSULTATION WITH THE DEPARTMENT OF CORRECTIONS AND THE JUDICIAL DEPARTMENT, SHALL SELECT FROM AMONG THE RESPONDING ENTITIES ONE ENTITY IN A RURAL COMMUNITY AND ONE ENTITY IN AN URBAN COMMUNITY TO OPERATE THE ADULT OFFENDER PILOT PROGRAM. THE DEPARTMENT SHALL BASE ITS SELECTION ON THE PARAMETERS SPECIFIED IN SUBSECTION (2) OF THIS SECTION AND ANY ADDITIONAL CRITERIA ADOPTED BY THE DEPARTMENT.

(2) AN ADULT OFFENDER PILOT PROGRAM OPERATING PURSUANT TO THIS SECTION SHALL PROVIDE HIGH-INTENSITY SUPERVISION AND TREATMENT SERVICES IN THE COMMUNITY TO ELIGIBLE ADULT OFFENDERS IN ORDER TO REDUCE RECIDIVISM AND THE NEED FOR HOSPITALIZATION. AT A MINIMUM, AN ADULT OFFENDER PILOT PROGRAM SHALL:

(a) ENSURE THAT SERVICES ARE PROVIDED TO ELIGIBLE ADULT OFFENDERS IN THE COMMUNITY IN WHICH THE PILOT PROGRAM OPERATES;

(b) PROVIDE PSYCHIATRIC SERVICES, MEDICATION SUPERVISION, AND CRISIS INTERVENTION SERVICES;

(c) MAINTAIN A LOW CLIENT-STAFF RATIO;

(d) PROMOTE EMPLOYMENT OF ELIGIBLE ADULT OFFENDERS AND DEVELOPMENT OF POSITIVE SOCIAL RELATIONSHIPS;

(e) PROVIDE CASE MANAGEMENT SERVICES, INCLUDING BUT NOT LIMITED TO ASSISTING THE ELIGIBLE ADULT OFFENDER IN MEETING ANY CONDITIONS OF RELEASE;

(f) PROVIDE BEHAVIOR-ORIENTED SERVICES THROUGH RESOURCES IN THE COMMUNITY TO TEACH DAILY LIVING AND EMPLOYMENT SKILLS SUCH AS MONEY MANAGEMENT AND HOW TO ACCESS TRANSPORTATION, OBTAIN APPROPRIATE HOUSING, AND OTHER SERVICES;

(g) WHERE POSSIBLE AND BENEFICIAL, WORK WITH FAMILIES OF ELIGIBLE ADULT OFFENDERS TO INVOLVE THEM IN TREATMENT FOR THE ELIGIBLE ADULT OFFENDERS.

(3) (a) EACH ENTITY THAT RESPONDS TO THE REQUEST FOR PROPOSALS ISSUED PURSUANT TO SUBSECTION (1) OF THIS SECTION SHALL DEMONSTRATE IN THE RESPONSE THAT THE ADULT OFFENDER PILOT PROGRAM WOULD OPERATE AS A COLLABORATIVE EFFORT AMONG, AT A MINIMUM:

(I) THE DISTRICT ATTORNEY'S OFFICE;

(II) THE DEPARTMENT OF CORRECTIONS;

(III) THE JUDICIAL DEPARTMENT;

(IV) COMMUNITY CORRECTIONS;

(V) LOCAL LAW ENFORCEMENT AGENCIES;

(VI) SUBSTANCE ABUSE TREATMENT AGENCIES;

(VII) COMMUNITY MENTAL HEALTH CENTERS; AND

(VIII) ANY OTHER INTERESTED COMMUNITY MENTAL HEALTH ORGANIZATIONS.

(b) THE RESPONSE SHALL ALSO DEMONSTRATE THAT SAID AGENCIES AND ORGANIZATIONS ARE IN AGREEMENT WITH THE PROPOSED STRUCTURE AND OPERATION OF THE ADULT OFFENDER PILOT PROGRAM, AS DESCRIBED IN THE RESPONSE.

16-8-204. Intensive treatment management pilot program for juvenile offenders - creation - request for proposals - parameters. (1) THERE IS HEREBY CREATED THE INTENSIVE TREATMENT MANAGEMENT

PILOT PROGRAM FOR JUVENILE OFFENDERS TO PROVIDE SUPERVISION AND MANAGEMENT SERVICES TO ELIGIBLE JUVENILE OFFENDERS WHO ARE CHARGED WITH OR ADJUDICATED FOR AN OFFENSE OR WHO ARE FOUND NOT GUILTY BY REASON OF INSANITY. ON OR BEFORE OCTOBER 1, 2000, THE DEPARTMENT, IN CONSULTATION WITH THE DIVISION OF YOUTH CORRECTIONS AND THE JUDICIAL DEPARTMENT, SHALL ISSUE A REQUEST FOR PROPOSALS FROM ENTITIES THAT ARE INTERESTED IN PARTICIPATING IN THE JUVENILE OFFENDER PILOT PROGRAM. ON OR BEFORE MARCH 1, 2001, THE DEPARTMENT, IN CONSULTATION WITH THE DIVISION OF YOUTH CORRECTIONS AND THE JUDICIAL DEPARTMENT, SHALL SELECT FROM AMONG THE RESPONDING ENTITIES ONE ENTITY IN A RURAL COMMUNITY AND ONE ENTITY IN AN URBAN COMMUNITY TO OPERATE THE JUVENILE OFFENDER PILOT PROGRAM. THE DEPARTMENT SHALL BASE ITS SELECTION ON THE PARAMETERS SPECIFIED IN SUBSECTION (2) OF THIS SECTION AND ANY ADDITIONAL CRITERIA ADOPTED BY THE DEPARTMENT.

(2) A JUVENILE OFFENDER PILOT PROGRAM OPERATING PURSUANT TO THIS SECTION SHALL PROVIDE HIGH-INTENSITY SUPERVISION AND TREATMENT SERVICES IN THE COMMUNITY TO ELIGIBLE JUVENILE OFFENDERS IN ORDER TO REDUCE RECIDIVISM AND THE NEED FOR OUT-OF-HOME PLACEMENT OR HOSPITALIZATION. AT A MINIMUM, A JUVENILE OFFENDER PILOT PROGRAM SHALL:

(a) PROVIDE INTEGRATIVE, COST-EFFECTIVE, FAMILY-BASED TREATMENT TO ELIGIBLE JUVENILE OFFENDERS RESIDING IN THE COMMUNITY IN WHICH THE JUVENILE OFFENDER PILOT PROGRAM OPERATES;

(b) PROVIDE SERVICES DESIGNED TO REDUCE DELINQUENT ACTIVITY AND OTHER DESTRUCTIVE BEHAVIORS SUCH AS DRUG AND ALCOHOL ABUSE;

(c) PROVIDE PSYCHIATRIC SERVICES, MEDICATION SUPERVISION, AND CRISIS INTERVENTION, AS NECESSARY;

(d) MAINTAIN A LOW CLIENT-TO-STAFF RATIO;

(e) PROMOTE EDUCATION AND VOCATIONAL SKILLS FOR ELIGIBLE JUVENILE OFFENDERS AND DEVELOPMENT OF POSITIVE SOCIAL RELATIONSHIPS;

(f) PROVIDE INTEGRATED FAMILY-BASED TREATMENT FOCUSED ON THE ELIGIBLE JUVENILE OFFENDER, THE ELIGIBLE JUVENILE OFFENDER'S FAMILY AND PEERS, AND THE ELIGIBLE JUVENILE OFFENDER'S EDUCATIONAL AND VOCATIONAL PERFORMANCE;

(g) PROMOTE THE DEVELOPMENT OF NEIGHBORHOOD AND COMMUNITY SUPPORT SYSTEMS FOR THE ELIGIBLE JUVENILE OFFENDER AND HIS OR HER FAMILY.

(3) AN ENTITY OPERATING A JUVENILE OFFENDER PILOT PROGRAM PURSUANT TO THIS SECTION MAY PROVIDE TRAINING, CONSULTATIVE SERVICES, MONITORING, AND EVALUATION FOR PERSONS PROVIDING SERVICES THROUGH THE JUVENILE OFFENDER PILOT PROGRAM.

(4) (a) EACH ENTITY THAT RESPONDS TO THE REQUEST FOR PROPOSALS ISSUED PURSUANT TO SUBSECTION (1) OF THIS SECTION SHALL DEMONSTRATE IN THE RESPONSE THAT THE JUVENILE OFFENDER PILOT PROGRAM WOULD OPERATE AS A COLLABORATIVE EFFORT AMONG, AT A MINIMUM:

(I) THE DISTRICT ATTORNEY'S OFFICE;

(II) THE DIVISION OF YOUTH CORRECTIONS;

(III) THE UNIT WITHIN THE DEPARTMENT OF HUMAN SERVICES THAT IS RESPONSIBLE FOR CHILD WELFARE SERVICES;

(IV) THE JUDICIAL DEPARTMENT;

(V) COMMUNITY CORRECTIONS;

(VI) LOCAL LAW ENFORCEMENT AGENCIES;

(VII) SUBSTANCE ABUSE TREATMENT AGENCIES;

(VIII) COMMUNITY MENTAL HEALTH CENTERS; AND

(IX) ANY OTHER INTERESTED COMMUNITY MENTAL HEALTH ORGANIZATIONS.

(b) THE RESPONSE SHALL ALSO DEMONSTRATE THAT SAID AGENCIES AND ORGANIZATIONS ARE IN AGREEMENT WITH THE PROPOSED STRUCTURE AND THE OPERATION OF THE JUVENILE OFFENDER PILOT PROGRAM, AS DESCRIBED IN THE RESPONSE.

16-8-205. Department - guidelines. THE DEPARTMENT SHALL ADOPT GUIDELINES, AS NECESSARY, FOR THE IMPLEMENTATION OF SECTIONS 16-8-203 AND 16-8-204, INCLUDING, AT A MINIMUM, GUIDELINES SPECIFYING THE DEADLINES, PROCEDURES, AND FORMS FOR RESPONDING TO THE REQUEST FOR PROPOSALS ISSUED PURSUANT TO SAID SECTIONS AND THE EVALUATIVE INFORMATION TO BE REPORTED PURSUANT TO SECTION 16-8-206. IN ADDITION, THE DEPARTMENT MAY ADOPT ADDITIONAL CRITERIA THAT ARE IN ACCORDANCE WITH THE PARAMETERS SPECIFIED IN SECTIONS 16-8-203 (2) AND 16-8-204 (2) FOR SELECTING THE ENTITIES THAT WILL OPERATE THE ADULT OFFENDER PILOT PROGRAM AND THE JUVENILE OFFENDER PILOT PROGRAM.

16-8-206. Intensive treatment management pilot programs - reporting requirements - evaluation. (1) ON OR BEFORE OCTOBER 1, 2002, AND ON OR BEFORE EACH OCTOBER 1 THEREAFTER, EACH ENTITY THAT IS SELECTED TO OPERATE AN ADULT OFFENDER PILOT PROGRAM CREATED PURSUANT TO SECTION 16-8-203 OR A JUVENILE OFFENDER PILOT PROGRAM CREATED PURSUANT TO SECTION 16-8-204 SHALL SUBMIT TO THE DEPARTMENT INFORMATION EVALUATING THE PROGRAM. THE DEPARTMENT SHALL SPECIFY THE INFORMATION TO BE SUBMITTED, WHICH INFORMATION AT A MINIMUM SHALL INCLUDE:

(a) THE NUMBER OF PERSONS PARTICIPATING IN THE PROGRAM AND AN OVERVIEW OF THE SERVICES PROVIDED;

(b) THE NUMBER OF PERSONS PARTICIPATING IN THE PROGRAM FOR WHOM DIVERSION, PAROLE, PROBATION, OR CONDITIONAL RELEASE WAS REVOKED AND THE REASONS FOR EACH REVOCATION;

(c) THE NUMBER OF PERSONS PARTICIPATING IN THE PROGRAM WHO COMMITTED NEW OFFENSES WHILE RECEIVING SERVICES AND AFTER RECEIVING SERVICES UNDER THE PROGRAM AND THE NUMBER AND NATURE OF OFFENSES COMMITTED;

(d) THE NUMBER OF PERSONS PARTICIPATING IN THE PROGRAM WHO REQUIRED HOSPITALIZATION WHILE RECEIVING SERVICES AND AFTER RECEIVING SERVICES UNDER THE PROGRAM AND THE LENGTH OF AND REASON FOR EACH HOSPITALIZATION.

(2) ON OR BEFORE JANUARY 15, AND ON OR BEFORE EACH JANUARY 15 THEREAFTER, THE DEPARTMENT SHALL SUBMIT A COMPILATION OF THE INFORMATION RECEIVED PURSUANT TO SUBSECTION (1) OF THIS SECTION, WITH AN EXECUTIVE SUMMARY, TO THE JOINT BUDGET COMMITTEE AND THE JUDICIARY COMMITTEES OF THE SENATE AND THE HOUSE OF REPRESENTATIVES

OF THE GENERAL ASSEMBLY. SAID COMMITTEES SHALL REVIEW THE REPORT AND MAY RECOMMEND LEGISLATION TO CONTINUE OR EXPAND THE ADULT OFFENDER PILOT PROGRAM OR THE JUVENILE OFFENDER PILOT PROGRAM.

16-8-206. Repeal of part. THIS PART 2 IS REPEALED, EFFECTIVE JULY 1, 2007.

SECTION 2. Safety clause. The general assembly hereby finds, determines, and declares that this act is necessary for the immediate preservation of the public peace, health, and safety.

DRAFT

Colorado Legislative Council Staff

STATE FISCAL IMPACT

BILL B

Drafting Number:	LLS 00-0372	**Date:**	November 26, 1999
Prime Sponsor(s):	Rep. Kester Sen. Wham	**Bill Status:**	Interim Committee on Mentally Ill in the Criminal Justice System
		Fiscal Analyst:	Geoff Barsch (866-4102)

TITLE: CONCERNING THE CREATION OF COMMUNITY-BASED MANAGEMENT PILOT PROGRAMS FOR PERSONS WITH MENTAL ILLNESS WHO ARE INVOLVED IN THE CRIMINAL JUSTICE SYSTEM.

Fiscal Impact Summary	FY 2000/2001	FY 2001/2002
State Revenues General Fund		
State Expenditures General Fund	$1,034,261	$2,970,782
FTE Position Change	6.3 FTE (Contract positions)	19.0 FTE (Contract positions)
Other State Impact: None		
Effective Date: Upon signature by the Governor.		
Appropriation Summary for FY 2000-2001: $1,034,261 GF to the Department of Human Services.		
Local Government Impact: None		

Summary of Legislation

This bill creates community-based intensive treatment management pilot programs to provide supervision and management services to mentally ill adults and juveniles who are involved in the criminal justice system.

The bill instructs the Department of Human Services to issue a request for proposals (RFP) and to select one rural entity and one urban entity to operate an adult offender pilot program and one rural entity and one urban entity to operate a juvenile offender pilot program. The bill lists specific requirements of each proposal and the agencies to be involved. The bill directs the Department of Human Services, in consultation with the Department of Corrections and the Judicial Department, to issue the RFP by October 1, 2000, and select the providers by March 1, 2001.

The bill further requires each entity operating a pilot program to report annually to the Department of Human Services specified information concerning the operation of the program, and

directs the department to report annually to the General Assembly. The pilot programs are repealed effective July 1, 2007.

State Expenditures

This bill is assessed as having a fiscal impact of $1,034,261 in FY 2000-01 and $2,970,782 in FY 2001-02.

The Department of Human Services reviewed programs currently operating in Colorado to estimate the cost of an adult offender pilot program and juvenile offender pilot program. The fiscal note assumes four pilot sites will be selected, one urban and one rural for both adult offenders and offenders. These pilot sites would operate beginning March 1, 2001 (4 months in FY 2000-2001) and accommodate 60 offenders annually.

Adult Offender Pilot Program. This program would be based on an Assertive Community Treatment (ACT) model and use 19 contract FTE (9.5 FTE at each site). Costs to operate the sites are detailed in Table 1. ACT programs are characterized by:

- community-based treatment approaches;
- multidisciplinary staff including psychiatrists, nurses, case managers, and counselors;
- low client to staff ratios (typically 10 to 1);
- psychopharmacologic treatment; and
- collaboration with families and assistance with children.

Table 1
Adult Offender Pilot Program

Expense	FY 2000-01 Costs Per Site (Four months)	FY 2000-01 Two Sites (Four months)	FY 2001-02 Two Sites (12 months)
Contract Personal Services 9.5 FTE per site	$137,577	$275,154	$825,462
Start up costs	$22,000	$44,000	
Client Housing and Expenses 60 clients per site	$134,100	$268,200	$804,600
Operating Expenses	$38,453	$76,906	$230,718
Leased Space	$25,000	$50,000	$150,000
Total	$357,130	$714,261	$2,010,782

Juvenile Offender Pilot Program. This program will be based on a Multi-systemic Treatment (MST) model and would purchase direct services from the selected provider. MST programs are characterized by:

- low caseloads (typically 5 families per clinician);
- service delivery in home or neighborhood settings;
- 24 hour, 7-day-a-week availability of therapists; and
- provision of comprehensive services.

The fiscal note assumes that contract services would cost $8,000 per client per year and would include training/consultation, supervision, direct services and data collection/evaluation. The total for the juvenille pilot program is $320,000 for four months of FY 2000-01. (60 clients x $8,000 year = $480,000 per site per year, $160,000 per site for four months and $320,000 for two sites).

State Appropriations

This fiscal note indicates a GF appropriation of $1,034,261 to the Department of Human Services will be required for four months of Fiscal Year 2000-01.

Departments Contacted

Corrections
Human Services
Judicial
Public Safety
Colorado District Attorney's Council

Bill C

BY SENATORS Martinez and Anderson;
also REPRESENTATIVES Tool, Kester, and Leyba.

A BILL FOR AN ACT

CONCERNING ELIGIBILITY OF INSTITUTIONALIZED PERSONS FOR AID TO THE NEEDY DISABLED.

Bill Summary

"Appl For Aid To Needy Disabled"

(Note: This summary applies to this bill as introduced and does not necessarily reflect any amendments that may be subsequently adopted.)

Interim Committee to Study the Treatment of Persons with Mental Illness Who are Involved in the Criminal Justice System. Clarifies that an inmate of a public institution who has been diagnosed with serious mental illness, a patient in any medical institution for mental disease, or a patient in any medical institution as a result of having been diagnosed as having psychosis shall not be prohibited from applying for aid to the needy disabled 90 days prior to release.

Excepts an inmate of a public institution who has been diagnosed with serious mental illness from the requirement to apply for supplemental security income benefits and to comply with recommendations for referrals made by the county department in order to qualify for aid to the needy disabled.

Clarifies that an inmate of a public institution who has been diagnosed with serious mental illness shall not be prohibited from applying to the aid to the needy disabled program 90 days prior to release.

Be it enacted by the General Assembly of the State of Colorado:

SECTION 1. 26-2-111 (1) (d), Colorado Revised Statutes, is amended to read:

26-2-111. Eligibility for public assistance. (1) No person shall be granted public assistance in the form of assistance payments under this article unless such person meets all of the following requirements:

(d) The person is not an inmate of a public institution, except as a patient in a public medical institution, or is not a patient in any institution for tuberculosis or mental diseases, or is not a patient in any medical institution as a result of having been diagnosed as having tuberculosis or psychosis; but the provisions of this paragraph (d) shall not be applicable to or in any way affect the class of old age pension recipients provided for in subsection (2) (a) (III) of this section. NOTHING IN THIS PARAGRAPH (d) SHALL BE CONSTRUED TO PROHIBIT APPLICATION FOR AID TO THE NEEDY DISABLED NINETY DAYS PRIOR TO RELEASE BY AN INMATE OF A PUBLIC INSTITUTION WHO HAS BEEN DIAGNOSED WITH SERIOUS MENTAL ILLNESS, A PATIENT IN ANY MEDICAL INSTITUTION FOR MENTAL DISEASE, OR A PATIENT IN ANY MEDICAL INSTITUTION AS A RESULT OF HAVING BEEN DIAGNOSED AS HAVING PSYCHOSIS.

SECTION 2. 26-2-111 (4) (b.5), Colorado Revised Statutes, is amended, and the said 26-2-111 (4) is further amended BY THE ADDITION OF A NEW PARAGRAPH, to read:

26-2-111. Eligibility for public assistance. (4) **Aid to the needy disabled.** Public assistance in the form of aid to the needy disabled shall be granted to any person who meets the requirements of subsection (1) of this section and all of the following requirements:

(b.5) He or she has applied for supplemental security income benefits and complied with any recommendations for referrals made by the county department except for good cause shown; EXCEPT THAT AN INMATE OF A PUBLIC INSTITUTION WHO HAS BEEN DIAGNOSED WITH SERIOUS MENTAL ILLNESS IS NOT

REQUIRED TO COMPLY WITH THE REQUIREMENTS SPECIFIED IN THIS PARAGRAPH (b.5).

(g) NOTHING IN THIS SUBSECTION (4) SHALL BE CONSTRUED TO PROHIBIT AN INMATE OF A PUBLIC INSTITUTION WHO HAS BEEN DIAGNOSED WITH SERIOUS MENTAL ILLNESS FROM APPLYING FOR THE AID TO THE NEEDY DISABLED PROGRAM NINETY DAYS PRIOR TO RELEASE FROM THE PUBLIC INSTITUTION IN ORDER TO BEGIN RECEIVING BENEFITS IMMEDIATELY AFTER RELEASE FROM THE PUBLIC INSTITUTION.

SECTION 3. Safety clause. The general assembly hereby finds, determines, and declares that this act is necessary for the immediate preservation of the public peace, health, and safety.

DRAFT

BILL C

Colorado Legislative Council Staff

STATE and LOCAL FISCAL IMPACT

Drafting Number:	LLS 00-0375	**Date:**	December 7, 1999
Prime Sponsor(s):	Sen. Martinez Rep. Tool	**Bill Status:**	Interim Committee to Study Treatment of Persons with Mental Illness in the Criminal Justice System
		Fiscal Analyst:	Janis Baron (303-866-3523)

TITLE: CONCERNING ELIGIBILITY FOR AID TO THE NEEDY DISABLED.

Fiscal Impact Summary	FY 2000/2001	FY 2001/2002
State Revenues		
~~General Fund~~		
State Expenditures		
General Fund	$ 1,558,356	$ 3,025,685
~~Cash Fund Exempt~~	~~365,991~~	~~756,421~~
FTE Position Change	1.0 FTE County Staff	2.0 FTE County Staff

Other State Impact: None

Effective Date: Upon signature of the Governor

Appropriation Summary for FY 2000-2001:
Department of Human Services $ ~~1,924,347~~ 1,558,356 Total GF
365,991 CFE - County Funds

Local Government Impact: The county share for the Aid to the Needy Disabled Program is 20 percent. FY 2000-01 costs are estimated at $365,991 and FY 2001-02 costs are estimated at $756,421. Counties will need 1.0 FTE in FY 2000-01 and 2.0 FTE in FY 2001-02. These FTE are not appropriated and are shown for informational purposes only.

Summary of Legislation

The bill clarifies that an inmate of a public institution diagnosed with serious mental illness, a patient in any medical institution for mental disease, or a patient in a medical institution as a result of a psychosis diagnosis, shall not be prohibited from applying for the Aid to the Needy Disabled (AND) Program 90 days prior to release. An inmate of a public institution diagnosed with serious mental illness is not required to apply for supplemental security income benefits and to comply with recommendations for referrals made by county departments of social services in order to qualify for AND.

State Expenditures

The bill is assessed at having a fiscal impact of $1,924,347 in FY 2000-01 and $3,782,106 in FY 2001-02. The number of persons who may be affected by this legislation is difficult to ascertain. Inmates released from county jails is estimated at 29,474, and is based upon data from Boulder County which represents approximately 9% of the state's total county prisoners. The number of persons coming out of hospitals who might qualify for benefits under the bill is unknown and is not included in the total population. Costs are predicated on an estimated population of 15,434, adjusted to reflect the following:

- approval rates;
- length of stay in the program (currently an average of 8 months annually);
- processing months;
- those persons who will apply for AND without the bill and are currently in the AND caseload (70%);
- those persons who will apply for AND due to the bill (30%); and,
- that provision of the bill which exempts an inmate of a public institution diagnosed with serious mental illness from applying for supplemental security income benefits.

Current Caseload. It is estimated that there are approximately 2,496 (70%) persons in the current AND caseload diagnosed with a mental illness. Of this number, 50% will apply for SSI and 50% will choose not to apply for SSI and remain on the AND-State Only Program (AND-SO). The cost to provide benefits to these persons is the difference between the gross average grant payment for AND-SO ($244.15 per month) and the net average grant payment for AND-SSI ($192.69 per month) —$51.46. Costs are estimated at $385,332 for FY 2000-01, and $770,565 for FY 2001-02. The total reflects average length of stay and processing months.

Increased Caseload Due to Bill. It is estimated that approximately 1,070 (30%) new persons will apply for AND and receive benefits under this bill. Of the total, 50% will apply for SSI and 50% will not and receive benefits through the AND-SO Program. The estimated cost to provide benefits to SSI eligible persons is $618,290 in FY 2000-01 and $1,301,270 in FY 2001-02. The estimated cost to provide benefits through the AND-SO program is $783,411 in FY 2000-01 and $1,631,643 in FY 2001-02. The total reflects average length of stay and processing months.

County Staff. It is estimated that 1.0 FTE eligibility technician will be needed in FY 2000-01, increasing to 2.0 FTE in FY 2001-02 in order to comply with the bill's requirements. Personal services and operating expenses are identified at $42,922 in FY 2000-01 and $78,628 in FY 2001-02.

Systems Changes. The Client-Oriented Information Network (COIN) System will require $94,392 for 1,311 hours of programming changes in FY 2000-01 only (1,311 hrs. X $72/hr. = $94,392).

Table 1 provides a summary of costs under the bill. Detailed worksheets are available in the Legislative Council fiscal note office.

TABLE 1 — COSTS	FY 2000-01	FY 2001-02
Current Caseload Impact	$ 385,332	$ 770,565
Increase in Caseload Due to Bill	1,401,701	2,932,913
County Staff	42,922	78,628
DHS - Systems Changes	94,392	0
Total	$ 1,924,347	$ 3,782,106

Local Government Impact

The fiscal impact to counties is estimated at $365,991 in FY 2000-01 and $756,421. These amounts represent the required 20 percent county share to fund the AND Program.

State Appropriations

The fiscal note indicates that the Department of Human Services should receive an appropriation for $1,924,437 in FY 2000-01. Of this amount, $1,558,356 is General Fund and $365,991 is cash funds exempt local funds.

Departments Contacted

Human Services

Bill D

BY SENATORS Anderson and Martinez;
also REPRESENTATIVES Leyba, Kester, and Tool.

A BILL FOR AN ACT

CONCERNING THE DEVELOPMENT OF A STANDARDIZED SCREENING PROCESS FOR MENTALLY ILL PERSONS IN THE CRIMINAL JUSTICE SYSTEM.

Bill Summary

"Std Screening For Mentally Ill Offenders"

(Note: This summary applies to this bill as introduced and does not necessarily reflect any amendments that may be subsequently adopted.)

Interim Committee to Study the Treatment of Persons with Mental Illness Who are Involved in the Criminal Justice System. Directs the judicial department, the department of corrections, the state board of parole, the division of criminal justice in the department of public safety, the alcohol and drug abuse division within the department of human services, and the unit responsible for mental health services within the department of human services to cooperate to develop a standardized screening process to detect mental illness in persons in the criminal justice system.

Directs the judicial department, the division of youth corrections, the unit responsible for child welfare services, the unit responsible for mental health services, and the alcohol and drug abuse division within the department of human services, the division of criminal justice within the department of public safety, and the department of corrections to cooperate to develop a standardized screening process to detect mental illness in persons in the juvenile justice system.

Requires a joint report to the house and senate judiciary committees regarding the procedures developed as a result of the act.

Repeals the act, effective July 1, 2002.

Be it enacted by the General Assembly of the State of Colorado:

SECTION 1. Title 16, Colorado Revised Statutes, is amended BY THE ADDITION OF A NEW ARTICLE to read:

ARTICLE 11.9

Standardized Screening Process for Mentally Ill Offenders

16-11.9-101. Legislative declaration. THE GENERAL ASSEMBLY HEREBY FINDS AND DECLARES THAT, BASED UPON THE FINDINGS AND RECOMMENDATIONS OF THE 1999 INTERIM COMMITTEE TO STUDY THE TREATMENT OF PERSONS WITH MENTAL ILLNESS IN THE COLORADO CRIMINAL JUSTICE SYSTEM, DETECTING MENTAL ILLNESS IN PERSONS IN THE CRIMINAL JUSTICE SYSTEM IS A DIFFICULT PROCESS WITH NO CURRENT STATEWIDE STANDARDS OR REQUIREMENTS. THE LACK OF A STANDARDIZED SCREENING PROCESS TO DETECT PERSONS WITH MENTAL ILLNESS IN THE CRIMINAL JUSTICE SYSTEM IS A SIGNIFICANT IMPEDIMENT TO CONSISTENT IDENTIFICATION, DIAGNOSIS, TREATMENT, AND REHABILITATION OF ALL MENTALLY ILL OFFENDERS, ULTIMATELY RESULTING IN AN INCREASED RATE OF RECIDIVISM. THEREFORE, THE GENERAL ASSEMBLY HEREBY RESOLVES TO CREATE A STANDARDIZED SCREENING PROCESS TO BE UTILIZED AT EACH STAGE OF THE CRIMINAL JUSTICE SYSTEM TO IDENTIFY PERSONS WITH MENTAL ILLNESS.

16-11.9-102. Mental illness screening - standardized process - development. (1) THE JUDICIAL DEPARTMENT, THE DEPARTMENT OF CORRECTIONS, THE STATE BOARD OF PAROLE, THE DIVISION OF CRIMINAL JUSTICE WITHIN THE DEPARTMENT OF PUBLIC SAFETY, THE ALCOHOL AND DRUG ABUSE DIVISION WITHIN THE DEPARTMENT OF HUMAN SERVICES, AND THE UNIT RESPONSIBLE FOR MENTAL HEALTH SERVICES WITHIN THE DEPARTMENT OF HUMAN SERVICES SHALL COOPERATE TO DEVELOP A STANDARDIZED SCREENING PROCEDURE FOR THE ASSESSMENT OF MENTAL ILLNESS IN PERSONS WHO ARE INVOLVED IN THE ADULT CRIMINAL JUSTICE SYSTEM. THE STANDARDIZED SCREENING PROCEDURE SHALL INCLUDE, BUT IS NOT LIMITED TO:

(a) DEVELOPMENT OF ONE OR MORE STANDARDIZED INSTRUMENTS TO USE IN SCREENING PERSONS WHO ARE INVOLVED IN THE ADULT CRIMINAL JUSTICE SYSTEM;

(b) IDENTIFICATION OF THOSE PERSONS WHO WILL BE SCREENED FOR MENTAL ILLNESS;

(c) THE STAGES WITHIN THE ADULT CRIMINAL JUSTICE SYSTEM AT WHICH A PERSON SHALL BE SCREENED FOR MENTAL ILLNESS; AND

(d) CONSIDERATION OF A STANDARD DEFINITION OF MENTAL ILLNESS, INCLUDING SERIOUS MENTAL ILLNESS.

(2) IN CONJUNCTION WITH THE DEVELOPMENT OF A STANDARDIZED MENTAL ILLNESS SCREENING PROCEDURE FOR THE ADULT CRIMINAL JUSTICE SYSTEM AS SPECIFIED IN SUBSECTION (1) OF THIS SECTION, THE JUDICIAL DEPARTMENT, THE DIVISION OF YOUTH CORRECTIONS WITHIN THE DEPARTMENT OF HUMAN SERVICES, THE UNIT RESPONSIBLE FOR CHILD WELFARE SERVICES WITHIN THE DEPARTMENT OF HUMAN SERVICES, THE UNIT RESPONSIBLE FOR MENTAL HEALTH SERVICES WITHIN THE DEPARTMENT OF HUMAN SERVICES, THE ALCOHOL AND DRUG ABUSE DIVISION WITHIN THE DEPARTMENT OF HUMAN SERVICES, THE DIVISION OF CRIMINAL JUSTICE WITHIN THE DEPARTMENT OF PUBLIC SAFETY, AND THE DEPARTMENT OF CORRECTIONS SHALL COOPERATE TO DEVELOP A STANDARDIZED SCREENING PROCEDURE FOR THE ASSESSMENT OF MENTAL ILLNESS IN JUVENILES WHO ARE INVOLVED IN THE JUVENILE JUSTICE SYSTEM. THE STANDARDIZED SCREENING PROCEDURE SHALL INCLUDE, BUT IS NOT LIMITED TO:

(a) DEVELOPMENT OF ONE OR MORE STANDARDIZED INSTRUMENTS TO USE IN SCREENING PERSONS WHO ARE INVOLVED IN THE JUVENILE JUSTICE SYSTEM;

(b) IDENTIFICATION OF THOSE PERSONS WHO WILL BE SCREENED FOR MENTAL ILLNESS;

(c) THE STAGES WITHIN THE JUVENILE JUSTICE SYSTEM AT WHICH A PERSON SHALL BE SCREENED FOR MENTAL ILLNESS; AND

(d) CONSIDERATION OF A STANDARD DEFINITION OF MENTAL ILLNESS, INCLUDING SERIOUS MENTAL ILLNESS.

16-11.9-104. Report to the general assembly. ON OR BEFORE MARCH 1, 2002, THE JUDICIAL DEPARTMENT, THE DEPARTMENT OF CORRECTIONS, THE STATE BOARD OF PAROLE, THE DIVISION OF CRIMINAL JUSTICE WITHIN THE DEPARTMENT OF PUBLIC SAFETY, AND THE DEPARTMENT OF HUMAN SERVICES SHALL JOINTLY MAKE A REPORT TO A JOINT MEETING OF THE JUDICIARY COMMITTEES OF THE SENATE AND THE HOUSE OF REPRESENTATIVES REGARDING THE STANDARDIZED SCREENING PROCEDURES DEVELOPED PURSUANT TO THIS ARTICLE AND THE NEED FOR AND UTILITY OF FURTHER LEGISLATION TO IMPLEMENT THE STANDARDIZED SCREENING PROCEDURES DEVELOPED PURSUANT TO THIS ARTICLE.

16-11.9-105. Repeal of article. THIS ARTICLE IS REPEALED, EFFECTIVE JULY 1, 2002.

SECTION 2. Safety clause. The general assembly hereby finds, determines, and declares that this act is necessary for the immediate preservation of the public peace, health, and safety.

DRAFT

BILL D

Colorado Legislative Council Staff

NO FISCAL IMPACT

Drafting Number:	LLS 00-0376	**Date:**	December 4, 1999
Prime Sponsor(s):	Sen. Anderson Rep. Leyba	**Bill Status:**	Interim Committee on Mentally Ill in the Criminal Justice System
		Fiscal Analyst:	Geoff Barsch (303-866-4102)

TITLE: CONCERNING THE DEVELOPMENT OF A STANDARDIZED SCREENING PROCESS FOR MENTALLY ILL PERSONS IN THE CRIMINAL JUSTICE SYSTEM.

Summary of Assessment

This bill directs the Judicial Department, the Department of Corrections, the State Board of Parole, the Department of Public Safety, and the Department of Human Services to cooperate in developing a standardized screening process to detect mental illness in persons in both the adult and juvenile criminal justice systems.

The bill requires the departments to report to a meeting of the joint House and Senate Judiciary Committees by March 1, 2002, on the need for further legislation to implement a standardized screening process. The bill is assessed as having no fiscal impact, as the departments have access to existing instruments and the expertise to analyze them for applicability. This assessment assumes that any costs required to implement a standardized screening process will be identified and included in the recommendation for additional legislation.

The bill is effective upon signature by the Governor and is repealed effective July 1, 2002.

Departments Contacted

Corrections
Human Services
Judicial
Public Safety