Task Force for the Continuing Examination of the Treatment of Persons with Mental Illness who are Involved in the Justice System

&

The Juvenile Justice/Mental Health Subcommittee

A FRAMEWORK FOR SYSTEM IMPROVEMENT ON BEHALF OF YOUTH WITH MENTAL ILLNESS AND CO-OCCURRING DISORDERS IN THE JUVENILE JUSTICE SYSTEM

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Executive Summary

Youth with mental illness and co-occurring disorders are disproportionately represented in the juvenile justice system. Nationally and in Colorado, data estimates that between 40 and 65 percent of detained and committed youth have mental health, substance abuse, developmental disability and other needs. Colorado has recognized that it must better serve these youths and, consequently, better protect and support families and communities. In 2004, legislation was passed requiring the Task Force for the Continuing Examination of the Treatment of Persons with Mental Illness who are Involved in the Justice System to develop a framework for addressing the needs of these youth. This document includes the framework and lays out the results of:

- Ten regional focus groups, including 5 family/youth focus groups (one Spanish speaking family and youth group, one confidential family conference call, one youth in transition group, one family group, and one youth in a commitment group) and five agency/systems focus groups in Grand Junction, Alamosa, Fort Collins, Denver, and Jefferson County;
- A statewide, open participation survey with three hundred and thirty participants answering questions across a range of juvenile justice and mental health issues and ranking priorities for change in the system;
- Task Force and subcommittee participant input from meetings throughout the process;
- research on best practices in Colorado and nationally on priority issues to identify year one recommendations, both legislative and non-legislative;
- research on best practices in Colorado and nationally on additional issues identified by stakeholders as priorities for future examination;
- recommendations for development of the legislatively mandated plan for effectively and collaboratively serving youth with mental illness in the juvenile justice system by July 1st, 2006; and
- recommendations on a range of other issues identified by juvenile justice stakeholders.

<u>Year One Recommendations</u>

Year one priority recommendations include two legislative and two non-legislative. The priority areas for focus were selected by the Juvenile Justice/Mental Health Subcommittee of the Task Force based on the issues identified through the focus groups and survey. The recommendations are:

- Developing legislation for the mandatory coverage of court ordered mental health services when health insurance plans would normally cover the services in a non-court involved situation; and
- Developing legislation to create pilot programs to incite the increased use of family advocacy for youth with mental illness and co-occurring disorders initially in targeted local communities, eventually statewide.

The non-legislative priority recommendations are:

- Assessing the implementation of the mental health screening tool, the MAYSI-2, in the juvenile justice system for the frequency, consistency, and equity of use as well as fidelity of implementation;

- Developing statewide consumer education materials on the juvenile justice system for families and youth with mental illness and co-occurring disorders; and
- Undertaking a planning process to develop a plan to effectively and collaboratively serve youth with mental illness and co-occurring disorders in the juvenile justice system, as required by statute.

The Framework

The framework includes additional recommendations that cover a wide range of community capacity building and systems improvement changes. Highlights include:

- improved assessment, prevention, and intervention services;
- incorporation of system of care principles in the improvement of the juvenile justice system;
- improved cultural competency and training for all parts of the juvenile justice system;
- expansion of diversion, restorative justice programs, and Crisis Intervention Training;
- systemic use of positive youth development models to prioritize both the strengths and needs of youths with mental illness and co-occurring disorders.

The recommendations throughout the framework do not include a specific timeframe. Rather, they require that the Task Force identify priorities for years two through five to address the issues noted in the framework.

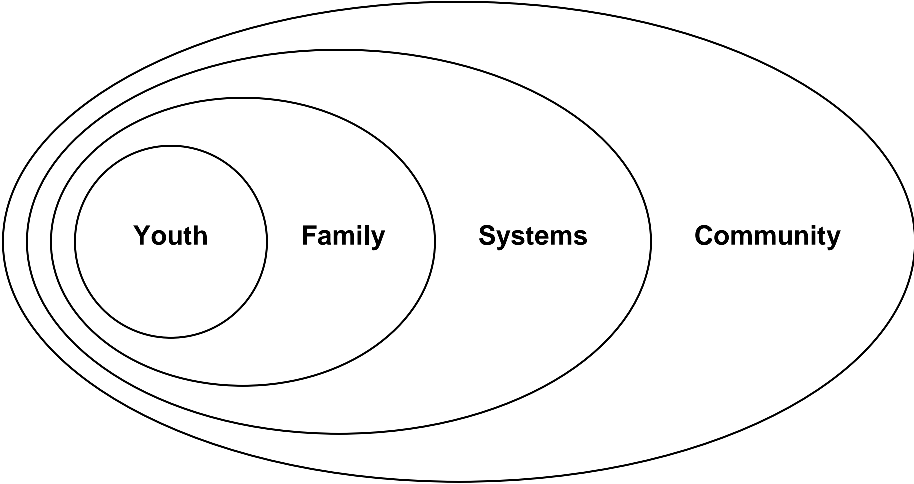
Next Steps

The next steps for the Taskforce will be to:

- Review the recommendations and identify areas of agreement and additional recommendations to consider;
- Prioritize the recommendations and develop a time line and plan to research and implement the changes in a progressive manner;
- Identify the necessary stakeholders and resources to act on the recommendations;
- Identify immediate steps to accomplishing the short term, priority recommendations; and
- Reengage local communities including focus group communities and statewide jurisdictions.

Framework Visual for Youth with Mental Illness and Co-occurring Disorders in the Juvenile Justice System

Youth in the Context of Need



RECOMMENDATION LOCATOR

Rec. #	*Page #*	*Recommendation Summary*	*Recommended Timeline*
1a	11	Develop legislation to ensure coverage of court ordered mental health treatment by health insurers.	Fall 2005
1b	11	Monitor the revisions of the HIFA waiver.	Fall 2005
2a	15	Develop legislation for pilot programs expanding the use of family advocates in the juvenile justice system.	2005 – 2006
2b	15	Identify and assess existing family advocacy models in the Colorado juvenile justice system.	2005 - 2006
3	19	Assess the implementation of the standardized mental health screening tool, the MAYSI-2.	2005 – 2006
4	21	Develop consumer education materials for families in the juvenile justice system.	2005 - 2006
5	24	Collaboratively develop the required plan for effectively and collaboratively serving youth with mental illness and co-occurring disorders in the juvenile justice system.	2005 - 2006
6	28	Invite and support family advocacy organizations and family members in the activities identified as next steps in response to the framework.	Next 5 Years
7	33	Identify and select one or more ways of expanding the use of community recreation centers.	Next 5 Years
8	37	Coordinate with the Prevention Leadership Council to increase juvenile justice prevention programming in Colorado.	Next 5 Years
9	38	Create flexible funding mechanisms for prevention and early intervention services within communities.	Next 5 Years
10	39	Examine the issue of mental health assessments in the juvenile justice system to identify possible concerns and any need for further action.	Next 5 Years
11	41	Identify national best practices and principles of best practice to support and endorse in treatment programs in Colorado’s juvenile justice system.	Next 5 Years
12	42	Assess the barriers to implementing evidence-based treatment programs in Colorado and identify possible solutions.	Next 5 Years

13	44	Assess existing model programs to identify opportunities for expansion.	Next 5 Years
14	45	Assess opportunities to require or support increased cultural competency in the juvenile justice system.	Next 5 Years
15	45	Review diversion programming in Colorado to identify need for and mechanisms to reinstate funding.	Next 5 Years
16	46	Examine restorative justice programming in Colorado to identify need for and opportunities to support and expand local and statewide programs.	Next 5 Years
17	47	Study the issue of specialty courts to identify models appropriate for use in Colorado.	Next 5 Years
18	48	Examine how Colorado communities and other states address the issue of privacy in juvenile justice proceedings.	Next 5 Years
19	48	Assess the need for and existence of cross-training for judicial, human service, and other juvenile justice staff at the state and local level.	Next 5 Years
20	49	Examine information sharing processes in use in Colorado to identify barriers to information sharing, opportunities for improvement, promising practices to build upon, and areas for possible legislative change.	Next 5 Years
21	50	Identify opportunities to engage in and support public education on mental illness and co-occurring disorders in the juvenile justice system.	Next 5 Years
22	51	Examine options for increasing cross-agency accountability in the juvenile justice system	Next 5 Years
23	51	Examine the juvenile justice court process to identify opportunities for decreasing the time prior to responding to the actions and needs of youth with mental illness and co-occurring disorders.	Next 5 Years
24	52	Improve crisis intervention responses in Colorado for families of youth with mental illness and co-occurring disorders.	Next 5 Years
25	53	Consider legislation to support the continuation of a statewide Crisis Intervention Training program.	Next 5 Years
26	54	Identify opportunities to support the increasing use of the positive youth development approach.	Next 5 Years

Introduction and Background to a Framework for Improving Outcomes for Youth with Mental Illness and Co-Occurring Disorders in the Juvenile Justice System

In 2004, the Colorado General Assembly passed Senate Bill 04-037 reauthorizing a task force to examine the issue of mental illness in the criminal justice system. The bill noted that in the previous four years, the task force had begun to, but not completed, its identification of legislative solutions including increased collaboration and communication, standardized screening, community-based treatment, law enforcement training, and local pilot programs. The Task Force for the Continuing Examination of the Treatment of Persons with Mental Illness who are Involved in the Justice System (the Task Force) was charged with a five year plan of activities to examine the identification, diagnosis, and treatment of mentally ill individuals in both the juvenile and criminal justice systems. By July 1, 2005 the Task Force was charged with specifically examining these issues related to juveniles and adopting a framework to address the needs of mentally ill youth and those with co-occurring disorders involved with the criminal and juvenile justice systems.

The Juvenile Justice and Delinquency Prevention Council of the Office of Adult and Juvenile Justice Assistance, Colorado Department of Public Safety (the Council) allocated funding in April of 2005 to conduct research and develop the framework. Consultants for Systems Integration (CSI) and the Colorado Chapter of the Federation of Families for Children's Mental Health (the Colorado Federation), overseen by the Juvenile Justice/Mental Health Subcommittee (the JJ/MH Subcommittee) of the Task Force, collected information to inform the framework. Three approaches for information gathering were used:

1. Ten focus groups facilitated throughout the state;
2. An online survey to allow for involvement by those individuals and communities not selected for the focus groups; and
3. Research on best practices, Colorado models, and other states' models for identification, diagnosis, and treatment of youth with mental illness and/or co-occurring disorders in the juvenile justice system.

CSI and the Colorado Federation held five focus groups across the state with system staff, providers, and other professionals in the juvenile justice and related systems. Juvenile Services Planning Committee members, who oversee SB 94 programming in each judicial district,[1] were invited as well as additional partners to reflect the full range of actors involved in and connected to the juvenile justice system. Another five focus groups were held with families and youth involved with the juvenile justice system. They included:

1) youth committed to the Division of Youth Corrections;
2) youth transitioning out of the juvenile justice system and into adulthood;
3) families in a community support group whose youth have been involved with the juvenile justice system and have mental health needs;
4) families statewide who participated via an anonymous conference call; and
5) Spanish speaking families and their youth who are involved with the juvenile justice system.

[1] SB 94 is a statewide program that provides funding to local jurisdictions to divert youth from detention.

Findings from the focus groups helped to identify priority areas for focus, inform the direction of best practices research, and are used throughout this report to note areas of public concern.

The focus group findings were supported by the findings from the statewide survey. A total of 330 respondents completed the survey and represented all regions of the state, rural and urban areas, and roles in the juvenile justice and related systems. Families, youth, providers, public agency staff at the local and state level, judicial staff, family advocates, and community members all responded to the survey. The survey participants were self-selected rather than randomly sampled, due to time limitations and the desire to allow all interested parties to participate in the information gathering. The close-ended questions covered a wide range of issues including education and information, the use of funding and resources, court practices and rules, screening and evaluation, treatment practices, short and long-term housing, and safety and liability concerns. Survey findings were used to identify priority areas of focus, particularly surrounding the implementation of screening tools, and are used throughout this report to support focus group findings.

Finally, research on best practices was conducted in depth on three issues selected by the JJ/MH Subcommittee as high priority in the short term:

1) Family advocacy and moving toward a family-centered approach to meeting the needs of youth with mental illness and co-occurring disorders in the juvenile justice system;
2) Health insurance coverage for court ordered mental health treatment services; and
3) Mental health screening using the MAYSI-2.

From these three issues, two recommendations for possible legislation and two recommendations for further study emerged. The remaining issues raised in focus groups, the survey, Task Force meetings, and JJ/MH Subcommittee meetings are included in the broader framework with recommendations regarding further study over the next five years. The framework is intended to serve as a roadmap for identifying, assessing, and responding to needs for change in the juvenile justice system as relates to youth with mental illness and co-occurring disorders.

Possible Legislative Recommendations for Changes in the Juvenile Justice System

Ensuring coverage of court ordered mental health treatment by health insurers will help to meet service delivery needs in the juvenile justice system.

Currently, private health insurance companies are not required to cover court ordered mental health treatment services for juveniles in the justice system even if the plan would normally cover such services were they not court ordered. Consequently, families and/or the public system may have increased costs or decreased options for paying for and accessing court ordered mental health services. This same issue was identified with court ordered substance abuse services in 2002 and was addressed legislatively.

In addition to affecting private health insurance this issue impacts children and youth covered by the Child Health Plan Plus. The Child Health Plan Plus is a public-private health insurance program for children from low-income families (above Medicaid and below 185% of the Federal Poverty Level). Services are provided by private health insurance plans and benefits are modeled after commercial health insurance approaches, but tailored to meet the needs of children. As a result, the same concern related to court ordered mental health treatment services for youth covered by private health insurance plans applies to youth covered by the Child Health Plan Plus.

Families, providers, and agency staff in the focus groups noted that the lack of health insurance coverage for court ordered services is a barrier for some families in the juvenile justice system. Although not all families have health insurance that covers the types of services being ordered by the courts, focus group participants indicated that those who do would benefit from requiring insurance coverage in such circumstances.

Historical Background and Examples of Similar Legislation

In 2002, House Bill 02-1263 was passed into statute (C.R.S.10-16-104.7) to provide coverage for substance abuse treatment services regardless of whether the treatment is voluntary or court-ordered as a result of contact with the criminal justice system. The legislation highlighted several specific contingencies for this coverage by health plans, including requirements for coverage if benefits:

- Are medically necessary and otherwise covered under the plan;
- Are rendered by a provider who is designated by and affiliated with the health plan; and
- Are subject to co-payment, deductible, and policy maximums and limitations.

The legislation stated that this could not be construed to mandate that any health benefit plan must provide coverage for substance abuse treatment, but that if the plan already was covering these services that they would be required to continue that coverage if mandated by the court.

The statute had an appropriation of $41,140 to the Department of Health Care Policy and Financing for this bill, but it was associated with an amendment related to the provision of

substance abuse services to Native Americans and not to the portion of the bill associated with court ordered substance abuse services.

Mental Health Legislation

In 2002, the Colorado General Assembly received a full report and recommendations from the Legislative Oversight Committee for the Continuing Examination of Persons with Mental Illness who are Involved in the Criminal Justice System. The committee recommended three priorities for legislation, including requiring health benefits plans that provide coverage for mental health services to continue to provide coverage and treatment regardless of whether it occurs as a result of a contact with the criminal or juvenile justice systems.[1]

In 2003, Senate Bill 03-003 was introduced to expand the legislative intent of the Substance Abuse Bill that passed in 2002 to include mental health services. The bill had similar language as the 2002 Substance Abuse Bill, but failed to pass the Colorado General Assembly.

Upon examination of the two processes, several issues stood out that were different and may have accounted for the varied successes.

- In 2002, HB 02-1263 was passed with a broad range of constituents at the table working together to discuss the issues, including stakeholders from substance abuse, criminal and juvenile justice, and health insurance industry. The constituents discussed the potential problems, barriers, and concerns from the different perspectives and found compromises to address the issues in the legislation. In contrast, the 2003 mental health legislation was put forth without the involvement of the health insurance industry to identify and address their concerns.
- The implementation of HB02-1263 warranted further study prior to proposing the mental health legislation. The health insurance industry and other stakeholders did not have an opportunity to discuss and address outcomes from the substance abuse bill including:
  - ✓ Implications of the bill on private health plans (cost, implementation, etc.);
  - ✓ Future concerns health plans may have in implementing a similar bill for mental health services; and
  - ✓ Provisions that need to be included in a new bill to address these concerns.

The debate over insurance coverage for court-ordered mental health treatment is a national issue. Other states face similar challenges to those identified in Colorado.

- ✓ In 2001, California passed AB 1424, which prohibits any (HMO) plan or disability insurer to use the voluntary or involuntary status of psychiatric inpatient admission for the purpose of determining eligibility for insurance coverage.[2]
- ✓ In 2001, Minnesota passed legislation mandating that private insurance plans (including managed care and indemnity plans), pay for court-ordered mental health services in situations where the:[3]
  - i. Services are otherwise covered by the plan;
  - ii. The court order is based on a behavioral care evaluation performed by a licensed psychiatrist or doctoral level licensed psychologist, which includes a diagnosis and an individual treatment plan for care in the most appropriate and lease restrictive environment; and
  - iii. Care is provided by a participating provider of the health plan company, or by another provider if appropriate care is not available through the plan, or if another provider is required by state law or rule.

It should be noted that both the substance abuse legislation in Colorado and other states' mental health legislation do not require new health insurance benefits. Rather, the laws prohibit private insurance providers from withholding treatment that is regularly included in the policy because the treatment is the result of a court order.

Other Relevant Legislation

Other changes to payment mechanisms for court ordered services are already underway in Colorado. Colorado is undergoing a revision of an existing waiver process known as an 1115 waiver (short for Section 1115 of the Social Security Act), also know as the Health Insurance Flexibility and Accountability Initiative (HIFA) Waiver. Since 2003, the Colorado Department of Health Care Policy and Financing (HCPF) has been involved in research to coordinate and streamline Medicaid, the Child Health Plan *Plus* (CHP+), and the Colorado Indigent Care Program (CICP). The goal is to reduce barriers to participation and create a more seamless system. The proposed waiver would place children (those without significant health needs or expenses) in a program that is similar to CHP+. Children with special health care needs would be put in the same program and given wrap around services or put in a separate program that would meet their needs. In 2005, legislation was passed (Senate Bill 05-221) to set up a legislatively oversight process via hearings in the summer of 2005 for developing and applying for the HIFA waiver.

The implications of this pending waiver for juveniles with mental health and co-occurring disorders are unknown at this time. However, many of the youth with mental illness, co-occurring substance abuse and developmental disabilities that are the focus of this report receive services through these programs. Thus, there is likely to be overlap between the issues addressed by this Task Force and the development of the HIFA waiver.

Recommendation Number 1a:

The Task Force should convene a facilitated dialogue in August 2005 to gain consensus on how to pass legislation on health insurance coverage of court ordered services. Key stakeholders who may be impacted by the issue and should be involved in the dialogue include:

- Mental Health;
- Criminal/Juvenile Justice;
- Judicial;
- Substance Abuse;
- Other representatives from the Task Force;
- Health insurance industry including Kaiser Permanente; and
- Division of Insurance/Commissioner of Insurance.

Recommendation Number 1b:

The Task Force should adopt a process for formally monitoring Colorado's pending HIFA Waiver regarding the revision of an existing Medicaid waiver process known as an 1115 waiver.

Increasing the use of family advocates in the juvenile justice system will support youth with mental illness and co-occurring disorders and their families.

The Colorado juvenile justice system can overwhelm families and youth with requirements and expectations that are complex and often inadequately explained. This may be even more of a problem for those families whose youth have mental health needs and other co-occurring disorders (including substance abuse and developmental disabilities). Beyond simply overwhelming families, the existing system lacks a family-focus that can achieve better outcomes for mentally ill youth and their families and communities. Nationwide, family advocacy has been found to be an important part of achieving a family-centered system that results in the best possible outcomes for youth and their families.

The survey on the juvenile justice system had two questions highly relevant to family advocacy.

1. Of respondents identified as family members, advocates, or youth in the juvenile justice system, 86% (N= 49) "agreed" or "strongly agreed" with the statement "Families are overwhelmed by court requirements." Many agency and provider respondents agreed with the family members, with 69% "agreeing" or "strongly agreeing" that families are overwhelmed (N = 195).
2. Over 70% (N = 42) of family, advocate or youth respondents disagreed with the statement "Families of youth in the juvenile justice system receive information about mental health disorders when their youth is diagnosed." Of the agency and provider respondents, 49% "disagreed" or "strongly disagreed" with the statement that families receive information about mental health disorders (N = 141) while half that number, 23% (N = 67), "agreed" or "strongly agreed" that families do receive information. One family member who responded to the survey noted that:

> *"The prevailing attitude among workers at county human service depts., RTC's, and juvenile justice system entities is that parents are a large part of the problem and therefore parents are not treated as full, equal partners of the 'treatment team'. My impression is that we are expected to wait quietly without expressing opinions until such time as the 'system' decides they have done all they can do or the youth's time is up at which point the family is to welcome the child back with open arms and live happily ever after."*

In the family and systems focus groups, participants consistently identified the need for enhanced advocacy throughout the juvenile and criminal justice systems to help (1) families better understand and navigate the system and (2) the system better respond to family and youth needs, especially as relates to families and youth with mental health and substance abuse needs. Additionally, focus group participants identified a need for a system that is:

- more family and youth centered;
- builds on family strengths;
- provides positive supports to youth and their families;
- utilizes consistent providers and messages;
- creates a team decision making process for sentencing and treatment recommendations; and
- builds on the family, youth, and communities' existing resources.

Focus group participants also stated that in order to transform the juvenile justice system to a more family and youth centered system it would be necessary to make a shift to a less punitive system that:

- is based in a more supportive, constructive, and restorative model;
- creates avenues to divert youth out of the system early;
- provides restorative justice options; and
- provides mental health placement as an alternative to detention.

Local Family Advocacy

Family Advocates exist within the Colorado juvenile justice system using different models and funding streams. For example:

- Colorado Cornerstone System of Care Initiative is a federally funded project located in Clear Creek, Denver, Gilpin, and Jefferson counties. It involves the use of family advocates, service coordinators, and wraparound teams to develop, implement, and monitor individualized service plans. Family advocates, working as paid staff, team with traditional case managers to help youth and their families with a wraparound case planning process. The advocates combine this work at the individual level with system wide advocacy on planning and decision making boards. This project is in its last federally funded year and some of the communities are continuing one or more components of the project using other funding sources.
- The Minority Family Advocacy Programs are funded by the Juvenile Justice and Delinquency Prevention Council federal grant funds. These advocacy programs connect paid minority advocates with minority families in the juvenile justice system. Mesa County has had success decreasing minority youth commitment and detention numbers as a result of the program.[4]

Other communities have used family advocates in the past, including Alamosa's Friends of Family Program that assisted family members in understanding legal expectations and processes. This program placed the family advocate in the mental health center but was closely tied to the juvenile justice system.

All of the above are examples of family advocates providing a service to the families and/or youth in the juvenile justice system. Family advocacy can also serve a second role, however, as noted with the Cornerstone Initiative. They can be part of the system wide planning and decision making. Other examples of this role can be seen in the seven communities implementing the HB04-1451 Memorandums of Understanding. The house bill created a mechanism for counties to opt into an interagency agreement focused on providing integrated services to children, youth, and families in the child welfare system. The bill allows for Family Advocates to be participants at the interagency planning table. Each community is presently implementing the bill with different approaches, including different models for engaging family advocates. Monitoring the development and use of family advocacy models within these processes to identify successes may be an important part of moving forward with local advocacy throughout the state including identifying the need for mandates, resources, and guidelines for full, non-token family participation.

Statewide Family Advocacy

External to the state and local juvenile justice system, family advocacy organizations in Colorado include such groups as the Federation of Families for Children's Mental Health~ Colorado Chapter, Empower Colorado, and Parent to Parent among others.

- The Federation of Families for Children's Mental Health, Colorado Chapter has been in operation as a nonprofit since 1995 and is based in the philosophy that families are the

experts on their children and partnering with them in the delivery of services, both at the individual case and the system planning level, will result in better outcomes for the children and youth. The Federation, staffed by family members whose children have been through the juvenile justice and mental health systems, has representatives on state policy boards, provides conferences, training, support groups, and information for families and system staff. Through support to local chapters and involvement in projects like the Cornerstone Initiative, they are involved in local level advocacy as well.

- Empower Colorado is focused on families whose children have mental health needs, including those who enter the juvenile justice system. It is another example of family advocacy at the state level, through providing ongoing daily support statewide to parents of mentally ill children. It uses multiple mechanisms including a support listserve that allows for anonymity, immediate response, and ongoing support from similarly situated parents; a parent matching program to connected parents in need to another parent in their area whose children are facing similar challenges; and monthly face-to-face groups that are informal and driven by the needs of parents in a given community and include training and support components. In addition to these types of family level advocacy, Empower supports parents who wish to advocate more broadly within the system.
- Parent to Parent of Colorado is a network of parents of kids with all types of special needs, often parents with children who have co-occurring disorders, e.g. developmental disabilities and mental illness. In addition to family level support activities similar to Empower, they also use cluster groups that go beyond support to be advocates in the system for broader systems change. The diversity of needs that bring parents to the group allows for family advocacy support that crosses the system silos and includes over five thousand parents.
- The National Alliance for the Mentally Ill, Colorado (NAMI) provides a similar combination of services. In addition to supportive services to families of individuals with mental health needs, NAMI also engages in public policy advocacy on issues relevant to the mentally ill.

Outside the juvenile justice and mental health systems, other organizations provide examples of advocacy models:

- The Colorado Coalition of Adoptive Families plays a very similar role to Empower for families who have adopted children through the social services system.
- The Arc of Colorado is an example of advocacy at both the individual family level and the systems change level that is undertaken by paid family advocates on behalf of individuals with disabilities.
- Family Voices of Colorado is a chapter of the national, grassroots organization composed of families and friends who care for and about children with special health care needs. Family leaders from around the nation organized Family Voices in December 1992. The primary goal of the organization is to ensure that children's health is addressed amidst change in public and private health care systems.
- Court Appointed Special Advocates (CASA) in the child welfare system provides advocates to speak on behalf of abused and neglected children. The privately funded, statewide network of CASA volunteers are paired with children to gather information and speak on their behalf in court.
- Victim advocates in the justice system are another example of an extensive, paid advocacy model in Colorado, where advocates are available throughout the state at the local level and receive support from a statewide organization. Unlike the previously mentioned advocacy models, Victims Advocates in Colorado are supported by a governmental organization, the Office for Victims Programs in the Division of Criminal Justice. The Victims Rights Act ensures victims receive notifications of court processes, have opportunities to be heard, receive specific types of information and support, and are treated with fairness, respect, and

dignity (C.R.S. 24-4.1-301). Local communities rely on a combination of paid and volunteer victim advocates to meet the requirements of the law.

Outcomes of Family Advocacy and Family Involvement

Researchers have found the family involvement, family-focused approach to system design and service delivery positively affects outcomes for the children, youth, and families involved in formal systems. For example, the following list of professional behaviors and skills were found, across multiple studies, to be an important part of effective mental health service delivery:[5]

- knowledgeable about early intervention;
- adoption of a family centered approach including establishing effective rapport and working relationships with families;
- supportive of families; and
- a positive attitude or outlook.

A second study found the following professional abilities to affect parents perceptions of the success of mental health services: "(1) creating a supportive environment; (2) demonstrating a total commitment to the family; (3) establishing rapport with the family; (4) reinforcing positive aspects of the child; (5) demonstrating sensitivity to family issues; (6) sharing information and building parent's confidence; (7) clarifying team members' expectations; and (8) listening and responding to parents."[6]

Partnerships of family and system were found to be most effective when they included respect for the skills and abilities of everyone involved, clearly defined roles and decision-making, voluntary participation in the collaboration, and honesty and trust building.[7]

Increased parental involvement through collaboration with treatment providers has positive impacts on both the parents and their youth including improved role-modeling by parents, decreased lengths of stay in out of home placement, and positive impacts on treatment outcomes for youth, resulting in cost savings. Parental involvement in their individual youth's case also has systemic impacts. It has been found to increase collaboration between systems (e.g. mental health, education, juvenile justice, etc.) as providers become more aware of the complexities facing the individual family. Parental involvement in case planning has also led to more flexible, adaptable systems as traditional approaches are found to be inadequate and new approaches are explored.[8]

Recommendation Number 2a:

The Task Force should consider legislation to develop pilot projects that:

- Incite local communities to implement family advocacy in a variety of juvenile justice settings, focusing on risk of entry or initial entry into the juvenile justice system (e.g. law enforcement, SB94, schools, assessment centers, etc.);
- Create a variety of mechanisms for engaging family advocacy organizations and individuals in the juvenile justice system;
- Focus on providing navigation, crisis response, and diversion from the juvenile justice system for youth with mental illness and co-occurring disorders and their families;
- Include training for juvenile justice system staff, advocates, and other stakeholders on the role of and partnerships with family advocates in the system;
- Build on existing family advocacy models both nationally and in Colorado;

- Are evaluated for their success including youth and family perceptions of success; and
- Lead to a statewide approach to family advocacy in the juvenile justice system for youth with mental illness and co-occurring disorders and their families.

These pilot projects should encourage:

- Local communities to identify the best setting to implement family advocacy along the continuum of systems;
- Participation through incentives and rewards;
- Consider using or modifying existing models from other systems such as the Child Care Pilots (C.R.S. 26-6.5-103); and
- Development of models and recommendations that lead to a statewide approach to family advocacy in the juvenile justice system.

Recommendation Number 2b:

The Task Force should additionally identify and assess the success of other family advocacy models already underway in Colorado. Such models include:

- HB 1451 communities who are implementing collaborative governing structures for services to children and families in the child welfare system and include, but do not mandate, family advocates;
- SB94 programs that include family advocates;
- Minority advocate programs including those funded through challenge grants from the Division of Criminal Justice;
- System of care advocacy approaches such as the Jefferson County Family Support Network;
- Communities using the Family Nexus materials and approaches; and
- Other local level family advocacy models already underway in Colorado.

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Non-Legislative, Priority Recommendations for Changes in the Juvenile Justice System

Mental health screening practices in the juvenile justice system are inconsistently implemented in the different jurisdictions and parts of the system.

The MAYSI-2 is nationally respected, research-based mental health screening tool implemented in the Colorado juvenile justice system. The Colorado General Assembly passed statutes authorizing, but not requiring, the implementation of the tool in 2002. At present, the implementation of the screening tool is inconsistent across Colorado with judicial districts differing in the extent and timing of the use of the screening tool. This raises issues of the fidelity of the implementation to the standards of the MAYSI-2 and the equity of the implementation for youth in Colorado's juvenile justice system.

The survey and focus groups identified the need to better understand the state of practice in the implementation of the MAYSI-2. The survey included two questions on mental health screening tools in Colorado.

1. The first, "The juvenile justice system needs to improve the screening tools used for identifying mental health needs," elicited responses of "agree" and "strongly agree" from 307 out of 350 respondents (88%).
2. The second, "Full mental health evaluations need to be administered for any youth whose screening identifies a possible mental health need," was selected by 92 respondents as a priority improvement to the juvenile justice system (26%) and was among the six top priorities out of 26 options.

The focus group discussions also highlighted concerns with screening instruments and provided more detail as to the likely causes of dissatisfaction. The primary issue identified by families, providers, and agencies was the lack of a consistent, standardized screening process implemented across all systems and communities to identify mental health and substance abuse needs of youth. Families and providers further highlighted the need for strengths based screening tools, not just risk based. Additional issues included:

1. Initial screenings need to be followed by (1) appropriate evaluation and (2) prioritization of the best course of treatment, developed in partnership with the family and interagency partners.
2. Information gathered from screenings and subsequent evaluations needs to be shared with the youth, family, and interagency partners to ensure the least restrictive, most appropriate sentencing and treatment decisions.
3. Several provider and agency focus groups identified juvenile assessment centers (e.g., JAC, HUB, LINK) as valuable places to screen youth for mental illness. The family participants strongly expressed concerns that the assessment centers were too limited in scope of services, but they did not have any specific concerns with the screening tools used at the assessment centers.
4. In one community, agency and provider participants noted that there is no mental health screening tool being used to identify youth with mental illness in the juvenile justice system, but there are other tools to identify youth and community safety risks.

The MAYSI-2

In 2000, the Colorado General Assembly passed legislation mandating the Division of Criminal Justice in the Department of Public Safety head an interdisciplinary board responsible for development or identification of one or more standardized screening tools for individuals in the adult and juvenile justice systems (16-11.9-102). Two years later, a second piece of legislation (Colorado Senate Bill 02-016) allowed the implementation of the selected screening tool (MAYSI – 2) across the juvenile justice system including in juvenile courts for pre-sentence investigations and post-sentence screening, juvenile diversion programs, and Division of Youth Correction facilities. It further explicitly allowed for the sharing of screening findings without a signed release between agencies participating in assessment centers for children, with the exception of schools. The legislation did not require any agency to implement the tool, nor did it provide funding for the implementation of the screening tool or resultant services identified for youth with mental health needs.

The Massachusetts Youth Screening Instrument (MAYSI-2) is a research based, validated tool with strengths that include:[1]

- nine areas of assessment (Alcohol and Drug Use, Angry-Irritable, Anxiety, Depressed Mood, Fighting, Somatic Complaints, Suicidal Ideation, Thought Disturbance, and Traumatic Experiences), with individual scores for each subscale;
- a scoring system that includes both “caution” and “warning” levels to identify those youth most in need of more expensive responses;
- administration of the test in less than 15 minutes for most youth;
- 5th grade reading level questions for youth to self administer the test; and
- scoring time of approximately three minutes.

The MAYSI-2 can be implemented by non-mental health professionals and is designed for use throughout the juvenile justice system. Over forty states have implemented the MAYSI-2 in probation, detention, and/or juvenile screening programs, 28 of which have statewide implementation.

Implementation of the MAYSI-2

The MAYSI-2 was originally implemented through a pilot program funded by the Juvenile Justice & Delinquency Prevention Council’s federal formula grant.[2] A train the trainer for 23 staff across the state, funded through the same mechanism, was implemented in 2003.[3] Concerns expressed by the trainees included the use of other state data as the basis for the training instead of Colorado data, the lack of buy-in across the state in the use of the MAYSI-2, and implementation concerns that they recommended be addressed prior to future statewide training.[4] For those communities interested in implementing the MAYSI-2, competitive and limited grant funds have been available through the Office of Adult and Juvenile Justice Assistance, funded by the Juvenile Justice & Delinquency Prevention Act II, Federal Formula Grant Program.

As of March 2004, the MAYSI-2 was not consistently in use around the state. Some districts were using it to screen for possible mental health needs at the probation level. Three districts also used it in their diversion programs. The screening tool was not in use in the Youthful Offender System at all.[5] Focus group and follow-up contacts undertaken by CSI indicate that the tool continues to be inconsistently implemented, with some communities not using it prior to adjudication, others using it only with high risk populations, and others implementing the

screening tool with all youth who are assessed by community assessment teams or assessment centers.

All Division of Youth Corrections (DYC) facilities have implemented the MAYSI. This includes detention and commitment facilities. Consequently, youth who enter detention receive more consistent screening than other youth who enter the system.

Other states have implemented the MAYSI-2 statewide in their juvenile justice systems. For example, Florida has mandated implementation of a standardized mental health screening tool prior to detention or commitment. Probation officers are responsible for intake assessments when a child enters the juvenile justice system (including for detention risk assessments, assessing for referral to diversion, teen courts, or other non-judicial processes, and special needs assessments) and are required to implement a mental health assessment with the child to identify the need for further evaluation (Florida statute 985.21(1)4(c)). The MAYSI-2 is the tool selected by the state of Florida to meet this mandate.

Recommendation Number 3:

The Task Force should examine the implementation of the MAYSI-2 over the past three years prior to recommending any changes in legislation. This examination should include:

1. Researching or continuing to research:
    a. Geographical differences in implementation of the mental health screening tool including the capacity of rural, urban, and frontier communities for screening and resultant service needs;
    b. Quality and oversight of trainings;
    c. Fidelity of implementation of the MAYSI-2 to national standards;
    d. The prevalence of mental illness and the needs of youth entering or in the system; and
    e. The processes, including integration and information sharing, in and between the different agencies implementing the screening tool.
2. Assessing costs related to implementation in those parts of the juvenile justice system that have partially or fully implemented the MAYSI-2;
3. Seeking to answer the question of how implementation of the tool can be standardized; and
4. Seeking to answer the question of how to respond to tool findings in communities with greater or lesser capacity to provide mental health services and supports.

Families of youth with mental illness and co-occurring disorders are overwhelmed by the complexities of the juvenile justice system.

Families and youth entering the juvenile justice system face many expectations, legal requirements, and choices. Denver County and Alamosa County have developed brochures to support all families in the juvenile justice system that include information such as:

- legal rights and obligations;
- timeline of hearings including the date and time of each hearing;
- helpful hints for attending and speaking in court;
- a detailed flow chart of progress through the juvenile justice system;
- justice system terminology;

- opportunities for parent involvement; and
- answers to frequently asked questions.

Jefferson Center for Mental Health in Jefferson County, Colorado, has sponsored an interagency group, the Juvenile Justice Behavioral Healthcare Advisory Committee, that hosts a training for parents of youth in the juvenile justice system. The training, awarded a Golden Light Bulb for best practices in the clinical arena from the Colorado Behavioral Healthcare Council, is an interactive overview of the justice system that provides families with a roadmap to guide their own involvement.[6] Although this training is more broadly focused on all youth in the juvenile justice system, it also has targeted information for youth with mental illness and co-occurring disorders and their families.

Another approach to consumer education is the Family Nexus Enriched Support Group Guide, a document developed through funding from the Division of Criminal Justice by a collaboration of the Colorado Federation, Mental Health Association of Colorado, and National Alliance for the Mentally Ill-Colorado. It includes educational modules to increase family knowledge of mental health issues and how to get help for their children. Topics include:[7]

- brain development;
- co-occurring substance abuse disorders;
- finding a mental health professional;
- communication skills;
- problem management;
- partnering with formal systems including education and juvenile justice;
- mental illness stigma;
- understanding how government works;
- advocacy; and
- building support systems.

While this document is designed to be part of support groups for families of children with mental illness, the information is comprehensive and may be useful in a variety of other settings. Other documents produced by family advocacy organizations can serve similar purposes and include guides to advocating on behalf of an individual child, how to access services and supports, and how to deal with specific problem behaviors.

Consumer Education Outside the Colorado Juvenile Justice System

Outside the juvenile justice and mental health systems, Colorado has prioritized consumer education. “Reliable, helpful, and unbiased” information on public health facilities has been mandated to support consumers in their choice of health care (C.R.S. 25-1-124). The General Assembly has found that consumer education regarding rules, regulations, and roles in the motor vehicle regulation are necessary for the protection of public interests (C.R.S. 12-6-101). The Department of Public Safety was required to develop materials for schools on information about sex offenders (C.R.S. 16-11.7-103) and in another educational setting, preschools, educational materials for consumers are considered part of “family support services” to be made available to participating families (C.R.S. 22-28-105).

Nationally, consumer education has been highlighted as a priority by a number of organizations including an interdisciplinary group that has joined together in the development of guidebooks to the child welfare and juvenile justice systems:

- National Technical Assistance Center for Children's Mental Health at Georgetown University;
- Center for Child and Human Development;
- Technical Assistance Partnership for Child and Family;
- Mental Health at American Institutes for Research;
- Federation of Families for Children's Mental Health;
- Child Welfare League of America;
- National Indian Child Welfare Association; and
- National Mental Health Association.

These organizations have developed guides that are well respected and available for use in states and local communities across the country. Topics in the guides include:[8]

- an overview of the systems;
- how investigations proceed;
- the arrest process, options, and alternative tracks;
- how to get an attorney and work with the attorney;
- working with probation officers and caseworkers;
- detention, community supervision, and services for youth in the justice system;
- in home and out of home services;
- the court experience and expectations of the families in the judicial process; and
- possible options and outcomes.

Consumer education materials have been recognized nationally and here in Colorado as important tools to help families of youth with mental illness and co-occurring disorders navigate the juvenile justice system. However, development of consumer education materials may be beyond the capacity of each individual judicial district.

Recommendation Number 4:

The Task Force should develop statewide documents on the juvenile justice system, mental illness, and co-occurring disorders that will be relevant to each jurisdiction to help guide families. To achieve this, the Task Force should fully engage family advocacy organizations and develop sufficient buy-in and respect for the document by judicial and government partners by:

- Creating a state level workgroup including at minimum the Department of Public Safety, Department of Human Services, State Court Administrators Office, local judicial districts, local SB94 coordinators, mental health organizations, and family advocacy organizations;
- Staffing the workgroup to draft bilingual brochures, completed within one year, that build on existing materials and best practices; and
- Publishing electronically in English and Spanish all final materials on websites of judicial agencies, family advocacy organizations, and mental health community partners.

Increasing collaboration and communication across systems will better meet the needs of juveniles with mental illness and co-occurring disorders.

The public and private agencies involved with the juvenile justice system in Colorado have a wide variety of missions, mandates, funding streams, eligibility criteria, case management functions, and service delivery models to meeting the needs of youth with mental illness and co-occurring disorders. This mixture of organizations and approaches can result in disconnected, unaligned, duplicative, or even conflicting processes for meeting the risk and treatment needs of these high-need youth. Survey and focus group participants noted the lack of collaboration in the juvenile justice system:

> *"Collaboration is often lacking. Many times youth and their families have a number of plans to follow and the left and right hand lack needed information."*

The focus group participants placed collaboration as a top priority in three communities and mentioned it in all communities. They emphasized the value of collaborating around the use of funds, on individual cases, and in the planning and policymaking for the juvenile justice system as a whole.

The Colorado General Assembly recognized the need for increased collaboration and communication on behalf of youth with mental illness and co-occurring disorders in the juvenile justice system. In 2004, the authorizing legislation for the Task Force noted this need and additionally required a plan by July 2006 to most "effectively and collaboratively" serve these juveniles (C.R.S. 18-1.9-104 (2)a(III)). Also in 2004, legislation was passed to create a mechanism for interagency collaboration on behalf of families in the child welfare system (HB04-1451, C.R.S. 24-1.9-101). This voluntary model identified key agencies, included optional partners such as family advocates, and provided incentives to communities who entered into the Memorandum of Understanding structure.

Increased collaboration is also recognized nationally as a priority for improving services. Models like System of Care and specific programs such as Wraparound Milwaukee prioritize the development of cross system collaboration combined with partnership with individual families and youth. Collaborative systems have many features that differ from the fragmented, conflicting systems that exist in communities today. These features include:[9]

- shared missions or visions for serving youth in their communities;
- cross-training for all levels of staff;
- alignment in philosophies of practice;
- flexible, aligned funding to meet the individualized needs of communities, families, and youth;
- successful public/private partnerships;
- shared approaches to information collection, dissemination, and use;
- formal processes for communication across agencies;
- dispute resolution processes for cross-agency conflicts;
- mutual planning to address a shared understanding of the needs and strengths in the community and system;
- policies and procedures adjusted to the collective approach; and
- joint evaluations and sharing of outcome information.

Some collaborative systems also prioritize using evidence-based programming and including high levels of family and consumer engagement in system-wide planning.

Best practices in the treatment of youth with mental illness in the juvenile justice system emphasize coordination and integration of services. A program that formerly operated in Denver has been highlighted nationally as a promising practice example of a treatment oriented response to juvenile crime. The Denver Juvenile Justice Integrated Treatment Network coordinated forty public and private agencies to provide integrated treatment for youth with substance abuse problems.[10]

The Boulder IMPACT program (Integrated Managed Partnership for Adolescent Community Treatment), which grew out of the child welfare managed care pilot program legislation in 1997, is another nationally respected model of integrated treatment for juveniles in the justice system. Among the population served by the IMPACT program are juveniles with mental illness and out of home placement needs. The coordinated service delivery approach allows for individualized case planning with flexible funds, non-duplicative services, and a treatment response for youth who may otherwise be detained or committed to the Division of Youth Corrections.[11]

Senate Bill 94 programming, which provides funds to all judicial districts in Colorado to help divert youth from detention, requires an interagency board in each local community. These local juvenile services planning committees have taken on a variety of different roles in many jurisdictions, overseeing programs beyond SB 94. As a collaborative structure, they are being used to make decisions on the commitment of cross-agency funding, make programmatic decisions for services, and make policy decisions regarding juvenile justice practices in a given jurisdiction.

Other Colorado communities and programs that focus on increased collaboration include the System of Care pilot communities. The Cornerstone Project focused on youth with mental illness in the juvenile justice system. It included multi-agency involvement in the governance structure and case management structure, flexible funding, and family involvement throughout the system. Cornerstone's community level boards were outside the justice system governance structure and consequently while being examples of collaborative structures, have not resulted in long term collaborative governance internal to the formal systems.

Initial entry into the juvenile justice system is an important place for collaboration to be successful. Screening and assessment, including mental health screening, sets up the information on which decisions will be made pre- and post-adjudication. Juvenile Assessment Centers are one approach to collaboration early in the juvenile justice system. In Colorado, a variety of models are in use. Some characteristics of most or all of the centers include:

- multi-agency commitments to the operation of the centers including funding and in-kind contributions;
- multi-agency co-located staff;
- information sharing between different parents of the juvenile justice and youth serving systems;
- opportunities for law enforcement to 'drop off' youth for assessment, providing an alternative to immediate release or detention;
- six hour holds for youth, with custody given to parents, guardians, or social services;
- screening and assessment tools for risk, mental health, substance abuse, and other needs; and
- services and referrals to services for both the youth and the family, varying in extensiveness by community.

Colorado joins others nationally in identifying a range of effective and collaborative approaches to meeting the needs of youth with mental illness and co-occurring disorders in the juvenile justice system. A systemic plan for the development of an approach for all of Colorado will require significant consideration of the options, tailoring of any selected approaches, and opportunities for feedback and buy-in from the many stakeholders involved in the juvenile justice system.

Recommendation Number 5:

The Task Force should include the following activities in development of the required plan, due to the legislature by July 1, 2006, for effectively and collaboratively serving youth with mental illness and co-occurring disorders in the juvenile justice system:

- Developing a planning process that includes state and local government, juvenile justice, child welfare, education, mental health, developmental disabilities, substance abuse treatment, families or family advocates, youth, other providers, and other stakeholders as interested;
- Supporting the planning process with research and facilitation staff to ensure timely completion of the plan;
- Assessing the value of juvenile assessment centers as a collaborative process in the justice system and possibilities for their enhancement and/or expansion;
- Identifying national and Colorado best practices in effective and collaborative service delivery that improves community, family, and youth outcomes;
- Identifying legislation in Colorado and other states that has improved effectiveness and collaboration in the juvenile justice system on behalf of youth with mental illness and co-occurring disorders; and
- Reviewing previous planning processes at the state level for a more collaborative system to identify barriers and opportunities.

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Youth in the Context of Need: Their Families, Supportive Systems, and Communities

Youth with Mental Illness and Co-Occurring Disorders

Youth in the juvenile justice system are more likely to have mental health, substance abuse, and other co-occurring disorders than youth in the general population.[1] The National Center for Mental Health and Juvenile Justice estimates that as many as 65% of youth in the juvenile justice system have diagnosable mental illnesses and 20% have serious mental illnesses. In contrast, only 9 – 13% of youth in the general population are estimated to have mental illnesses.[2] In Colorado's Division of Youth Corrections, approximately 40% of committed youths have been diagnosed with moderate or high mental health needs.[3]

The needs of the youth in the juvenile justice system are often not identified and go untreated. Even those youth who receive treatment may not get the type or quality that they need. At the same time, the juvenile justice system becomes the treatment of last resort for those youth whose mental illnesses have not been addressed in the community for a variety of reasons, from lack of family and community resources to stigma to lack of diagnoses. Co-occurring substance disorders are another challenge for many of the youth in the juvenile justice system and may mask underlying mental illnesses.[4]

Youth with mental illness and co-occurring disorders in the juvenile justice system may be male or female, a fact that sometimes gets lost due to the prevalence of male offenders. Females make up approximately one quarter of all juveniles in the justice system[5] and their arrest rates are on the rise for many types of crime,[6] including violent offenses.[7] Girls in the juvenile justice system are highly likely to have mental health and/or co-occurring disorders. A study commissioned by the American Bar Association and National Bar Association to increase understanding of mental illness in the juvenile justice system found almost all girls in the juvenile justice system suffered from either physical or mental health problems.[8] Rates for mental illness are high among incarcerated girls, as are rates for meeting diagnostic criteria for multiple disorders.[9] Misdiagnosis is a serious problem for girls in the justice system, with studies finding justice systems more likely to focus on girls' behaviors rather than the underlying causes including emotional disorders.[10] Girls in the juvenile justice system are also likely to be abusing drugs and alcohol, sometimes to self-medicate and mask symptoms of mental illness and posttraumatic stress disorder.[11]

The youth committed to the Division of Youth Corrections that participated in the focus group for this project described a range of needs, from severe mental illnesses that result in out of control behavior to largely medication-controlled illnesses. They emphasized the importance of medication for mentally ill youth, though they also wanted to better understand and have input into the medication choices made on their behalf and avoid overmedication. The youth discussed the unique and multiple needs they each face including issues such as traumatic responses to being restrained due to past experiences, anger management problems, a need

for consistently available medication while committed and once released, drug and alcohol addictions, developmental delays, and other individual needs. Transitioning youth in a second focus group noted the need for and value of receiving mental health treatment including counseling and other programs available through mental health centers. They emphasized the importance of teaching youth with mental illness the many different ways of managing their illness to prevent deeper involvement in the system, from traditional medication and therapy to alternatives and additions to such as exercise and recreational activities.

The families who participated in the focus groups also described youth with complex mental health needs and co-occurring disorders. They shared the fears they have had of their youths with metal illness when they have been out of control. They described the difficulty of their youth in understanding the connection between actions and consequences. The picture they painted included late diagnoses, failures at multiple levels in the community and formal system, and desperate attempts to get help before things spiraled out of control.

The statistics collected on the total numbers of youth in the juvenile justice system and the stories told about being involved with the system paint a bleak picture. Yet, these youth can successfully terminate their involvement with the juvenile justice system and go on to lead productive, healthy adult lives. Such positive outcomes usually result from best practice programs that provide mental health services to youth; these programs tend to have lower recidivism rates than traditional juvenile justice approaches. Youth in the transitioning focus group gave a face to such successes, demonstrating the ability of youth with mental illness to make good choices when they are supported and their families, communities, and the juvenile justice system meet their needs.

The Family Context

Families are at the core of the ecological system that supports a youth and they serve as the primary socializing force. In their role as a support system, some families may need external help to fully meet the needs of their youth, particularly those youth with mental illness and/or co-occurring disorders. When parents do not receive the support they need to help their youth, or when they are unable to be supportive of their youth, the juvenile justice system may become involved. In fact, studies have found that many of the girls in the juvenile justice system have a history of fragmented families, including placements in multiple foster homes.[12]

While the family may play a role in the behavior of a youth, rather than viewing this as a family failure, successful systems may engage families fully in the treatment process, reopening the opportunity for the family to be the primary support for their youth. Engagement of families is not an easy process for many systems, as traditional approaches tend to view families as part of the problem and highlight their noncompliance or inability to meet the needs of their youth. Treatment providers may also recognize that the parents themselves may have mental illnesses and/or co-occurring disorders. Finally, involvement of families in the youth's treatment process may be hindered due to out-of-community placements, timing of treatment, or transportation limitations.[13]

Despite these challenges, involving families in the treatment process and ensuring they remain at the core of their youth's life is an important part of safely transitioning a mentally ill youth out of the juvenile justice system and back into the community. Family advocacy organizations like

the Federation of Families for Children's Mental Health, Colorado Chapter have put forth principles for family involvement that include:[14]

- Ensuring family members are equal partners in the planning, implementation, and evaluation of services;
- Viewing the child as a whole person and the family as a whole unit, rather than emphasizing the disability;
- Empowering families and children to make decisions about their own lives; and
- Encouraging innovative programming that increases the options and promotes the integration of services

The System of Care approach to mental health services recognizes the role of the family on behalf of both their own youth and all youth in the system. This approach emphasizes that family members should be involved at the policy level, management level, and service level. At the policy level, families can participate in the development and governance of a system. At the management level, family members can work actively on improving the day to day operations of a service delivery system, including evaluating its successes. At the service level, families can be engaged in their own youth's case planning, receive services and supports to stabilize the whole family, and may additionally serve as advocates for other families. System of care approaches recommend that families be invited to work with the system at all three levels, trained to allow for full participation, and supported in their roles.[15]

Recommendation Number 6:

The Task Force should invite and support family advocacy organizations and family members in the activities identified as next steps in response to the framework including:

- Partnering on bringing family voices into local level pilot projects;
- Partnering on the development of any possible legislation that impacts youth and their families in the juvenile justice system; and
- Creating resources to support the involvement of family members, e.g. stipends for family member participation on policy boards at the state and local level.

The System Context

Colorado operates under a decentralized system, serving youth through both state and locally administered programs. Youth engaged in Colorado's Juvenile Justice System receive treatment and intervention from various points of entry into systems that function in various stages of integration and collaboration. The purpose of the following section is to provide a brief overview of the executive and judicial branch roles in juvenile justice system as relates to youth with mental illness and co-occurring disorders.

The Colorado Department of Public Health and Environment

The Colorado Department of Public Health and Environment (CDPHE) seeks to protect and preserve the health and environment for all people in Colorado through its work and administration of programs. CDPHE is currently operating under a three-year strategic plan that prioritizes prevention and intervention services for Colorado children and youth through

improved state and local collaboration. The plan specifically addresses the importance of promoting the provision of financial assistance to communities for the improvement of public safety and to reduce violence and high-risk behaviors among youth.[16] Other activities in the Department that relate to the juvenile justice system include:

- The Prevention Leadership Council (PLC), which consists of individuals from across state agencies, foundations and statewide organizations that are committed to coordinating and streamlining state processes and enhancing the quality and accessibility of prevention and early intervention services for children, youth and families in Colorado. Several of the participants in the PLC provide direct services and treatment for youth with mental illness who are involved with the juvenile justice system.
- The Tony Grampsas Youth Services (TGYS) Program, which is a statutory program housed in the Child, Adolescent and School Health Section, within the Prevention Services Division of the Colorado Department of Public Health and Environment. The TGYS Program was established to provide funding to local organizations that target youth and their families with programs designed to reduce youth crime and violence. In addition, the TGYS Program focuses on funding programs that prevent or reduce child abuse and neglect. Currently, the TGYS Program funds 104 local programs in 61 counties across the state. All TGYS programs must be congruent with the TGYS Logic Model, which focuses the support of children and youth by seeking to either prevent abuse and neglect, or reduce youth crime and violence. Thus, many of the TGYS Programs impact youth with mental illness who are involved with the juvenile justice system.[17]

The Colorado Department of Human Services

The Colorado Department of Human Services oversees many Divisions who provide services, oversight, or coordination to the service delivery component of the juvenile justice system. It also includes the Division of Youth Corrections, bringing the juvenile justice system into the human services system. The Divisions include:

- Division of Youth Corrections, which has responsibility for the housing, treatment and education of juveniles in detention and commitment and supervising juvenile offenders who are placed on parole. The Division also oversees the SB 94 programming, which allocates detention diversion funds to the local judicial districts.
- The Division of Mental Health, which serves the general public with mental health needs, including juveniles, through a continuum of community-based mental health services. It also houses the Cornerstone Initiative, a system of care project focused on youth with mental illness in the juvenile justice system.
- The Alcohol and Drug Abuse Division, which seeks to reduce alcohol and substance abuse and abuse-related illnesses and deaths for individuals and communities. In 2004, 82 percent of individuals (adult and juvenile) with new court commitments in Colorado were identified as substance abusers.[18] ADAD also contracts with the Division of Youth Corrections for direct treatment services.
- The Division of Child Welfare, which provides protection, treatment, and supports to neglected and abused children and their families through a state administered and locally managed service system. Research supports the correlation between children who have experienced abuse, neglect, domestic violence, and other child maltreatment, and increased risk for behaviors that result in involvement with the juvenile justice system. Additionally, youth in the juvenile justice system can receive court ordered services through child welfare for mental health and substance abuse.

The Colorado Department of Health Care Policy and Financing

The Colorado Department of Health Care Policy and Financing is the state agency that is responsible for the administration of the Medicaid program, Child Health Plan Plus, and the Colorado Indigent Care program.

- The Medicaid program is the joint federal and state financing program that pays for the health and long-term care costs of low-income and special needs Colorado residents. The Medicaid program finances various components of treatment and care for youth with mental illness involved with the juvenile justice system. Approximately 30% of Colorado's Division of Youth Corrections beds are located in Residential Treatment Centers, and thus are Medicaid eligible.
- The Child Health Plan Plus is health insurance coverage for low-income children under 19 years of age, who are not eligible for Medicaid, and whose families have incomes at or below 185% of federal poverty level. Coverage includes a package of benefits designed specifically for children and youth and provided by commercial insurers.
- The Colorado Indigent Care program provides limited health care services to individuals and families who are not eligible for health and medical services through any other programs.

The Department is responsible for overseeing the financing, administration and oversight of these programs.

In 2003, the Department initiated research into the development and implementation of a Health Insurance Flexibility and Accountability (HIFA) waiver application to the federal government that would allow for the coordination and streamlining of Medicaid, the Child Health Plan *Plus* (CHP+), and the Colorado Indigent Care Program (CICP) into a single, healthcare program that provides comprehensive benefits to all participants, including the expansion of services to children who require more extensive care. Currently, the Department is reviewing the findings of its research to develop recommendations to implement changes to streamline these programs. Many of the youth with mental illness, co-occurring substance abuse and developmental disabilities that are the focus of this report receive services that are being funded by these programs. Therefore, as the Department develops the HIFA waiver and associated legislation, it will be critical to monitor and ensure that recommended changes to these programs help to improve the provision of needed services for these youth to prevent their fall deeper into the juvenile justice and other systems.

The Colorado Department of Education

The Colorado Department of Education provides oversight for the statewide public education systems, which are locally managed by 178 school districts. Truancy continues to be a primary concern in relation to delinquency, with truancy petitions increasing by 150% between FY 1997/98 to FY 2000/01.[19] Other school incidents of concern include weapons violations, assaults, and drug and alcohol possession and use. These issues are relevant to youth with mental illness who are involved with the juvenile justice system because disciplinary action at schools are often correlated with later entry into the juvenile justice system.[20] The Department also oversees the Safe and Drug Free Schools program, which seeks to prevent violence in and around schools.

The Colorado Department of Public Safety

The Colorado Department of Public Safety oversees the Division of Criminal Justice. Within the Division is the Office of Adult and Juvenile Justice Assistance, which has the responsibility for improving the juvenile justice system through collaborative activities with a wide range of stakeholders in Colorado. The office manages the federal Juvenile Justice and Delinquency Prevention fund and provides grants to local and statewide projects.

The Colorado Department of Corrections

The Department houses the Colorado Youth Offender System (YOS). It was established to create a mid-level option for youth between traditional adult and juvenile corrections, targeted for violent youth felons. The YOS seeks to provide youth offenders with a controlled and regimented environment that affirms dignity of self and others, promotes value of work and self-discipline, and develops useful skills and abilities through a comprehensive, needs-based phased program preparing the youth offenders for positive reintegration followed with supportive aftercare. [21]

The Colorado State Judicial Branch

The juvenile courts and probation are located in the Judicial Branch. Juvenile cases can be heard in district courts, county courts, and municipal courts, which are run by local cities. Judges and magistrates hear juvenile cases and have the ability to sentence youth to probation, to services through the Department of Human Services, to commitment in the Division of Youth Corrections, or to special programs available in various jurisdictions.

The Community Context

Youth and their families live within the context of their communities, including both the formal system supports, informal community supports through schools, recreation centers, and churches, and the individual supports from neighbors and key individuals within the community.

Communities provide natural supports to youth with mental illness and co-occurring disorders and their families.

Natural supports are those supports that are within a community, accessible to youth and their families, are consistent with the cultural beliefs, practices, and needs of the family, and not part of a formal service delivery system. They can include such things as community activities, key individuals in the community, community beliefs and norms, and a variety of informal resources. For example, church or sports team members and activities can serve as natural supports. Natural supports, once engaged by a family, serve to build the capacity of the family to support their high-needs youth within the community.

> *Natural supports are the backbone of society that provide the life long supports for community members. These supports were there before formal services and should be there after formal services are no longer needed. A primary focus of services and supports is to engage and strengthen the natural supports for children and families and should not supplant them.* [22]

Natural supports have specific value to youth with mental illness and co-occurring disorders. They can serve to normalize life for a youth facing problems outside the norm, both by engaging them with other youth who have similar needs and by engaging them with youth throughout the community. Parents can benefit in a similar way, finding support from others who have handled similar situations and finding a network of support for their own needs, separate from the needs of their youth. Natural supports serve as an important aspect of a more formal treatment process, as they serve to enhance the treatment and provide long-term support when treatment involvement decreases or ends.

Schools, recreation centers, and community-based programs are all examples of and opportunities to enhance natural supports in the community.

Prevention in Public Schools

Schools provide access to almost all children and are positive, community-based settings where prevention programming can be made widely available. The Positive Behavior Supports (PBS) program supported by the Colorado Department of Education is an example of school-wide programming that promotes "effective school environments that maximize academic achievement and behavioral competence of all learners in Colorado."[23] PBS relies on a combination of rules, routines, and physical arrangements, developed by school staff, to decrease problem behaviors. It focuses on building respect, developing shared norms, and helping students understand and engage in appropriate behavior.

The PBS approach brings parents into the prevention programming, connecting the family and community context for youth. Participation for parents includes joining planning teams for the school, being involved in individual planning for their youth, learning skills for teaching their children to respect others, and participating in a variety of school activities.[24]

Other school-based prevention programs target behaviors linked to future delinquency. For example, bullying prevention programs focus on decreasing childhood aggression, a risk factor for delinquency in teenage years. Similar to PBS, the evidence-based program, Bullying Prevention Program, is school wide and engages all students in most of the program components. Activities include assessing the extent of the bullying problem, opening a dialogue in the school around bullying, setting rules and norms, and maintaining open communication through classroom meetings.[25]

Services in Recreation Centers and Drop-in Centers

Participants in both the provider and family focus groups indicated that recreation centers and community-based programs for youth need to be further developed to strengthen the community based supports for youth, families and communities. These types of programs provide low or no-cost natural supports, mentors, safe activities to youth and their families, and help build self esteem, social engagement, increased independence, and positive peer groups to keep youth out of the juvenile justice system. Additionally, these accessible, youth and family-friendly settings can be used to provide resources specific to mental illness and co-occurring disorders.

Recreation centers are generally community-based centers that offer a variety of scheduled and unscheduled activities, youth programs, and family programs. They also include space

available for community meetings. Examples in Colorado include small cities like Durango that have one recreation center and networks of recreation centers in larger cities like Denver.

Community-based programs include drop-in centers for youth, where socializing is combined with services to create a friendly, safe, and supportive environment. For example, Urban Peak's The Spot is a youth drop-in center that offers a safe place off the streets for high-risk youth (including those with mental illness and co-occurring disorders) while engaging in educational, recreational, and artistic programs. Youth at The Spot can also be connected to the full array of supportive services for high-risk youth available through Urban Peak and its affiliates, creating an extensive continuum of care. Urban Peak's affiliates serve young people in the community by offering a broad range of programs and services including:

- street outreach;
- health services;
- a 40-bed overnight shelter in Denver and another under development in Colorado Springs;
- basic services such as nutritious meals, clothing and hygiene products;
- case management;
- a GED program;
- job skills and job placement;
- computer education;
- creative arts programs; and
- housing options for homeless and high-risk youth.

Recommendation Number 7:

The Task Force should identify and select one or more ways of expanding natural supports through the use of community recreation centers in Colorado for:

- Safe places for youth to engage in pro-social activities;
- Access to services for mental illness and co-occurring disorders;
- Access to other supportive services for youth and their families; and
- Access to services for low-income youth.

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Youth in the Context of Systems: The Components for Successful Systems

Structure: Collaboration, Integration, Funding, Resources

Partnering with the Prevention Leadership Council to enhance prevention in the juvenile justice system will benefit youth with mental illness and co-occurring disorders.

Primary and secondary prevention was highlighted as a priority in focus groups, the project survey and Task Force meetings. The state prioritized prevention and early intervention outside the juvenile justice system as well with legislation in 2002 to create the Prevention Leadership Council (the Council) in the Colorado Department of Public Health and Environment (C.R.S. 25-20.5). The Council is an interagency group with a mission of providing "a strong, unified voice for prevention and early intervention in Colorado" and promoting "coordinated planning, implementation, and evaluation of quality prevention and early intervention services for children, youth, and families at the state and local level." The Council seeks to meet its mission through activities related to coordinating and aligning prevention programming around the state, promoting the use of best practices, increasing collaboration and communication, and supporting local communities.[1]

The Council has a broad focus and includes thirty five different programs to prevent problem behaviors and increase positive behaviors at the state level that address such things as:[2]

- violence, alcohol and drug abuse, child abuse, drinking and driving, positive youth development;
- healthy child care, school readiness, school drop-out prevention, safe/drug free schools;
- injury prevention, child health, healthy nutrition and obesity prevention, smoking, oral health;
- positive parenting, family strengthening, suicide prevention and related mental health issues; and
- teen pregnancy prevention/abstinence and prevention of sexually transmitted diseases.

This existing structure for examining prevention programming and needs in Colorado creates an opportunity to focus on juvenile justice prevention programming. As of 2003, a total of 43 prevention programs were identified and included in the legislatively mandated yearly report on prevention. Of these, only two came out of the Office of Adult and Juvenile Justice Assistance. This suggests a need to partner effectively with other prevention programming to identify shared prevention needs and opportunities to blend resources.

Recommendation Number 8:

The Task Force should formally coordinate with the Prevention Leadership Council to ensure:

- The Task Force and Council are working toward aligned or shared goals as relates to prevention;
- The Task Force and Council share relevant information as relates to each of their mandates and missions; and
- The Council has adequate membership from the juvenile justice agencies and overlapping membership with the Task Force to ensure prevention programming in the juvenile justice system is part of the larger prevention dialogue.

Understanding the multiple funding streams within the juvenile justice system and partner systems may create opportunities for more flexible and/or preventive programming.

Funding issues, both the use of funds and the amount of funding available, were themes in the meetings and focus groups held during the development of this framework. Concerns ranged from the lack of flexibility in funding to the need for more funding for early intervention and prevention services. Although increased funding across the board for the juvenile justice system was frequently mentioned, many stakeholders further emphasized the value of creating a better organized system of funding.

Colorado's juvenile justice funding provides for the housing, treatment, medical care and education of juveniles who are detained while awaiting adjudication or who have been convicted. Over the past 20 years, the committed youth population in Colorado has grown dramatically from 614 children in 1994 to more than 1,300 children in 2003. State funding for Youth Corrections Institutional Programs has grown at a compounded average annual growth rate of 9.2% since 1994.[3]

The DYC budget is divided among three primary areas: Institutional Placement ($45.2 million General Fund), Community Programs ($52.8 million net General Fund), and Administration ($1.2 million General Fund). These budgets have grown significantly in the past 20 years. From FY 1984-85 through FY 2004-05, the *net* General Fund appropriation to the Division grew from $18.8 million to $100.1 million, an increase of $81.3 million. This growth rate represents a compound annual growth rate of 8.7 percent over the 20-year period.[4] During the 12 years since the 6.0 percent limit on General Fund appropriations was established, General Fund appropriations to the Division have exceeded that limit by an average of 3.2% a year.

The General Assembly has taken several steps to control DYC's costs, including reducing the period of mandatory parole from nine months to six months and capping the number of juvenile detention beds.[5]

Since 2000, funding for youth corrections community programs in Colorado has not kept pace with the growing number of adjudicated youth. Additionally, funding for institutional programs and detention for youth involved in the juvenile justice system has grown rapidly, while funding for alternatives to incarceration and mental health treatment for adjudicated youth has declined

substantially. In 2003, the Colorado General Fund appropriation for the Department of Corrections budget surpassed the Department of Human Services budget, a trend which has only continued to grow since then (http://www.state.co.us/gov_dir/leg_dir/jbc/FY05-06apprept.pdf, p. 18).

Colorado provides various community-based alternatives to incarceration for adjudicated youth. Such services include case management, tracking, electronic monitoring, intensive supervision and work programs, mentoring, counseling, and referral to mental health and/or alcohol treatment. Funding for services to divert youth from detention and commitment has been cut by 34% since 2002.

The percentage of youth with High Moderate and Severe Mental Health issues who are committed to the DYC has increased significantly over the last five years. At the same time, the total number of youth has been increasing. The percentage of youth with High Moderate to Severe Mental Health needs has risen from 20.4 percent of the total commitment population in FY 1998-99 to 39.6 percent in FY 2003-04. While the number of youth with High Moderate and Severe Mental Health needs has been increasing over the last six years, the growth has been significant in the youth with Severe Mental Health needs. The number of youth with Severe Mental Health needs has risen from 43 in FY 1998-99 to 97 youth in FY 2003-04, an increase of over 125 percent.[6]

Attempting to address the increasing mental health needs, Colorado established a pilot program to provide mental health services for youth in detention. Funding for this program, Enhanced Mental Health for Detained Youth, was eliminated by the General Assembly in fiscal year 2004 as an overall budget reduction measure, and reinstated in 2005. This targeted mental health service delivery program is an example of funds intended to prevent further penetration into the juvenile justice system.

Recommendation Number 9:

The Task Force should create flexible funding mechanisms for prevention and early intervention services within communities for youth with mental illness and co-occurring disorders in the juvenile justice system including:

- Conducting a formal assessment of communities currently modeling successful *flexible use and/or blending of funds* throughout Colorado (such as the Boulder IMPACT model) and nationwide (such as the Wraparound Milwaukee model), toward statewide implementation of increased funding flexibility.
- Developing legislation to address barriers identified by Colorado collaborative funding projects;
- Identifying legislation to develop more efficient, cross-system, integrated funding streams; and
- Prioritize improving systems integration, particularly as relates to flexible and blended funding, as a means to decrease duplicative spending and increase overall system efficiencies.

Juvenile Justice System Services: Community-based, Family-focused, Individualized, Culturally Competent

Mental health assessments in the juvenile justice system may not be meeting the needs of youth and families in the system.

Survey respondents indicate concern with the quality and timing of mental health screening and assessments in the juvenile justice system. Recommendation number 3 covered the issue of mental health screening using the MAYSI-2, but did not consider any issues related to mental health and substance abuse assessment. Issues that came up in focus groups related to evaluation tools included:

- the lack of information sharing from assessments;
- the length of time between when a full mental health or substance abuse assessment is ordered and when it is completed;
- the quality of the tools in use; and
- the availability of follow-up services once assessments are completed.

Recommendation Number 10:

The Task Force should examine the issue of mental health assessments in the juvenile justice system to identify possible concerns and any need for further action.

The System of Care model for service delivery provides guidance on principles for effective mental health treatment.

Focus group and survey participants mentioned system of care as a model that should be expanded in Colorado.

> *"There needs to be more funding to create an integrated system of care between mental health and juvenile justice."*
>
> *"We need to look at developing a system of care that includes the juvenile justice system in a community planning effort. No one system can resolve the issues facing youth, families and communities. We don't need to invent new services within the juvenile justice system; we just have to agree on the basic community collaborative plan, fund better, coordinate better and use better the services that already are working, and fill in the gaps already identified."*

The Colorado System of Care Collaborative put forth goals and principles for systems change in Colorado in 2003. Their focus is on children and youth with complex needs involved in multiple systems. Some of the goals focus on the services delivered in a collaborative, multi-agency system of care. The goals include:[7]

- **Program quality and standards:** Children, youth, and families will receive high quality services and supports through programs that have and meet defined standards of quality and promote positive outcomes for children, youth, families, and communities; and

- **Program structure and availability:** There will be enough easily accessible and appropriately timed services and supports to meet the needs of children, youth, and families.

A provider and agency focus group provided specific insight into the problems with program structures and availability. They pointed out that many staff in residential treatment centers and other placements do not receive training on the unique needs of youth with mental illness and co-occurring disorders. This lack of appropriate placements results in negative and costly outcomes for the youth including multiple placements and deeper penetration into the juvenile justice system. Specifically, some youth will have additional charges filed as a result of acting out in placements not prepared to deal with their mental illness.

The Collaborative principles include:

- **Child Centered.** Services and supports are provided in the best interest of the child to ensure that the child's and family's needs are being addressed.
- **Family-Focused**. The child is viewed as a part of the whole family. System, services and supports are based on the strengths and needs of the entire family. Children, youth and their families shall participate in discussions related to their plans, have opportunities to voice their preferences and ultimately feel that they own and drive the plan.
- **Individualized.** Plans and supports for children, youth and their families are tailored to the unique culture, beliefs and values, strengths, and needs of each child and family. Funding sources must be flexible to support individualization.
- **Strengths-Based.** Services and supports are based on identified strengths of the child, youth, family, and community.
- **Early Access.** Services and supports should have a prevention and early intervention focus to facilitate wellness for the family.
- **Community-Based.** Services and supports are provided in the most appropriate and least restrictive environment and in the home community of the child, youth and family. The System of Care is community oriented with the location of services, management and decision-making responsibility resting at the community level.
- **Outcome Based and Cost Responsible.** Services and supports are outcome based with clear accountability and cost responsibility. The system values and funds outcome and quality management. This accountability includes prudent and effective use of public and private funds. As communities find ways to reduce the use of restrictive care the funding is retained in the community and reinvested in the prevention and early intervention that has made these improvements possible.

These goals and principles are designed to inform the structure of a service delivery system. National best practices share many of the same key components. According to a National Institute of Mental Health report on best practices, many of the most successful programs "adhere to the values and principles of the system of care framework."[8] For example, Wraparound Milwaukee emphasizes services and supports that are strength-based, individualized to the child, and collaborative across systems. The program is a managed care approach to the delivery of services to children and adolescents who have serious behavioral or mental health needs and are at risk of out of home placement including placement in a juvenile correctional facility. This nationally recognized best practice model has been evaluated for its success and found to decrease recidivism, increase school attendance, and improve children's functioning at home and in their schools.[9]

National and Colorado experts respect wraparound, a core component of the Milwaukee program, in its own right. The wraparound process is based in the youth's community and seeks to engage system resources and natural supports. It emphasizes the importance of the least restrictive environment for service delivery and providing strength-based, individualized services. Wraparound is noted for its focus on culturally competent services and service planning. By fully engaging the family and youth in the development of their service delivery plan, the process recognizes, respects, and draws upon the cultural strengths and uniqueness of the family. Wraparound also engages multiple systems, bringing together a team that includes providers and families, community supports for the family, and others who the family requests to participate. Ideally, the family and their informal supports make up half or more of the total team. Often the plans that emerge from a wraparound process will require flexible funding and include non-traditional services. For example, a family may need help with access to recreation centers, paying their rent, or purchasing transportation. Finally, wraparound processes are very focused on the outcomes for the youth and their family and the safety of all involved, including the community. The individualized nature of services is a key to ensuring successful and safe outcome.[10] Both family and provider/agency focus groups noted the value of wraparound in the juvenile justice system. Family groups prioritized the need to expand the use of wraparound in their communities.

Focus group participants also noted that mental health treatment is more widely available once a youth penetrates deep into the system, in commitment and detention centers. Access to services at this point in the system is neither early intervention nor community-based treatment. Participants in multiple communities also noted that a comprehensive continuum of care is not available in their communities. Rather, funding meets targeted needs at specific points within the system.

Recommendation Number 11:

The Task Force should identify national best practices and principles of best practice to support and endorse in Colorado's juvenile justice system on behalf of youth with mental illness and co-occurring disorders. This may include:

- Assessing the state of practice in Colorado with regards to high quality programs and services;
- Assessing the use of early interventions and preventions versus high-cost alternatives in the Division of Youth Corrections;
- Identifying opportunities for improvement;
- Developing legislative and non-legislative solutions to improve programs and services to youth with mental illness and co-occurring disorders.

Evidence-based practices should be more widely used in the Colorado juvenile justice system.

The Colorado General Assembly recognizes the value of evidence-based programs, as seen in their inclusion in the juvenile Community Accountability Program (C.R.S. 19-2-309.5). The statute identifies Multisystemic Therapy and Functional Family Therapy, two blueprint programs that have been found to improve outcomes for youth and families in the juvenile justice system. Additionally, state pilot programs and local jurisdictions have implemented a variety of evidence-based programming. The Prevention Leadership Council supports the identification of these

best practice programs by providing a website list of prevention programs that meet best practice standards (http://www.cdphe.state.co.us/ps/ipsp/index.html). Focus group participants also prioritized the use of evidence-based practices, specifically mentioning Multisystemic Therapy, and bringing more research into practice throughout the juvenile justice system.

The federal Substance Abuse and Mental Health Services Administration provides tool kits for evidence-based mental health treatment practices as well as a registry of evidence-based programs and practices for treatment of mental illness and co-occurring disorders (http://mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/default.asp). This resource, as well as many others around the country, increases access to information about evidence-based practices. However, barriers to community level implementation of these practices still exist throughout the country including:[11]

- Medicaid does not always cover evidence-based practices or places limits on coverage that create barriers to implementing the practice with fidelity;
- Consumers, family members, direct care providers, administrators, and policymakers may not be aware of the existence and value of evidence-based practices;
- Available clinicians lack the skills and training to deliver evidence-based practices;
- Leadership for implementation and continued high quality of evidence-based services is lacking;
- Evidence-based practices have not always been researched for their effectiveness with different racial and ethnic groups; and
- Systemic infrastructure supports standard practice and not evidence-based programming.

Recommendation Number 12:

The Task Force should assess the barriers to implementing evidence-based treatment programs in Colorado and identify possible solutions.

Model programs in the Colorado juvenile justice system have been successful and should be expanded.

Colorado has many promising programs that could serve as models for expansion to serve additional youth with mental illness and co-occurring disorders. Many have been found through evaluations to be highly successful at meeting their goals, have received positive feedback in the focus groups from families and youth, and are supported by the local and statewide systems. The following are examples of successful programs currently serving youth in Colorado. This list is by no means comprehensive and any examination of model programs should include stakeholder input to identify other programs.

- Job Training Partnership Act provides assessments to economically disadvantaged youth for vocational skills and training needs. This program also assists with child-care, financial aid, job search workshops, transportation, on-the-job training, and skills development.
- Delinquency Adolescent Review Team (DART) is similar to an Individual Education Plan model for kids on the verge of being committed. This county level program brings in the youth's family and a team of stakeholders around the youth to develop the best possible plan at both post-adjudication and pre-sentencing.

- Youth Advocate Program was formerly a grant-funded program and is now funded through the Division of Youth Corrections. The client-centered program follows youth through and across systems by providing one consistent adult figure to guide youth. This program also helps to educate providers through process to better meet the needs of the youth.
- Youthful Offender System (YOS) creates a middle ground between adult prison and the juvenile system for the state's population of serious youthful offenders. YOS uses cognitive-behavioral redirection, a short-term boot-camp phase, structured residential placement with educational programs that include earning a high school diploma or GED, college courses and vocational training, and life skills training in order to prepare youthful offenders for release. After release, youthful offenders are supervised by community parole officers who must make at least two contacts per week. The Colorado Department of Corrections reports that only 16% of offenders who complete the program return to prison within three years of release. This is in contrast to Colorado's adult offenders, nearly half of which recidivate within three years of release, and Colorado's juvenile system, which has a 30% recidivism rate in the first year after release.
- Enhanced Mental Health for Detained Youth is a pilot program to provide mental health services for youth in detention. System-wide, the Division of Youth Corrections had a problem with readmissions to detention and believed that many of the readmitted juveniles suffered from mental health problems that were not being treated in the community.
- Mental Health and Substance Abuse Joint Pilot Initiative provides mental health and substance abuse assessment and treatment services to youths in detention and in post-detention outpatient programs.
- Juvenile Justice Tracking provides intensive supervision of court ordered youths to assist them in remaining in the community in lieu of incarceration.
- Family Support Services is a program shown to be effective in system navigation and assisting with services quickly.
- Workforce Investment Act (WIA) promotes youth employment through federal funding to local communities. Under WIA, eligible youth can be characterized by one or more of the following: a high school dropout, homeless, deficient in basic literary skills, runaway or foster child, pregnant or parenting, an offender, and an individual who requires additional assistance to complete an education, or to secure and hold employment. Along these lines, youth can fall into eight targeted groups: individuals who are school dropouts, basic skills deficient, whose educational attainment is one or more grade levels below the grade level appropriate to the age of the individual, pregnant or parenting youth, individuals with disabilities, including learning disabilities, homeless or runaway youth, offenders, or youth that face serious barriers to employment and identified by each local WIB. Weld, Larimer, and Mesa Counties are among the Colorado communities utilizing WIA for youth in need.
- Youth Conservation Corps/Americorps trains young people to meet the needs of our community through mentoring programs and community-based employment. Youth ages 16-24 year-olds engage in paid, productive, full-time service work to build and establish workforce experience. Larimer and Mesa Counties are among the Colorado counties utilizing this program.

Recommendation Number 13:

The Task Force should create a comprehensive list of existing programs and assess as follows:

- Identify those that could be expanded to serve additional youth with mental illness and co-occurring disorders in Colorado;
- Identify federally funded programs that could increase their integration with the state funded system to expand state juvenile justice resources; and
- Identify new or redirected funding possibilities for expanding the programs.

Families and providers prioritize improving the cultural competency of the juvenile justice system.

Focus group participants prioritized the need to increase capacity for culturally competent and appropriate providers, trainings, services, and information across systems to address cultural issues, treatment in a culturally appropriate setting, and respect for different cultures and values. Cultural competency should not be limited to addressing language barriers. A comprehensive and relevant effort to improve cultural competency should include considerations of community and family roles, perspectives, values, and traditions. It should also include consideration of faith or spiritual practices.

Over the last 10 years, Colorado cities have experienced a dramatic demographic shift. The most prominent is the growth of the Latino population reported in Colorado from 1990 – 2000. State census data show that Latinos now compose 17.1% of Colorado's population, a 73.4% change from 1990.[12] Projections further demonstrate that this dramatic shift in demographics will continue in the coming decades. This population shift or one in any other demographic should be a primary consideration in the planning and implementation of services for youth.

Many Colorado communities have already begun to address this need by including Cultural Diversity Trainings SB 94, and recruiting bilingual staff. Other examples of improved cultural competency include:

- The Mesa County Minority Representation Committee was formed to address issues of cultural competency in the western slope communities in and around Grand Junction. While identifying and addressing concerns of minority overrepresentation in the system, the Committee also initiated an action plan for systemic improvement and hired a bilingual family advocate to work between the justice system and families primarily for translation and system navigation. They report a notable decline of minority overrepresentation since implementation of the Committee, from 60% minority representation in the justice system to 20% currently.
- La Vereda (The Path) is a program of Servicios de la Raza in Denver. The year round program under the Federal Workforce Investment Act, administered through the Mayors Office of Workforce Development, is designed to assist low income, high-risk minority students, 16 to 18 years of age, in achieving their academic and career pursuits. La Vereda also provides year round tutorial assistance along with professional case management services to meet the needs of the student and their families. This program is designed specifically to engage youth in not only acquiring academic skills and abilities, but to attain education goals, actively explore and pursue career options. The

program also provides youth with the opportunity to gain paid and unpaid work experience.

- The Minority Family Advocacy Programs are funded by the Juvenile Justice and Delinquency Prevention Council federal grant funds. These advocacy programs connect paid minority advocates with minority families in the juvenile justice system. Mesa County has had success decreasing minority youth commitment and detention numbers as a result of the program.[13]

Recommendation Number 14:

The Task Force should assess opportunities to require or support increased cultural competency in the juvenile justice system to better meet the needs of youth with mental illness and co-occurring disorders.

Juvenile diversion programs in Colorado have decreased their capacity due to budget cuts.

Juvenile diversion programs in Colorado seek to prevent further entry into the system. They are authorized in statute and diversion is defined in the Colorado Children's Code as "a decision made by a person with authority or a delegate of that person in which the result is that a specific official action of the legal system is not taken against the youth in lieu of participating in individually designed services provided by a specific program" (C.R.S. 19-2-303). Juvenile diversion programs exist in most of the 22 judicial districts. Prior to Fiscal Year 2003, the state had provided partial funding to diversion programs. However, with budget cuts that year, funding was removed and judicial districts across the state responded by decreasing their capacity or, in some cases, closing down the program. Three focus groups prioritized returning funding to diversion programming, discussing its success in their community at preventing further penetration into the system for many youth.

Recommendation Number 15:

The Task Force should review diversion programming in Colorado for:

- Changes due to the statewide budget cuts;
- Outcomes for youth with mental illness and co-occurring disorders; and
- Interest in and value of recovering funding for these programs.

Colorado is supportive of the principles of restorative justice at both the state and local level.

Colorado communities are implementing a variety of different models that focus on improving outcomes for youth in the juvenile justice system through decreased use of primarily punitive measures. For example, restorative justice programs have been implemented in Colorado counties as diverse as Boulder, Denver, Larimer, El Paso, Alamosa, and Pueblo. Restorative justice programs are based on the principle of repairing the harm to individuals and communities. They require that the offender is held accountable for their actions, works with the community and system to repair them, demonstrates their desire to regain their status in the

community, accepts guidance and support from their community, participates in activities to increase empathy with crime victims, builds upon their assets, and addresses their needs to increase their capacity to be a contributing member of the community. The restorative justice model is based on strengths, addresses risks to the community, and moves the justice system into the community.[14]

Focus group participants prioritized the use of restorative justice programs, including emphasizing the need for more paid staff instead of primarily volunteer programs. They described restorative justice as a more appropriate model for protecting community safety than traditional justice system approaches. The Colorado General Assembly recognized the value of restorative justice approaches when they passed legislation in 2001 to create a juvenile Community Accountability Program that includes restorative justice principles and programming (C.R.S. 19-2-309.5). The Colorado Division of Probation Services also values restorative justice principles and uses a Common Ground Statement that reflects them:[15]

> "Colorado Probation is committed to public safety, victim and community reparation through offender accountability, skill and competency development and services to the communities of Colorado."

Recommendation Number 16:

The Task Force should examine restorative justice programming in Colorado including:

- The capacity of Colorado communities to initiate and support restorative justice programming;
- The interest of Colorado communities in receiving support to develop restorative justice programs;
- The models used in other states to initiate and expand restorative justice programming; and
- The outcomes of Colorado and nationwide restorative justice programs for youth with mental illness and co-occurring disorders.

Specialty court models are being considered nationally and here in Colorado as possible solutions to the difficulty of serving mentally ill youth in the juvenile justice system.

Focus group participants mentioned existing and past models of specialty courts in Colorado, including drug courts and teen courts. They also discussed models presently being pursued in their own communities. One focus group prioritized the 'integrated court' model that brings all the cases for one youth or family into one courtroom and another focus group prioritized the use of mental health courts. Specialty courts have received significant attention nationwide and include a broad range of approaches that may be appropriate for youth with mental illness and co-occurring disorders:

- Teen courts (also called youth courts) are based in the belief that for a low level offense, judgment by a youth's peers will have more impact than judgment by an adult. Participation in a teen court is usually a voluntary alternative for the youth, which if accepted diverts the youth from the traditional justice system. Research on the success of teen courts has been varied, with some studies finding very low recidivism rates and others finding little improvement over the traditional justice process. The variation in findings may be the result of the broad range of court and evaluation designs.[16] Worth

noting, one of the provider and agency focus groups that has experience with a teen court expressed concerns that in their experience youth peers tend to be more punitive than traditional courts.

- Drug courts have been defined as "a special court given the responsibility to handle cases involving drug-addicted offenders through an extensive supervision and treatment program." [17] Drug courts vary in their models as they are customized to each jurisdiction, but features include multi-agency involvement in the planning and implementation of the court, training for court officials on drug and alcohol issues, monitoring of drug and alcohol usage, and access to a broad continuum of services and supports, Drug courts are strongly supported by the U.S. Department of Justice and have seen favorable outcomes for participants.[18]
- Mental health courts are designed to replace adversarial processes with more treatment oriented approaches. They use a team decision-making approach where multiple systems come together with judicial oversight to plan for and meet the needs of a mentally ill offender. As of 2005, over 100 mental health courts were in operation around the United States.[19]
- The unified family court model brings all cases involving members of one family in front of one judge. This can include a broad range from domestic violence, substance abuse, abuse and neglect, divorce, and mental illness, to more general criminal acts against property or others. This court model is designed to allow the court to address the needs of the family with a long-term, rehabilitative model. Beyond simply bringing cases into one court, family court models also include collaboration on the part of the systems involved with the family, education for the judge on the variety of issues that come in front of the court, and access to a continuum of services.[20]

Recommendation Number 17:

The Task Force should study the issue of specialty courts to:

- Assess the value of supporting or expanding the use of specialty courts in Colorado;
- Collect existing evaluation information on the outcomes from specialty courts including safety, youth development, and cost savings outcomes; and
- Identify existing specialty courts in Colorado and barriers they are facing that could be addressed through legislation.

Courtrooms do not provide adequate privacy for juveniles with mental illness and co-occurring disorders.

Family and youth participants in the focus groups noted that the courtrooms they had experienced were very public venues, with audiences of other youth and families waiting for their cases to be called. Provider and agency participants also noted this as an issue and discussed privacy as a legal issue due to juvenile records being sealed. One focus group participant noted that their community's city court was held in council rooms where the discussion between the judge and family was quiet enough to remain private, although the room itself was public. The issue of privacy is particularly important for youth and families with mental illness and co-occurring disorders. Reasons for maintaining privacy included embarrassment related to stigma and the increased likelihood of the youth "acting out" in front of their peers.

Recommendation Number 18:

The Task Force should examine how Colorado communities and other states address the issue of privacy in juvenile justice proceedings, particularly pertaining to youth with mental illness and co-occurring disorders.

Learning: Information, Education, Communication, Training

Cross-systems training for professionals in the juvenile justice system is an important part of increasing collaboration.

Survey respondents noted that judicial knowledge of mental health issues and resources is low, with 226 (62.9%) respondents agreeing or strongly agreeing that judges lack information on mental health resources and 211 (59.6%) respondents disagreeing or strongly disagreeing that judges are knowledgeable about mental health issues. Focus group participants, including judges, also discussed the need for increased training, including cross-system training on funding streams and specific training on evidence-based and best practices for serving youth with mental illness.

Collaborative models for service delivery such as system of care emphasize the importance of cross-system training. In fact, many authors have noted the fact that the disciplinary training of system staff is one of the barriers to collaboration as it creates differing lenses through which staff view the needs of youth and families.[21]

Recommendation Number 19:

The Task Force should assess the existing training programs for judicial, human service, and other juvenile justice staff at the state and local level to:

- Identify if cross-training is occurring and to what extent;
- Identify areas for improvement; and
- Identify strong cross-training programs that can be expanded.

Information sharing between different parts of the juvenile justice system is often not easy or successful.

The need for improved information sharing on a case level came up repeatedly in the focus groups. One focus group discussed the challenge of city court officials getting sufficient information about past or pending cases in other courts. Another focus group of all family members emphasized the lack of information sharing between agencies involved with their youth. A priority change identified in a system/provider focus group was the development of a data collection system to streamline sharing information between systems. According to the focus groups, information such as outcomes from screenings and assessments, successes or failures in treatment programs, court histories, previously diagnosed mental illnesses, and case management histories are not being shared.

One focus group of providers and agency staff prioritized dealing with what they called “chaos” in the courtroom, where lack of information and turnover of staff combine to delay court processes. They suggested interagency staffing models like team decision making and wrap-around, where information is shared and decisions are made as a group, as a better model of decision making. Another group prioritized increasing access to treatment related information for individual youth, seeking to improve their outcomes by making sure the best possible treatment decisions are made. Yet another focus group prioritized creating a less disjointed juvenile justice system by finding ways to share information across all levels as a youth moves more deeply into or back out of the system.

Recommendation Number 20:

The Task Force should examine information sharing processes in use in Colorado jurisdictions to identify barriers to information sharing, opportunities for improvement, promising practices to build upon, and areas for possible legislative change to support increased information sharing while still protecting the confidentiality rights of the youth and their family.

The public and policymakers need to receive more education on mental health issues in the juvenile justice system.

One of the major challenges in confronting a public health problem is to increase awareness of the epidemic; with mental illness and co-occurring disorders including substance abuse and developmental disabilities this involves addressing stigma. Raising awareness in the general public, policymakers, service providers, system staff, grant-makers, families, and youth includes focusing on eliminating stigma and promoting early identification, treatment, and interventions.

A top priority emerging from the focus groups was the need for increased education on mental health issues for:

- the *general public*;
- policymakers at state and local levels;
- system staff including judicial; and
- families and youth in the system.

One survey participant noted that, “*Mental Illness education is necessary at all levels, especially the court system.*”

Approaches to public education and awareness efforts include:

- Public awareness campaigns such as the National Mental Health Association’s grassroots initiative, *Campaign for America’s Mental Health*. The goal of this program is to increase the understanding of local educators, primary care providers, and families about children’s mental health disorders. The objectives are to increase public awareness, combat stigma, and also improve both the detection and treatment of children’s mental illnesses. The campaign uses mechanisms such as musicians around the country who do concerts with a children’s mental health theme; advertisements; and other local level activities.
- Education campaigns targeted specifically at policymakers and community leaders. Such programs may focus on mental health, substance abuse, developmental disabilities, and the juvenile justice system. Mechanisms for information sharing may

include presentations, briefs, testimony, and trainings, including opportunities to present to the Mental Health Caucus, Health and Human Services Committees, Task force legislators, and Joint Budget Committee hearings. Issues covered in the educational materials should be relevant to the policymaker, such as avenues to create and enhance effective and flexible funding and programming; recommendations for action; research on outcomes in the juvenile justice system; and other policy relevant issues.

- Education and training to cross-systems staff involved in the juvenile justice system. In addition to the broader concept of cross-systems trainings, specific information about mental illness can be included in training for all system staff.
- Education and information materials for families and youth who have mental illnesses and co-occurring disorders. As noted in the consumer information recommendation, families may also need information about the mental illness and juvenile justice process with which their youth is involved.

In Colorado, organizations such as the Mental Health Association of Colorado, the National Alliance for the Mentally Ill, and the Colorado Federation of Families for Children's Mental Health are dedicated to raising awareness and public understanding of mental health issues.

Recommendation Number 21:

The Task Force should identify opportunities to:

- Regularly communicate and share information with policymakers;
- Partner with community-based non-profits and foundations in educational campaigns and awareness building; and
- Provide regular trainings to staff and educational information to families and youth on mental health and co-occurring disorders.

Outcomes: Accountability, Safety, Youth Development

Interagency boards are a useful way to create systemic accountability, rather than agency level accountability.

Best practice programs like Wraparound Milwaukee and Boulder IMPACT rely on interagency boards to provide oversight and accountability for the system. The system of care model also emphasizes the importance of including consumers and family members on such boards, adding another lay of accountability and creating more opportunities for systemic improvement. Colorado has embraced the multi-agency planning and oversight model in the juvenile justice system through the SB 94 boards, the juvenile services planning committees. The recent child welfare legislation, HB 1451, also supports the use of an interagency board to improve the system. These models hold the individual agencies accountable for their responses to the needs of youth and families in the system. As the juvenile justice system changes and improves to better meet the needs of youth with mental illness and co-occurring disorders, cross agency oversight as part of increased collaboration may be one means of ensuring success.

Recommendation Number 22:

The Task Force should examine options for increasing cross-agency accountability in the juvenile justice system including:

- Assessing the success of interagency oversight in programs like Boulder IMPACT and Wraparound Milwaukee;
- Extending the scope of authority for juvenile services planning committees presently over SB 94 programming;
- Identifying opportunities to coordinate cross-agency accountability with existing efforts such as the Prevention Leadership Council; and
- Considering legislation requiring interagency oversight of the broad range of local juvenile justice services and processes.

Slow court processes that delay consequences for delinquent acts decrease youth accountability for their actions.

Family and youth participants in the focus groups indicated that too much time elapses between when a youth commits a crime and when the court process delivers consequences for the youth's actions. Providers and agency participants also noted that a variety of steps within the juvenile justice system take longer than is absolutely necessary. For example, court processes are often delayed when participants at a hearing lack necessary information or when prosecutors and/or defendant council changes.

Although some focus group participants focused on the punitive response to youth who commit crimes, the research explored during the development of this framework emphasizes the success of strength-based responses. Consequently, at issue may be the need for both more timely consequences for youth in the more traditional juvenile justice model, but also more timely supports and services for youth with mental illness and co-occurring disorders.

Recommendation Number 23:

The Task Force should examine the juvenile justice court process to identify opportunities for timesavings and decreasing the time prior to responding to the actions and needs of youth with mental illness and co-occurring disorders.

Families need help staying safe when their youth with mental illness or co-occurring disorders is in crisis.

During the family focus groups, participants indicated that one of the values of juvenile assessment centers was the opportunity to remove a youth in crisis from his/her home, keeping both the youth and family safe. However, families felt the six-hour limitation on hold times in assessment centers failed to recognize the need for crisis intervention that lasts long enough to de-escalate the problem and ensure the youth and their family are safe when the youth returns home. Provider and agency focus groups also noted the need for more respite care options

when families are in crisis, providing enough time for youth to "cool down" before returning home.

These concerns suggest more information is needed on the options available in communities for short-term placement for youth with mental illness and co-occurring disorders. The Substance Abuse and Mental Health Services Administration describes crisis placements as short-term, 24-7 placements that occur outside a hospital. They are used when a child with a mental illness or co-occurring disorder is out of control and displays aggressive behavior. Parental access to crisis placements helps with stabilizing the child, avoiding deeper penetration into the mental health system, and identifying the next steps for meeting the needs of the child and family.[22]

As of the 1999 publication of the Surgeon General's report on Mental Health in the United States, crisis intervention services including both placement and non-placement options were just beginning to be researched for successful outcomes. Many of these early studies were not controlled research designs, limiting the usefulness of the findings. However, it is worth noting that these studies consistently found that crisis intervention services decreased length and cost of services, out of home placements, and psychiatric placements for children with mental illness.[23]

Recommendation Number 24:

The Task Force should examine the crisis intervention options in Colorado including:

- Identifying the role of assessment centers in crisis intervention approaches;
- Identifying the range of options available for youth with mental illness and co-occurring disorders;
- Identifying gaps in services; and
- Developing recommendations for improved crisis response.

Law enforcement can serve as an important first responder to keep youth, families, and communities safe when youth are in crisis.

Focus group participants highlighted Crisis Intervention Training (CIT) as a strength in their community. CIT prepares law enforcement to effectively deal with situations that pertain to mental illness. More than just training, CIT is designed to divert the mentally ill from the criminal justice system and into treatment programs. In addition to individual officers attending and passing the five day CIT class, communities who are undertake CIT also begin a dialogue between law enforcement, mental health agencies, and hospitals to improve their understanding of the different systems and ensure the mentally ill receive the best possible response.

The CIT model is highly targeted to the needs of a first responder and includes training on mental illness, legal issues, civil commitment, mood disorders, thought disorders, communication and de-escalation skills, pharmacology, co-occurring drug and alcohol abuse, anxiety disorders, phobias, personality disorders, suicide, suicide by cop, elder issues, developmental disabilities, post traumatic stress syndrome, community resources, and tactical considerations. Additionally, the state will pilot a juvenile curriculum this fall, developed through a grant from the Juvenile Justice and Delinquency Prevention Council. This two-day training is

targeted for School Resource Officers and also includes a focus on enhancing the communication and collaboration between schools, mental health, and law enforcement.

Colorado supports CIT through a grant-funded program housed at the Colorado Department of Public Safety. This statewide office has, over the last four years, spearheaded the development of CIT regions, provided coordination and technical assistance to local jurisdictions, ensured consistency and quality of trainings across the state, and expanding the program to cover juveniles. The grant funding for this statewide office ended in June 2005 and the long-term role of the office is uncertain.

Local funding for CIT comes from a variety of sources. The statewide office has covered some training expenses including materials for local communities. Some communities fully cover all their CIT expenses and others partner with surrounding areas to decrease the expense of the training. In 2004, the Colorado General Assembly passed legislation requiring 20% of the fee collected from prisoners for committing and discharging to be used on law enforcement training. Training pertaining to crisis situations and mental health is included in the bill language as one of the optional uses of the funds (C.R.S. 30-1-119).

Recommendation Number 25:

The Task Force should consider legislation to support the continuation of a statewide Crisis Intervention Training program to ensure:

- Consistency and quality of CIT across the state;
- Continued expansion of CIT to new jurisdictions in the state; and
- Broader implementation of the pilot juvenile justice CIT program.

Youth development and strength-based approaches to structuring services, systems, and supports for youth should be more widely utilized.

Focus group participants repeatedly noted the need for strength-based approaches to serving youth with mental illness and co-occurring disorders. Positive youth development is one such approach. It is based in research and provides a model for structuring services, systems, and supports for youth to develop necessary skills and competencies and transition successfully to adulthood. Grounded in the concept of resiliency, positive youth development seeks to help youth overcome or deal with risk factors in their lives. It also seeks to take advantage of opportunities presented by the various stages of adolescent development to influence behaviors, attitudes, and self-esteem.[24]

The youth development approach is most successful when it goes beyond programs, encompassing the community-wide approach to meeting the needs of youth. It is not separate or different from intervention and prevention programming, but rather an approach to doing both. It emphasizes the *protective factors* and *developmental assets* that prepare youth for successful lives. This asset-based approach can also be combined with a risk reduction approach for successful interventions and prevention.

Programs that are staples of many communities, including YMCAs, Boys and Girls Clubs, 4-H programming, and others are examples of positive youth development in specific programming. More community-wide use of positive youth development has been found to decrease risks and

improve positive outcomes for youth. Having diverse programs with many opportunities for youth to become involved enhances this outcome, creating more opportunities for engagement and brain development. [25]

In its application to the mentally ill youth in the juvenile justice system, the positive youth development approach suggests a comprehensive examination of the programmatic and case management practices. Mentally ill youth and those with co-occurring disorders who are in the Colorado juvenile justice system may already face many risk factors. Additional emphasis must be placed on issues of positive youth development specific to girls in the juvenile justice system. Girls have different developmental paths than boys, including placing higher priority on peer relationships, relationships to adults, and connections to others. They are also are more likely to suffer from depression and anxiety.[26]

As noted above in the discussion of evidence-based practices and model programs, Colorado has already taken steps to better meet the needs of these youth through programming that builds on protective factors (e.g. the use of Multisystemic Therapy). With best practices research suggesting the strength-based, individualized model of system of care to be successful with mentally ill youth and positive youth development found to be successful for a broader spectrum of youth, Colorado has an opportunity to transition its services, supports, and management of youth with mental illness and co-occurring disorders to a more strength-based, successful approach.

Recommendation Number 26:

The Task Force should identify opportunities to support the increasing use of the positive youth development approach as they make changes to the juvenile justice system to better meet the needs of youth with mental illness and co-occurring disorders including:

- Changes to case management approaches in the Division of Youth Corrections, probation, and other parts of the juvenile justice system;
- Changes to court practices including specialty courts;
- New or modified intervention or prevention programming; and
- Development of community-based programming and/or supports.

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Conclusion and Next Steps

This report provides recommendations for system improvement on behalf of youth with mental illness and co-occurring disorders in the juvenile justice system. It is designed to include a framework with specific actionable steps to achieve short and long term changes to the juvenile justice system to improve outcomes for these youth in Colorado.

To achieve these changes, the next steps for the Taskforce will be to:

- Review the recommendations and identify areas of agreement and additional recommendations to consider;
- Prioritize the recommendations and develop a time line and plan to research and implement the changes in a progressive manner;
- Identify the necessary stakeholders and resources to act on the recommendations;
- Identify immediate steps to accomplishing the short term, priority recommendations; and
- Reengage local communities including focus group communities and statewide jurisdictions.

Engaging local communities in the next steps for the framework may be accomplished in a variety of ways. Making meetings accessible via conference calls will open participation to stakeholders outside the Denver-metro area. Continuing the use of online surveying, focus groups, and other forms of outreach as additional research is conducted may also be helpful. Finally, learning from local communities how they would like to be involved is important for both successfully engaging them and building support for changes in the juvenile justice system.

Colorado's juvenile justice system has many strengths on which to build: model programs, dedicated staff, a commitment to providing mental health services in the Division of Youth Corrections, actively engaged family advocacy organizations, a steadily increasing commitment to collaboration, and jurisdictions successfully implementing many of the nationally recognized best practices. The opportunity exists to build a strong, successful system that can meet the needs of youth with mental illness and co-occurring disorders in the juvenile justice system.

Appendix A
Legislative Oversight Committee Members

Cheri Jahn, Chair
Representative, District 24

Sue Windels, Vice Chair
Senator, District 19

Judy Solano
Representative, District 31

Ken Kester
Senator, District 2

Debbie Stafford
Representative, District 40

Stephanie Takis
Senator, District 25

Appendix B
Task Force for the Continuing Examination of the Mentally Ill in the Justice System Members (by Appointment)

Departments of Human Services

Debra Kupfer
Division of Mental Health

Maurice Williams
Division of Youth Corrections

Melinda Cox
Child Welfare Services

Janet Wood
Alcohol and Drug Abuse

Michele Manchester
Colorado Mental Health Institute at Pueblo

Diana Dilka
Mental Health Planning and Advisory Committee

Practicing Mental Health Professionals

Michael Cugini

Carrie Merscham

Community Mental Health Centers

Harriet Hall
Jefferson Mental Health

Person with knowledge of public benefits and housing in the state

Christine Highnam

Department of Education

Vacant

Departments of Law

Jeanne Smith

Departments of Social Services

Cindy Dicken
Director of Human Services, Clear Creek County

Local Law Enforcement

George Epp,Director
Sheriffs of Colorado

Bill Kilpatrick, Chief
Golden Police Department

Colorado District Attorney's Council

Ms. Kathy Sasak
Assistant District Attorney

Colorado Criminal Defense Bar

Abraham Hutt
Private Practice

David Kaplan
Public Defender's Office

Person who is a practicing forensic professional in the state

Richard Wihera

Members of the Public

Kay Heil
Deirdre Parker
Steven White

Appendix C
Juvenile Justice/Mental Health Subcommittee Members

Karen Ashby
Presiding Judge
Denver Juvenile Court

Bill Bane
Children's Mental Health Services
Colorado Division of Mental Health

Lily Boyce
Family Advocate
Colorado Federation of Families

Debra Cady
Director, Medical/Psychiatric Services
Colorado Division of Youth Corrections

Teresa Chavez
Supervisor
Arapahoe County, Department of Human Services

Susan Colling
Juvenile Programs
State Court Administrator's Office

George DelGrosso
Executive Director
Colorado Behavioral Healthcare Council

Nora Earnest
Associate Executive Director
The ARC of Colorado

Margie Grimsley
Technical Assistance Coordinator
Colorado Federation of Families

Harriet Hall
CEO
Jefferson Center for Mental Health

Pilar Ingargiola
Policy Consultant
Consultants for Systems Integration

Anna Lopez
Grant Specialist
Division of Criminal Justice/Office of Adult and Juvenile Justice Assistance

Michele Lovejoy
Program Manager
Division of Criminal Justice/Office of Adult and Juvenile Justice Assistance

Jewlya Lynn
Policy Consultant
Consultants for Systems Integration

Ann L Schrader
Executive Director
Colorado Federation of Families

Ray Slaughter
Director
Colorado Division of Criminal Justice

Emily Stoddard
Youth Coordinator
Colorado Federation of Families

Tracy Kraft-Tharp
Project Specialist
Kid Connects

Becky Updike
Policy Consultant
Consultants for Systems Integration

Pamela Wakefield
Chief Deputy District Attorney
18th Judicial District, District Attorney's Office

Meg Williams
Manager
Division of Criminal Justice/Office of Adult and Juvenile Justice Assistance

Appendix D
Juvenile Justice and Delinquency Prevention Council Members

Lindi Sinton, Council Chair
Volunteers of America, Colorado

Katie Wells, Council Vice-Chair
Alcohol and Drug Abuse Division

Katy Avila
Community Member- Youth

Bill Bane
Colorado Division of Mental Health

Steve Bates
Office of Children, Youth and Families
Colorado Department of Human Services

Steve Brittain
Chief Probation Officer
6th and 22nd Judicial Districts

Alison Bujanovich
Community Member- Youth

Susan Colling
State Court Administrator's Office

Jim Covino, Esq.
Attorney

Wendy DeBell
Board of Education, Cherry Creek Schools

Kayla Duran
Community Member- Youth

Regis Groff
Community Member- Former State Senator

Joe Higgins
Mesa County Partners

Chief Rick Holman
Breckenridge Police Department

Larry Hudson
Greenberg Traurig, LLP

Sheriff Gerry Oyen
Bent County Sheriff's Office

Representative Rosemary Marshall
Colorado General Assembly

Bob Pence
Community Member, former Law Enforcement

Kathryn Prose
Community Member- Youth

Judge David L. Shakes
District Judge-State of Colorado

Crystal Talamante
Community Member- Youth

Judge Richard Toth
Senior Judge, Retired

Ted Trujillo
Child Welfare Services

Dianne Pacheco Van Voorhees
Attorney at Law

Pam Wakefield
Chief Deputy District Attorney

Debbie Wilde
Executive Director, YouthZone

Jeremy Wilson
Community Member- Youth

Division of Criminal Justice
Raymond T Slaughter, Director
Carol Poole, Deputy Director

DCJ/Office of Adult and Juvenile Justice Assistance (OAJJA)- Staff
Meg Williams, Manager
Sue Bradley
Susan Davis
Carol Gould
Cindy Johnson
Anna Lopez
Michele Lovejoy
Kenya Lyons
Betty Shipton Mahaffey
Deb Ristow

NOTE: This bill has been prepared for the signature of the appropriate legislative officers and the Governor. To determine whether the Governor has signed the bill or taken other action on it, please consult the legislative status sheet, the legislative history, or the Session Laws.

An Act

SENATE BILL 04-037

BY SENATOR(S) Anderson, Windels, Evans, Fitz-Gerald, Groff, Hanna, Keller, Kester, Phillips, Sandoval, Takis, Tapia, and Veiga;
also REPRESENTATIVE(S) Stafford, Boyd, Butcher, Carroll, Coleman, Frangas, Jahn, Johnson R., Larson, Madden, Marshall, McFadyen, McGihon, Merrifield, Plant, Romanoff, and Williams S.

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

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 1.9
Continuing Examination of the Treatment of Persons with Mental Illness Who are Involved in the Justice System

18-1.9-101. Legislative declaration. (1) THE GENERAL ASSEMBLY

Capital letters indicate new material added to existing statutes; dashes through words indicate deletions from existing statutes and such material not part of act.

HEREBY FINDS THAT:

(a) IN NOVEMBER OF 1998, THE COLORADO DEPARTMENT OF CORRECTIONS REPORTED THAT TEN PERCENT OF ITS CORRECTIONAL POPULATION MET THE DIAGNOSTIC CRITERIA FOR SERIOUS MENTAL ILLNESS, WHICH NUMBER WAS DOUBLE THE NUMBER IDENTIFIED TWO YEARS EARLIER, AND FIVE TO SIX TIMES THE NUMBER DOCUMENTED IN 1988, ONLY TEN YEARS EARLIER;

(b) THE COLORADO DEPARTMENT OF CORRECTIONS ESTIMATES THAT IN 2002, SIXTEEN PERCENT OF ITS INMATE POPULATION MET THE DIAGNOSTIC CRITERIA FOR MAJOR MENTAL ILLNESS;

(c) THE COLORADO DIVISION OF YOUTH CORRECTIONS ESTIMATES THAT TWENTY-FOUR PERCENT OF JUVENILES IN THE JUVENILE JUSTICE SYSTEM ARE DIAGNOSED WITH MENTAL ILLNESS;

(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 SERIOUS MENTAL ILLNESS;

(e) IT IS ESTIMATED THAT NATIONALLY, NEARLY NINE PERCENT OF ALL ADULTS AND JUVENILES ON PROBATION HAVE BEEN IDENTIFIED AS HAVING SERIOUS MENTAL ILLNESS;

(f) FOR THE 1998-99 FISCAL YEAR, APPROXIMATELY FORTY-FOUR PERCENT OF THE INPATIENT POPULATION AT THE COLORADO MENTAL HEALTH INSTITUTE AT 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 AND JUVENILE JUSTICE SYSTEMS;

(h) THE EXISTING PROCEDURES AND DIAGNOSTIC TOOLS USED BY PERSONS WORKING IN THE CRIMINAL AND JUVENILE JUSTICE SYSTEMS MAY NOT BE SUFFICIENT TO IDENTIFY APPROPRIATELY AND DIAGNOSE PERSONS

WITH MENTAL ILLNESS WHO ARE INVOLVED IN THE CRIMINAL AND JUVENILE JUSTICE SYSTEMS;

(i) THE CRIMINAL AND JUVENILE JUSTICE SYSTEMS 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;

(j) STUDIES SHOW THAT, FOR OFFENDERS UNDER COMMUNITY SUPERVISION, TREATMENT OF THE MENTAL ILLNESS OF THE OFFENDER DECREASES REPEAT ARRESTS BY FORTY-FOUR PERCENT; AND

(k) 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) THE GENERAL ASSEMBLY FURTHER FINDS THAT PURSUANT TO THE FINDINGS IN A REPORT REQUESTED BY THE JOINT BUDGET COMMITTEE IN 1999 THAT RECOMMENDED CROSS-SYSTEM COLLABORATION AND COMMUNICATION AS A METHOD FOR REDUCING THE NUMBER OF PERSONS WITH MENTAL ILLNESS WHO ARE INVOLVED IN THE CRIMINAL AND JUVENILE JUSTICE SYSTEMS, THE LEGISLATIVE OVERSIGHT COMMITTEE AND ADVISORY TASK FORCE FOR THE EXAMINATION OF THE TREATMENT OF PERSONS WITH MENTAL ILLNESS WHO ARE INVOLVED IN THE CRIMINAL JUSTICE SYSTEM WERE CREATED IN 1999 AND EXTENDED FOR AN ADDITIONAL THREE YEARS IN 2000. OVER THE COURSE OF FOUR YEARS, THE LEGISLATIVE OVERSIGHT COMMITTEE AND ADVISORY TASK FORCE BEGAN TO ADDRESS, BUT DID NOT FINISH ADDRESSING, THE ISSUES SPECIFIED IN SUBSECTION (1) OF THIS SECTION, THROUGH BOTH LEGISLATIVE AND NON-LEGISLATIVE SOLUTIONS INCLUDING, BUT NOT LIMITED TO:

(a) COMMUNITY-BASED INTENSIVE TREATMENT MANAGEMENT PROGRAMS FOR JUVENILES INVOLVED IN THE JUVENILE JUSTICE SYSTEM;

(b) AN EXPEDITED APPLICATION PROCESS FOR AID TO THE NEEDY DISABLED BENEFITS FOR PERSONS WITH MENTAL ILLNESS UPON RELEASE FROM INCARCERATION;

(c) STANDARDIZED INTER-AGENCY SCREENING TO DETECT MENTAL

ILLNESS IN ADULTS WHO ARE INVOLVED IN THE CRIMINAL JUSTICE SYSTEM AND JUVENILES WHO ARE INVOLVED IN THE JUVENILE JUSTICE SYSTEM;

(d) TRAINING OF LAW ENFORCEMENT OFFICERS TO RECOGNIZE AND SAFELY DEAL WITH PERSONS WHO HAVE MENTAL ILLNESS THROUGH THE USE OF CRISIS INTERVENTION TEAMS; AND

(e) CREATING LOCAL INITIATIVE COMMITTEE PILOT PROGRAMS FOR THE MANAGEMENT OF COMMUNITY-BASED PROGRAMS FOR ADULTS WITH MENTAL ILLNESS WHO ARE INVOLVED IN THE CRIMINAL JUSTICE SYSTEM.

(3) EXPERTS INVOLVED IN CROSS-SYSTEM COLLABORATION AND COMMUNICATION TO REDUCE THE NUMBER OF PERSONS WITH MENTAL ILLNESS WHO ARE INVOLVED IN THE CRIMINAL AND JUVENILE JUSTICE SYSTEMS RECOMMEND A FIVE-YEAR PLAN TO CONTINUE THE WORK OF THE TASK FORCE AND THE LEGISLATIVE OVERSIGHT COMMITTEE IN ORDER TO MORE FULLY EFFECTUATE SOLUTIONS TO THESE ISSUES.

(4) 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 AND JUVENILE JUSTICE SYSTEMS AND TO MAKE ADDITIONAL RECOMMENDATIONS TO A LEGISLATIVE OVERSIGHT COMMITTEE FOR THE CONTINUING DEVELOPMENT OF LEGISLATIVE PROPOSALS RELATED TO THIS ISSUE.

18-1.9-102. Definitions. AS USED IN THIS ARTICLE, UNLESS THE CONTEXT OTHERWISE REQUIRES:

(1) "COMMITTEE" MEANS THE LEGISLATIVE OVERSIGHT COMMITTEE ESTABLISHED PURSUANT TO SECTION 18-1.9-103.

(2) "TASK FORCE" MEANS THE TASK FORCE FOR THE CONTINUING EXAMINATION OF THE TREATMENT OF PERSONS WITH MENTAL ILLNESS WHO ARE INVOLVED IN THE CRIMINAL AND JUVENILE JUSTICE SYSTEMS ESTABLISHED PURSUANT TO SECTION 18-1.9-104.

18-1.9-103. Legislative oversight committee - creation - duties. (1) **Creation.** (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 AND JUVENILE JUSTICE SYSTEMS.

(b) THE COMMITTEE SHALL CONSIST OF SIX MEMBERS. THE PRESIDENT OF THE SENATE, THE MINORITY LEADER 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 TWO SENATORS TO SERVE ON THE COMMITTEE, AND THE MINORITY LEADER OF THE SENATE SHALL APPOINT ONE SENATOR TO SERVE ON THE COMMITTEE;

(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) (I) NOTWITHSTANDING THE PROVISIONS OF SECTION 2-2-307, C.R.S., THE COMMITTEE MAY RECEIVE PAYMENT OF PER DIEM AND REIMBURSEMENT FOR ACTUAL AND NECESSARY EXPENSES AUTHORIZED PURSUANT TO SAID SECTION AND ANY OTHER DIRECT OR INDIRECT COSTS ASSOCIATED WITH THE DUTIES OF THE COMMITTEE SET FORTH IN THIS ARTICLE ONLY FROM MONEYS APPROPRIATED FROM THE EXAMINATION OF THE TREATMENT OF PERSONS WITH MENTAL ILLNESS IN THE CRIMINAL JUSTICE SYSTEM CASH FUND CREATED IN SECTION 18-1.9-106.

(II) THE DIRECTOR OF RESEARCH OF THE LEGISLATIVE COUNCIL AND THE DIRECTOR OF THE OFFICE OF LEGISLATIVE LEGAL SERVICES MAY SUPPLY STAFF ASSISTANCE TO THE COMMITTEE AS THEY DEEM APPROPRIATE, WITHIN EXISTING APPROPRIATIONS. IF STAFF ASSISTANCE IS NOT AVAILABLE WITHIN EXISTING APPROPRIATIONS, THEN THE DIRECTOR OF RESEARCH OF THE LEGISLATIVE COUNCIL AND THE DIRECTOR OF THE OFFICE OF LEGISLATIVE LEGAL SERVICES MAY SUPPLY STAFF ASSISTANCE TO THE TASK FORCE ONLY IF MONEYS ARE CREDITED TO THE EXAMINATION OF THE TREATMENT OF

PERSONS WITH MENTAL ILLNESS IN THE CRIMINAL JUSTICE SYSTEM CASH FUND CREATED IN SECTION 18-1.9-106 IN AN AMOUNT SUFFICIENT TO FUND STAFF ASSISTANCE.

(2) **Duties.** (a) THE COMMITTEE SHALL MEET AT LEAST ONCE ON OR BEFORE AUGUST 1, 2004. BEGINNING IN 2005 AND CONTINUING EACH YEAR THEREAFTER THROUGH 2009, THE COMMITTEE SHALL MEET AT LEAST THREE TIMES EACH YEAR 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, 2005, AND BY EACH JANUARY 15 THEREAFTER THROUGH JANUARY 15, 2010. THE ANNUAL REPORTS SHALL SUMMARIZE THE ISSUES ADDRESSING THE TREATMENT OF PERSONS WITH MENTAL ILLNESS WHO ARE INVOLVED IN THE CRIMINAL AND JUVENILE JUSTICE SYSTEMS THAT HAVE BEEN CONSIDERED AND ANY RECOMMENDED LEGISLATIVE PROPOSALS.

18-1.9-104. Mentally ill offender task force - creation - membership - duties. (1) **Creation.** (a) 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 AND JUVENILE JUSTICE SYSTEMS IN COLORADO. THE TASK FORCE SHALL CONSIST OF TWENTY-NINE MEMBERS APPOINTED AS PROVIDED IN PARAGRAPHS (b) AND (c) OF THIS SUBSECTION (1).

(b) THE CHIEF JUSTICE OF THE COLORADO SUPREME COURT SHALL APPOINT FOUR MEMBERS WHO REPRESENT THE JUDICIAL DEPARTMENT, TWO OF WHOM SHALL REPRESENT THE DIVISION OF PROBATION WITHIN THE DEPARTMENT, ONE OF WHOM SHALL HAVE EXPERIENCE HANDLING JUVENILE JUSTICE MATTERS WITHIN THE DEPARTMENT, AND ONE OF WHOM SHALL HAVE EXPERIENCE HANDLING ADULT CRIMINAL JUSTICE MATTERS WITHIN THE DEPARTMENT;

(c) THE CHAIR AND VICE-CHAIR OF THE COMMITTEE SHALL APPOINT TWENTY-FIVE 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) TWO MEMBERS WHO REPRESENT LOCAL LAW ENFORCEMENT AGENCIES, ONE OF WHOM SHALL BE IN ACTIVE SERVICE AND THE OTHER ONE OF WHOM SHALL HAVE EXPERIENCE DEALING WITH JUVENILES IN THE JUVENILE JUSTICE SYSTEM;

(IV) SIX MEMBERS WHO REPRESENT THE DEPARTMENT OF HUMAN SERVICES, AS FOLLOWS:

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

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

(C) ONE MEMBER WHO REPRESENTS THE UNIT WITHIN THE DEPARTMENT OF HUMAN SERVICES THAT IS RESPONSIBLE FOR CHILD WELFARE SERVICES;

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

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

(F) ONE MEMBER WHO REPRESENTS THE MENTAL HEALTH PLANNING AND ADVISORY COMMITTEE WITHIN THE DEPARTMENT OF HUMAN SERVICES;

(V) ONE MEMBER WHO REPRESENTS THE INTERESTS OF COUNTY DEPARTMENTS OF SOCIAL SERVICES;

(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, ONE OF WHOM SHALL HAVE EXPERIENCE REPRESENTING JUVENILES IN THE JUVENILE JUSTICE SYSTEM;

(X) TWO MEMBERS WHO ARE LICENSED MENTAL HEALTH PROFESSIONALS PRACTICING WITHIN THE STATE, ONE OF WHOM SHALL HAVE EXPERIENCE TREATING JUVENILES;

(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 IN THE CRIMINAL JUSTICE SYSTEM IN THIS STATE;

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

(d) A VACANCY OCCURRING IN A POSITION FILLED BY THE CHIEF JUSTICE OF THE COLORADO SUPREME COURT PURSUANT TO PARAGRAPH (b)

OF THIS SUBSECTION (1) SHALL BE FILLED AS SOON AS POSSIBLE BY THE CHIEF JUSTICE OF THE COLORADO SUPREME COURT IN ACCORDANCE WITH THE LIMITATIONS SPECIFIED IN PARAGRAPH (b) OF THIS SUBSECTION (1). IN ADDITION, THE CHIEF JUSTICE OF THE COLORADO SUPREME COURT MAY REMOVE AND REPLACE ANY APPOINTMENT TO THE TASK FORCE MADE PURSUANT TO PARAGRAPH (b) OF THIS SUBSECTION (1).

(e) A VACANCY OCCURRING IN A POSITION FILLED BY THE CHAIR AND VICE-CHAIR OF THE COMMITTEE PURSUANT TO PARAGRAPH (c) OF THIS SUBSECTION (1) SHALL BE FILLED AS SOON AS POSSIBLE BY THE CHAIR AND VICE-CHAIR OF THE COMMITTEE IN ACCORDANCE WITH THE LIMITATIONS SPECIFIED IN PARAGRAPH (c) OF THIS SUBSECTION (1). IN ADDITION, THE CHAIR AND VICE-CHAIR OF THE COMMITTEE MAY REMOVE AND REPLACE ANY APPOINTMENT TO THE TASK FORCE MADE PURSUANT TO PARAGRAPH (c) OF THIS SUBSECTION (1).

(f) 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.

(2) **Issues for study - five-year plan.** THE TASK FORCE SHALL EXAMINE THE IDENTIFICATION, DIAGNOSIS, AND TREATMENT OF PERSONS WITH MENTAL ILLNESS WHO ARE INVOLVED IN THE STATE CRIMINAL AND JUVENILE JUSTICE SYSTEMS, INCLUDING AN EXAMINATION OF LIABILITY, SAFETY, AND COST AS THEY RELATE TO THESE ISSUES. THE TASK FORCE SHALL SPECIFICALLY CONSIDER, BUT NEED NOT BE LIMITED TO, THE FOLLOWING ISSUES:

(a) ON OR BEFORE JULY 1, 2005, THE FOLLOWING ISSUES:

(I) THE DIAGNOSIS, TREATMENT, AND HOUSING OF JUVENILES WITH MENTAL ILLNESS WHO ARE INVOLVED IN THE CRIMINAL JUSTICE SYSTEM OR THE JUVENILE JUSTICE SYSTEM; AND

(II) THE ADOPTION OF A COMMON FRAMEWORK FOR EFFECTIVELY ADDRESSING THE MENTAL HEALTH ISSUES, INCLUDING COMPETENCY AND CO-OCCURRING DISORDERS, OF JUVENILES WHO ARE INVOLVED IN THE CRIMINAL JUSTICE SYSTEM OR THE JUVENILE JUSTICE SYSTEM;

(b) ON OR BEFORE JULY 1, 2006, THE FOLLOWING ISSUES:

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

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

(III) THE DEVELOPMENT OF A PLAN TO MOST EFFECTIVELY AND COLLABORATIVELY SERVE THE POPULATION OF JUVENILES INVOLVED IN THE CRIMINAL JUSTICE SYSTEM OR THE JUVENILE JUSTICE SYSTEM;

(c) ON OR BEFORE JULY 1, 2007, THE FOLLOWING ISSUES:

(I) THE DIAGNOSIS, TREATMENT, AND HOUSING OF ADULTS WITH MENTAL ILLNESS WHO ARE INVOLVED IN THE CRIMINAL JUSTICE SYSTEM;

(II) THE ONGOING TREATMENT, HOUSING, AND SUPERVISION, ESPECIALLY WITH REGARD TO MEDICATION, OF ADULTS AND JUVENILES WHO ARE INVOLVED IN THE CRIMINAL AND JUVENILE JUSTICE SYSTEMS AND WHO ARE INCARCERATED OR HOUSED WITHIN THE COMMUNITY AND THE AVAILABILITY OF PUBLIC BENEFITS FOR SUCH PERSONS;

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

(IV) THE IDENTIFICATION OF ALTERNATIVE ENTITIES TO EXERCISE JURISDICTION REGARDING RELEASE FOR PERSONS FOUND NOT GUILTY BY REASON OF INSANITY, SUCH AS THE DEVELOPMENT AND USE OF A PSYCHIATRIC SECURITY REVIEW BOARD, INCLUDING RECOMMENDATIONS RELATED TO THE INDETERMINATE NATURE OF THE COMMITMENT IMPOSED;

(d) ON OR BEFORE JULY 1, 2008, THE IDENTIFICATION, DIAGNOSIS, AND TREATMENT OF MINORITY PERSONS WITH MENTAL ILLNESS, WOMEN WITH MENTAL ILLNESS, AND PERSONS WITH CO-OCCURRING DISORDERS, IN THE CRIMINAL AND JUVENILE JUSTICE SYSTEMS;

(e) ON OR BEFORE JULY 1, 2009, THE FOLLOWING ISSUES:

(I) THE EARLY IDENTIFICATION, DIAGNOSIS, AND TREATMENT OF

ADULTS AND JUVENILES WITH MENTAL ILLNESS WHO ARE INVOLVED IN THE CRIMINAL AND JUVENILE JUSTICE SYSTEMS;

(II) THE MODIFICATION OF THE CRIMINAL AND JUVENILE JUSTICE SYSTEMS TO MOST EFFECTIVELY SERVE ADULTS AND JUVENILES WITH MENTAL ILLNESS WHO ARE INVOLVED IN THESE SYSTEMS;

(III) THE IMPLEMENTATION OF APPROPRIATE DIAGNOSTIC TOOLS TO IDENTIFY PERSONS IN THE CRIMINAL AND JUVENILE JUSTICE SYSTEMS WITH MENTAL ILLNESS; AND

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

(3) **Additional duties of the task force.** ON OR BEFORE AUGUST 1, 2005, AND ON OR BEFORE EACH AUGUST 1 THEREAFTER THROUGH AUGUST 1, 2009, THE TASK FORCE SHALL ORALLY PROVIDE GUIDANCE AND MAKE FINDINGS AND RECOMMENDATIONS TO THE COMMITTEE FOR ITS DEVELOPMENT OF REPORTS AND LEGISLATIVE RECOMMENDATIONS FOR MODIFICATION OF THE CRIMINAL AND JUVENILE JUSTICE SYSTEMS, WITH RESPECT TO PERSONS WITH MENTAL ILLNESS WHO ARE INVOLVED IN THESE SYSTEMS. IN ADDITION, THE TASK FORCE SHALL:

(a) ON OR BEFORE AUGUST 1, 2004, AND BY EACH AUGUST 1 THEREAFTER THROUGH AUGUST 1, 2008, SELECT A CHAIR AND A VICE-CHAIR FROM AMONG ITS MEMBERS;

(b) MEET AT LEAST SIX TIMES EACH YEAR FROM THE DATE OF THE FIRST MEETING UNTIL JANUARY 1, 2010, OR MORE OFTEN AS 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 (2) 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 THE 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, 2004, AND BY EACH OCTOBER 1 THEREAFTER THROUGH OCTOBER 1, 2009, 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.

(4) **Flexibility.** NO REQUIREMENT SET FORTH IN PARAGRAPHS (a) TO (e) OF SUBSECTION (2) OF THIS SECTION SHALL PROHIBIT THE TASK FORCE FROM STUDYING, PRESENTING FINDINGS AND RECOMMENDATIONS ON, OR REQUESTING PERMISSION TO DRAFT LEGISLATIVE PROPOSALS CONCERNING ANY ISSUE DESCRIBED IN SUBSECTION (2) OF THIS SECTION AT ANY TIME DURING THE EXISTENCE OF THE TASK FORCE.

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

18-1.9-105. Task force funding - staff support. (1) THE DIVISION OF CRIMINAL JUSTICE IN THE DEPARTMENT OF PUBLIC SAFETY, ON BEHALF OF THE TASK FORCE, IS AUTHORIZED TO RECEIVE AND EXPEND CONTRIBUTIONS, GRANTS, SERVICES, AND IN-KIND DONATIONS FROM ANY PUBLIC OR PRIVATE ENTITY 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 MAY SUPPLY STAFF ASSISTANCE TO THE TASK FORCE AS THEY DEEM APPROPRIATE WITHIN EXISTING APPROPRIATIONS. IF STAFF ASSISTANCE IS NOT AVAILABLE FROM A GOVERNMENTAL AGENCY WITHIN EXISTING APPROPRIATIONS, THEN THE EXECUTIVE DIRECTORS OF THE

DEPARTMENTS REPRESENTED ON THE TASK FORCE, THE DIRECTOR OF RESEARCH OF THE LEGISLATIVE COUNCIL, AND THE DIRECTOR OF THE OFFICE OF LEGISLATIVE LEGAL SERVICES MAY SUPPLY STAFF ASSISTANCE TO THE TASK FORCE ONLY IF MONEYS ARE CREDITED TO THE EXAMINATION OF THE TREATMENT OF PERSONS WITH MENTAL ILLNESS IN THE CRIMINAL JUSTICE SYSTEM CASH FUND CREATED IN SECTION 18-1.9-106 IN AN AMOUNT SUFFICIENT TO FUND STAFF ASSISTANCE. THE TASK FORCE MAY ALSO ACCEPT STAFF SUPPORT FROM THE PRIVATE SECTOR.

18-1.9-106. Cash fund. (1) ALL PRIVATE AND PUBLIC FUNDS RECEIVED THROUGH GRANTS, CONTRIBUTIONS, AND DONATIONS PURSUANT TO THIS ARTICLE SHALL BE TRANSMITTED TO THE STATE TREASURER, WHO SHALL CREDIT THE SAME TO THE EXAMINATION OF THE TREATMENT OF PERSONS WITH MENTAL ILLNESS IN THE CRIMINAL JUSTICE SYSTEM CASH FUND, WHICH FUND IS HEREBY CREATED AND REFERRED TO IN THIS SECTION AS THE "FUND". THE MONEYS IN THE FUND SHALL BE SUBJECT TO ANNUAL APPROPRIATION BY THE GENERAL ASSEMBLY FOR THE DIRECT AND INDIRECT COSTS ASSOCIATED WITH THE IMPLEMENTATION OF THIS ARTICLE. ALL MONEYS IN THE FUND NOT EXPENDED FOR THE PURPOSE OF THIS ARTICLE MAY BE INVESTED BY THE STATE TREASURER AS PROVIDED BY LAW. ALL INTEREST AND INCOME DERIVED FROM THE INVESTMENT AND DEPOSIT OF MONEYS IN THE FUND SHALL BE CREDITED TO THE FUND. ANY UNEXPENDED AND UNENCUMBERED MONEYS REMAINING IN THE FUND AT THE END OF A FISCAL YEAR SHALL REMAIN IN THE FUND AND SHALL NOT BE CREDITED OR TRANSFERRED TO THE GENERAL FUND OR ANOTHER FUND. ALL UNEXPENDED AND UNENCUMBERED MONEYS REMAINING IN THE FUND AS OF JULY 1, 2010, SHALL BE TRANSFERRED TO THE GENERAL FUND.

(2) COMPENSATION AS PROVIDED IN SECTIONS 18-1.9-103 (1) (d) AND 18-1.9-105 (2) FOR MEMBERS OF THE GENERAL ASSEMBLY AND FOR STAFF ASSISTANCE TO THE COMMITTEE AND TASK FORCE PROVIDED BY THE DIRECTOR OF RESEARCH OF THE LEGISLATIVE COUNCIL AND THE DIRECTOR OF THE OFFICE OF LEGISLATIVE LEGAL SERVICES SHALL BE APPROVED BY THE CHAIR OF THE LEGISLATIVE COUNCIL AND PAID BY VOUCHERS AND WARRANTS DRAWN AS PROVIDED BY LAW FROM MONEYS APPROPRIATED FOR SUCH PURPOSE AND ALLOCATED TO THE LEGISLATIVE COUNCIL FROM THE FUND.

18-1.9-107. Repeal of article. THIS ARTICLE IS REPEALED, EFFECTIVE JULY 1, 2010.

SECTION 2. Appropriation. In addition to any other appropriation, there is hereby appropriated, out of any moneys in the examination of the treatment of persons with mental illness in the criminal justice system cash fund created in section 18-1.9-106, Colorado Revised Statutes, not otherwise appropriated, to the legislative department, for the fiscal year beginning July 1, 2004, the sum of twenty-one thousand eight hundred twenty-six dollars ($21,826) and 0.4 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.

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John Andrews PRESIDENT OF THE SENATE	Lola Spradley SPEAKER OF THE HOUSE OF REPRESENTATIVES

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Mona Heustis SECRETARY OF THE SENATE	Judith Rodrigue CHIEF CLERK OF THE HOUSE OF REPRESENTATIVES

APPROVED____

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Bill Owens
GOVERNOR OF THE STATE OF COLORADO