



*Colorado
Commission*

on

*Criminal
&
Juvenile
Justice*

CDPS

Offenders with Behavioral Health Issues in the Criminal Justice System

March 13, 2009

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* The "In Brief" bullet points are a quick visual reference for the primary presentation points for each presenter as identified by CCJJ staff. Any mischaracterization of the presentation points are the mistake of the staff. Please refer to the "Complete" presentation content for the original and supplementary information provided by the authors. There may be additional materials located in the meeting packet.

IMI - Inmate with mental illness. May refer any behavioral health issue: mental illness, substance abuse problems, or both (co-occurring).

BHIs - Behavioral health issues

PANEL ONE

Police

Bill Kilpatrick Golden Police Chief

[See Complete version p. 15]

- Training and funding for CIT
- Alternatives available to police officers: Do nothing, 72-hr. hold, or jail.
- Complications of co-occurring disorders
- Lack of options for those who do not need a hospital, but do need help
- Need for crisis services

Jail (County)

Grayson Robinson Arapahoe County Sheriff

[See Complete version p. 16]

- Recidivism or the revolving door problem (County jails: *De facto* MH institutions)
- Cost of care of IMIs compared to non-MIs (roughly 1/2 to 1/3 higher)
- Jail staff not typically qualified to manage unique challenges of IMIs

Pre-Trial Services

Mike Jones Manager, Criminal Justice Planning, Jefferson County

[See Complete version p. 17]

- IMIs may be unavailable for pre-trial assessment interviews due to housing restrictions or behavior problems (affecting bond conditions)
- IMIs provide unreliable information (affecting bond conditions)
- During pre-trial, indigent IMIs have more difficulty managing and, consequently, will penetrate the system further resulting in greater expense
- IMIs have greater difficulty following instructions resulting in poor compliance thus requiring more time, assistance and other supervision resources from staff

Courts

Gil Martinez Chief Presiding Judge, 4th Judicial District, Colorado Springs

[See Complete version p. 18]

- Insufficient placement and treatment options, especially in rural area, for both in- and out-patient services
- Monitoring and management of patient medications (and restoration) increases jail time
- Inmate movements causing disruptions in medication coordination (e.g., to and from Colorado Mental Health Institute)
- Problem of provision of resources for patients who are in county jails for a significant period of time.
- Additional resources are needed by the probation department to work with clients

Prosecution

Pete Hautzinger **District Attorney, 17th Judicial District**

[See Complete version p. 19]

- Prosecutors attempt to identify those with genuine mental illness issues for intervention to avoid incarceration unless a threat to self or others requires incarceration
- Lack of a legal mechanism to get early mental evaluations early in the process
- Difficulty in differentiating for the public and press the difference between individuals who have committed a “crazy” (unreasonable) act and those who are not legally responsible for their behavior.

Defenders

Doug Wilson **State Public Defender**

[See Complete version p. 20]

- The "Revolving Door" of continuity of care, including medication changes.
- Inadequate intervention while incarcerated.
- Lack of community resources for the poor who have been convicted of a crime.
- Lack of quality experts that will work for a \$100.00 per hour limit.
- Lack of dual diagnosis beds.

Probation

Tom Quinn **Director of Probation Services**

[See Complete version p. 21]

- Lack of treatment options (especially in rural areas).
- Case management is not sufficiently individualized, linked to assessment.
- Lack of fidelity to EBP on the part of treatment providers.

Department of Corrections

David Stephens **Chief of Behavioral Health, Clinical Services**

[See Complete version p. 22]

- Cross-system communication difficulties - obstacles getting information from community treatment agencies or jail systems regarding offenders with mental illness/co-occurring disorders
- Re-entry difficulties - obstacles transitioning offenders with mental illness/co-occurring disorders to community treatment providers following incarceration in the DOC
- Differential medication management from the community, to jail, to DOC
- Comprehensive training for DOC officers (custody and parole) on specialized information and skill-set necessary to manage offenders with mental illness/co-occurring disorders (e.g. criminogenic needs, motivational interviewing and enhancement, CIT, etc.)
- Treatment challenges in the correctional environment [See “Complete” for details]

Parole

Todd Helvig **Manager, Community Mental Health Services**

[See Complete version p. 23]

- Limited comprehensive case management to facilitate continuity of care (those invested in the oversight of these cases) for mentally ill offenders throughout the criminal justice system
- Non-specific behavioral health links to community resources for mentally ill offenders.
- Medication – continuity, resources, availability
- Limited formal specialized training for Community Parole Officers and Re-entry Specialists regarding specialized skill-set to facilitate their management of mentally ill offenders (i.e., Motivational Interviewing/enhancement, CIT)
- Behavioral health system gap in oversight of mentally ill offenders who have been placed on involuntary medications while incarcerated and, consequently, parole or discharge without any required follow-up or case management
- Lack of parole resources to manage specialized caseloads that are complex and intensive requiring time, knowledge, and specialized skill set, especially for the most complex cases (homeless sexual offenders with mental illness and dev. disability)

Community Corrections

Glenn Tapia **Training and Evaluation**

[See Complete version p. 24]

- The cost of evidence-based treatment for MI offenders is substantial, whether delivered to persons transitioning from prison or being diverted to community corrections.
- Treatment efforts must effectively address the many offenders with serious mental illness who also suffer from co-occurring disorders of substance abuse.
- While many offenders have similar BHIs, it can be challenging to adequately assess felons as individuals and to place them in programming that will appropriately address individual criminogenic and behavioral health needs.

Victims

Steven Siegel **Victim Representative, 2nd Judicial District**

[See Complete version p. 25]

- Offenders with BHIs often are unable to comply with court dictates, leaving the victim without a sense of justice, a sense of safety from further victimization, or a reasonable likelihood of receiving restitution
- Offenders with BHIs often have inadequate resources for treatment and support increasing the potential for the negative consequences in the previous point
- Offenders with BHIs who victimize individuals with BHIs create a complex circumstance for law enforcement and the courts jeopardizing justice, accountability, and victim/community safety
- Victims of crime with BHIs face myriad recovery challenges
- Victims of crime who develop BHIs due to their victimization face significant challenges creating a “new normal” in the aftermath

Department of Human Services, Division of Behavioral Health

Charlie Smith Division Deputy Director

[See Complete version p. 26]

- Justice system penetration due to inadequate funding of community-based mental health and substance abuse treatment services, insufficient diversion efforts, and a lack of standardized behavioral health screening in jails
- Community-based behavioral healthcare should be more easily accessible, coordinated with the criminal justice system, and staffed with a sufficient workforce
- Transition to the community is limited by the lack of personal identification, healthcare benefits, employment/training opportunities, housing, and family re-unification and social supports
- The NIMBY problem is aggravated by system illiteracy, discriminatory behavior and stigmatizing attitudes

PANEL TWO

Department of Human Services, Division of Behavioral Health

Janet Wood Division Director

STATE AGENCY

[See Complete version p. 27]

- Maintain and grow resources targeted to offenders with BHIs
- Ensure quality services for offenders with behavioral health needs through improved licensure guidelines and monitoring and program reporting
- Create mechanisms to ensure real-time (web-based) feedback regarding supervision and treatment of offenders\
- Interagency work towards overall system improvement

Mental Health Planning and Advisory Council

Harriet Hall MHPAC Subcommittee Co-Chair

ADVISORY

(also, President, Jefferson Center for Mental Health)

[See Complete version p. 28]

- No loss of Medicaid when incarcerated
- Funding for evidenced-based programs that provide a link/warm hand off between jail services and community based services
- Support and funding for Crisis Intervention Team models of care that include a behavioral health case management component allowing follow-up to CIT police officer intervention.

Mental Health and Substance Abuse Roundtable

Stephen Kopanos Chair, The Roundtable **ADVOCACY**
(also, V. P. of Public Policy & Systems Advocacy, Mental Health America - Colorado)
[See Complete version p. 30]

- Address the issue that there are hundreds of trained CIT officers, but an acute lack of appropriate beds for those identified as having a mental health or substance abuse issues
- Improve current funding mechanisms and treatment access for those who would be best served in outpatient settings, rather than being taken to emergency rooms and jails due to a lack of viable options
- Build a broad coalition to pass a long term funding mechanism, possibly through a ballot initiative, to provide needed critical services to the people of Colorado
- Decrease the need for incarceration by funding such programs as Metro Crisis Triage Center, diversion services, sustained recovery services, or Integrated Dual Diagnosis Treatment

The Mighty Coalition

George DelGrosso Member **ADVOCACY**
(also, Executive Director of Colorado Behavioral Healthcare Council)
[See Complete version p. 31]

- Present as one voice to policy makers whenever possible
- Reduce stigma
- Ensure services are recovery and resiliency focused
- Increase the influence of mental health in state government
- Advocate for access to appropriate medications in the most cost effective way

Colorado Coalition for the Homeless

Louise Boris V.P. of Programs **DIRECT SERVICE / ADVOCACY**
[See Complete version p. 32]

- Access to affordable mental health treatment and medication for those on parole and probation
- Transition planning for individuals who have completed their sentences so that mental health treatment and medication can be sustained
- Identification of those individuals experiencing mental illness and/or traumatic brain injury that may qualify them for SSI/SSDI and better linkage to those resources
- Continuity of care from jails and prison to community providers
- Ongoing training for staff in community corrections, parole and probation, as well as staff of half-way houses, in the identification of mental health and TBI issues
- Access to inpatient psychiatric treatment.

Colorado Association of Alcohol & Drug Service Providers

Carmelita Muniz

Executive Director

ADVOCACY: DIRECT SERVICE

[See Complete version p. 34]

- Untreated substance abuse problems have a profound financial impact on Colorado's criminal justice, human services and health care systems.
- Invest in substance abuse prevention, intervention, treatment and recovery
- Inform, support and implement improvements in substance abuse prevention, intervention, treatment and recovery

CO Behavioral Healthcare Council

Doyle Forrestal Director of Public Policy

ADVOCACY: DIRECT SERVICE

[See Complete version p. 35]

- Increase and support opportunities for additional community-based diversion and transition programs that are collaborations between criminal justice system and community providers
- Streamline systems to improve continuity of care between the criminal justice system and the community to increase access to care and the connection to treatment needs
- Enhance the creation of and connection to community-based programs and services that reduce recidivism, such as mental health and substance abuse treatment, medications, housing, benefits, vocational training
- Improve education and outreach efforts to the community to reduce the stigma associated with individuals that have had contact with the criminal justice system, and especially for those who also have mental health conditions

National Alliance for the Mentally Ill

Nita Brown

President, Arapahoe/Douglas County

ADVOCACY: CONSUMERS

[Primary contact: Lacey Berumen Executive Director, NAMI Colorado]

[See Complete version p. 37]

- Improve the availability of appropriate treatments for mental illness, substance abuse and co-occurring disorders
- Improve the behavioral health assessment environment and the provision of medications
- Improve the transition linkages and continuity of care between jail/prison and community treatment and other support services through improved case management
- Increase funding for inpatient and community-based services

Mental Health America-Colorado

Jeanne Rohner

Executive Director

ADVOCACY

[See Complete version p. 40]

- Implement a full-service crisis system like the Metro Crisis Triage Project
- Advocate for diversion programs, mental health and drug courts and treatment in jails/corrections including reintegration services
- Engage in sentencing reform
- Fully fund services

Metro Area County Commissioners: Mentally Ill Inmates Task Force

Paul Siska Co-Chair
(also, Adams Co. Undersheriff)
[See Complete version p. 41]

ADVISORY

- Provide housing particularly for mentally ill offenders to build their recovery
- Explore diverse mental health funding options and funding for indigent services
- Resources for long term care users who require this level of care
- Explore creating more diversion opportunities at intercepts #2 (initial detention and hearing) and #3 (jails and courts)
- Expand reentry initiative services through formation of an inter-county task force of the MACC
- Explore a medication assistance program

Mentally Ill in the Justice System Task Force

Harriet Hall Co-Chair
(also, President of Jefferson Center for Mental Health)
[See Complete version p. 42]

LEGISLATIVE

- Sufficient treatment resources to maintain persons with mental illness or co-occurring disorders who are involved with the criminal justice system in or return them to the community, including the development of programs and facilities and the training of staff
- The importance of providing housing and employment in addition to treatment for persons with mental illness or co-occurring disorders who are involved with the criminal justice system, in order to prevent recidivism and promote public safety
- The demonstration of positive outcomes and cost-savings resulting from effective treatment and community supports of individuals with mental illness or co-occurring disorders who are involved with the criminal justice system, to justify directing additional resources towards such programming.
- The demonstration of the effectiveness of prevention and early intervention, including but not limited to juveniles, in preventing individuals with mental illness or co-occurring disorders from coming into the justice system
- The availability of public benefits for persons with mental illness or co-occurring disorders who are involved with the criminal justice system

TRANSFORMATION TRANSFER INITIATIVE GROUP

Behavioral Health Cabinet (& Working Group)

Leslie Herod Governor's Office

In the winter of 2007, Governor Bill Ritter, Jr. authorized an unprecedented meeting of his relevant Cabinet members to discuss the cross-system impacts of mental health and substance abuse (i.e. behavioral health) in Colorado. Out of this meeting, the Governor authorized the creation of a Behavioral Health Cabinet lead by the Executive Directors of the Departments of Corrections, Health Care Policy and Financing (the state's Medicaid agency), Human Services, Labor and Employment, Local Affairs, Public Health and Environment and Public Safety; other members included the State's Chief Medical Officer and the Director of the Governor's Office of Policy and Initiatives.

Beginning early in 2008 the Behavioral Health Cabinet began the long process of understanding each department's role in the provision of behavioral health care services and attached funding streams. The Cabinet also reviewed recent efforts including the recommendations of the HJR 1050 Task Force and the Task Force for the Continuing Examination of the Treatment of Persons with Mental Illness who are Involved in the Justice System. While the Cabinet was able to make joint recommendations and support each other's efforts, it was understood that increased coordination with advocacy and stakeholder groups was vital to the success of behavioral health transformation. To this end, the Cabinet, working with the Dept. of Human Services has awarded a Transformation grant to Tri-West to assist the Cabinet in developing a process to secure on-going, meaningful input from consumers and stakeholders on decisions, implementation plans and system changes.

Transformation Transfer Initiative

Andy Keller Tri-West, Inc.

See the HJR 1050 Recommendations on the next page

The Powerpoint slides appear after the 1050 Recommendations page

HJR-1050 Task Force Recommendations

Colorado Behavioral Health Cabinet Transformation Transfer Initiative

The HJR-1050 Task Force proposes as **Recommendation #1**, that Colorado establish a Behavioral Health (BH) Commission (“Commission”) with leadership from the three branches of state government, adult and youth consumers and families, providers, and communities. The Commission’s charge would be to implement the HJR-1050 Task Force’s and its own recommendations and provide oversight and support to Colorado’s vision for an integrated BH system.

The remaining recommendations are based on the themes that emerged through the research process and HJR-1050 Task Force and Committee discussions. Recommendations #2 through #6 specifically describe alignment opportunities for Colorado’s integrated BH system.

Recommendation #2, Shared Outcomes proposes developing and implementing a set of shared outcomes across key systems to enable joint accountability and to improve the lives of Colorado’s adult, youth, and child consumers with BH issues, their families, and the communities in which they live.

Recommendation #3, Alignment of Service Areas proposes the alignment of service areas across systems so that adult, youth, and child consumers and their families have equitable, timely access to a full continuum of services provided through an integrated BH system regardless of where they live in Colorado.

Recommendation #4, Joint Auditing across Systems recommends the expanded use of joint auditing across systems, which could include fiscal and/or programmatic audits.

Recommendation #5, Joint Budget Planning across Systems addresses the need for a multi-year joint budget and strategic planning process across departments to support long term and cross-system needs.

Recommendation #6, Integrated BH Policies, Rules and Regulations addresses the barriers created by state and federal funding requirements that make collaboration and integration of mental health and substance abuse services difficult at the local level. It recommends developing integrated BH fiscal policies, rules, and regulations that align with integrated BH service delivery.

Recommendation #7, Financing Reform to Support an Integrated BH System addresses financing reform to maximize and efficiently utilize funds to support an integrated BH system.

Recommendation #8, Electronic Cross-System Data Collection, Sharing, and Evaluation proposes the use of electronic cross-system data collection, sharing, and evaluation, including an electronic health record and shared screening tools, assessments, and evaluations.

Recommendations #9, Cultural Competency and **Recommendation #10, Adult, Youth, and Child Consumer and Family Involvement** recommends that Colorado adopt consistent cross-system standards for cultural competency/responsiveness and for adult, youth, and child consumer and family involvement.

Recommendation #11, Work Force Development addresses the need for workforce development strategies for an integrated BH system.



State of Colorado Behavioral Health Transformation Transfer Initiative

Behavioral Health Transformation and Adult Criminal Justice: Coordination Between BHTTI and CCCJJ

March 13, 2009



TRIWEST GROUP

Andrew Keller, PhD
Jesús Sanchez, PhD



Advocates for Human Potential, Inc.

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Project Beliefs, Values and Commitments

- Believing that every person can recover
- Believing in the resilience of individuals and families
- Believing in the value of diverse people, communities, and opinions
- Believing in prevention and early intervention
- Valuing communities and life within them
- Valuing public safety and accountability
- Valuing consensus; committing to honest representation
- Commitment to the principles of involvement & transparency
- Commitment to openness, compassion, candor, tolerance, humor, and flexibility in our interactions




TRIWEST GROUP



Advocates for Human Potential, Inc.

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Experience Partnering with Consumers, Youth, Family Members, Parents and Advocates

- AHP authored SAMHSA's KITs (formerly called toolkits) for Consumer-Operated Services and Programs
- TriWest developed standards for Washington State's certification of consumer-run and youth-run organizations
- TriWest partnered with Washington State consumers, youth, its statewide network for parent organizations and NAMI affiliates to develop certification standards for consumer-run, youth-run, parent-run, and family-run organizations
- AHP partners regularly with NAMI and is completing SAMHSA's KIT for Supported Housing
- Our team includes consumers, parents, family members, and advocates



Experience Partnering with Providers

- TriWest specializes in helping providers across the country adopt empirically-supported practices
- AHP is a national leader in disseminating evidence based practices
- Our team includes past senior managers of mental health and substance abuse service providers
- Our team includes licensed providers



Experience Partnering with Colorado Communities

- TriWest has partnered with Colorado foundations, MHA affiliates, other advocates, and community members in six diverse Colorado communities through Advancing Colorado's Mental Health Care
- TriWest and AHP are involved in many current and past Colorado initiatives
- Our team includes people who live in Colorado and people who wish they still did



Overall Project Goals

Nine month project to review the work Colorado has completed to date and develop a roadmap for continued progress that:

1. Develops a process for sustained, ongoing involvement of consumers, families, and other stakeholders for **an ongoing, authoritative collaborative body**.
2. Establishes a transformation structure to support the work of the **Collaborative Body** and implement at least two of the recommendations of the HJR-1050 Task Force.
3. **Secure ongoing funding, as well as staff and necessary supports**, to institutionalize, sustain, and achieve true behavioral health system transformation.



Initial Stakeholder Involvement

- February / March: Interviews to plan Collaborative Body to involve Cabinet and Stakeholders

- April: Regional Forums with 12 Distinct Stakeholder Groups
 - Goal: To prioritize “entry opportunities” among the 11 HJR-1050 Task Force Recommendations
 - 60 forums (plus a few extra)



April Stakeholder Forums – Tentative Dates

- Western Slope (Grand Junction) – 4/8 and 9
- Denver / Denver Metro – 4/12 to 4/14
- Rural/Frontier Multi-Site Video Conferences – 4/12 to 4/13
 - Craig
 - Durango
 - Lamar / La Junta
 - Sterling
 - Trinidad
 - Summit (tentative)
- Southern Front Range (Pueblo) – 4/21 to 4/22
 - Colorado Springs – 4/22 – one meeting in p.m.
- Northern Front Range (Fort Collins) – 4/23



April Stakeholder Forums - Process

- Two full days each, twelve 1 to 1.5-hour forums:
 - (1) Adult Consumers
 - (2) Youth
 - (3) Parents /Caregivers of children and youth served
 - (4) Family Members of adult consumers
 - (5) Substance Abuse Providers (intervention and prevention)
 - (6) Mental Health Providers
 - (7) Criminal Justice / Law Enforcement / Corrections
 - (8) Juvenile Justice / Child Welfare / Schools
 - (9) Primary Care / Behavioral Health Integration
 - (10) Early Childhood
 - (11) Private Insurance
 - (12) Community / Business Leaders



Stakeholder Involvement Process

- April: Summarize input on ongoing "Collaborative Process" and review with stakeholders, Behavioral Health Cabinet
 - Thursday, 3/19 – 11:30-1:00pm Webinar; 6:00-7:30pm Meeting in Denver
- May / June / July: Implement and Refine ongoing Collaborative Process with stakeholders and Cabinet
- August: Report Finalization
 - August 1 – Post draft report on line for public review
 - Mid August – Two statewide videoconferences with stakeholders to receive input on report
 - Late August – Finalize report based on all input
- September: Deliver final report




Opportunities for Collaboration with Justice Commission



- Today – focused input into our stakeholder decision process
- April: Participation of law enforcement, probation offices, judicial officers, district attorneys in regional forums
- May / June / July: Interaction with subject matter experts to develop draft implementation plans for stakeholder priorities around HJR-1050 recommendations
 - Detailed planning, feasibility assessment, detailed implementation plans
 - Future meetings with CCCJJ
- Other ideas



Questions and Discussion



Discussion and Consensus Building



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PRESENTER CONSENSUS POINTS

1. Treatment Availability

- *Revolving Door*
- *Medication Management and Monitoring*
- *Continuity of Care*
- *Treatment Availability/Affordability*
- *Resources for Treatment*

2. Training

3. Screening and Assessment

4. Co-occurring Disorder Issues

5. Access to Public Benefits

CONSENSUS POINTS FROM SUBMITTED SPEAKER DOCUMENTS **March 13, 2009**

Treatment Availability (18 Presenters Mentioned this Topic)

Panel One System Issues (10)

Revolving Door

- Once inmates are release from jail, they historically return to unacceptable behavior and require the attention of law enforcement again.
- If can't afford treatment or meds, they commit new crimes or fail to comply with supervision.

Medication Management/Monitoring

- Individuals end up in court for having committed felony, misdemeanor or petty offenses because they have quit taking their meds.
- Need coordination of meds between county jails and Colorado Mental Health Institute.
- Differential medication management from the community, to jail, to DOC.
- Medication-continuity, resources, availability.

Continuity of Care

- The "revolving door" due to the lack of continuity of care.
- Inconsistent coordination between criminal/juvenile justice systems and community-based behavioral health treatment systems.
- Need coordinated discharge planning.
- Need for simple referral and access to care and coordinated discharge planning.
- Information and data sharing between systems.

Treatment Availability

- Police contacts taken to the ER because danger to self/others are usually released back into the community without having received any services related to the crisis that put them there.
- Lack of quality experts that will work for a \$100 per hour limit.
- Lack of treatment options (especially in rural areas).

Treatment Access for Low-Income Individuals

- Most defendants with behavioral health issues and who are indigent/impoverished cannot afford their medications or treatment, or they have a difficult time keeping a job or insurance.
- Not a sufficient number of treatment providers for low income individuals.
- Lack of community resources for the poor who have been convicted of a crime.
- Difficult to obtain adequate resources for medications.

Resources for Treatment

- Difficult to obtain adequate resources for evidence-based treatment.
- Offenders with behavioral health issues often have inadequate resources for treatment and support.
- State has fewer community behavioral health treatment dollars while there are more individuals with behavioral health issues and in need of treatment.

Panel Two-Priority (8)

Medication Management/Monitoring

- Provide a funding stream to continue medication(s) for individuals leaving jail or prison until they have benefits or other funding streams to pay for those medications.
- When medications are given to treat symptoms, it increases the likelihood that an individual will adhere to a treatment plan.
- Explore medication assistance program.

Continuity of Care

- Funding for evidenced based programs that provide a link/warm hand off between jail services and community based services.
- Funding services at the appropriate level through an integrated system of care.
- Collaborative transition planning for individuals who have completed their sentences so that mental health treatment and medication can be sustained. (2)
- Continuity of care from jails and prison to community providers. (4)
- Case management is essential to provide effective continuity of care.

Treatment Availability/Affordability

- Access to affordable mental health treatment and medication for those on parole and probation.
- Caseworkers for CIT program to connect individuals to treatment.
- When individuals with mental illnesses are properly diagnosed, stabilized and receive services, they are far less likely to commit subsequent crimes.
- Funding for indigent services.

Treatment Access for Low-Income Individuals

- Funding for indigent services.

Training (9 Presenters Mentioned this Topic)

Panel One-System Issue (5) and Panel Two-Priority Combined (4)

Training for:

- Police (1)
- Jail Staff (3)
- DOC Officers (4 total)
 - Custody (1)
 - Parole (3)
- Probation (1)
- Community Corrections (1)
- Entire CJ workforce working with BH offenders (3)

Screening and Assessment (9 Presenters Mentioned this Topic)

Panel One System Issue (6)

- Pretrial staff cannot always interview defendants with behavioral health issues because they may be in special housing or be non-participatory because of their behavior or mental health/intoxicated condition.
- When interviewed, defendants with behavioral health issues do not as reliably provide correct information. Both of these conditions (including above bullet) may lead to pretrial release conditions that do not maximize public safety.
- Lack of a legal mechanism to get meaningful mental evaluations of persons charged criminally early in the process.
- Case management is not sufficiently individualized, linked to assessment.
- Need for appropriate and accurate assessments leading to targeted, individualized treatment interventions in a correctional setting. Accurate assessment, however, is limited by a multitude of factors. (2)
- Lack of standardized behavioral health screening in jails.

Panel Two-Priority (2)

- Availability of Appropriate Treatment: Proper assessments by a qualified mental health professional are essential to an individual receiving proper treatment. Without this, people will further decompensate.
- Advocate for Diversion Programs, Mental Health and Drug Abuse Courts and Treatment in Jails/Corrections including Reintegration to include at the front end, services for identifying, assessing and referring available to those arrested for issues related to mental health and substance abuse.

Co-occurring Disorder Issues (6 Presenters Mentioned this Topic)

Panel One System Issue (4)

- When a person is under the influence of drugs and/or alcohol the situation becomes even more problematic because virtually no one will “treat” the underlying mental health crisis until the effects of the substance have dissipated.
- Most defendants in the criminal justice system either have alcohol or drugs related to their crime or have an alcohol or drug history that contributes to their criminality or hinders their rehabilitation.
- Lack of dual diagnosis beds.
- Many offenders with serious mental illness also suffer from the co-occurring disorder of substance abuse. Treatment efforts must effectively address both conditions.

Panel Two-Priority (2)

- Using long-term funding mechanism to provide Integrated Dual Diagnosis Treatment (EBP) (2)

Public Benefits (5 Presenters Mentioned this Topic)

Panel One System Issue (1)

- Terminated healthcare benefits/insurance (e.g., Medicaid/Medicare, SSI, SSDI).

Panel Two-Priority (4)

- Identification of those individuals experiencing mental illness and/or traumatic brain injury that may qualify them for SSI/SSDI and better linkage to those resources.
- Expand Benefits Acquisition Teams and Specialists.
- Benefit programs like Social Security Disability, Supplemental Security Income, Medicaid, Medicare, food stamps, housing assistance must be made more easily available.
- The availability of public benefits for persons with mental illness or co-occurring disorders who are involved with the criminal justice system.

COMPLETE PRESENTATIONS

POLICE - BILL KILPATRICK

My name is Bill Kilpatrick and I am the Police Chief in Golden, Colorado. I am a member of the CCJJ and I represent the Colorado Association of Chiefs of Police on this Commission. I am also the Chair of the Board of Directors of the Metro Crisis Triage Project.

Some of the issues facing the police officer or deputy sheriff (and for that matter dispatchers, probation officers, parole officers and, you get the point) when encountering individuals, on the street, who may be suffering from a mental illness or who are in the midst of a mental health crisis are discussed briefly below.

1. Training and Funding.

Does the police officer or sheriff's deputy have the ability to recognize that the person they are encountering is in fact suffering from mental illness? Assuming they are able to make that determination does she have the training to deescalate the situation? This concern was the genesis of the Crisis Intervention Training program. Over 2,800 law officers have been trained in this method across the State. It is a forty hour class.

2. Alternatives available to the police.

- Do nothing.
- Utilize a 72 hour mental health hold if the person is an immediate danger to self/others. This frequently results in a trip to an ER (emergency room). Transport to the facility can then be an issue. Once there the staff's primary objective is to determine if there is a "medical" condition requiring inpatient status. If not, the patient is usually released back into the community without having received any services related to the crisis that put them there.
- Take the person to jail.

3. Co-occurring disorders.

- When a person is under the influence of drugs and/or alcohol the situation becomes even more problematic because virtually no one will "treat" the underlying mental health crisis until the effects of the substance have dissipated.

4. There are virtually no options available to law enforcement for those individuals who do not need transport to a hospital but who are in need of help. When your only options are jail or an ER you know the system needs fixing.

5. 24 hour emergency crisis services are needed offering a full range of treatment options.

JAIL - GRAYSON ROBINSON

Sheriff Grayson Robinson, Arapahoe County Colorado
Representing the County Sheriff's of Colorado

The Sheriffs of Colorado are responsible for the public safety, to include the delivery of complete law enforcement services and the management of local detentions facilities (jails).

Challenges associated with the incarceration of those suffering behavioral health issues:

- Recidivism

The inmate populations of the local jails, managed by the Sheriffs of Colorado, are consistently increasing at rates that cause most jails to be seriously overcrowded. The overcrowded conditions of existing detentions facilities is the direct result of an increase in admissions to the jail and extended lengths of stay for those held in the facilities. Individuals experiencing behavioral health challenges are likely to be repeatedly held in the local jail as the result of their actions which result in allegations of criminal behavior. As funding for mental health intervention measures has declined, the percentage of the general jail population suffering from behavioral health issues (currently 22%-25%) has dramatically increased. The county jails across the United States have sadly and inappropriately become the largest mental health institutions of our country. While in the direct care of dedicated detentions facility staff, inmates with behavioral health issues, receive nutritious meals, regular medication, consistent rest, exercise and direct supervision. Once inmates are released from the structured environment associated with incarceration in a jail, they historically fail to properly medicate, fail to receive nutritious meals, fail to adequately rest, do not participate in adequate exercise and are not monitored by a responsible adult. Without proper structure and direction, the individuals are inclined to involve themselves in unacceptable behavior which requires the attention of law enforcement officers, who typically have no other alternative than incarceration to resolve the situation of concern.

- Cost of Care

The Arapahoe County Sheriff's Office Detentions Facility has determined that the daily cost of care for an inmate that is not suffering from behavioral health issues is \$68.32 per day. Inmates that are suffering behavioral health issues cost the tax payers of Arapahoe County more than \$94.50 per day.

- Management Challenges

Although by default, the local jails of our country have become the only alternative available for the housing of those suffering behavioral health issues, the majority of the staff assigned to a local detentions facility are not qualified to deal with the unique challenges associated with the mentally ill, other than providing immediate care and protecting the inmate population and individual inmate.

PRE-TRIAL SERVICES - MIKE JONES

Presenter's name

Michael R. Jones, Criminal Justice Planning Manager

Organization

Jefferson County Criminal Justice Planning Unit

Organization's purpose

To provide the members of the Jefferson County Criminal Justice Strategic Planning Committee (the County's equivalent to the CCJJ) with the information and ideas they need to make data-guided, collaborative policy decisions to improve the effectiveness and efficiency of the local justice system.

Top problems or challenges when dealing with persons with behavioral health issues at the pretrial phase

Problems and challenges can occur in two main areas during the pretrial phase: (1) Pretrial risk assessment and (2) Pretrial supervision.

1. Pretrial risk assessment

- Pretrial staff cannot always interview defendants with behavioral health issues because they may be in special housing or be non-participatory because of their behavior or mental health/intoxicated condition. Without an interview, the Court must set the type and conditions of bail bond with incomplete information, which may result in pretrial release conditions that do not maximize public protection or appearance at later court hearings.
- When interviewed, defendants with behavioral health issues do not as reliably provide correct information about their employment, residence, or criminal or behavioral health history, or they do not provide a contact person who can verify the information that is provided. Without reliable or verified information, the court is at higher risk of setting pretrial release conditions that do not maximize public protection or appearance at later court hearings.

2. Pretrial supervision

- Most defendants with behavioral health issues and who are indigent/impoverished cannot afford their medications or treatment, or they have a difficult time keeping a job or insurance. Thus, their symptoms persist or worsen, and they commit new crimes or fail to comply with supervision (probation, pretrial) and get deeper into the system. Persons who cannot afford their medications or treatment require more government funds for these services.
- Defendants with behavioral health issues have a more difficult time following instructions (initiating check-ins, appearing at court hearings), and require more staff resources or expenses (e.g., frequent drug/alcohol testing) to facilitate their compliance with court-ordered conditions of supervision and bail bond.

Lastly, for both pretrial functions, defendants with behavioral health issues require more resources in the form of more staff time and costs. Mentally ill defendants take longer to interview, and substance abusing defendants take more staff because of their sheer volume. Most defendants in the criminal justice system either have alcohol or drugs related to their crime or have an alcohol or drug history that contributes to their criminality or hinders their rehabilitation.

COURTS - GIL MARTINEZ

Chief Presiding Judge, 4th Judicial District, Colorado Springs

- (1) Placement and Treatment both in and outpatient
- (2) Monitoring of the medications of the patients.
- (3) Coordination between Colorado Mental Health Institute and jail concerning medications.
- (4) How to continue resources for patients who are in county jails for a significant period of time.
- (5) Resources to the probation department to work with clients

As judicial officers it is very apparent that there are not a sufficient number of treatment providers for low income individuals. In urban areas there are a number of options however there is usually a waiting period for treatment and or admission. In addition the rural areas may not have treatment facilities that are near the patients home or family.

Concerning the monitoring of medication issue we see a number of clients who commit felony, misdemeanor or petty offenses because they have quit taking their medications. Once they have stabilized and are again on their medications the patient us usually back on track. However this process may take a number of days and the patient may be in a county jail unable to post any type of bond.

Item three the coordination of medication between the county jail and Colorado Mental Health can be a problem when a defendant is sent to the Colorado Mental Health Institute for competence or insanity evaluations. Again any disruption in the defendants medications is very disruptive to the defendant.

Items four and five are self explanatory.

PROSECUTION - PETE HAUTZINGER

District Attorney, 17th Judicial District

1) As prosecutors we are concerned first and foremost with preserving public safety. When we are presented with someone with genuine mental health issues which appear to be contributing to criminal behavior, our priority will almost always be to find a way to eliminate the criminal behavior. If the criminal behavior can be eliminated through therapy, medication, better supervision, etc., we will almost always get behind that as opposed to incarceration. At the same time, however, it is not unusual for us to be presented with an individual who has genuine mental health issues but also is a constant and ongoing threat to the safety of others. At some point we as prosecutors have to look at incarcerating these people in order to simply protect the public at large.

2) A large frustration for us as prosecutors is the lack of a legal mechanism to get meaningful mental evaluations of persons charged criminally early in the process. I personally handle the initial felony bond arguments on all new arrests, at least whenever I am in the office (these are done via a video link between the jail and the Justice Center). At least once or twice a month I have a case where it is perfectly evident to me, the police and the Judge that there are profound mental health issues which probably are driving the criminal conduct, but we are all essentially powerless to do anything to address this unless and until a defense attorney is appointed. Even then, the only real mechanism for early review is a challenge to the defendant's competency, which is in truth a significantly different analysis than whether the mental illness is driving the crime and whether it can be adequately addressed.

3) Another area of concern for prosecutors would be the difference between NGRI/ diminished capacity and mental illness contributing to or causing the criminal behavior. It's often difficult for us as prosecutors to adequately educate the public and/ or press as to these crucial distinctions. Most everyone's common-sensical definition of "crazy" includes much if not all of the violent criminal conduct we deal with every day. That is a far cry from a person not being legally responsible for their actions and that is a very difficult issue for us to handle, especially in a 15 second sound bite.

DEFENSE - DOUG WILSON

State Public Defender

The Office of the State Public Defender (OSPD) operates as a constitutionally mandated, single-program agency whose unique purpose is to provide competent legal representation to indigent clients accused of a crime that is commensurate with the same level of representation afforded non-indigent clients by a private attorney. We were established in 1970 in order to comply with the United States Supreme Court case, *Gideon v. Wainwright*, 372 U. S. 335 (1963), which mandated that counsel be appointed for all indigents accused of a crime.

Mental health and substance abuse issues drive many of our cases. While insanity and incompetency issues are involved in a small portion of our caseload, mental health issues that do not rise to the level of these two legal concepts continue to impact a substantial portion of our clients.

Mental health challenges that the OSPD face include:

- The "Revolving Door" of continuity of care, including medication changes.
- Inadequate intervention while incarcerated.
- Lack of community resources for the poor who have been convicted of a crime.
- Lack of quality experts that will work for a \$100.00 per hour limit.
- Lack of dual diagnosis beds.

PROBATION - TOM QUINN

Presentation for Mental Health Panel, March 13, 2009

- a. Name: Tom Quinn, Director
- b. Agency: Division of Probation Services (DPS), Judicial Department
- c. Role: DPS serves as the state administrative arm for the 23 Probation Departments, which are run by local Chief Probation Officers appointed by the Chief Judge of that district. DPS sets the standards, delivers the training, acts as liaison to the legislative and executive branches, and provides support and quality control to the field.
- d. Top Issues/Challenges dealing with offenders with behavioral health issues:
 1. Lack of treatment options (especially in rural areas).
 2. Case management is not sufficiently individualized, linked to assessment.
 3. Lack of fidelity to EBP on the part of treatment providers.

Additional information:

- the description and mission of your organization (see attached Fact Sheet)
- summaries of additional challenges or problems (Panel 1)
- names of individuals working at DPS in the area of offenders and mental illness:
 - Eric Philp eric.philp@judicial.state.co.us
 - Member of the Legislative Task Force for the Continuing Examination of the Treatment of Persons with Mental Illness Who are Involved in the Criminal Justice System
 - Working with Chief Probation Officers on a Rural Initiative to meet their needs with MH, substance abuse
 - Susan Colling susan.colling@judicial.state.co.us
 - Also on the above Legislative Task Force
 - Member of the McArthur Foundation Grant oversight committee. This grant is testing a screening tool (MAYSI) and developing a curriculum for “crisis intervention teams” (CIT) for youth.
 - Involved with CO LINKS for Mental Health, promoting partnerships
 - Affiliated with the “Building Bridges” grant to Department of Education which is building Positive Behavior Support model in the schools.
 - Heather Garwood heather.garwood@judicial.state.co.us
 - Trainer – liaison for contracted staff for 2 day training for Adult MH and separate 2 day training for Juvenile MH training for POs, offered annually.
- supplementary brochures or other materials:
 - Probation Research in Brief for Colorado field probation staff on “Probation, Mental Health, and Mandated Treatment” issued 11/08

DEPARTMENT OF CORRECTIONS - DAVID STEPHENS INSTITUTIONAL CHALLENGES

Institutional summary of behavioral health challenges:

Presented by David Stephens, Psy. D., Chief of Behavioral Health for CDOC

1. Cross-system communication difficulties - obstacles to getting information from community treatment agencies or jail systems regarding offenders with mental illness/co-occurring disorders
2. Re-entry difficulties - obstacles to transitioning offenders with mental illness/co-occurring disorders to community treatment providers following incarceration in the DOC
3. Differential medication management from the community, to jail, to DOC
4. Comprehensive training for DOC officers (custody and parole) on specialized information and skill-set necessary to manage offenders with mental illness/co-occurring disorders (e.g. criminogenic needs, motivational interviewing and enhancement, CIT, etc.)
5. Treatment challenges in the correctional environment

Topical point - "Expansion of Treatment Challenges:

There are numerous behavioral health treatment challenges in the correctional setting. These include: appropriate and accurate assessment; targeted, individualized treatment interventions; appropriate use of medications; motivation enhancement; addressing of criminogenic needs and criminal behaviors for those with behavioral health disorders; and assisting offenders in moving towards relapse and recidivism prevention and recovery. While these are all critical issues, and need further elaboration, we will highlight the issue of accurate assessment in particular.

Accurate assessment in the correctional system is limited by a number of factors. Included in these are the high prevalence of substance use, difficulty obtaining full and accurate treatment histories, and the correctional environment itself. If we are to accurately and appropriately assess offenders in a criminal justice setting we need to do a better job of acknowledging the impact and inter-connected nature of these factors. Correctional environments create significant levels of stress that can appear to be mental illness, which needs to be taken into account in the assessment process. When this is combined with histories of substance use and a lack of information about prior treatment, we are prone to inaccurate diagnoses, which lead to inappropriate interventions and use of resources."

DEPARTMENT OF CORRECTIONS - TODD HELVIG PAROLE CHALLENGES

Parole specific behavioral health challenges:

Presented by Todd Helvig, Ph.D., Community Behavioral Health Services for CDOC / Division of Adult Parole, Community Corrections, and the Youthful Offender System

- A. Limited comprehensive case management to facilitate continuity of care (those invested in the oversight of these cases) for mentally ill offenders throughout their movement in the criminal justice system, including jail, prison, community corrections, and parole.
- B. Non-specific behavioral health links to community resources for mentally ill offenders.
- C. Medication – continuity, resources, availability
- D. Limited formal specialized training for Community Parole Officers and Re-entry Specialists regarding specialized skill-set to facilitate their management of mentally ill offenders (i.e., Motivational Interviewing/enhancement, CIT).
- E. Behavioral health system gap in oversight of mentally ill offenders who have been placed on involuntary medications while incarcerated. These offenders parole or discharge their sentence without any required follow-up or case management regarding mental illness or necessity of medication for their own safety and the safety of the community.
- F. Lack of parole resources to manage specialized caseloads (CPOs and Re-entry Specialists).
 - A) Cases are complex and intensive requiring time, knowledge, and specialized skill set.
 - B) Limited resources throughout the State for the most complex cases (homeless sexual off w/ mental illness + dev. disabil.).

COMMUNITY CORRECTIONS - GLENN TAPIA

Presenter: Glenn Tapia, M.P.A.

Organization: Division of Criminal Justice, Colorado Department of Public Safety

In partnership with the Department of Corrections, the Division of Behavioral Health and the State Judicial Department, the Division of Criminal Justice (DCJ) is statutorily responsible for quality assurance at the state's thirty-six authorized community corrections programs. DCJ is also the paymaster for community corrections programs, which will receive more than \$50 million in reimbursement for services provided to more than 10,000 felons during the current fiscal year.

Principal Behavioral Health Problems and Challenges

- Some estimates suggest that about 20% of the offenders in Colorado's prisons and jails suffer from serious mental illness. The cost of evidence-based treatment for these offenders is substantial, whether delivered to persons transitioning from prison or to persons who have been diverted from prison to community corrections. Especially during difficult budgetary times, it can be difficult to obtain adequate resources for evidence-based treatment, including medication.
- Many offenders with serious mental illness also suffer from the co-occurring disorder of substance abuse. Treatment efforts must effectively address both conditions.
- While many offenders have similar behavioral health issues, it can be challenging to adequately assess felons as individuals and to place them in programming that will appropriately address individual criminogenic and behavioral health needs.

VICTIMS - STEVE SIEGEL

Victim Representative, 2nd Judicial District

a. Your name

Steve Siegel

b. The organization or entity you represent

Denver DA's Office and Colorado Organization for Victim Assistance....Representing Crime Victims Issues

c. If not obvious by the organization name, a very brief description of the purpose of your organization

d. If you are listed in Panel 1 (see attached letter), a few sentences on each of the top 3 - 5 problems or challenges dealing with offenders with behavioral health issues

If you are listed in Panel 2 (see attached latter), a few sentences on the top 3 - 5 priorities of your organization in the area of offenders with behavioral health issues

A. Offenders with Behavioral Health issues often are unable to comply with court dictates which leaves the victim without; 1. a sense of justice. 2. a sense of safety that further victimization will not take place. 3. a reasonable likelihood that restitution will be completed

B. Offenders with Behavioral Health issues often have inadequate resources for treatment and support which yields a higher likelihood that item A will occur.

C. Offenders with Behavioral Health issues who victimize individuals with Behavioral Health issues create a complex circumstance for law enforcement and the courts. The ability to get to the heart of the matter and seek justice, accountability, and victim/community safety is compromised.

D. Victims of Crime who have Behavioral Health issues at the time of their victimization face a myriad of challenges in recovery.

E. Victims of Crime who develop Behavioral Health issues due to their victimization face a significant challenge is creating a new normal in the aftermath of their victimization.

DEPARTMENT OF HUMAN SERVICES - CHARLIE SMITH

Date: Friday, March 13, 2009
 Name: Charles Smith, PhD, Deputy Director
 Represent: Division of Behavioral Health, Colorado Department of Human Services

- State Mental Health Authority and Single State Authority for Substance Abuse

Top 3 - 5 problems or challenges dealing with offenders with behavioral health issues

Criminal & juvenile justice system penetration

- Inadequate funding of community-based mental health and substance abuse treatment services (prevention programs, early intervention programs, and treatment/recovery programs).
 - If we have fewer community behavioral health treatment dollars to meet the need, then...
 - a. there are more individuals with behavioral health issues (BHI) in need of treatment who do not get treatment;
 - b. there are more individuals with BHI who have contact with the criminal/juvenile justice system;
 - c. there are fewer options for the criminal/juvenile justice system to divert or release individuals to the community; and
 - d. individuals with BHI are more likely to stay in the criminal/juvenile justice system longer and penetrate deeper.
- Insufficient diversion efforts: CIT, problem solving courts (drug & mental health courts)
- Lack of standardized behavioral health screening in jails

Community-based behavioral healthcare for offenders

- Need for immediate, simple, and trouble-free referral and access to care
 - “No-Wrong Door”
- Inconsistent coordination between criminal/juvenile justice systems and community-based behavioral health treatment systems
 - Information and data sharing between systems
 - Coordinated discharge planning
 - Community behavioral health “reach-in” initiatives
- Insufficient workforce: mental health and substance abuse clinicians in jails, prisons, and rural/frontier communities

Transitioning to living in the community

- Difficulty obtaining Personal Identification
- Terminated healthcare benefits/insurance (e.g., Medicaid/Medicare, SSI, SSDI)
- Limited employment/supportive employment/training opportunities dedicated to offenders with behavioral health disorders
- Insufficient housing capacity (with adequate case managed services)
- Family re-unification and social supports

System/Issue illiteracy, discrimination, and stigma (NIMBY)

- Behavioral Health Literacy
- Criminal and Juvenile Justice Literacy
- Coordinated Workforce Education and Training: forensic behavioral healthcare

DEPARTMENT OF HUMAN SERVICES - JANET WOOD

Date: Friday, March 13, 2009

Name: Janet Wood, M.B.A., M.Ed., Director

Represent: Division of Behavioral Health, Colorado Department of Human Services

- State Mental Health Authority and Single State Authority for Substance Abuse

Top 3 - 5 priorities dealing with offenders with behavioral health issues

Maintain and grow resources targeted to this population

- Existing State and Federal resources include (but not limited to)
 - Drug Offender Surcharge - Strategies for Self-Improvement and Change Curriculum (adult males, adolescent, and gender-specific version for women)
 - Forfeiture Funds - detoxification and treatment services
 - STIRRT - residential and continuing care funding
 - SB97 (tobacco settlement - Tier II funding) - pays for offender behavioral health demonstration programs among select Community Mental Health Centers; and restores some portion of funding cuts to substance abuse prevention and treatment from 2003 budget cuts
 - Turnabout Program - Mental Health detention pilot with the Division of Youth Corrections
 - Federal Block Grant funding when the offender also is an identified priority population (pregnant women, intravenous drug user, seriously mentally ill, etc.)

Ensure quality services for offenders with behavioral health needs

- Specific licensure for offender treatment (license all programs receiving public funds-but only fund 41)
- Monitor offender treatment programs and act upon the license where there are problems (typically in concert with referring agencies)
- All licensed programs report demographics and treatment outcomes to DBH

Create mechanisms to ensure real-time feedback regarding supervision and treatment of offenders

- Development of the web-based Treatment Management System (TMS) reporting for DUI offenders (included focus groups with probation officers, treatment agencies, establishment of specific codes and operability to enhance the supervision and treatment of offenders and reduce paperwork and redundancy)
- Future plans for the drug court offender and offenders with mental health needs

Interagency work towards overall system improvement

- Interagency Advisory Committee on Adult and Juvenile Correctional Treatment
- Taskforce for the Continuing Examination of the Treatment of Persons with Mental Illness Involved in the Justice System
- State Methamphetamine Task Force
- Interagency Taskforce on Treatment-SB03-318 funding
- Behavioral Health Cabinet and Transformation Transfer Initiative (TTI) Grant
- Prevention Leadership Council

MENTAL HEALTH PLANNING AND ADVISORY COUNCIL

**Harriet Hall, MHPAC Subcommittee Co-Chair
(also, President, Jefferson Center for Mental Health)**

The PURPOSE of the Colorado MHPAC is:

- 1) To exchange information and develop, evaluate, and communicate ideas about mental health planning
- 2) To write and amend strategic plans for mental health services in the State of Colorado
- 3) To advise the Colorado state government concerning proposed and adopted plans for mental health services provided or coordinated by the state and the implementation thereof
- 4) To monitor, review, and evaluate the allocation and adequacy of mental health services in Colorado and to advise the Colorado state government concerning the need for and quality of services and programs for persons with mental illness in the state
- 5) To develop and take advocacy positions concerning mental health legislation and regulations

Offenders with Behavioral Health Issues Priorities:

MHPAC has discussed the following as important in the area of offenders with behavioral health issues:

- 1. No loss of Medicaid when incarcerated**
- 2. Funding for evidenced based programs that provide a link/warm hand off between jail services and community based services**
- 3. Support and funding for Crisis Intervention Team models of care that include a behavioral health case management component; this allows follow up to CIT police office intervention.**

MHPAC Funding Priorities FY 2009-10 (FY 2010-11 priorities not yet approved)

The funding priorities of the Colorado Mental Health Planning and Advisory Council (the Council) focus on the thousands of Coloradoans, who have or are at risk of serious mental illness, emotional disorders, and/or co-occurring mental health/substance abuse disorders and who, despite their critical need for mental health care, are not able to access treatment and services in the public mental health system. The Council affirms the need to preserve all elements of an effective continuum of care in Colorado. Therefore, the priorities include the full spectrum of care – from community-based care to inpatient services – for indigent and underinsured or uninsured children, adolescents and adults.

Priority A: *Reduce Recidivism in the Criminal and Juvenile Justice System*

Provide integrated diversion and transition services for successful re-entry and reduced recidivism for people with mental health, emotional, and/or co-occurring mental health/substance abuse disorders who are involved in the juvenile and adult justice systems.

Priority B: *Serve persons who are uninsured and under-insured*

Increase general fund dollars for services and supports to serve an additional 3,000 persons with mental health, emotional, and/or co-occurring mental health/substance abuse disorders who are indigent and underinsured or uninsured.

Priority C: *Crisis triage and stabilization for adults who are experiencing a mental health, emotional, and/or co-occurring mental health/substance abuse crisis*

Avoid costly emergency room services and divert from jail by providing essential community-based crisis stabilization and care 24 hours a day, 7 days a week. Fifty percent (50%) of the consumers/patients served are projected to be indigent and underinsured or uninsured.

Priority D: *Increase accessibility of needed treatment to Veterans, Reservists and National Guard and their families*

Use demonstration programs and best practices from other challenging populations to better serve the complex needs of Veterans, Reservists and National Guard and their families.

Priority E: *Enhance and Support Statewide Performance Measures*

Obtain the necessary resources to support and maintain a performance management and statewide reporting system to demonstrate cross-systems outcomes and benefits.

MENTAL HEALTH ROUNDTABLE - Stephen Kopanos

Chair, The Roundtable

(also, V. P. of Public Policy & Systems Advocacy, Mental Health America - Colorado)

Colorado Mental Health and Substance Abuse Roundtable "The Roundtable"

Roundtable Mission:

To bring together the Substance Abuse and Mental Health Community in Colorado, speaking and acting with a unified voice, to advocate for funding and improved outcomes in mental health and substance abuse on behalf of all the people of Colorado. The Roundtable was formed in 2007.

Key Goals of Roundtable:

- Present common, unified voice to the people and Government of Colorado for Mental Health and Substance Abuse issues.
- Reduce stigma and discrimination through development of a unified media campaign.
- Run a successful ballot initiative to secure funding for unfunded programs and services that would benefit those with mental health or substance abuse conditions.
- Investigate long term impact of a unified roundtable on policy and health reform.

Associated Organizations:

Denver PD, NAMI Colorado, Mental Health America of Colorado, Denver Health Medical Center, Crime Prevention & Control Commission, Colorado Coalition for the Homeless, Centura Health, City of Golden, Colorado Cross-Disability Coalition, Federation of Families for Children's Mental Health-Colorado Chapter, Health Care Systems Consulting, SE2, Signal Behavioral Health Network, Denver Sheriff Department, Denver Office of Drug Strategy, North Range Behavioral Health, RDM Communications, Exempla, PSL/Health One, Colorado Association of Alcohol and Drug Service Providers, Arapahoe House, Boulder County Managed Service Organization, Jefferson Center for Mental Health, Peer Assistance Program, Larimer Center for Mental Health, Colorado Cross-Disability Coalition, M.I.N.D.S., Foothills Behavioral Health, AD DD, WE CAN! of Colorado, The Colorado Health Foundation, Colorado Access, Colorado Behavioral Healthcare Council.

Impact to Criminal Justice:

Lack of funding has plagued the mental health system and led to a shift in outcomes for people with mental health and substance abuse conditions. Currently, there are hundreds of trained CIT officers and an acute lack of appropriate beds for those identified as having a mental health or substance abuse disorder. Current funding mechanisms and treatment access is limited and those who would be best served in outpatient settings, are taken to emergency rooms and jails due to the lack of viable options. The Roundtable is currently seeking to build a broad coalition to pass a long term new funding mechanism, possibly through a ballot initiative, to provide needed critical services to the people of Colorado. Some possible recipients of such funding could be the Metro Crisis Triage Center, diversion services, sustained recovery services, or Integrated Dual Diagnosis Treatment. All these measure would impact the jail population in Colorado. Improved services lead to decreased need for incarceration and significant cost savings over incarceration.

Current Chair: Stephen Kopanos,

Vice President for Public Policy

Mental Health America of Colorado

720-208-2224



THE MIGHTY COALITION
GEORGE DELGROSSO Member
(also, Executive Director of Colorado Behavioral Healthcare Council)

About the Mighty Mental Health Coalition



The Mighty Mental Health Coalition (Mighty) is a long-standing group of stakeholder organizations including the National Association of Social Workers-Colorado Chapter, the Federation of Families for Children’s Mental Health-Colorado Chapter, the Colorado Psychological Association, Colorado Psychiatric Society, National Alliance on Mental Illness (NAMI) Colorado, WE CAN! of Colorado, Colorado Behavioral Healthcare Council and Mental Health America of Colorado.



Mighty Mission:

To raise awareness of mental health issues and ensure quality systems of care and treatment, policy and funding for mental health through unified efforts and action.



Key Goals of Mighty:

- Present as one voice to policy makers whenever possible
- Reduce stigma
- Ensure services are recovery and resiliency focused
- Increase the influence of mental health in state government
- Advocate for access to appropriate medications in the most cost effective way



Purpose of the Mighty Collaborative Approach:

To build a shared culture that will enable us to:

- 1) achieve our vision, mission and goals,
- 2) bring each organization to a new level of effectiveness by expanding our capacity to develop and share resources, information and expertise,
- 3) develop long-term collaborative relationships between the organizations.



Executive Leadership:

- Amanda Kearney-Smith--We Can! of Colorado
- Renee Rivera--National Assoc. of Social Workers, Colorado Chapter
- Lacey Berumen--NAMI Colorado
- Jeanne Rohner--Mental Health America of Colorado
- Tom Dillingham--The Federation of Families for Children's Mental Health--Colorado Chapter
- Laura Michaels--Colorado Psychiatric Society
- Karen Wojdyla--Colorado Psychological Association
- George DelGrosso--Colorado Behavioral Healthcare Council



COLORADO COALITION FOR THE HOMELESS LOUISE BORIS V.P. of Programs



Agency Mission

The mission of the Colorado Coalition for the Homeless is to work collaboratively toward the prevention of homelessness and the creation of lasting solutions for homeless and at-risk families, children, and individuals throughout Colorado. CCH advocates for and provides a continuum of housing and a variety of services to improve the health, well-being and stability of those it serves.

Agency Background

Colorado Coalition for the Homeless (CCH) was established in 1984 as a 501(c)(3) non-profit corporation. It was founded by a group of individuals with a will to take action on behalf of Colorado's homeless. They recognized the struggles of working people living in poverty. And they refused to tolerate the dangers faced by those people sleeping in their cars, in tents or on the streets.

A major milestone for the organization was the opening of Stout Street Clinic (SSC) in 1985. Nearly 25 years later, many of the underlying social causes of homelessness persist, like poverty, shortages of affordable housing, and unattainable healthcare. The Coalition's integrated housing, healthcare including mental health, substance treatment, co-occurring mental health and substance treatment and supportive service programs have been highly effective at responding to these conditions over time.

Agency Priorities

- 1) Access to affordable mental health treatment and medication for those on parole and probation
- 2) Transition planning for individuals who have completed their sentences so that mental health treatment and medication can be sustained
- 3) Identification of those individuals experiencing mental illness and/or traumatic brain injury that may qualify them for SSI/SSDI and better linkage to those resources
- 4) Continuity of care from jails and prison to community providers
- 5) Ongoing training for staff in community corrections, parole and probation, as well as staff of half-way houses, in the identification of mental health and TBI issues
- 6) Access to inpatient psychiatric treatment.

For more information, please contact Louise Boris at 303-285-5203 or lboris@coloradocoalition.org

Support Narrative

Access to mental health and co-occurring treatment in the community for persons either currently involved in the criminal justice system or for those who have recently exited the system is an enormous issue for the individuals and for the service system trying to accommodate their needs. Individuals may come out of prison or jail having received psychiatric services and having been prescribed medication. Many either want to remain in treatment or they are told they must remain in treatment as a condition of release; however, they cannot find affordable treatment and perhaps more significantly the medication. Stout Street Clinic Mental Health is often the first stop for individuals in need of such services. It should be remembered that CCH serves those who find themselves homeless and so it is to those who meet this definition on whom this is focused.

The waiting list for an intake at the Stout Street Mental Health Clinic was 175 people as of February 25, 2009. SSC, Substance Treatment Services (STS) estimates that 25% of all screenings (staff screen 12-15/week, and turn away about that many), have some current involvement with the criminal justice system: mainly court-ordered "treatment" including Antabuse. Many have a co-occurring mental illness, but seek substance treatment as substance use is what precipitated their involvement in the criminal justice system. Most of these individuals can not afford the Antabuse as required by the terms of their probation.

In addition to the services provide through SSC, CCH developed numerous programs like Housing First/Assertive Community Treatment to address the needs of this population. Even with the excellent and profound level of services provided, some need a higher level of treatment than that provided through a "hospitals without walls." model. The critical missing link is psychiatric hospital availability and the corresponding appropriate discharge planning.

On Monday February 23, 2009 eleven new patients presented at the Stout Street Mental Health Clinic for intake. Seven of those made some endorsement of being involved in the criminal justice system, either recent discharge from prison or jail or currently on probation or parole.

Residents of half-way houses are also frequently sent to Stout Street Mental Health. They are told by their case managers they can either receive free services at Stout Street or pay for a medical consult visit in the community and for their medications. These individuals are usually unemployed, often due to their mental health issues. They are not homeless, but their case managers appear to have few other options.

One gentleman with schizophrenia was recently sent to SSC Mental Health from his half-way house wearing an ankle tracking bracelet. The SSC provider assessed that he was clearly disabled and not able to work; though obtaining a job was a requirement of his release. CCH staff in the Benefit Acquisition and Retention Team (BART) and the mental health clinic worked with him to obtain benefits and treatment. Advocacy calls were made to the half-way house explaining that his serious mental illness prevented him from working so that he would not be sent back to prison. Stout Street Clinic staff considered him to still be in the custody of the Department of Corrections, but treated him anyway as it was clear that he would not receive treatment anywhere else.

For more information, please contact Louise Boris at 303-285-5203 or lboris@coloradocoalition.org

COLORADO ASSOCIATION OF ALCOHOL AND SUBSTANCE ABUSE PROVIDERS - CARMELITA MUNIZ Executive Director

The impact of substance abuse on Colorado Citizens. Beyond the observed effects substance abuse exerts on Colorado citizens and their families, these preventable and often untreated problems have a profound financial impact on Colorado's criminal justice, human services and health care systems.

What would it mean to Colorado to invest in substance abuse prevention, intervention, treatment and recovery.

The role and opportunity the Colorado Providers Association has to inform, support and implement improvements in substance abuse prevention, intervention, treatment and recovery. It is important at this difficult economic time, for all of us to work together in common cause to help solve these and other complex social problems. COPA stands ready to serve as a partner to help impact Colorado's significant substance abuse issues.

VISION

The Vision of the Colorado Association of Alcohol and Drug Service Providers (The Providers Association) is to optimize the health of the people of Colorado by ensuring access to a full continuum of substance abuse prevention, intervention, treatment, and recovery services.

MISSION

The Providers Association is a professional trade association focusing on reducing barriers, coordinating and improving existing services, and developing new programs to improve the availability, quality, and comprehensiveness of services for the people of Colorado now and into the future.

VALUES

- Community oriented
- Celebrate the diversity within the alcohol and drug services industry
- Value the contribution of each and every member
- Through our members, value the direct link to the thousands of Colorado citizens that our prevention, intervention, treatment, and recovery services touch each year

KEY OBJECTIVES

- Develop integrated systems of care with primary and behavioral health using grant programs like SBIRT and Access to Recovery, that can be sustained over time
- Advocate for alcohol and drug prevention, intervention, treatment, and recovery support providers
- Cultivate leadership
- Promote the effective use, integration, and coordination of alcohol and drug prevention, intervention, treatment, and recovery services
- Partner, collaborate, and support networks, systems, and communities
- Foster system and policy formulation and changes to improve access, quality, and program services
- Seek new funding streams
- Promote cross-system collaboration
- Promote effective best practices for prevention, intervention, treatment, and recovery services
- Educate community and collaborative partners about substance abuse prevention, intervention, treatment, and recovery effectiveness

COLORADO BEHAVIORAL HEALTHCARE COUNCIL

DOYLE FORRESTAL Director of Public Policy

Top Criminal Justice Priorities

- Increase and support opportunities for additional community-based diversion and transition programs that are collaborations between criminal justice system and community providers
- Streamline systems to improve continuity of care between the criminal justice system and the community to increase access to care and the connection to treatment needs
- Enhance the creation of and connection to community-based programs and services that reduce recidivism, such as mental health and substance abuse treatment, medications, housing, benefits, vocational training
- Improve education and outreach efforts to the community to reduce the stigma associated with individuals that have had contact with the criminal justice system, and especially for those who also have mental health conditions

Colorado Behavioral Healthcare Council--Potential Priority Items for 2009

Priority #1--Increase collaborations between community mental health centers and the criminal justice system

- **Community Corrections/Community Mental Health Collaborations**--Create and enhance collaborative efforts for prison transition programs for mentally ill, and dually diagnosed offenders, that include a local community corrections provider and the community mental health center. The concept is to enhance and expand on programs such as the JERP program.

Priority #2--Streamline systems to enhance continuity of care between incarceration and community

- **Mobile Van for IDs for Jail Population**--Support the acquisition of a mobile van for the Division of Motor Vehicles.
- **Caseworkers for CIT Program**--Provide funding for each county to hire one-two case workers that are responsible for Crisis Intervention Treatment (CIT) cases. The case manager will work together with the identified person to connect them to services. In some cases the case manager will provide support services until they are assigned a treatment provider.
- **Expand Crisis Intervention Training to jail staff**—Provide for opportunities for all jail staff to receive CIT training. This could potentially reduce conflict and increase referrals to programs.
- **Statute review to give preference to mentally ill offenders**--Review all relevant statutes to ensure that individuals with mental illness and substance abuse issues are given priority for treatment services and options.
- **Medication assistance**--Provide a funding stream and other coordination necessary to continue medication(s) for individuals leaving jail or prison until they have benefits or other funding streams to pay for those medications.

Priority #3--Create and Enhance Programs and Services That Reduce Recidivism

- **Increase use of mental health and substance abuse screens**—Increasing early screening at all access points to increase penetration rates into existing programs, and provide alternatives for diversion into treatment.
- **Vocational Programs**--Create additional vocational programs for offenders in the community.
- **Residential and housing options for offenders in community mental health centers**--Create alternative residential treatment options for offenders who do not need the structure of community

corrections that are based in community mental health centers (CMHCs) for transition and diversion programs.

- **Build community awareness and acceptance**--Create public service announcements and other educational efforts to help the public, community corrections boards, and the judicial system to better understand and support the needs and potential recovery of offenders with mental health and co-occurring substance abuse disorders.
- **Expand Benefits Acquisition Teams and Specialists**--Create and expand upon programs to assist individuals throughout the claims process.

How the Community Mental Health System can help alleviate the growing problem of mentally ill inmates in the criminal justice system

Background

Many of Colorado's community mental health centers are currently working with offenders that have mental health conditions. Over the years, programs have been developed to divert this population from jail, while other programs are designed to successfully transition the offender when they are released from prison.

Programs

The following list describes just a few of the community-based programs that have had a positive impact on the recidivism rate of this population.

The PACE Program. The PACE Program is a collaboration of a variety of agencies in Boulder County including Mental Health, Community Justice Services, 20th Judicial District Court & Probation Departments, Boulder County Sheriff's Department and the Public Health Department. Designed to reduce the number of inmates at the Boulder County Jail and to bring help to those who would benefit from extra services, PACE targets those who are dually diagnosed (mental health and substance use) and who have a history of involvement in the criminal justice system.

Members of the PACE team evaluate each person who is referred to the program to determine if the client is appropriate. Once screened and approved by the team, the Court makes a determination about whether or not to sentence the client to PACE either as a condition of probation or as a condition of bond.

The PACE Program is an outpatient diversion program designed to reduce the rates of incarceration through treatment alternatives and integration of services. Clients include both misdemeanants and felons.

The services that PACE provides include:

- Medication monitoring;
- Observation of mental status and sobriety, as well as, periodic sobriety testing via breathalyzers, urine screens and/or oral swabs;
- Assistance with housing, medical/dental care, bus transportation and accessing self-help groups;
- Assistance and support in securing and maintaining employment;
- Life skills training;
- Substance abuse and psychiatric treatment, both individual and groups;
- Meetings with probation officer, therapist, psychiatrist, nurse and case manager all in one office.

JERP (The John Eachon Re-entry Program). The Jefferson County Integrated Parole Treatment Demonstration Program (also known as the John Eachon Re-Entry Program or JERP) is a collaborative project to increase public safety and reduce recidivism by providing wrap-around services to prison inmates who suffer from serious and persistent mental illnesses, and substance abuse disorders, and who are placed in community corrections or paroled to Jefferson County. The program is designed to treat co-occurring

substance abuse issues by providing Integrated Dual Disorders Treatment (IDDT), an evidence-based practice. The program began in November 2005.

- **Eligibility**--Inmates/parolees with serious and persistent mental illness who are placed in community corrections or paroled to Jefferson County
 - Referrals must come from the Department of Corrections to the Community Transition Unit, per the normal referral process
- **The Program**--The program has two phases:
 - 1) residential (community corrections)
 - 2) aftercare (parole status)
- **Services include:**
 - ICCS (community corrections) programming
 - Daily Living Skills, Communication, Anger Management, Correctional Supervision, etc.
 - Mental Health Substance Abuse Treatment, average of 13-19 Individual and Group sessions, Cognitive-Behavioral Therapy, Integrated Dual Diagnosis Treatment, Recovery orientation, and Case Management
 - Medication and Medication management
 - Vocational counseling, job skills, job search
 - Community living skills – community integration

Assertive Community Treatment (ACT)--Denver's Court to Community Program. Act is an evidence-based program which reports demonstrated decreased days of incarcerations, inpatient hospital admissions and lengths of stays, days of homelessness and substance abuse indicators. In Denver, the Court to Community Program is a flexible and responsive special services court docket and system to manage municipal offenders with serious and persistent mental health issues.

The program allows for access to evaluation and treatment referrals for participants. Services are provided by participating Assertive Community Treatment (ACT) Case Management teams for at least 36 adults at any given time. Program participants are supervised through frequently scheduled court reviews. The goals of the program are to:

- Protect Public Safety
- Reduce the use of jail and repeated interaction with the criminal justice system by persons with serious and persistent mental health issues
- Reduce psychiatric ER & hospital use
- Reduce substance abuse in target population
- Improve the likelihood of ongoing success and improve psychiatric well-being among target population by way of: connecting/reconnecting with treatment, providing access to housing or shelter, providing linkage with other critical supports for the mentally ill

The Court to Community Program is staffed by the Denver City Attorney's Office, the Defense Council, a County Court Judge, a Court to Community Coordinator, Mental Health Center of Denver, and Colorado Coalition for the Homeless.

NATIONAL ALLIANCE FOR THE MENTALLY ILL

NITA BROWN President, Arapahoe/Douglas County

[Primary contact: Lacey Berumen Executive Director, NAMI Colorado]

Introduction

NAMI is the National Alliance on Mental Illness, the nation's largest grassroots organization for people with mental illnesses and their families. Founded in 1979, NAMI has affiliates in every state and in more than 1,100 local communities across the country. NAMI members work to fulfill our mission by providing support, education and advocacy.

NAMI Colorado is a statewide nonprofit organization whose mission is to give strength and hope to individuals with mental illness and their families. At NAMI Colorado we give individuals and families, who are devastated by the diagnosis of severe mental illness, hope for a better future for themselves and their loved ones. We are working for a future time when persons with mental illnesses are well cared for, involved in meaningful work, and accepted as valuable members of their community. NAMI Colorado is about hope and recovery. At NAMI Colorado we know that, given the right treatment and access to services, individuals with mental illness can live rich and fulfilling lives. Indeed, we strive to help individuals and families cope with the illness and improve their lives through various programs.

Following are the top priorities of NAMI Colorado.

#1 Priority - Availability of appropriate treatment

- Mental illnesses are genuine neurobiological diseases of the brain. Just as in the case of diabetes, where no amount of willpower can make a diseased pancreas secrete appropriate amounts of insulin to control blood sugars, the functioning of the brain is essentially outside the direct control of the individual.
- The public mental health system is a fragmented network of programs, services, and funding streams. More cooperation and collaboration between entities can improve treatment.
- In the criminal justice system, adequate training for personnel needs to be addressed so they are better able to identify people with mental health needs. Personnel who have not had training regarding symptoms and behavior of mental illness may not understand an individual's difficulty in processing information and understanding directions and rules.
- Many people with mental illnesses have never been diagnosed. Many who have been diagnosed do not accept their diagnosis. Proper assessments by a qualified mental health professional is essential to an individual receiving proper treatment. Without this, people will further decompensate.

- When individuals with mental illnesses are properly diagnosed, stabilized and receive services, their quality of life improves and they are far less likely to commit subsequent crimes.
- When medications are given to treat symptoms, it increases the likelihood that an individual will adhere to a treatment plan. Not only is this humane, it is cost effective.
- That treatment works is indisputable. Medications and therapy have been developed that manage symptoms effectively and enable many individuals with mental illnesses to lead successful and productive lives. Without medications, there is little hope for recovery. Without recovery, the “revolving door” and continued contact with the criminal justice system will continue.
- Integrated Treatment for individuals with co-occurring disorders (mental illnesses and substance use) is an Evidence Based Practice. This single treatment plan is essential to recovery and should result in reduced criminal contact.

#2 Priority - Availability of Community Resources

- Individuals being released from jail/prison must be linked with community treatment and other support services
- Benefit programs like Social Security Disability, Supplemental Security Income, Medicaid, Medicare, food stamps, housing assistance must be made more easily available. Access to benefits is determined by an individual’s ability to access these services. Many individuals are too ill to complete applications for benefits, if they even know that benefits are available for which they might be eligible. Procedures for accessing benefits programs can be complicated. Many first time applications are denied. Benefits and entitlements are the only legitimate source of income for many with mental illnesses. Lack of income can lead to homelessness and crimes of survival like shoplifting, public urination, and panhandling which lead to contact with the criminal justice system.
- Case management is essential to provide effective continuity of care. This will ensure that individuals receive the help to access needed community services. Case management can coordinate effective collaboration among entities like the mental health centers, corrections, community corrections, and government agencies. It can facilitate appropriate re-entry to the community from corrections. When individuals are linked to services, they can become stable which will reduce recidivism.
- Supported Housing and Residential Care
- Medical Care is essential for the well being of everyone. It is crucial for persons with mental illnesses. Medications can cause other physical conditions. The challenges of living with a severe mental illness can be physically debilitating. A recent study of persons with mental illnesses demonstrates that their lifespan may be reduced by an average of 25 years.

- Supported Employment is an Evidence Based Practice where an employment specialist, probably with the mental health center, helps the consumer to find a job that matches skills and provides on-the-job support. Vocational training and interpersonal skills training are also needed to obtain and retain employment.
- Family and Peer Support are vital to recovery. Both can be effective in helping consumers understand their illnesses, adhere to a treatment plan, and re-integrate into the community. Family Psychoeducation is an Evidenced Based Practice.
- Not everyone needs all services, and not all communities are able to provide all services. Effective community service providers can and do offer services that reduces the likelihood of re-arrests.

#3 Priority - Increased Funding for Services

Funding for inpatient and community based services for individuals with mental illnesses must be increased significantly so their needs are addressed. Adequate funding will result in savings for the Criminal Justice System. Jails are being asked to function as inpatient psychiatric treatment facilities. The three largest in-patient institutions for the mentally ill in the country are the Los Angeles County Jail, Chicago's Cook County Jail and New York City's jail complex on Riker's Island. This is inhumane; it is not treatment; and it is not cost effective. People can be treated more effectively in the community at a significantly lower cost.

Conclusion

In closing I want to offer a quote from Dr. Ken Duckworth, a former commissioner of mental health in Massachusetts who now serves as medical director for NAMI: "There are things that happen in the mental health care system you couldn't imagine happening in the so-called 'health system' — as if the parts of the body are disconnected. I can tell you there's no parallel thing happening in American cardiology. People are not languishing or being neglected in cardiology wards across America."

'Nita Brown
President NAMI Arapahoe/Douglas Counties
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Executive Director, NAMI Colorado
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MENTAL HEALTH AMERICA - Colorado

JEANNE ROHNER Executive Director

Agency Name: Mental Health America of Colorado

Mission: Mental Health America of Colorado is the recognized leader, collaborating to promote mental health, expand access to services and transform systems of healthcare.

Problem:

People with mental health and substance abuse issues are ending up in jails and corrections at an alarming rate

A one-day snapshot of the adult mental health population in one jail revealed that:

- 73% had a co-occurring mental health and substance abuse issue
- 82% needed costly medications to control symptoms
- 82% were indigent
- 55% were homeless at the time of arrest

Solutions

- Crisis System – like the Metro Crisis Triage Project
 - Includes a crisis call center, crisis centers (assessment and stabilization) and a web-based information sharing network linking the crisis system to hospitals, law enforcement, Mental Health and Substance Abuse providers.
 - Will operate 24/7/365.
 - Estimated to respond to over 100,000 crisis calls and provide urgent psych care to over 17,000 people each year.
 - Project is “shovel ready”
- Advocate for Diversion Programs, Mental Health and Drug Abuse Courts and Treatment in Jails/Corrections including Reintegration
 - At the front end, services for identifying, assessing and referring available to those arrested for issues related to mental health and substance abuse
 - Mental Health Center Providers in Justice System need to reintegrate person back to community once person is released from justice system
 - Mental Health Center needs to provide integration services for everyone coming out of the justice system
 - Sentencing reform is necessary
 - Services need to be fully funded

METRO AREA COUNTY COMMISSIONERS: MENTALLY ILL INMATES TASK FORCE - PAUL SISKA

PRESENTER: Paul C. Siska
Undersheriff
Adams County

ORGANIZATION: Metro Area County Commissioner
(MACC) Mentally Ill Inmates Task Force

PURPOSE: The Task Force is made up with County Jail and Community Mental Health Professionals from the seven metro counties: Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas, and Jefferson Counties to look at the high cost associated with incarcerating individual with serious mental illness and develop strategies to encourage positive policy changes both in our operations and at the state level that help keep this vulnerable population successful in the community and out of the criminal justice system.

TOP CHALLENGES:

- Cost of incarceration in county jails of individuals with serious mental illness.
- Suspension of Benefits SBO8-06
- State ID's for seriously mentally ill inmates SB09-06
- 2009 Priorities for MACC Mentally Ill Inmates Task Force County work groups:
 1. Provide housing particularly for mentally ill offenders to build their recovery
 2. Funding for indigent services
 3. Resources for long term care users who require level of care
 4. Explore diverse mental health funding options
 5. Explore creating more diversion opportunities at intercepts #2 (initial detention and hearing) and #3 (jails and courts)
 6. Expand reentry initiative services through formation of an inter-county task force of the MACC
 7. Explore a medication assistance program

MENTALLY ILL IN THE JUSTICE SYSTEM TASK FORCE*

HARRRIET HALL Co-Chair

(also, President of Jefferson Center for Mental Health)

[*Task Force of the Legislative Oversight Committee for the Continuing Examination of the Treatment of Persons with Mental Illness Who Are Involved in the Justice System]

Legislative Oversight Committee Members

Senators - Betty Boyd (chair), Maryanne Keller, Scott Renfroe

Representatives - Jim Kerr, Judy Solano, Debbie Stafford

Priorities

1. Sufficient treatment resources to maintain persons with mental illness or co-occurring disorders who are involved with the criminal justice system in or return them to the community, including the development of programs and facilities and the training of staff
2. The importance of providing housing and employment in addition to treatment for persons with mental illness or co-occurring disorders who are involved with the criminal justice system, in order to prevent recidivism and promote public safety
3. The demonstration of positive outcomes and cost-savings resulting from effective treatment and community supports of individuals with mental illness or co-occurring disorders who are involved with the criminal justice system, to justify directing additional resources towards such programming.
4. The demonstration of the effectiveness of prevention and early intervention, including but not limited to juveniles, in preventing individuals with mental illness or co-occurring disorders from coming into the justice system
5. The availability of public benefits for persons with mental illness or co-occurring disorders who are involved with the criminal justice system;

Mission Statement

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. They must operate within the specific parameters of their authorizing legislation.

Vision Statement

Improved, coordinated criminal justice responsiveness to adult and juvenile offenders with mental health issues.

Structure

The Task Force works under the auspices of the Legislative Oversight Committee for the Continuing Examination of the Treatment of Persons with Mental Illness who are Involved in the Justice System. When issues studied by the task force indicate a need for legislative action, the task force recommends legislation to the Oversight Committee. When the committee approves moving forward with legislative recommendations, sponsors of such legislation do not need to include such bills within their mandated number of bills.

Members

Members listed below. Four are appointed by the Chief Justice of the CO Supreme Court, the rest are appointed by the chair and vice-chair of the task force (30 total members).

There is also a Legislative Oversight Committee, comprised of three State House Members and three State Senators.

Department of Human Services (6)

- Charles Smith, Division of Behavioral Health
- Caren Leaf, Division of Youth Corrections
- Melinda Cox, Division of Child Welfare
- Janet Wood, Division of Behavioral Health
- Michele Manchester, Colorado Mental Health Institute at Pueblo
- Jeanne Rohner, Mental Health Planning and Advisory Council/Mental Health America of Colorado

Practicing Mental Health Professionals (2)

- Julie Krow, University of Colorado Health Sciences Center
- Diane Reichmuth, The Children's Hospital

Community Mental Health Centers (1)

- Harriet Hall, Jefferson Center for Mental Health

Person with knowledge of public benefits and housing in the state (1)

- VACANT

Department of Education (1)

- Michael Ramirez

Department of Law (1)

- Tom Raynes, Attorney General's Office

Judicial Department (4)

- Susan Colling, Juvenile Programs Coordinator Probation Services
- Eric Philp, Probation Services
- Judge Martin Gonzales, Alamosa Combined Court
- Magistrate Rebecca Koppes-Conway, 19th Judicial District

Local Department of Social Services (1)

- Susie Walton, Elbert County Department of Social Services

Local Law Enforcement (2)

- Paul Siska, Adams County Sheriff's Office
- VACANT

Colorado District Attorney's Council (1)

- Bruce Langer, Boulder County District Attorney's Office

Colorado Criminal Defense Bar (2)

- Gina Shimeall, Arapahoe Douglas Mental Health Network
- Kathleen McGuire, Public Defender's Office

Person who is a practicing forensic professional in the state (1)

- Gregory Kellermeyer, M.D., Denver Health Medical Center

Members of the Public (3)

- VACANT
- Deirdre Parker
- Steven White

Department of Public Safety (1)

- Jeanne Smith, Director, Division of Criminal Justice

Department of Corrections (2)

- Jeaneene Miller, Division of Parole
- Joan Shoemaker, Director Clinical Services

Department of Health Care Policy and Financing (1)

- Sandeep Wadhwa, M.D., MBA State Medicaid Director

Activities

2005:

- Facilitated federal grant funding for the John Eachon Re-Entry Pilot Program (JERP) which began operations in September 2005.
- Advisory Task Force and Legislative Oversight Committee worked extensively with Consultants for Systems Integration (Center for Systems Integration) in developing a framework for use in addressing the issue of juveniles with mental illness in the criminal justice system.
- Recommended Senate Bill 06-005 requiring that health benefit plans cover mental health services to cover those that are mandated by a court order. The bill was signed into law.
- Recommended House Bill 06-1070 Creating demonstration programs for juvenile justice family advocates. The bill was postponed indefinitely.

2006:

- Created a subcommittee to further study the issue of crisis management and mental health needs in jails. The subcommittee created and distributed a survey to each of the 64 sheriffs in Colorado to learn what type of initial bookings and screenings are being done, figure out how long it takes to complete and assessment, obtain treatment or resources for the detainee, complete discharge planning and insure continuity of care. Due to lack of funding for additional training for jail personnel the issue was tabled. In 2007, the Task Force began collaborating with the Metro Area County Commissioners (MACC) Jail Diversion subcommittee, which is working on many of the issues initially discussed in the Task Force.
- The Advisory Task Force extensively discussed the implications of a verdict of not guilty by reason of insanity and considered, but decided against, the possibility of developing legislation to add a plea to the Colorado statutes. However, the Task Force recommended a bill concerning the creation of an advisory board within the Department of Human Services which would create standards of training, education, and experience for individuals who conduct competency evaluations in criminal cases.
- The Task Force studied and discussed various juvenile justice issues and recommended two bills.
 - ✓ The first bill created a demonstration program for juvenile justice family advocates and passed in the 2007 session.
 - ✓ The second bill reinstated amended provisions of Section 19-2-702, C.R.S., which was repealed in 2005. The bill passed in 2007 and requires anyone involved in a juvenile delinquency proceeding to raise the issue of emotional disturbance when it is appropriate. It directs the court to order a mental health assessment when the issue of emotional disturbance is raised and allows the court to order mental health treatment or services as part of the case disposition.

2007:

- During 2007, the Task Force focused on offenders and public benefits, a continued emphasis on juvenile justice and examining the issue of psychiatric security review boards.
- Three legislative proposals were generated and passed during the 2008 legislative session:
 - ✓ Expanding the task force membership to include a representative of the Department of Health Care Policy and Financing
 - ✓ Addressing the provision of public benefit application assistance for confined individuals

- ✓ Allowing a temporary suspension rather than a termination of benefits for anyone subject to court-ordered confinement.
- A legislative proposal developing pilot programs expanding the use of family advocates in the juvenile justice system was developed and successfully passed in 2007.
- The Task Force studied the possible development and use of a psychiatric security review board (PSRB) and agreed that the development and use of a PSRB is not in the best interest of Colorado at this time.

2008:

- Through various presentations regarding co-occurring disorders, the Task Force learned that approximately 80 percent of offenders with severe mental disorders have co-occurring substance abuse disorders.
- The Task Force studied the issues and challenges for offenders with mental health issues in finding adequate housing which is a significant barrier to successful re-entry into their communities.
- The Task Force recommended two bills related to housing:
 - ✓ Senate Bill 09-016 awards grants to local governments to facilitate changes in zoning regulations to accommodate the housing needs of mentally ill individuals who are involved in the criminal justice system.
 - ✓ House Bill 09-1022 awards grants for local recidivism reduction programs, allows grant funding for transitional and residential housing services, as well as various re-entry programs that create or expand mental health services and supports.
- The Task Force recommended Senate Bill 09-006 which creates a mobile unit to process identification cards for inmates in county jails.
- The Task Force recommended House Bill 09-1021 which reauthorizes the oversight committee and Task Force.
- The Task Force has identified several state-level groups with which it will coordinate efforts on issues related to the mentally ill in the criminal justice system.

Goals

July 2004 to June 2005:

- To examine the identification, diagnosis, treatment, and housing of juveniles with mental illness who are involved in the criminal or juvenile justice systems.
- 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 or juvenile justice systems.

July 2005 through June 2006:

- To examine the prosecution of and sentencing alternatives for persons with mental illness that may involve treatment and ongoing supervision.
- To examine the civil commitment of person with mental illness who have been criminally convicted, found not guilty by reason of insanity, or found to be incompetent to stand trial.
- The development of a plan to effectively and collaboratively serve the population of juveniles involved in the criminal or juvenile justice systems.

July 2006 through June 2007:

- To examine the diagnosis, treatment and housing of adults with mental illness who are involved in the criminal justice system.
- To examine 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.
- To examine the ongoing assistance and supervision, especially with regard to medication, of persons with mental illness after discharge from sentence.
- 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.

July 2007 through June 2008:

- To examine 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.

July 2008 through July 2009:

- To examine the early identification, diagnosis, and treatment of adults and juveniles with mental illness who are involved in the criminal and juvenile justice systems.
- To examine 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.
- To examine the implementation of appropriate diagnostic tools to identify persons in the criminal and juvenile justice systems with mental illness.
- To examine any other issues concerning persons with mental illness who are involved in the criminal and juvenile justice systems that arise during the course of the task force study.

July 2009 through July 2014 (pending approval of 09-1021):

6. The diagnosis, treatment, and housing of persons with mental illness or co-occurring disorders who are convicted of crimes, or incarcerated or who plead guilty, nolo contendere, or not guilty by reason of insanity or who are found to be incompetent to stand trial;
7. The diagnosis, treatment, and housing of juveniles with mental illness or co-occurring disorders who are adjudicated, detained, or committed for offenses that would constitute crimes if committed by adults or who plead guilty, nolo contendere, or guilty by reason of insanity or who are found to be incompetent to stand trial;
8. 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 these persons;
9. The safety of the staff who treat or supervise persons with mental illness and the use of force against persons with mental illness.

For a complete list of issues studied by the Task Force prior to 2005, go to http://www.state.co.us/gov_dir/leg_dir/lcsstaff/2005/comsched/05MICJSIssuesandoutcomes.pdf

TRANSFORMATION TRANSFER INITIATIVE GROUP

BEHAVIORAL HEALTH CABINET (& WORKING GROUP)

LESLIE HEROD

In the winter of 2007, Governor Bill Ritter, Jr. authorized an unprecedented meeting of his relevant Cabinet members to discuss the cross-system impacts of mental health and substance abuse (i.e. behavioral health) in Colorado. Out of this meeting, the Governor authorized the creation of a Behavioral Health Cabinet lead by the Executive Directors of the Departments of Corrections, Health Care Policy and Financing (the state's Medicaid agency), Human Services, Labor and Employment, Local Affairs, Public Health and Environment and Public Safety; other members included the State's Chief Medical Officer and the Director of the Governor's Office of Policy and Initiatives.

Beginning early in 2008 the Behavioral Health Cabinet began the long process of understanding each department's role in the provision of behavioral health care services and attached funding streams. The Cabinet also reviewed recent efforts including the recommendations of the HJR 1050 Task Force and the Task Force for the Continuing Examination of the Treatment of Persons with Mental Illness who are Involved in the Justice System. While the Cabinet was able to make joint recommendations and support each others efforts, it was understood that increased coordination with advocacy and stakeholder groups was vital to the success of behavioral health transformation. To this end, the Cabinet, working with the Dept. of Human Services has awarded a Transformation grant to Tri-West to assist the Cabinet in developing a process to secure on-going, meaningful input from consumers and stakeholders on decisions, implementation plans and system changes.

TRANSFORMATION TRANSFER INITIATIVE

ANDY KELLER (TRI-WEST, INC.)

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