Colorado Commission on Criminal and Juvenile Justice
Behavioral Health Recommendations

Task Group Topics and Participants

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Recommendation Rankings

Recommendations Descriptions

CCJJ BH/CJ Working Group Recommendations in Rank Order

(from April 21, '09 meeting and by follow-up e-mails April 27-30)

Recommendations by Rank and (sequentially)	# of Votes (of 32)	Topic
1. (1)Brief Screening Instrument to be used throughout justice system	20	Screen/Assess
2. (2)Given that psychotropic medications are some of the costliest types of medication, treat the access to psychotropic medications as a priority, resulting in a change in the way medication and treatment costs and coverage for the indigent is addressed	18	Benefits
3. (3)Clearly articulated system for accessing services	17	Treatment
4. (4)Cross-training on co-occurring disorders for substance abuse and mental health providers who treat offenders	15	Co-Occurring
5. **TIED** - (5) Assessment of training needs using Intercept Model, to include system navigation and clinical training; include both adult and juvenile	14	Training
TIED - (6) Integrate re-entry strategies between DOC and community to enhance the transition process for offenders released from prison and jails.	14	Treatment/ Co-Occurring
7. (7) Because housing is necessary component of treatment, address the difficulties treatment providers encounter providing and/or finding housing for offenders	13	Benefits
8. **TIED** - (8) Standardized/centralized data collection, storage and sharing system	10	Screen/Assess
**** TIED** - (9) Address housing needs for offenders who do not qualify for HUD/Section 8 by addressing zoning issues	10	Benefits
**** TIED** - (10) Fund a crisis call center	10	Treatment
11. **TIED** - (11) Increased resources for treatment especially in rural/frontier areas	8	Treatment
**** TIED** - (12) Utilize the Intercept Model to capture the resources statewide	8	Treatment
TIED - (13) Address barriers to benefits suspension and acquisition	8	Benefits
**** TIED** - (14) Enhance the availability for offenders to get state ID by funding a statewide effort	8	Treatment
**** TIED** - (15) Fund and support peer mentors and family advocates to help with system navigation	8	Treatment
16. (16) Create Benefits Acquisition Team	7	Benefits
17. **** TIED** - (17) Create a common formulary statewide	6	Treatment
**** TIED** - (18) Expand Mental Health First Aid / Behavioral Health First Aid in Colorado	6	Treatment
19. Provide a process for providers in the mental health and substance abuse systems to look at similarities and develop/agree on approach to co-occurring treatment	5	Co-Occurring
20. Increase public education to reduce stigma	3	Treatment
21. **TIED** - (21) Hospital Provider Fee Bill-waiver for childless adults to receive comprehensive benefits	2	Benefits
TIED - (22) Integrated funding for substance abuse and mental health treatment	2	Co-Occurring

****These recommendations may be included in others or may stand alone.**

BH Recommendations Descriptions

1. Identify and implement a brief behavioral health screening instrument across the adult criminal justice system and upon admission to city/county jails, probation, community corrections, and DOC to individuals charged with a municipal or state offense. (Votes= 20, Rank=1)

Problem/Background. Adults with behavioral health problems are often in contact with public safety authorities yet no standardized approach to the identification and assessment of behavioral health disorders exists across all systems. The lack of a coherent and standardized system to identity behavioral health problems is a clear public safety issue and contributor to recidivism.

Action Entity. Legislative Task Force for the Continuing Examination of Individuals with Mental Illness in the Criminal Justice System (MIJS) in coordination with the CCJJ and the Behavioral Health Cabinet.

Action.

- Pull current statutory language from previous work by MIJS
- Identify a behavioral health screening instrument
- Training on the use of the adopted instrument

2. Given that psychotropic medications are some of the costliest types of medication, treat the access to psychotropic medications as a priority, resulting in a change in the way medication and treatment costs and coverage for the indigent is addressed. (Votes= 18, Rank=2)

Problem/Background. Individuals quit taking their meds and end up in court having committed a misdemeanor, petty offenses or felonies. There needs to be better coordination of medications between jails, DOC, the Colorado Mental Health Institutes, and the community. The creation of a common formulary would be advantageous. *(See Recommendation # 18)* When medications are given to treat symptoms, it increases the likelihood that an individual will adhere to a treatment plan.

Action Entity.

Action. 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.

3. Develop a clearly articulated system to access services. (Votes= 17, Rank=3)

Problem/Background.

- Efficiency of resource usage
- Improve understanding of available resources and gaps
- Shows needed collaboration
- Existence of silos
- Clear tie to overall goal of reducing recidivism
- Cost of doing nothing is too great

Action Entity. DOC, CDHS: DBH and MHI, law enforcement (sheriffs, jails), courts/judges, providers (CBHC, Community corrections, Substance abuse), local business community, Colorado Coalition for the Homeless, offenders with mental health / substance abuse issues, legislators, community-based organizations including faith-based, and public defenders

Action.

- Pool resources "put a contribution on the table"
- Break down or connect silos
- Fund a crisis call center
- Enumerate all the major players / parts of the system
- Utilize the Intercept Model *(see Appendix A for description of Intercept Model)* to capture the resources statewide

4. Make cross training more available and accessible to both in mental health and substance abuse providers who treat offenders.

(Votes= 15, Rank=4)

Problem/Background. A majority of professionals in mental health systems don't have substance abuse training and vice versa. There are barriers to getting cross training.

[Consistent with JAG grant application "Multiagency Training Center on Evidence Based Practices"]

Action Entity. Division of Behavioral Health and DOC for treatment providers within the system.

Action. Evaluate CAC requirements to include co-occurring requirements. Develop co-occurring criteria for inclusion in mental health training.

5. Determine training needs and develop a comprehensive training model to create a cohesive approach to the behavioral health and criminal justice systems.

a. Conduct a needs assessment employing a strategic Intercept Model (or similar mapping model) to define the current system and develop strategic plan to address identified gaps. The effort should include local jurisdictions and information.

b. Provide training on system navigation to those who deliver and receive clinical training.

c. Provide training on both juvenile and adult systems.

(Votes= 14, Rank=Tied for 5)

Problem/Background. Systems are unaware of what happens in respective systems. Agencies need to be educated about other systems allowing for continuity of care and appropriate referrals.

[Consistent with JAG grant application "Multiagency Training Center on Evidence Based Practices"]

(See Appendix A for description of "The Sequential Intercept Model.")

Action Entity. State agencies, treatment providers, community leaders (e.g., faith based), family/consumers, and non-profits.

Action. A steering committee needs to be developed to be responsible for maintaining the training, track the use of the training, and ensure training evaluation is conducted. The steering committee should include representatives of all agencies, non-profits, etc. and be responsible for the system mapping. The steering committee could seat a subcommittee allowing an expansion of representatives to determine training goals, development, implementation, and maintenance and to assess the need for "booster training." This training would be available to all agencies statewide.

Outcome Measurement. After the development of a training package/curriculum, hire an evaluator to conduct a process and outcome evaluation including tracking trainings, fidelity, and outcomes. Participation in outcome measurement should be required by each agency utilizing a pay for performance approach.

6. Integrate re-entry strategies between DOC and community to enhance the transition process for offenders releasing from prison and jails. (Votes= 14, Rank=Tied for 5*)

Problem/Background

- Silos pose barriers to integration
- History of blame exists between systems
- Need to acknowledge that issues presented by offenders with behavioral health are shared, hence collaboration is essential

[Consistent with the overall work of the CCJJ and Re-Entry Oversight Committee of the CCJJ, particularly Recommendation BP-44 Offender Release Assessment Coupled with Services]

Action Entity.

- Healthcare Policy and Financing/private insurers, families
- DOC, CDHS: DBH and MHI, law enforcement (sheriffs, jails), courts/judges, providers (CBHC, Community corrections, Substance abuse), local business community, Colorado Coalition for the Homeless, offenders with mental health / substance abuse issues, legislators, community-based organizations including faith-based, and public defenders

Action.

- State-wide coordinated planning for integration (more of this type of planning process)
- Better use of technology / telemedicine to enhance transitions
- Common formulary statewide ***[see Appendix C for description of formulary]***
- Improve engagement strategies with offenders including reach-in models (face-to-face contact)
- Develop treatment options for severely mentally ill / criminal justice populations in incarcerated settings
    - Create step down models and outline clear transition to the community (poor outcomes result when offenders are involuntarily medicated/restrained and then simply released to the street)
- Engage family and support network and involve community-based organizations, including faith-based organizations
- Create a Behavioral Health Commission

*This item is a combination of two similar recommendations from two separate working groups. One received 14 votes and the other 13 votes.

7. Because housing is a necessary component of treatment, address the difficulties treatment providers encounter providing and/or finding housing for offenders. (Votes= 13, Rank=7)

Problem/Background.

[Consistent with 2008 CCJJ Recommendations GP-25 Educate Housing Authorities and BP-49 Develop Additional Housing Resources for Offenders]

Action Entity.

Action.

8. Develop a standardized data collection and centralized data storage system. (Votes= 10, Rank=Tied for 8)

Problem/Background.

[Identified as a critical issue by the CCJJ]

[Overlaps with 2008 CCJJ Recommendations BP-46 Standardized Comprehensive Offender Profile and BP-47 Offender Profile to Follow through the System.]

Action Entity. Legislative Task Force for the Continuing Examination of Individuals with Mental Illness in the Criminal Justice System in coordination with the CCJJ and the Behavioral Health Cabinet

Action. Examine data collection / storage systems around country.

Phase I -	Identify a tool/process
	Implementation plan (statute, fiscal impact, system readiness)
Phase II -	Address data collection, storage, sharing
Phase III -	Connection of screening to assessment
	How assessment informs the criminal justice system

9. Address housing needs for offenders who do not qualify for HUD/Section 8 by addressing zoning issues. (Votes= 10, Rank=Tied for 8)

Problem/Background. Housing is a transition need and therefore a treatment need. Many organizations and communities would like to create transitional housing, but run into barriers that go beyond financing. Should also explore attaining potential HUD and Section 8 exceptions for people who have had contact with the criminal justice system.

Action Entity.

Action.

10. Fund a crisis call center. (Votes= 10, Rank=Tied for 8)

Problem/Background.

[Consistent with JAG grant application "Metro Crisis and Access Line"]

Action Entity.

Action.

11. Increase resources to pay for treatment and necessary wrap-around services (e.g., housing and employment) with increased emphasis in rural/frontier areas. (Votes= 8, Rank=Tied for 11)

Problem/Background.

- There is a clear lack of resources (demand exceeds supply)
- Need for substance abuse and mental health funding, for example
    - per capita spending on mental health services - Rank 32nd or $74.28[1]
    - staffed inpatient psychiatric care beds - Rank 50th or 11.8 per 100,00[2]
    - percent of those needing but not receiving drug treatment - Rank 44th or 2.87%[3]
    - percent of those needing but not receiving alcohol treatment - Rank 43th or 8.56%[3]
    - percent of substance abuse treatment facilities providing no-charge treatment for clients who cannot pay - Rank 50th or 26.5%[4]

[Consistent with JAG grant application "Criminal Justice Clinical Specialists in Community-Based Behavioral Health Agencies"]

[Consistent with 2008 CCJJ Recommendations GP-20 Increase in Mental Health and Substance Abuse Treatment and GP-21 Increase Funding for Substance Abuse and Mental Health Treatment]

Action Entity.

- Social Security Administration
- DOC, CDHS: DBH and MHI, law enforcement (sheriffs, jails), courts/judges, providers (CBHC, Community corrections, Substance abuse), local business community, Colorado Coalition for the Homeless, offenders with mental health / substance abuse issues, legislators, community-based organizations including faith-based, and public defenders

Action.

- Suspension of benefits rather than termination
- Enhance the availability for offenders to get state ID
    - Fund a statewide effort
- Have specialists available for benefits
- More BARTs (benefit acquisition teams—see Appendix B)
- Fund and support peer mentors and family advocates to help with system navigation

[1] 2005 National Association of State Mental Health Directors Research Institute, Inc. (http://www.nri-inc.org/projects/Profiles/RevExp2005/T24.pdf)

[2] 2009 Report, American College of Emergency Physicians (http://www.emreportcard.org/Colorado.aspx)

[3] 2008 Report, SAMHSA State Estimates of Substance Use from the 2005-2006 National Surveys on Drug Use and Health (http://www.oas.samhsa.gov/states.cfm)

[4] 2008 Report, SAMHSA National Survey of Substance Abuse Treatment Services: 2007State Estimates of Substance Use (http://www.oas.samhsa.gov/dasis.htm#nssats2)

12. Utilize the Intercept Model to capture the current resources statewide. (Votes= 8, Rank=Tied for 11)

Problem/Background.

[Consistent with 2008 CCJJ Recommendation GP-22 Identify and Address Re-Entry Service Gaps]

Action Entity.

Action.

13. Address barriers to benefits suspension and acquisition.

a. Seek indefinite suspension at the national level for social security benefits.
b. Implement SB08-006 on suspension of benefits.
c. Eliminate barriers for offenders to apply for benefits prior to release.

(Votes= 8, Rank=Tied for 11)

Problem/Background. When people are incarcerated or confined their benefits are closed, but they should be suspended so they can be immediately reinstated upon release.

Action Entity. Department of Healthcare Policy and Financing, Governor's Office

Action.

- Department of Healthcare Policy and Financing implement SB 08-006
- Governor and other stakeholders support national indefinite suspension of benefits.

14. Enhance the availability for offenders to get state ID by funding a statewide effort.

(Votes= 8, Rank=Tied for 11)

Problem/Background.
[Overlaps with existing portion of 2008 CCJJ Recommendation BP-50 Verifiable Identification for All Offenders Leaving Incarceration which is currently moving through the legislative process-SB09-06]

Action Entity.

Action.

15. Fund and support peer mentors and family advocates to help with system navigation.

(Votes= 8, Rank= Tied for 11)

Problem/Background.
[Consistent with Phase II work of CCJJ Transition Task Force regarding social supports]

Action Entity.

Action.

16. Benefit acquisition teams should be created. These teams should not be associated with one particular system but rather can span the criminal justice system and connect individuals to community resources. These teams will also identify barriers to benefits programs and systematically work to remove these barriers.

(Votes= 7, Rank=16)

Problem/Background.
(See Appendix B for brief description of Texas Benefits Acquisition Team)

Action Entity.

Action. Replicate CCH "Benefit Acquisition and Retention Team" (BART) process with other providers in Colorado.

17. Create a common medication formulary statewide.

(Votes= 6, Rank=Tied for 17)

Problem/Background. Too many systems are using their own "pharmaceutical contracts" to dictate medication use/management and can cause more harm to the patient than good.

(See Appendix C for brief description of a prescription formulary)

Action Entity.

Action.

18. Expand training on Mental Health First Aid / Behavioral Health First Aid in Colorado.

(Votes= 6, Rank=Tied for 17)

Problem/Background. Mental Health First Aid enhances the skills to deal with mental health crises and serves a public education effort to reduce the stigma attached to mental illness.

[Consistent with JAG grant application "Multiagency Training Center on Evidence Based Practices"]

(See Appendix D for a description of "Mental Health First Aid.")

Action Entity.

Action.

19. Provide a process for providers in the mental health and substance abuse systems to examine similarities and develop/agree on approach to co-occurring treatment.

(Votes= 5, Rank=19)

Problem/Background. Systems are not integrated at the community level and gaining mutual understanding of the definition of co-occurring and developing an agreed on model to implement are necessary steps to achieve integration.

Action Entity. Division of Behavioral Health

Action. Structured meetings in communities across the state to include mental health and substance abuse providers (both clinicians and administrators).

20. Increase public education regarding behavioral health in order to reduce stigma.

(Votes= 3, Rank=20)

Problem/Background.

- Lack of understanding by the public
- Public doesn't realize the cost of not treating this population and that most offenders are returning to the community

Action Entity.

- Workforce development centers, Chambers of Commerce
- DOC, CDHS: DBH and MHI, law enforcement (sheriffs, jails), courts/judges, providers (CBHC, Community corrections, Substance abuse), local business community, Colorado Coalition for the

Homeless, offenders with mental health / substance abuse issues, legislators, community-based organizations including faith-based, and public defenders

Action.

- Utilize the local public education television stations (create state presentations that locals can use)
- Create toolkits and utilize families to help share the message
- Host town hall meetings using experts to lead discussion
- Bring Mental Health First Aid / Behavioral Health First Aid to Colorado
- Include communities of color
- Educate business community and partner with them focusing on employment and hiring offenders
- Utilize technology (webinars) to access info
- Utilize local community newspapers in Colorado

21. As part of the hospital provider access fee, complete the waiver for the childless adult population allowing acquisition of comprehensive behavioral health benefits, including: Medication, medication management, and case management. (Votes= 2, Rank= Tied for 21)

Problem/Background. Many of the criminal justice population are childless adults who are not at the level where they qualify for disability benefits but need treatment and access to medications.

[See Appendix E for a description of Healthcare Affordability Act.]

Action Entity. Department of Healthcare Policy and Financing

Action. Create state waiver.

22. Integrate funding for substance abuse and mental health treatment. (Votes= 2, Rank=Tied for 21)

Problem/Background. Silos pose barriers to integration. Lack of integrated funding streams leads to lack of integration of treatment services.

Action Entity. Department of Corrections, Division of Behavioral Health, and Department of Public Safety

Action.

- State-wide coordinated planning for integration (more of what we are doing, but be sure to coordinate
- State Behavioral Health Commission
- Develop integrated funding systems

APPENDIX A

"The Sequential Intercept Model provides a conceptual framework for communities to use when considering the interface between the criminal justice and mental health systems as they address concerns about criminalization of people with mental illness. The model envisions a series of points of interception at which an intervention can be made to prevent individuals from entering or penetrating deeper into the criminal justice system. Ideally, most people will be intercepted at early points, with decreasing numbers at each subsequent point. The interception points are law enforcement and emergency services; initial detention and initial hearings; jail, courts, forensic evaluations, and forensic commitments; reentry from jails, state prisons, and forensic hospitalization; and community corrections and community support. The model provides an organizing tool for a discussion of diversion and linkage alternatives and for systematically addressing criminalization. Using the model, a community can develop targeted strategies that evolve over time to increase diversion of people with mental illness from the criminal justice system and to link them with community treatment."
[Munetz, M. R., & Griffin, P. A. (2006). Use of the Sequential Intercept Model as an approach to decriminalization of people with serious mental illness. *Psychiatric Services, 57,* 544-549.]

APPENDIX B

"Using evidence-based practices, [benefit acquisition teams] assist those with disabilities to expedite acquisition of federal benefits and entitlements (SSI/DI and Medicaid/Medicare). With those benefits, they may then access the comprehensive and specialized health and behavioral healthcare, supported housing and other services they need to stabilize their conditions and become more self-sufficient."
[Excerpt from http://www.centralcityconcern.org/_pdf/BEST.pdf]

Colorado Coalition for the Homeless' Benefits Acquisition and Retention Team members help clients with the application, which they complete together and submit to the local Social Security Administration (SSA) office. They also compile a complete medical evidence package, which is sent with the application. The application is flagged and expedited by SSA and Disability Determination Services (DDS). The Office of Hearings and Appeals (OHA) also expedites hearings when an appeal is necessary. Due to relationships BART has developed, the staff has open communication with SSA and DDS, who will contact them when further information is needed to make a determination. This open and expedited communication process has shown great success. In Denver, only 10 percent of homeless applicants were approved on initial application (compared to the national average of 37 percent for all applicants). When DDS dedicated a staff person to focus on applications from homeless adults, the approval rate rose to 20 percent. Since the BART team began assisting applicants, 75 percent of initial applications are approved, and the average processing time is only 40 days.
[Excerpt from http://www.prainc.com/SOAR/soar101/PromisingPractices.pdf]

APPENDIX C

A **formulary** is a list of prescription drugs. Formularies are based on evaluations of efficacy, safety, and cost-effectiveness of drugs, personal clinical experience, research-demonstrated effectiveness, FDA approved indications, and exposure through continuing education or professional meetings. Most formularies cover at least one drug in each drug class, and encourage generic substitution (also known as a preferred drug list). The key issues impacting the maintenance of formularies (in addition to potential evaluation criteria listed above):

- Are drug types available to meet the diagnosed needs of clients?
- Are drug selections monitored for transition to available generics?
- Are drug selections empirically based, in order to address Medicare legislation issues and selection justifications (demanded by manufacturers)?
- Does the formulary account for the necessity of specialty drugs?
- Who creates, develops, and maintains the formulary?
- Who selects and how are members selected for the formulary development team?

[Excerpted from Gilderman, A. (2004). Trends in effective formulary development. *Pharmacy Benefit Insider Newsletter* from https://www.prescriptionsolutions.com/c/pbi/pbi_view.asp?docid=463]

APPENDIX D

The goal of Mental Health First Aid is to increase mental health literacy. Like CPR training helps a non-medical professional assist an individual following a heart attack, Mental Health First Aid training helps an individual who doesn't have clinical training assist someone experiencing a mental health crisis. In both situations, the goal is to help support an individual until appropriate professional help arrives, with the added underlying intention to promote health literacy. (Excerpt from http://www.thenationalcouncil.org/cs/about_the_program)

Mental Health First Aid is a 12-hour training course designed to give members of the public key skills to help someone who is developing a mental health problem or experiencing a mental health crisis. The growing evidence behind the program demonstrates that it does build mental health literacy — helping the public identify, understand and respond to signs of mental illness (see http://www.mhfa.com.au/evaluation.shtml for supporting evidence).

Mental Health First Aiders learn a single strategy that includes assessing risk, respectfully listening to and supporting the individual in crisis, and identifying and contacting appropriate professional help. Trainees are taught how to apply this strategy in a variety of situations, such as helping someone through a panic attack or with an acute stress reaction, engaging with someone who may be suicidal, supporting a person experiencing psychosis and helping an individual who has overdosed. Trainees are also introduced to the risk factors and warning signs of specific illnesses such as anxiety, depression, psychosis and addiction; engage in experiential activities that build understanding of the impact of illness; and learn information about evidence-supported treatment programs. (Excerpt from http://www.wiche.edu/mentalhealth/)

APPENDIX E

Colorado Healthcare Affordability Act

More than 40 states utilize this financing strategy, including 20 states that assess a provider fee on hospitals. The fee assessed on Colorado hospitals will generate approximately $600 million a year for the state and can be used to drawn down an equal amount in federal funds, for total new revenue of approximately $1.2 billion annually.

This new revenue can be used for only three purposes: 1) providing coverage to the uninsured by expanding eligibility for Medicaid and CHP+; 2) increasing hospital reimbursement rates under Medicaid and CICP; and 3) covering administrative costs of the Department for implementing the program.

Public insurance program expansions

* Medicaid expansions for parents and childless adults up to 100 percent FPL-$22,050 for a family of four. This is a new population with the exception of very low-income parents of children on Medicaid - 30 percent of the FPL- $6,120 for a family of four (one parent and three children).
* CHP+ expansions for kids and pregnant women up to 250 percent FPL - $55,125/ year for a family of four. The FPL is currently 205% - $45,202/year for a family of four.
* Buy-in program for disabled adults and kids up to 450 percent FPL - $48,735/individual/year. A buy-in program does not currently exist. There is currently Medicaid coverage for adults who have SSI.
* Continuous eligibility for Medicaid children. Eligibility is currently determined on a month to month basis. This greatly improves the continuity of care for a year.

Proposed hospital payment increases:

* Reimbursement for Medicaid inpatient and outpatient care will be increased to the upper payment limit, which is the maximum allowable reimbursement under Medicaid. We currently pay 92% of the Medicare rate for in-patient stays.
* CICP reimbursement will be increased up to 100 percent of cost- We currently pay 40% of cost.

This is a win-win-win because:

* Hospitals get an increase in rates, which will help reduce uncompensated care and cost shifting in the health care system.
* Coverage is provided to the uninsured as eligibility for public health insurance programs is expanded.
* The state draws down a dollar-for-dollar federal match without putting up any General Fund.

The plan will be submitted to the federal Centers for Medicare & Medicaid Services (CMS) for final approval. Implementation is expected to begin in the spring of 2010. A 13-member Oversight and Advisory committee will be responsible for working with the Department of Health Care Policy and Financing to implement the new law. The Governor's Office of Boards and Commissions has released a call for applications for members of the public interested in serving on this committee. Click here for more information or go to www.colorado.gov/governor and visit the Boards and Commissions page.

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