BEHAVIORAL HEALTH/CRIMINAL JUSTICE AREAS OF FOCUS

May 14-15, 2009

Key: Bold underlined headings = Recommendation area
Blue items = Broad goal
Purple items = Short term action items

Background/History

In Colorado and across the nation, the number of incarcerated offenders who suffer from mental illness is on the rise. In 1998, the Colorado Department of Corrections (DOC) reported that 10 percent of the correctional population had serious mental illness (SMI), five to six times higher than the number documented in 1988.[1] That number grew to 25 percent both in Colorado prisons by 2006[2] and in state-run facilities across the United States, according to the Bureau of Justice Statistics.[3]

Likewise, the number of mentally ill persons in county jails in Colorado has increased dramatically in recent years. One metro area jail reported an increase from 16 percent to 31 percent seriously mentally ill inmates within a three-year period. Correspondingly, both the 2007 and 2008 Task Force reports from the seven-county Denver Metro County Commissioners indicated that, on average, 20 percent of current jail inmates had a serious mental illness and the jail stay of these inmates was approximately 5.5 times longer than the general jail population. The costs over the same period associated with these offenders with mental illness in these seven jails were approximately $36 million.[4]

Additionally, in 2006 James and Glaze reported that 76 percent of jail and 74 percent of state inmates had some form of substance dependence.[5] This population of offenders poses significant challenges not only during their incarceration, but even more so after their release, the point commonly known as "re-entry."

Offenders in prisons and jails account for only a portion of the problem. The need for mental health and substance abuse treatment is magnified significantly when including offenders in other criminal justice systems (for example, probation, parole, and community corrections). Along with the need for increased treatment is the corresponding necessity to increase service capacity.

The following summary outlines the priority areas identified by Colorado experts working in the fields of behavioral health and criminal justice who were convened by the Colorado Commission on Criminal and Juvenile Justice at meetings in March and April 2009.

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[1] See *Offenders With Serious Mental Illness: A Multi-Agency Task Group Report to the Colorado Legislative Joint Budget Committee* (CDOC, 1998).
[2] Schnell, M. and O'Keefe Leipold, M (2006). *Offenders with mental illness in Colorado.* Colorado Department of Corrections, Office of Planning and Analysis.
[3] James, D. J., and Glaze, L. E. (2006). *Mental health problems of prison and jail inmates.* Washington, DC: U.S. Department of Justice, Bureau of Justice Statistics.
[4] Metro Area County Commissioners: Mentally Ill Inmates Task Force. 2007 and 2008 Annual Reports.
[5] James, D. J., and Glaze, L. E. (2006). *Mental health problems of prison and jail inmates.* Washington, DC: U.S. Department of Justice, Bureau of Justice Statistics.

1. **Treatment Availability** Police contacts taken to the ER because those who are a danger to self/others are usually released back into the community without having received any services related to the crisis that put them there. The lack of treatment options due to limited capacity and expertise of mental health centers to deal with the offending population presents substantial difficulties in connecting offenders to the services they need.

Access to Services: The existence of silos leads to inefficient use of resources. These silos also lead to enormous confusion for offenders and professionals of available resources.

Need clearly articulated system for accessing services.

a. Utilize the Intercept Model to capture the resources statewide and enumerate all the major players/parts of the system.[6]
   (See Appendix A for a further description of "The Sequential Intercept Model")
b. Fund and support peer mentors and family advocates to help with system navigation.
c. Fund a crisis call center.
   [Consistent with JAG grant application "Metro Crisis and Access Line"]
d. Create integrated funding for substance abuse and mental health treatment.

Continuity of Care: Inconsistent coordination between criminal/juvenile justice systems and community-based behavioral health treatment systems leads to a "revolving door".

Integrate re-entry strategies between DOC and community to enhance the transition process for offenders released from prison and jails.

a. Need for simple referral and access to care and coordinated discharge planning.
b. Information and data sharing between systems, i.e. developing common release forms.
   (See Screening and Assessment)
   [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]
c. Collaborative transition planning for individuals who have completed their sentences so that mental health treatment and medication can be sustained.

Medication Management/Monitoring: Individuals end up in court for having committed felony, misdemeanor or petty offenses because they have quit taking their meds. When individuals with mental illnesses are properly diagnosed, stabilized and receive services, they are far less likely to commit subsequent crimes.

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.

[6] The Sequential Intercept Model provides a conceptual framework and strategic planning process for communities to use when considering the interface between the criminal justice and behavioral health systems. The GAINS Center has facilitated the use of this model throughout the metro region and would be contacted to conduct a similar process for this endeavor.

a. Create a common medication formulary statewide.[7] Too many systems are using their own "pharmaceutical contracts" to dictate medication use/management and can cause more harm to the patient than good.
b. 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.

(See Appendix B for a further description of a prescription formulary)

2. Training Criminal justice, mental health, and substance abuse professionals are often unaware of what happens in respective systems. Agency personnel need to be educated about other systems allowing for continuity of care and appropriate referrals.

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.
(See Appendix A for description of "The Sequential Intercept Model.")
b. Increase public education regarding behavioral health in order to reduce stigma by creating toolkits, using town hall meetings, and utilizing the local public education television stations.
c. Expand Mental Health First Aid / Behavioral Health First Aid in Colorado.[8]
[Consistent with JAG grant application "Multiagency Training Center on Evidence Based Practices"]
(See Appendix C for a further description of "Mental Health First Aid.")[9]
d. Develop a steering committee to be responsible for creating, maintaining, and tracking the training. They would also ensure training evaluation is conducted.
e. Provide training on system navigation to those who deliver and receive clinical training.
f. Provide cross training opportunities to both mental health and substance abuse providers who treat offenders.
g. Provide cross training opportunities to criminal justice professionals on issues related to offenders with behavioral health issues.

3. Screening and Assessment Myriad issues exist because of the lack of appropriate and accurate assessments leading to targeted, individualized treatment interventions in a correctional setting: a lack of standardized behavioral health screening in jails; the 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; and pretrial release conditions could be set that do not necessarily maximize public safety.

a. Identify or create a common brief screening instrument to be used throughout justice system. Develop protocols and policies to allow for the sharing of data collected from the screening instrument in order to improve continuity of care for offenders, i.e. creating common scoring profiles.

[7] A **formulary** is a list of prescription drugs.
[8] 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.

4. Public Benefits Applications are confusing and are often not approved the first time individuals apply, causing major delays in accessing the necessary funding to pay for treatment and medication. Additionally, when people are incarcerated or confined, their benefits (e.g., Medicaid/Medicare, SSI, SSDI) are closed, rather than being suspended. Thus they cannot be immediately reinstated upon release**.**

Address barriers to benefits suspension and acquisition.

a. Expand Benefits Acquisition Teams and Specialists.[9]
   (See Appendix D for further description of Texas Benefits Acquisition Team)
b. Hospital Provider Fee Bill-waiver for childless adults to receive comprehensive benefits.[10]
   [See Appendix E for a further description of Healthcare Affordability Act.]
c. Implement SB08-006 concerning the suspension rather than termination of medical benefits during periods of incarceration.
d. Because housing is necessary component of treatment, address the difficulties treatment providers encounter providing and/or finding housing for offenders.
    a. Address housing needs for offenders who do not qualify for HUD/Section 8 by addressing zoning issues.

   [Consistent with 2008 CCJJ Recommendations BP-49 and GP-25]
e. Seek indefinite suspension at the national level for social security benefits.
f. Eliminate barriers for offenders to apply for benefits prior to release.

[9] Using evidence-based practices, benefit acquisition teams assist those with disabilities to expedite acquisition of federal benefits and entitlements (SSI/DI and Medicaid/Medicare).
[10] A provision of the Colorado Healthcare Affordability Act would provide for Medicaid expansions for parents and childless adults up to 100 percent FPL-$22,050 for a family of four.

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

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?

APPENDIX C

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 D

"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 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.

Joanne C. Lindsay, Public Information Officer
Department of Health Care Policy and Financing
1570 Grant Street Denver, Colorado 80203
Phone - 303-866-3144
Fax - 303-866-4411
joanne.lindsay@state.co.us
colorado.gov/hcpf