

MINUTES

Task Force for the continuing Study of the Treatment of Persons with Mental Illness Who are Involved in the Criminal Justice System

September 20, 2012

10:00 a.m. – 12:30 p.m.

Legislative Services Building

Call to Order – 10:02 a.m.

The Task Force for the Continuing Study of the Treatment of Persons with Mental Illness who are Involved in the Criminal Justice System meeting was called to order at 10:02 a.m. by Jeanne Smith.

Introductions and Welcomes

Introductions were made around the room. Task Force members and guests introduced themselves.

Minutes Approval

Marc Condojani moved that the August 16, 2012 minutes of the Task Force for the Continuing Study of the Treatment of Persons with Mental Illness who are Involved in the Criminal Justice System be approved as provided. Libbie Stoddard seconded. Motion passed.

Treatment Issues Related to Persons with Mental Illness Who Are Incarcerated in DOC

Peggy Heil gave an overview of Mental Health Services in Colorado Department of Corrections. Services include clinical treatment and management of offenders with mental illnesses and developmental disabilities, crisis intervention with acutely disturbed or self-injurious offenders, rehabilitation programs, and coordination of transitional services for offenders with mental health needs. DOC provides mental health services, alcohol and drug treatment services, sex offender treatment services, and includes quality assurance components and offender complaint options.

Outpatient services in general population include group and individual therapy, crisis intervention, monitoring and referrals to special placements. Acute care includes infirmaries and facility mental health watches, intermediate/long term placements in San Carlos Correctional facility and Denver Women's Correctional facility and hospitalizations when needed in Colorado Mental Health Institute in Pueblo. Transition support services include a variety of specialized and in-reach programs.

Jill Lampela, Psy.D., gave an overview of CSP Offenders with Mental Illness (OMI) Program. The OMI Program has two separate tracks to accommodate AXIS I (serious mental illness) offenders, AXIS I with AXIS II (antisocial behavior, borderline) and primarily AXIS II with mood disorder or mood disorder not otherwise specified offenders.

Separate tracks are developed for these offenders to meet their needs separating severely mentally ill offenders from those who engage in criminal thinking. Seriously mentally ill treatment involves illness management recovery framework. Various treatment groups are used. Wellness recovery action plan is used to transition them into general population.

Louise Boris asked how medication is administered and how that is possible that offenders may give up their medication. Dr. Lampela and Peggy Heil confirmed the medication is administered under supervision; however there are some offenders who find a way to save theirs.

Second track involves cognitive behavioral treatment with individuals who engage in criminal thinking. When they transition to general population we do the transition release. Journaling has been found effective. David Mosher asked if this track involves a substance abuse piece. We do have substance abuse piece as well as a medical piece to help reduce substance abuse.

Dr. Lampela invited everyone to visit and see the OMI program.

Gina Shimeall asked when the orientation takes place and also about the number of people who go through this program. Dr. Lampela confirmed there is a total of 54 people in all three categories (AXIS I, AXIS II and AXIS I and II). When somebody comes into our facility the orientation and evaluation is conducted. Day halls are broken into communities. Gina Shimeall asked some clarification on how many tracks are there and what are the criteria. Dr. Lampela and Peggy Heil confirmed that there are two tracks and we are looking at what issue is predominant. Gina Shimeall asked what is the ratio between severely mentally ill and just AXIS I and II. Jill Lampela confirmed it is about 50/50.

Caren Leaf asked what the percentage of those who would need either AXIS I or II is. Peggy Heil confirmed that 35% of their population have identified mental health needs that need treatment. 9% of population is seriously mentally ill. 20% of the population has more chronic diagnoses and this is the group we are working with. Caren Leaf asked if there are gender specific services for female offenders that are available. Peggy Heil responded that they get referred from general population with mental health overlay and they may be referred to San Carlos correctional facility. Denver facility is used for female offenders. Mental health needs in women population is much higher than in male.

Fernando Martinez asked about the recidivism rate in the population discussed. Peggy Heil responded that the recidivism rate for severely mentally ill is slightly higher than the general population. Currently, 55 percent of offenders with mental illnesses recidivate within three years of community release.

Gina Shimeall asked about the return rate for those who went through the tracks and transitioned into general population. The data is available at DOC however the numbers are not available at today's meeting. Jill Lampela added that when a patient is ready to go to general population, we think of the facility, we get the therapist come and meet the offender; we also use a buddy system.

Gina Shimeall asked if there is a standard ratio of treatment providers and offenders in the mental health arena. We keep looking for this so we can justify a need for additional clinicians. Peggy Heil responded it is a very good question. There is a ratio for psychiatrists, however not for clinicians.

Continuing observation, stabilization for regression due to mental illness decompensation occurs in stabilization unit (AXIS I). Caren Leaf asked if it comes from OMI program as a referral. Yes it does. If there is no reason for offenders to be in a high security facility, we make efforts to transition them into a lower custody facility.

Peggy Heil added that smooth transition into the community has been a focus of collaborative work in the past year. DOC has been working with Behavioral Healthcare Council and community mental health centers on a collaborative services plan. Evidence based research shows that simply providing psychiatric services doesn't reduce recidivism. We are trying to develop collaborative, evidence-based continuity of care between the prison and mental health centers, developing same language, establishing clinician in-reach. There are funding needs to make this happen. We put together a grant, however didn't get the grant (Second chance, Bureau of Justice Assistance).

Have you looked at private funding? Peggy Heil mentioned they haven't however they are open to suggestions, as she is excited about this as this program will reduce recidivism. Fernando Martinez mentioned this is exciting as a dialog piece has been missing. Gina Shimeall added that mentioning the ratio standard discussed earlier in a grant might be helpful. Parole model mentioned by Gina is a good model to look at.

Marc Condojani added that DBH had a grant (Criminal Justice Clinical Specialist Program) set up for community health centers and provider community that allowed for some in-reach opportunity. The funding went away, however we can work with our community providers to ask for a model to do in-

reach. SB97 funding for offender mental health programs is also going down. He added that even though the funding sources might change with the Health Care Reform, keeping specialization of programs addressing criminogenic risks and mental health services that impact recidivism is crucial.

Fernando Martinez added that funding is crucial for 19 mental health centers in the state.

Louise Boris added that all health care benefits don't come with stipend to cover housing.

Michael Ramirez wanted to know more about the developmental disabilities programs and outcomes offered at DOC. Peggy Heil responded that there is a section at San Carlos that treats developmental disability population. Territorial correctional facility, where they have groups together; and more sheltered work locations are utilized. Staff that is more educated in the needs of this group, sex offender treatment is adjusted to developmental disability population. DOC has a broader definition of this population. Michael Ramirez asked when these individuals transition from DYC do they get the support or recidivate. It is both.

Jeanne Smith asked if presenters would share a single or top three things they would fix if they could.

Peggy Heil highlighted that establishing staffing ratios would be great. Some ratios that we have come from court cases, she could provide those to this group.

Caren Leaf mentioned DYC creates their own ratios looking at our own population and assign staff. She suggested looking at places whose primary business is providing mental health services like mental health centers, etc. that could be helpful for our ratio determinations.

Gina Shimeall added that getting ratios based on different level of services would be helpful. Caren Leaf asked if DOC has separate line items for medical and behavioral health as DYC has one line item for medical and behavioral health. Peggy Heil responded that within DOC clinical services there are separate line items for mental health, substance abuse and sex offender treatment.

Jeanne Smith asked if Debbie Wagner's group would be interested in looking at standardization question. Debbie Wagner responded that determining an average offender cost that will include these costs might be helpful.

Michael Ramirez asked if there is a research regarding the recommended ratios. Peggy Heil responded it is hard to find such research.

Caren Leaf asked how DOC addresses trauma. Peggy Heil responded we are trying to increase trauma training on facilitating groups, trauma responses for clinicians. Trauma informed is our approach.

Gina Shimeall added that in addition to getting the ratios, we also need the specialists who use evidence based programs. Todd Helvig mentioned Housing First program model that has a central person coordinating care, housing, employment, etc.

Peggy Heil mentioned that Evidence-Based Practices Implementation for Capacity (EPIC) has been an amazing project including motivational interviewing and mental health first aid training DOC officers got trained in. She wishes EPIC stayed and took on the trauma informed training. Gina Shimeall commended EPIC as well.

Jeanne Smith added that the EPIC project was created by the Colorado Commission on Criminal and Juvenile Justice (CCCJJ) to implement evidence-based practices into the criminal justice system. It focuses on the change of behavior of the workforce. We had tremendous response to training. The grant runs out in February; however a JAG grant was received. CCCJJ will likely endorse EPIC to become permanent, but it will require securing funding.

Jeanne Smith thanked presenters for their time and information.

NGRI curriculum summary will be presented at our October meeting.

Subcommittees Updates

There are no updates from any of the subcommittees

Behavioral Health Transformation Council Update

Jeanne Smith reported the retreat is taking place next Friday. Jeanne Smith will report on the new directions of the Council after that meeting. Regular meetings are open to the public.

Other Updates

Gina Shimeall mentioned she has been reaching out to Oregon; we should have a plan on how our state is going to be using healthcare dollars coming to our state for criminal justice programs.

Debbie Wagner proposed having someone from Governors Policy Law Office or from the Colorado Health Benefit Exchange to make a presentation to this group. Marleen Fish is on the Exchange outreach committee.

Jeanne Smith asked if a decision was made how much Colorado will contribute. Debbie Wagner doesn't think this decision was made. She will send a link to the [Colorado Health Benefit Exchange](#) to this group.

11:44 p.m. – Adjourn