

Final
STAFF SUMMARY OF MEETING

TREATMENT OF PERSONS WITH MENTAL ILLNESS IN THE CRIMINAL JUSTICE
SYSTEM

Date: 09/21/2015

ATTENDANCE

Time: **01:00 PM to 04:00 PM**

Humphrey X

Lee X

Place: SCR 356

Newell X

Woods X

This Meeting was called to order by
Senator Martinez Humenik

Singer *

Martinez Humenik X

This Report was prepared by
Amanda King

X = Present, E = Excused, A = Absent, * = Present after roll call

Bills Addressed:	Action Taken:
Call to Order	Witness Testimony and/or Committee Discussion Only
Presentation by Project EDGE	Witness Testimony and/or Committee Discussion Only
Presentation by The Link	Witness Testimony and/or Committee Discussion Only
Presentation by Arapahoe House	Witness Testimony and/or Committee Discussion Only
Discussion of Future Activities of the Advisory Task Force	Witness Testimony and/or Committee Discussion Only
Committee Discussion and Votes on Motions to Request Bill Drafts	Recommendation(s) Approved
Public Comment	Witness Testimony and/or Committee Discussion Only

01:02 PM -- Call to Order

Senator Martinez Humenik called the meeting to order. A meeting agenda (Attachment A) was distributed to the committee.

01:02 PM -- Presentation by Project EDGE

Bill Myers, Chief Community Engagement Officer for Project Early Diversion, Get Engaged (Project EDGE), and Charlie Davis, Community Crisis Connection Program Manager for Project EDGE, introduced themselves. They provided the committee with two handouts about Project EDGE (Attachments B and Attachment C). Project EDGE is a pilot program in Boulder County that aims to divert individuals who have behavioral health issues from the criminal justice system, and instead engage them in appropriate treatment. Mr. Myers stated that the program is funded through a three-year grant from the federal Substance Abuse and Mental Health Administration. He stated that it is one of three sites nationwide to receive this early diversion grant award. Mr. Myers outlined how mental health professionals engage with law enforcement officers in Boulder County to provide diversion services when an incident occurs. He provided information about the program staffing and reviewed data about the program, which began in March 2014.

01:08 PM

Mr. Myers answered questions about the information in the handouts. Mr. Myers and Mr. Davis responded to questions about what happens to people who have an encounter with a Project EDGE worker, but do not seek behavioral health treatments. In response to a question, Mr. Davis listed the criteria that would result in a mental health hold.

01:12 PM

Representative Singer relayed his experience observing Project EDGE. Mr. Myers answered questions about how the program provides cost savings, including reductions in emergency department visits and placements in jails. Mr. Davis discussed the value that police departments find in the program. Mr. Myers stated that program costs are about \$525,000 per year, covered both by the federal grant and by Mental Health Partners. Mr. Myers discussed the desire to continue the program after the federal funding expires. He referenced other communities that are interested in participating in the program.

01:21 PM

In response to a question, Mr. Davis outlined how a Project EDGE worker responds to a situation where law enforcement has been called. He relayed the details of a specific case where Project EDGE was engaged. In response to a question about the follow-up services provided by the program, Mr. Davis discussed peer support specialists who are involved in the program who follow up with the clients to provide support and guidance. He listed the charges that cannot be diverted under the program.

01:30 PM

Mr. Davis answered questions about the Project EDGE response times when a call is made to a police department. Representative Singer shared additional details about his experience observing Project EDGE. In response to a question, Mr. Davis discussed the common factors that are prevalent in the Project EDGE cases. Mr. Davis responded to a question about whether the program can be abused to avoid criminal charges. Mr. Davis said that people do not get a second chance to divert charges if they engage once with Project EDGE, but do not seek treatment after the initial contact.

01:38 PM

Senator Martinez Humenik suggested expanding the data collected by Project EDGE. There was discussion about the types of data the committee members would be interested in receiving about Project EDGE. Representative Singer discussed the potential for expanding Project EDGE statewide. Senator Martinez Humenik discussed substance use by teens and young adults. Mr. Davis discussed the potential of expanding Project EDGE by stationing workers in county jails. Mr. Davis explained the training that occurs through the program.

01:51 PM

Committee members continued to dialogue with Mr. Davis and Mr. Myers about Project EDGE. Mr. Myers reiterated that this is a pilot program that has only existed for 17 months. Mr. Myers explained why the program is restricted to Boulder County. Senator Martinez Humenik thanked Mr. Myers and Mr. Davis for their presentation.

01:56 PM -- Presentation by The Link

Lonnie Matz, Program Manager for The Link, introduced himself and provided an overview of the organization, which is a community assessment and resource center for youth and families that serves Adams and Broomfield counties. He provided the committee with two handouts (Attachments D and Attachment E). He stated The Link has seven different programs it provides and outlined the populations The Link serves. Mr. Matz discussed the evidence-based assessment tools used to determine services, the number of referrals made by The Link, and marijuana use by youth. He referenced outcome studies that have been conducted on the program. Mr. Matz answered questions about providing services to homeless teenagers and discussed the partnership The Link has with Shiloh Homes to provide temporary shelter to homeless teenagers. Mr. Matz responded to questions about the availability of additional data about decreased workloads for other local government agencies and other outcome data about the program. He referenced the gang activity occurring in Adams County.

02:11 PM

The committee dialogued with Mr. Matz about substance use by teenagers and the number of municipal charges received by youth after being involved with The Link. He discussed the involvement of the program with the court systems. Senator Martinez Humenik asked Mr. Matz to provide follow-up data to staff to share with the committee. Mr. Matz answered questions about whether The Link provides any training to its law enforcement partners and about The Link's engagement of youth who are in the foster care system.

02:19 PM

Senator Martinez Humenik thanked Mr. Matz for his presentation.

02:19 PM -- Presentation by Arapahoe House

Michelle Flake and Caroline Chadima, representing Arapahoe House, introduced themselves. Ms. Flake provided an overview of Arapahoe House, which provides a continuum of accessible, affordable, and effective services for individuals and families with alcohol, drug, and other behavioral health problems. She stated Arapahoe House provides both inpatient and outpatient services. Ms. Flake discussed the Short-Term Intensive Residential Remedial Treatment (STIRRT) Program and provided the committee with a handout (Attachment F) about the program.

02:22 PM

Ms. Chadima said that there are 12 beds available in the inpatient STIRRT Program. She discussed the two phases of the continuing care provided under the STIRRT Program. She discussed the entities that make referrals to the STIRRT Program, the population served by the program, and the funding for the program. She shared data about the STIRRT Program and its clients. Ms. Chadima answered questions about her caseload and the data she presented.

02:34 PM

Ms. Chadima reviewed the principles employed by the STIRRT Program that were developed by Dr. Edward Latessa. She listed the therapeutic tools and medications used by the STIRRT Program. She discussed the curriculum used in the STIRRT Program.

02:42 PM

Ms. Chadima answered questions about the risk assessment tools used by the STIRRT Program. In response to a question, Ms. Flake said that STIRRT Program is funded through the Office of Behavioral Health in the Department of Human Services. Ms. Chadima and Ms. Flake answered questions about the STIRRT Program and the drugs used by the clients before entering the program. Senator Martinez Humenik thanked the presenters.

02:48 PM -- Discussion of Future Activities of the Advisory Task Force

Camille Harding, Task Force Concerning the Treatment of Persons with Mental Illness in the Criminal and Juvenile Justice Systems (MICJS) Task Force Co-chair and representing the Department of Health Care Policy and Financing, introduced herself. She provided the following four handouts to the committee: MICJS Legislative Oversight Committee Meeting Responses from Tuesday, August 18 (Attachment G), Table of Preferred Formulary Psychotropic Medications (Attachment H), MICJS Jail Recidivism and Behavioral Health Services Focus Group Questionnaire (Attachment I), and The Colorado Opportunity Project Life Stages diagram (Attachment J). She reviewed information related to the preferred formulary psychotropic medications and medication consistency efforts.

02:51 PM

Ms. Harding discussed recidivism data from the Department of Corrections, the Division of Youth Corrections in the Department of Human Services, and jails. Senator Martinez Humenik commented on the gaps in available data on recidivism. Ms. Harding discussed the MICJS Jail Recidivism and Behavioral Health Services Focus Groups that will be conducted in October in partnership with the Colorado Regional Health Information Organization. Ms. Harding answered questions about information sharing between various agencies. Senator Martinez Humenik commented on information sharing between jurisdictions and the federal Health Insurance Portability and Accountability Act. Ms. Harding referenced Title 42 of the Code of Federal Regulations and discussed the differing interpretations of those regulations.

03:00 PM

Ms. Harding outlined the strategies for improving access to mental health and addiction treatment services in rural parts of the state. She discussed the Colorado Opportunity Project and the life stages diagram in regards to outcome measures and tracking youth who enter the juvenile justice system. Ms. Harding stated that the Department of Public Safety is still waiting to find out if it has received the Bureau of Justice Assistance grant to develop a statewide interagency strategic plan for a justice and health information exchange infrastructure, as was discussed at the August 18, 2015, MICJS Legislative Oversight Committee meeting. She said that even if the department does not receive the grant a technical assistance request will be submitted to the Bureau of Justice Assistance to seek funds for strategic planning regarding the project. She outlined the counties that have jails that provide jail based behavioral health services. Ms. Harding answered questions about how law enforcement agencies address the mental health needs of prisoners if the agency does not provide jail based behavioral health services.

03:08 PM

Ms. Harding discussed the availability of data regarding juvenile competency evaluations and restoration services. She stated that a work group of the MICJS Task Force met on August 28, 2015, and determined that the task force would like to study the availability of restoration services in the community. There was discussion about the possibility of addressing juvenile competency through legislation. Senator Martinez Humenik commented on the ability of the task force to bring forth legislation in the coming years. Senator Newell shared her experience serving on the committee. Senator Newell discussed the efforts by the task force to address juvenile competency and housing issues. Senator Martinez Humenik expressed the need to make the task force more efficient. Ms. Harding commented on providing better reporting to the committee when issues are addressed in a nonlegislative manner.

03:24 PM

Ms. Harding stated that she is still working on collecting additional data requested by the committee regarding the number of people who are released from the criminal justice system with mental illness who qualify for disability benefits, and how many are veterans. She discussed the MICJS Task Force retreat scheduled for September 25, 2015. Discussion occurred about studying the barriers to workers' compensation for law enforcement officers, corrections employees, and other first responders experiencing post-traumatic stress disorder. Ms. Harding again referenced the MICJS Jail Recidivism and Behavioral Health Services Focus Group Questionnaire that will be used in focus groups being conducted in October and said the report resulting from the focus groups should be available in November.

03:29 PM

In response to a question, Ms. Harding discussed the fragmentation of data and providing services across state agencies. Senator Martinez Humenik thanked the MICJS Task Force for their work. She suggested the task force focus on a few key priorities. Senator Martinez Humenik encouraged the committee members to attend the MICJS Task Force retreat on September 25, 2015. Ms. Harding discussed the importance of data sharing between systems and the ability to reimburse certain programs through Medicaid for providing medically necessary services. Senator Martinez Humenik discussed the number of providers for restoration services.

03:40 PM -- Committee Discussion and Votes on Motions to Request Bill Drafts

Amanda King, Legislative Council Staff, reviewed the interim committee bill drafting deadlines. She stated the committee will meet on October 29, 2015, to take final action on the bill drafts. The committee discussed the procedure for requesting interim committee bill drafts. House Bill 15-1025, concerning competency to proceed for juveniles involved in the juvenile justice system (Attachment K), was distributed to the committee. Jane Ritter, Office of Legislative Legal Services, discussed the interim committee bill drafting guidelines and the importance of providing additional drafting information to the Office of Legislative Legal Services in a timely manner. Ms. King stated that the committee can recommend up to five bills to Legislative Council.

03:46 PM

Representative Singer discussed drafting a bill addressing mental health impairment, and specifically post traumatic stress disorder (PTSD), parity in workers' compensation for Department of Corrections employees and emergency responders. He referenced House Bill 14-1343, concerning workers' compensation coverage for post-traumatic stress disorder for peace officers, and the resulting report. There was discussion about the scope of the bill and which professions could be included under the bill.

BILL:	Committee Discussion and Votes on Motions to Request Bill Drafts	
TIME:	03:47:42 PM	
MOVED:	Singer	
MOTION:	Moved that a bill be drafted concerning mental health impairment, and specifically PTSD, parity in workers' compensation for Department of Corrections employees and emergency responders. The motion passed without objection.	
SECONDED:		
		VOTE
	Humphrey	
	Lee	
	Newell	
	Woods	
	Singer	
	Martinez Humenik	
YES: 0 NO: 0 EXC: 0 ABS: 0 FINAL ACTION: Pass Without Objection		

03:48 PM

Senator Newell discussed drafting a bill similar to House Bill 15-1025. Ms. Ritter asked if there were any changes to the 2015 legislation Senator Newell would like to incorporate into the bill draft. Committee discussion occurred about the bill and possible suggestions for changes resulting from further discussion with MICJS Task Force members during the September 25 retreat. Committee discussion about the bill idea ensued.

BILL:	Committee Discussion and Votes on Motions to Request Bill Drafts	
TIME:	03:54:56 PM	
MOVED:	Newell	
MOTION:	Moved that a bill be drafted regarding juvenile competency, similar to House Bill 15-1025. The motion passed without objection.	
SECONDED:		
		VOTE
	Humphrey	
	Lee	
	Newell	
	Woods	
	Singer	
	Martinez Humenik	
YES: 0 NO: 0 EXC: 0 ABS: 0 FINAL ACTION: Pass Without Objection		

03:55 PM

Representative Singer discussed establishing a matching grant program for local law enforcement to co-locate the provision of mental health services, similar to Project Edge.

BILL:	Committee Discussion and Votes on Motions to Request Bill Drafts	
TIME:	03:56:26 PM	
MOVED:	Singer	
MOTION:	Moved that a bill be drafted to establish a matching grant program for local law enforcement to co-locate the provision of mental health services. The motion passed without objection.	
SECONDED:		
		VOTE
	Humphrey	
	Lee	
	Newell	
	Woods	
	Singer	
	Martinez Humenik	
YES: 0 NO: 0 EXC: 0 ABS: 0 FINAL ACTION: Pass Without Objection		

03:56 PM

Senator Newell discussed the collaborative management process, established under Section 24-1.9-101, *et seq.*, C.R.S. She discussed ensuring that a mental health professional is included in the collaborative management group. Ms. Harding stated she would work with the MICJS Task Force members and review the current statutes to determine whether there is a needed revision to the statute to address this issue.

BILL:	Committee Discussion and Votes on Motions to Request	
	Bill Drafts	
TIME:	03:57:41 PM	
MOVED:	Newell	
MOTION:	Moved that a bill be drafted to ensure that a mental health professional is included in collaborative management groups established under Section 24-1.9-101, <i>et seq.</i> , C.R.S. The motion passed without objection.	
SECONDED:		
		VOTE
	Humphrey	
	Lee	
	Newell	
	Woods	
	Singer	
	Martinez Humenik	
YES: 0 NO: 0 EXC: 0 ABS: 0 FINAL ACTION: Pass Without Objection		

04:00 PM -- Public Comment

No members of the public signed up to provide public comment to the committee.

04:00 PM

Senator Martinez Humenik adjourned the committee.

AGENDA

**Legislative Oversight Committee Concerning the
Treatment of Persons With Mental Illness in the
Criminal and Juvenile Justice Systems**

Monday September 21, 2015

1:00 p.m.

Senate Committee Room 356

State Capitol Building

-
- 1 p.m.** **Call to Order**
- *Senator Beth Martinez Humenik, Legislative Oversight Committee Chair*
- 1:05 p.m.** **Presentation by Project EDGE**
- *Bill Myers, Chief Community Engagement Officer*
 - *Charlie Davis, Community Crisis Connection Program Manager*
- 1:35 p.m.** **Presentation by The Link**
- *Lonnie Matz, Program Director*
- 2:05 p.m.** **Presentation by Arapahoe House**
- *Presenter to be determined*
- 2:35 p.m.** **Discussion of Future Activities of the Advisory Task Force**
- *Camille Harding, Advisory Task Force Co-chair and Department of Health Care Policy and Financing*
- 3 p.m.** **Committee Discussion and Votes on Motions to Request Bill Drafts**
- 3:30 p.m.** **Public Comment**
- 4 p.m.** **Adjourn**



PROJECT EDGE

EARLY DIVERSION, GET ENGAGED

Project EDGE
Early Diversion Get Engaged

A partnership between behavioral health treatment providers and Boulder County law enforcement agencies

What is the purpose of Project EDGE?

Project EDGE aims to **divert** individuals who have behavioral health issues from the criminal justice system, and instead **engage** them in the **treatment** that is the **best fit** for them.

EDGE **creates a resource** for law enforcement officers for cases that can be **better served by behavioral health treatment** than by involvement in the criminal justice system.

Participation in EDGE is voluntary. If a person chooses to participate, no criminal charges are filed and the person agrees to engage in behavioral health treatment.

What can EDGE clinicians do?

EDGE clinicians provide **on-scene crisis de-escalation and behavioral health resources**.

They **refer individuals to behavioral health treatment**, including mental health and substance use treatment providers in our community.

EDGE **Peer Support Specialists** follow up with clients to provide support and guidance.

The EDGE team can also help connect agencies with **training opportunities**, including Crisis Intervention Team and Mental Health First Aid.

Who are the EDGE clinicians?

EDGE clinicians are **mental health professionals** who specialize in emergency psychiatric services, including crisis de-escalation and motivational interviewing.

These clinicians are funded through a partnership between Mental Health Partners and the Boulder County Sheriff's Office.

EDGE clinicians are dispatched by law enforcement personnel to **accompany officers to a scene**, or they provide emergency services for individuals taken to Mental Health Partners' 24/7 Walk-In Center.

Who can call Project EDGE for help?

Partner law enforcement agencies in Boulder County request an EDGE worker via dispatch. Current EDGE partner agencies are:

- Boulder County Sheriff's Office
- Longmont Police Department
- Boulder Police Department

If you or a loved one are in behavioral health crisis and need law enforcement response, contact law enforcement and ask for EDGE.

Another option to turn to if you or a loved one are in crisis is **Mental Health Partners' Crisis Line at 303-447-1665** and the **Walk-In Center located at 1000 Alpine Ave.**

Questions?

Maggie Werther, EDGE program supervisor
mwerther@mhpcolorado.org / 720-854-4011



Project EARLY DIVERSION, GET ENGAGED (EDGE)

Overview:

- Initially funded as three-year, \$966,666 federal grant from the Substance Abuse and Mental Health Administration (SAMHSA)
- Boulder County one of three sites nationwide to receive this early diversion grant award
- SAMHSA's goal/program design to divert individuals with mental health and/or substance use disorders from the criminal justice system before arrest
- Clinicians accompany law enforcement officers to respond to calls in the community which involve an individual with suspected or diagnosed behavioral health conditions

Collaborative Partners:

- Mental Health Partners
- Boulder County Sheriff's Office
- City of Boulder Policy Department
- City of Longmont Police Department

EDGE Team Response:

- 6 behavioral health clinicians and 2 part-time peer support specialists
- Provides coverage in the cities of Boulder and Longmont, as well as county-wide response with Sheriff's Office; hours 8am-10pm/7 days/week
- Assists client in accessing behavioral health services including psychotherapy/counseling, substance use & detoxification treatment, case management, housing & employment support
- Assists client and law enforcement in accessing other community-based services

Additional Project Goals:

- Reduce ED visits and 72-hour holds
- Increase law enforcement capacity in crisis intervention

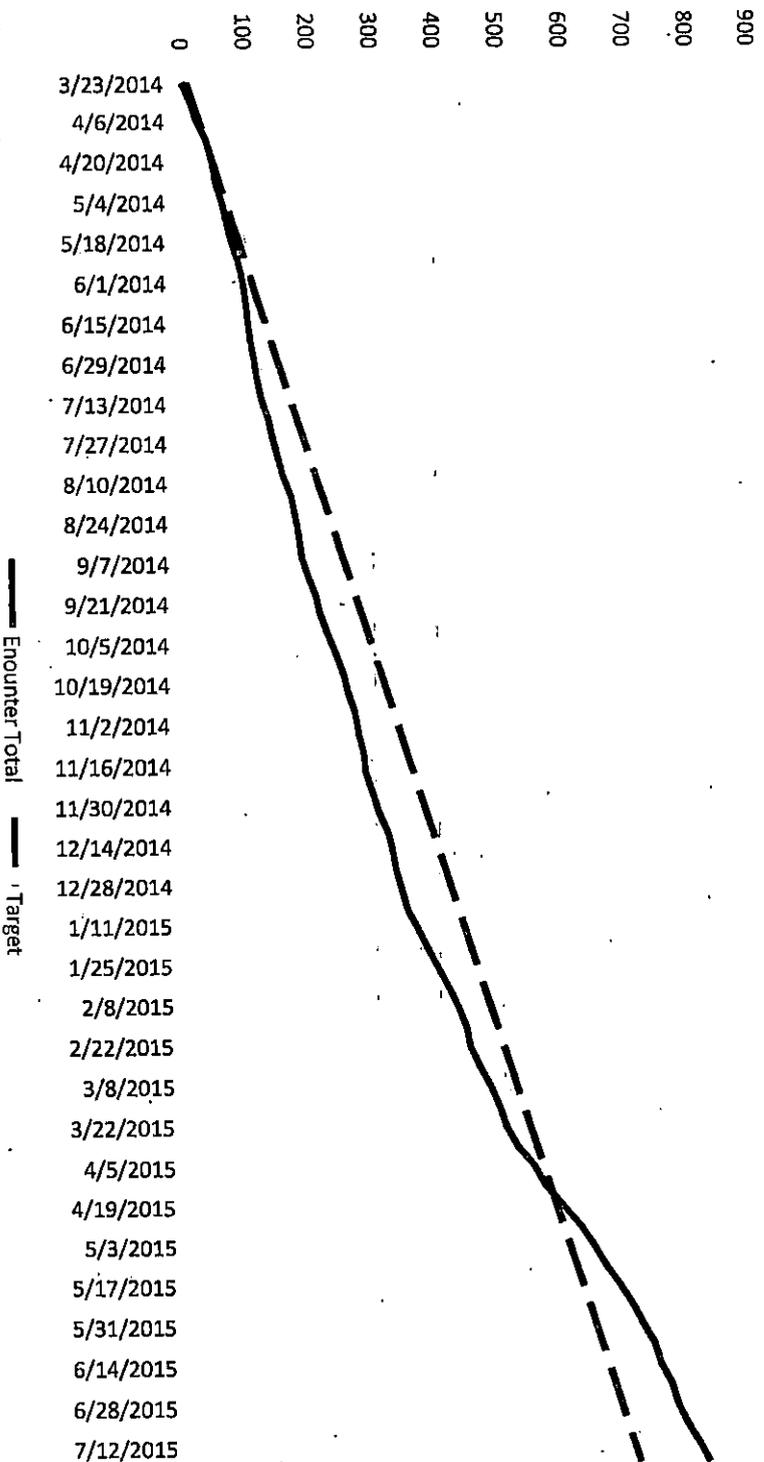
Demographic Experience to Date:

- > 800 encounters from 3/2014 – 7/2015; avg. 70 encounters/month (40 Longmont, 30 Boulder)
- Approx. 23% are 18-29 years; range from 14 to 60+; genders roughly equal in total
- Nearly 44% of encounters complete at least one visit with behavioral health provider

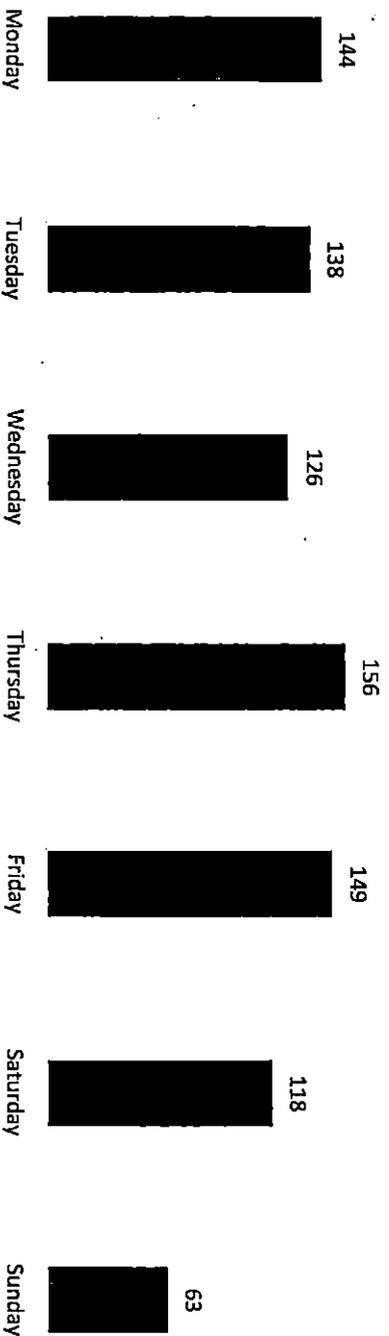
For More Information Contact:

Bill Myers, Chief Community Engagement Officer
 Mental Health Partners, 1333 Iris Avenue, Boulder, CO 80304
 720.737.8024 or bmyers@mhpcolorado.org

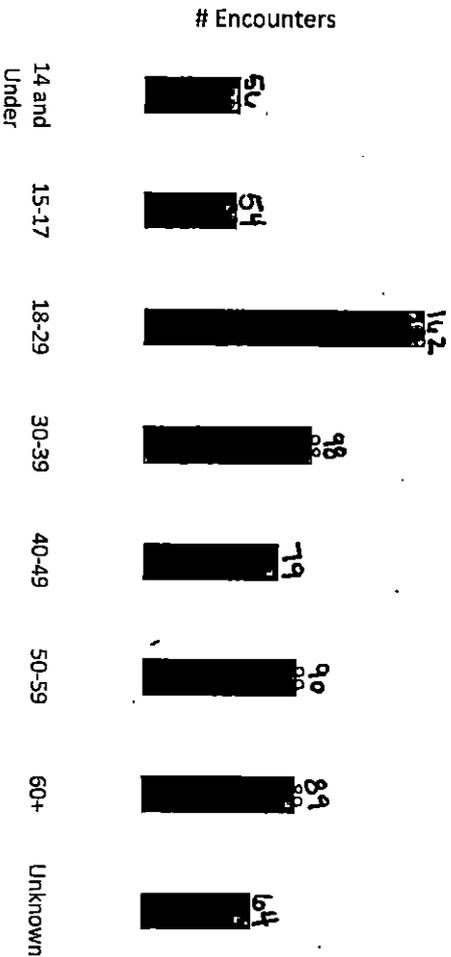
Encounters: Project to Date



Encounter by Day of the Week



Encounters by Age Group





A Community Assessment & Resource Center

8461 Delaware Street
 Thornton, CO 80260
 Phone: 720-292-2811
 Fax: 720-292-2812

The mission of *The Link* is to ensure assessment driven preventions and intervention services for at-risk youth and their families.

Programs and services provided at *The Link*:

- Alternative to Expulsion Case Management [SD's 1, 12, 14, 27] and 50]
- Detention Screens
- Electronic Home Monitoring
- ENGAGE-early gang intervention
- Family Interventions
- *Link* Case Management
- Municipal probation and diversion
- Personal Recognizance Bonds
- On-site groups for anger management, MRT and parenting
- Shelter care, when necessary
- Transports

Alternative to Expulsion:

The alternative to expulsion program provides youth with an opportunity to avoid expulsion by completing a 90-120 day behavioral contract and case management services with *The Link*. The behavioral contract consists of input from the school, youth, parent and the risks identified by the assessment. Youth can earn points towards an incentive at the end of the program by completing the assignments of the contract and attending school. Youth meet weekly with their case manager. The family is offered supportive services including referrals for resources.

Detention Screens:

The Link is the authorized provider for detention screens in the 17th Judicial District. Through a contract with SB94 *The Link* provides screening 24/7. All youth charged with a detainable offence in the 17th Judicial District must be screened (assessed) before being admitted the Adams County Youth Services Center. Once the screen is completed *Link* staff coordinates the youth's transport to the detention center and completes a court report.

Electronic Home Monitoring:

Pursuant to a contract with SB94 *The Link* can place and supervise a youth on an ankle monitor until they return to court, if the assessment scores the youth for that level of care that includes bond recommendations, as well as recommendations for additional services.

ENGAGE (Empowering Neighborhoods with Gang Awareness and Gang Education)

Designed as an early gang intervention youth are provided intensive case-management/mentoring designed to offer youth alternatives to gang involvement. The theoretical basis for the program comes from the social disorganization theory adopted by the OJJDP Comprehensive Gang Model. In addition to meeting one on one with a gang intervention specialist, youth are also visited in the school to encourage and

support changed behaviors and better decision making. The program supports involvement in pro-social activities such as sports, recreation, drama and music. *The Link* collaborates with law enforcement, school personnel and human service staff to provide support services as needed by the targeted youth. The goal is to offer alternatives to gang involvement, increase attendance and reduce recidivism. This program also works with other youth at high risk of involvement with the juvenile justice system for issues such as violence and extreme anger concerns.

Family Interventions:

Any family whose youth is struggling with life issues can be referred (including self-referral) to *The Link* for case management and referral services. An appointment is scheduled to complete an assessment with both the youth and family. The assessment helps to determine what referrals and services are necessary. Family mediation and ongoing case management are offered as well. Youth and family can also access any on site groups at *The Link*.

Link Case Management:

Youth who are transported to *The Link* by law enforcement are afforded the same case management and support services as those outlined in family interventions.

Municipal probation and diversion:

Youth are referred by the municipal court to *The Link* for either diversion or probation for a period of 90-120 days. Working with a case manager the youth and family establish a behavioral contract that includes any conditions ordered by the court such as community services or drug/alcohol classes. The case manager supports the family in ensuring the youth completes the expectation of the court and assists the family in accessing additional services as identified during the assessment.

Personal Recognizance Bonds:

The Link staff is authorized by the district court to activate Personal Recognizance bonds for youth with misdemeanor and municipal warrants in Adams County not requiring detention.

On-site groups:

The Link currently offers weekly anger management groups and cognitive behavioral groups such as, Moral Recognition Therapy, Girls Circle and Boys Council. Additionally, two staff is trained facilitators for informed supervision.

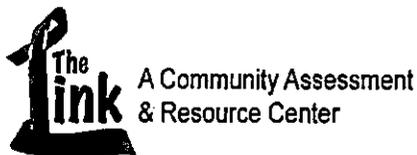
Shelter Care:

The Link, in partnership with Shiloh Homes, can provide short term shelter care for youth who need respite care or whose parents cannot be located during overnight hours.

Transports:

The Link provides law enforcement a safe and structured environment to drop off a juvenile for such things as beyond control of parent, runaway or a municipal ticket. *Link* staff conducts an assessment to determine the strengths of the youth and family and identify risks in order to recommend the most appropriate intervention. *The Link* offers family mediation, referrals for community based services and resources to help with the family's needs. *The Link* also offers case management to assist families in accessing services and meeting basic needs.

⋮



Located at the Sanctuary,
8461 Delaware St
Thornton, CO 80260
Office: 720.292.2811
Fax: 720.292.2812

History of *The Link*, A Community Assessment and Resource Center Serving the 17th Judicial District of Adams and Broomfield Counties

In early 1999, the then Adams County District Attorney's Office and the North Metro Youth Diversion Board recruited representatives of the Adams County community concerned with and involved in juvenile justice issues, to serve on a new Juvenile Crime Enforcement Coalition (JCEC). These JCEC members, numbering 39, were chosen from law enforcement, schools and existing groups that focused on youth, as well as from the community at large.

Both the 17th Judicial District Attorney's Office and the North Metro Youth Diversion Board had previously explored and identified a need for a Juvenile Assessment Center. At the Coalition's first meeting, on March 9th, 1999, 17th Judicial District Attorney Robert S. Grant was elected Chairperson, and the JCEC endorsed using JAIBG grant funds to create a Juvenile Assessment Center, that would address the majority of ideas and concerns expressed. After commitments from participants to contribute the required 10% cash match, the Advisory Committee, led by Assistant DA, and primary proposal author, Heather Turner, met on March 26th to complete the JAIBG grant proposal. At its next meeting on April 2nd, the JCEC approved the joint plan to establish a Juvenile Assessment Center to serve Adams County, and using JAIBG program funds, *The Link* opened its doors with record speed six months later on October 4th, 1999.

After eight months of operation, the effectiveness and potential of *The Link* were clearly demonstrated, and at its June, 2000 meeting the JCEC approved a joint plan to continue operating *The Link* and to expand and formalize new services, comprised of municipal probation services to youth and, via contract for services, referrals from school districts for suspended and expelled youth, as well as detention-screening services through the Senate Bill 94 Program.

Early in 2004, the JCEC had approved an application to the IRS for tax-exempt 501(c) (3) status, and in October *The Link* began operation as an independent non-profit agency with the hope of expanded grant and foundation funding opportunities.

Near the end of 2005 with federal JAIBG grand funds decreasing and long-time Executive Director Zenia Tata departed. Under new Executive Director, Dr. Annie Alexander, it became clear funding was becoming critical and a major effort to negotiate an IGA for sustaining *The Link* into the future. In April 2006, *The Link* won a five year, annually renewable contract for SB94 detention screening and assessment services, and in June Adams County Human Services awarded *The Link* a contract for to provide services to support reunification efforts and prevent youth from entering the human service system.

In October, new Executive Director Valorie Ladwig took the helm and in late 2006 an IGA with 6 municipalities and the Adams Co. Sheriff's office for countywide support was approved, funding *The Link's* services through 2007. The IGA has been renewed every year thereafter representing local law enforcement, municipal and county government's commitment to the services provided by *The Link*.

Under the leadership of the new director, *The Link* expanded programs to offer case management to youth transported to the agency by law enforcement and restructured the alternative to expulsion program to a cognitive behavior model. In 2008, a work group was created to discuss a way to open a combined assessment center and shelter for Adams County youth. Within 18 months and through a partnership with Shiloh Homes a building was purchased and renovated with space to also include a therapeutic residential program, as well as collocating SB-94 and PATHS staff. The combined assessment center and shelter, The Sanctuary, opened in June 2010. The Link was able to return to 24/7 staffing with an on-call system for overnight and Sundays.

In 2009 the JCEC endorsed *The Link's* partnership with Adams County Youth Initiative/Safe Schools Healthy Students collaboration to provide seed money to develop an early gang intervention program called ENGAGE (Empowering Neighborhoods with Gang Awareness and Gang Education). *The Link* also collaborated with a truancy court initiative in 2010 to provide assessment and case management services to truant youth. The program receives funding from the 1451 Collaboration and school referrals for services. In April 2011 *The Link* was once again awarded the SB94 5 year

RFP to provided detention screening in the 17th Judicial District. In the fall of 2010 expanded services to include a drug and alcohol group, gender specific anger management groups, as well as Improving Family Dynamics and Girl's Circle and Boy's Council.

Recognizing the need for accurate data, the JCEC supported the development of a new records management system for *The Link*. The CARE data base became operational in December 2011. The data base was built with the ability to expand to an index or information sharing system for future needs. The agency currently has an MOU for information sharing with Youth and Family Connections in Weld County. For the first time in the agency's history a logo for marketing and branding purposes was created by the executive director.

The plan defining *The Link* was developed through a broad-based, multidisciplinary community process that directly involved 39 representatives and incorporated experience from nearby Juvenile Assessment Centers in its design. It specifies key characteristics of *The Link* as:

- 1) A single point of entry through *The Link* to facilitate access to services both for law enforcement, youth and families.
- 2) A comprehensive assessment process that begins with a family strength-based approach, and evaluates the youth's needs in a wide range of areas, including substance abuse, mental health, education, employment and training and other needs. The assessments will be carried out by on-site Intake Specialists paid through grant funds.
- 3) A comprehensive, integrated computer data system that will meet the information sharing and case management needs of *The Link*, as well as assist in data collection for evaluation of program effectiveness.
- 4) An integrated case management system that will link youth with services and provide ongoing services monitoring that strengthens, but does not duplicate existing case management efforts.

The Link is a single point of entry for assessment and case management for juvenile offenders, at-risk youth, and families.

A *juvenile offender* is defined as a youth who:

- is 10-17 years old (until 18th birthday), and
- has received a municipal citation, or
- has been arrested, or
- has been diverted (pre-filing or post-filing), or
- is on pretrial status, or
- is adjudicated as delinquent.

An *at-risk youth* is one who:

- is 8-17 years old (until 18th birthday), and/or
- is less than 10 years old and has committed a criminal act, and/or
- is truant, and/or is or has a history of runaway(s), and/or
- is out of parent/guardian control (as defined by parent/guardian), and/or
- is homeless without proper care or is not domiciled with a parent, guardian or legal custodian, and/or
- requests assistance.

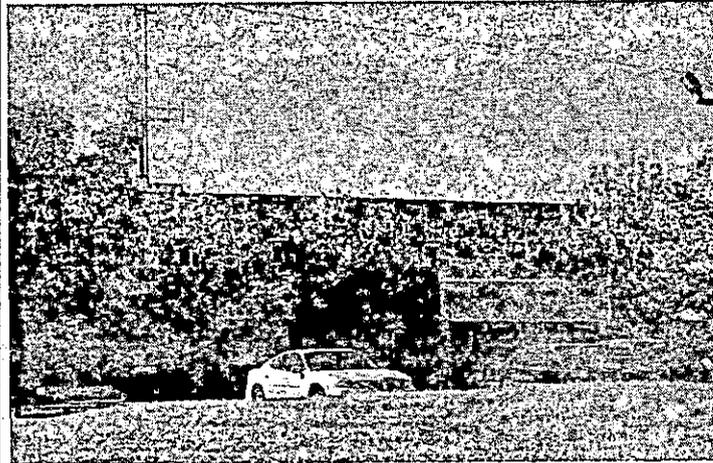
By offering immediate intervention to juveniles who are beyond the control of their parents, *The Link* significantly impacts the burden placed on county child protection agencies and local law enforcement agencies, both of which are often called to intervene in family situations where the adolescent is beyond the control of their parent, yet poses no imminent danger to self or others. In the past 15 years *The Link* has served 4,486 juveniles who were brought to *The Link* because they were beyond the control of their parents, and 1,574 runaways, who otherwise would have been referred to human services. Therefore, by being the first contact for these 6,060 families and trying to provide them with appropriate referrals and family mediation, the agency is able to lift a significant burden from Adams County Human Services allowing their staff to focus on issues of child neglect and/or abuse. *The Link* transport services have saved law enforcement over 30,000 hours in the past 15 years allowing officers to return to duty as quickly as possible.

Getting to Know STIRRT Continuing Care

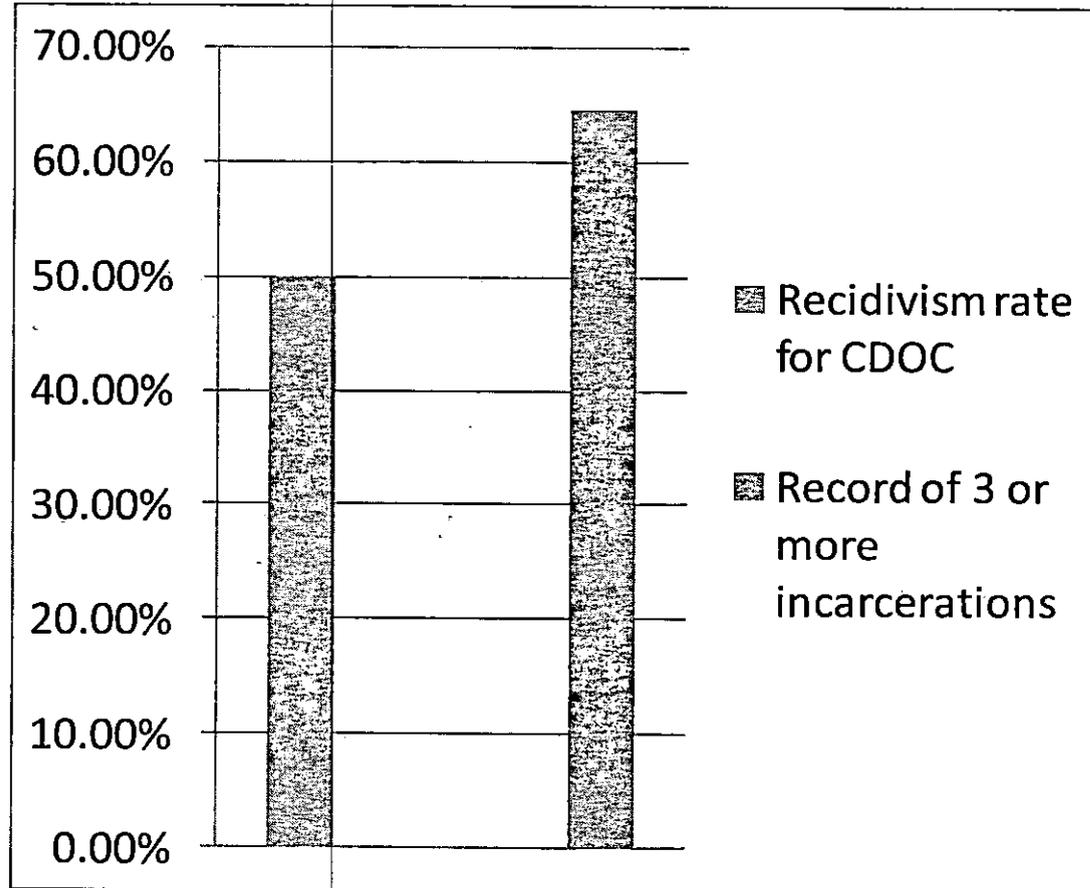
What is STIRRT?

Short Term Intensive Residential Remedial Treatment

- About
- Programs
- Referral Process
- Funding Sources

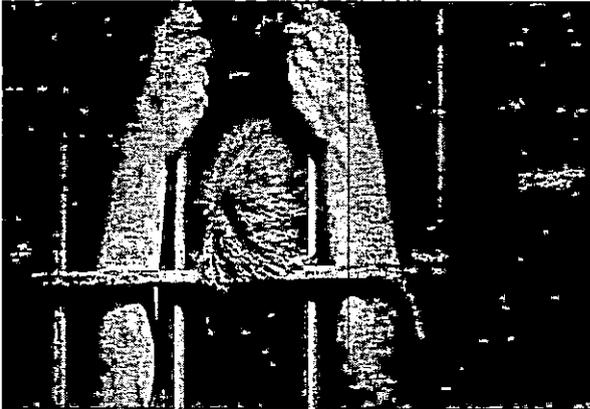


Recidivism Statistics

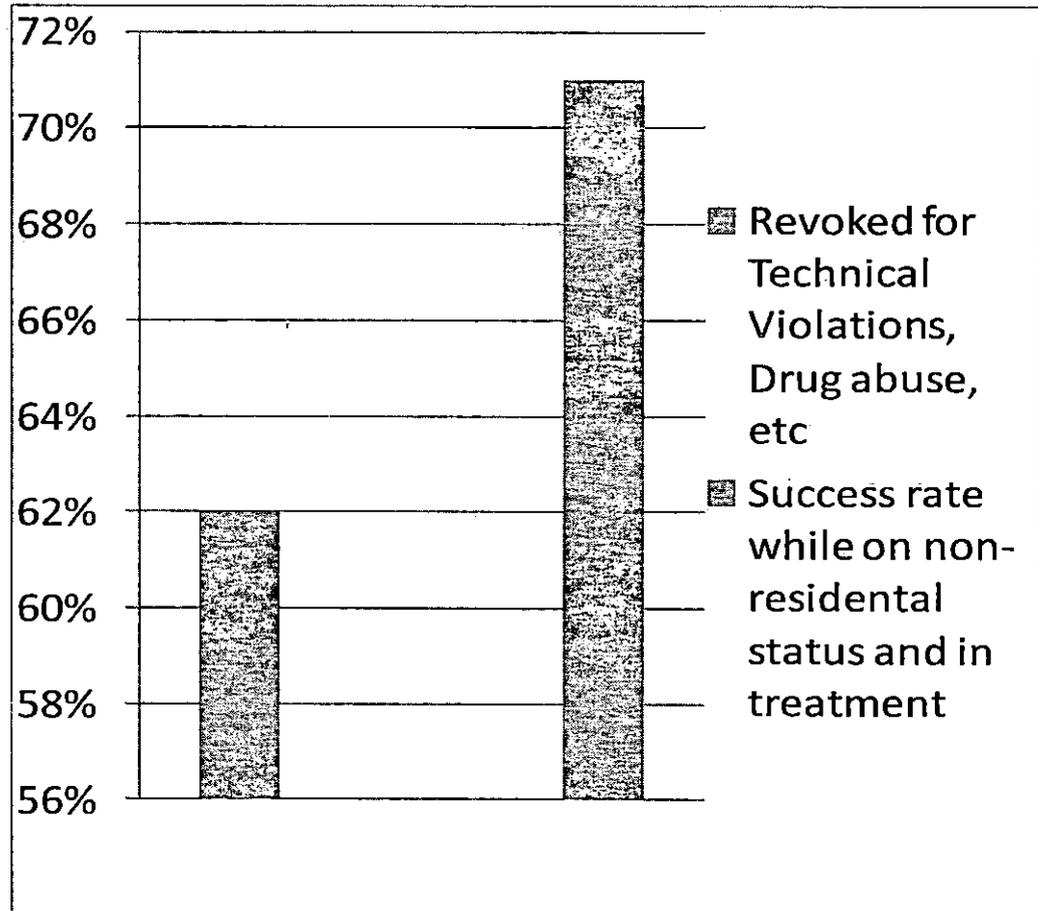


Annual State
Report Fiscal
Year 2013
Division of
Criminal
Justice
Colorado
Department
of safety 2013

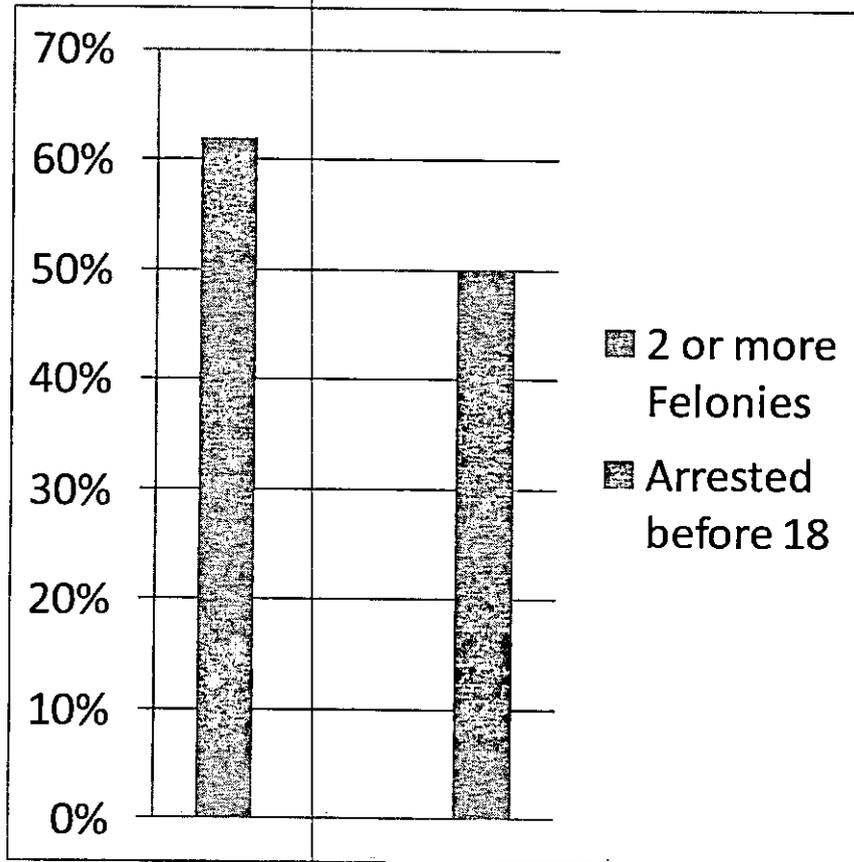
Treatment vs. Incarceration Statistics

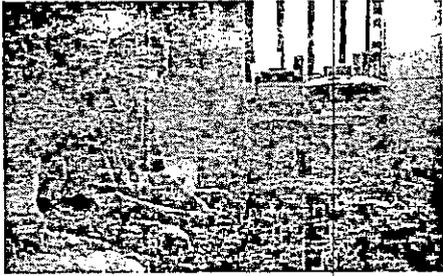


Annual State Report Fiscal Year
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Division of Criminal Justice
Colorado Department
of safety 2013

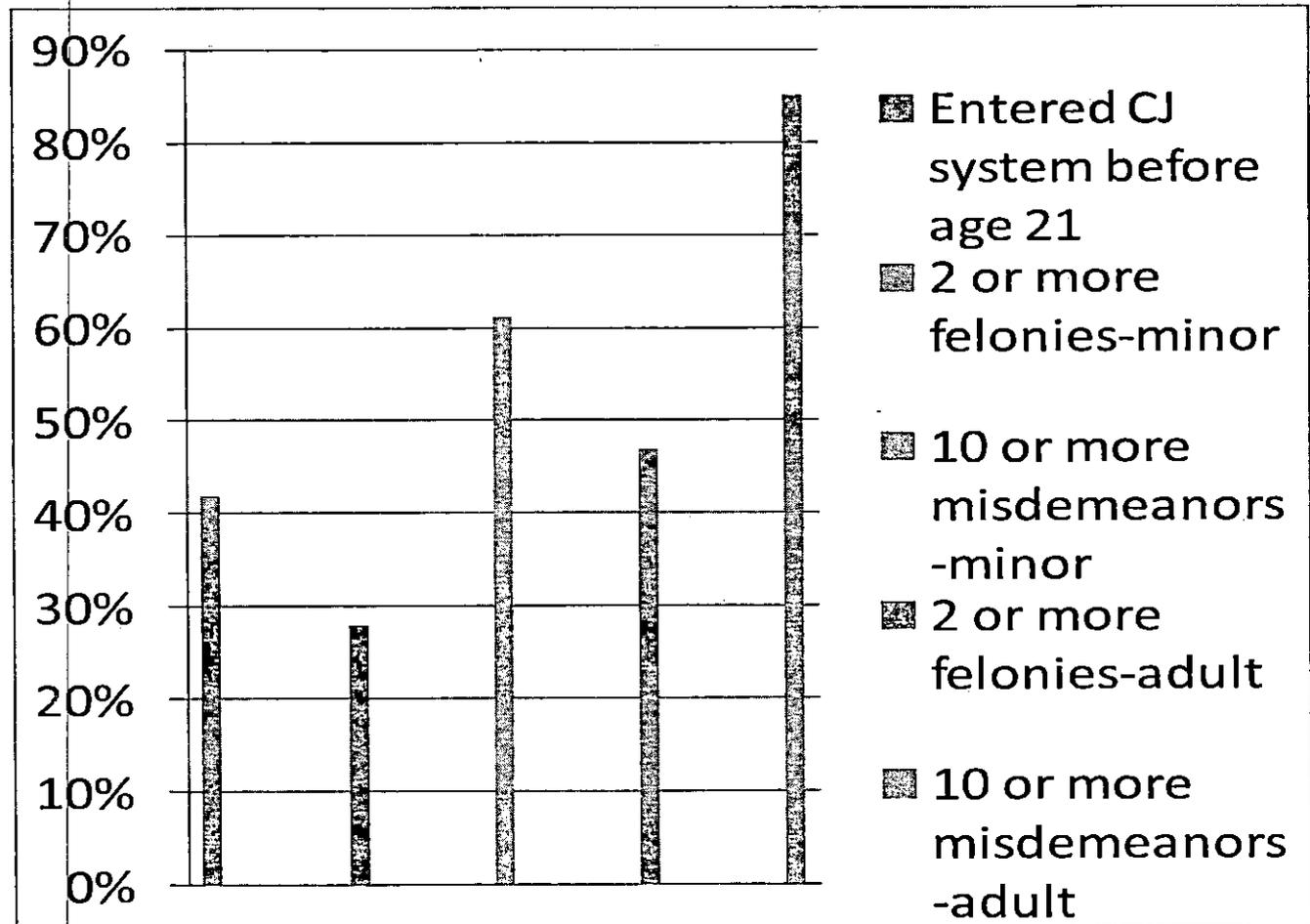


STIRRT CC Clients

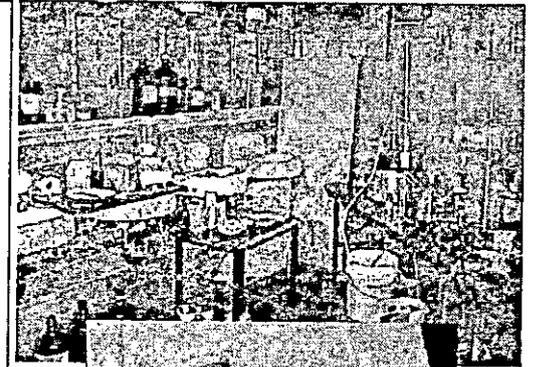
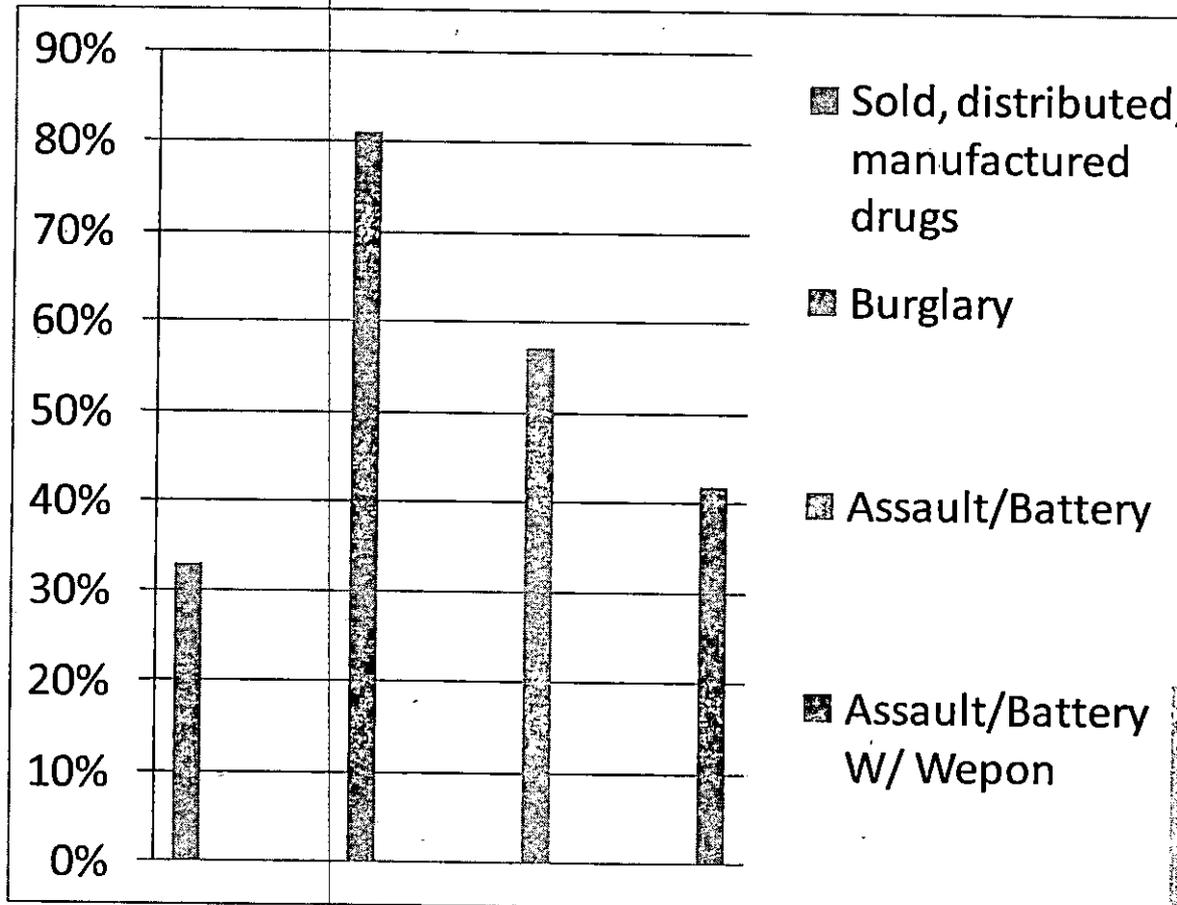




Legal (males)

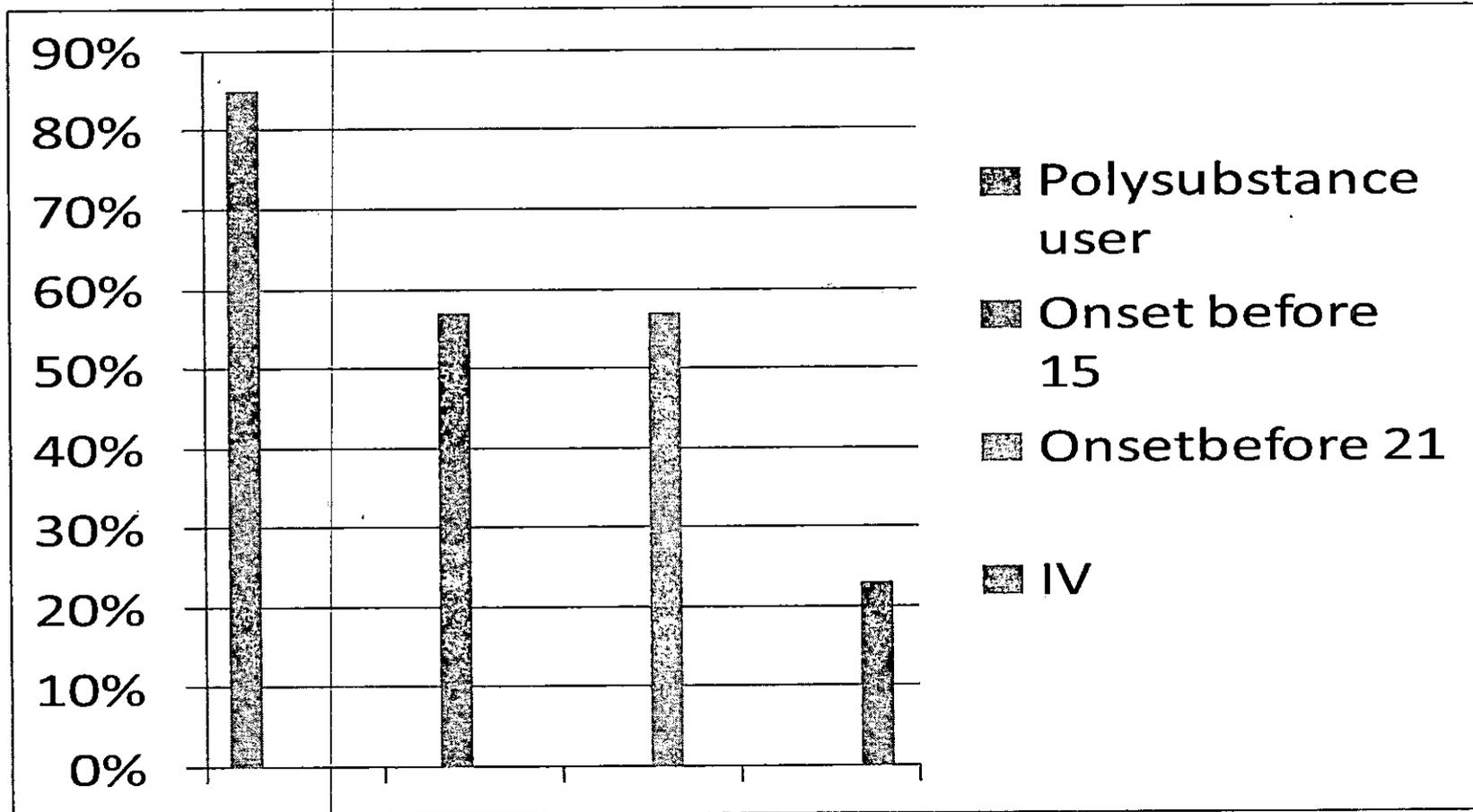
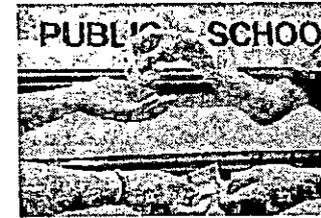


Crimes as Adults (males)



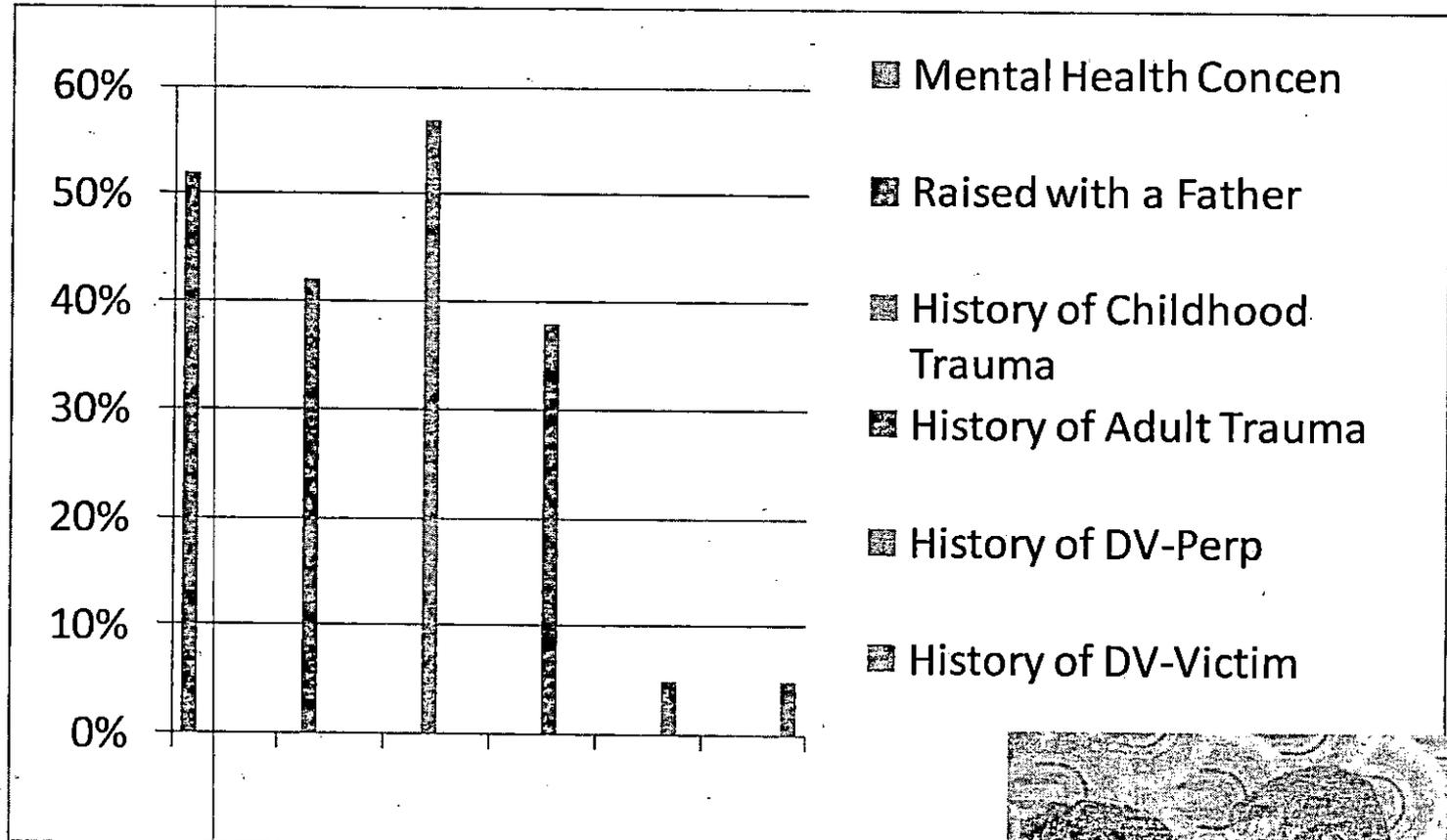


AOD (males)

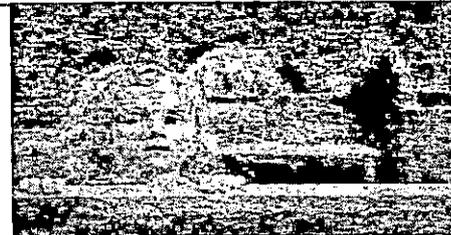
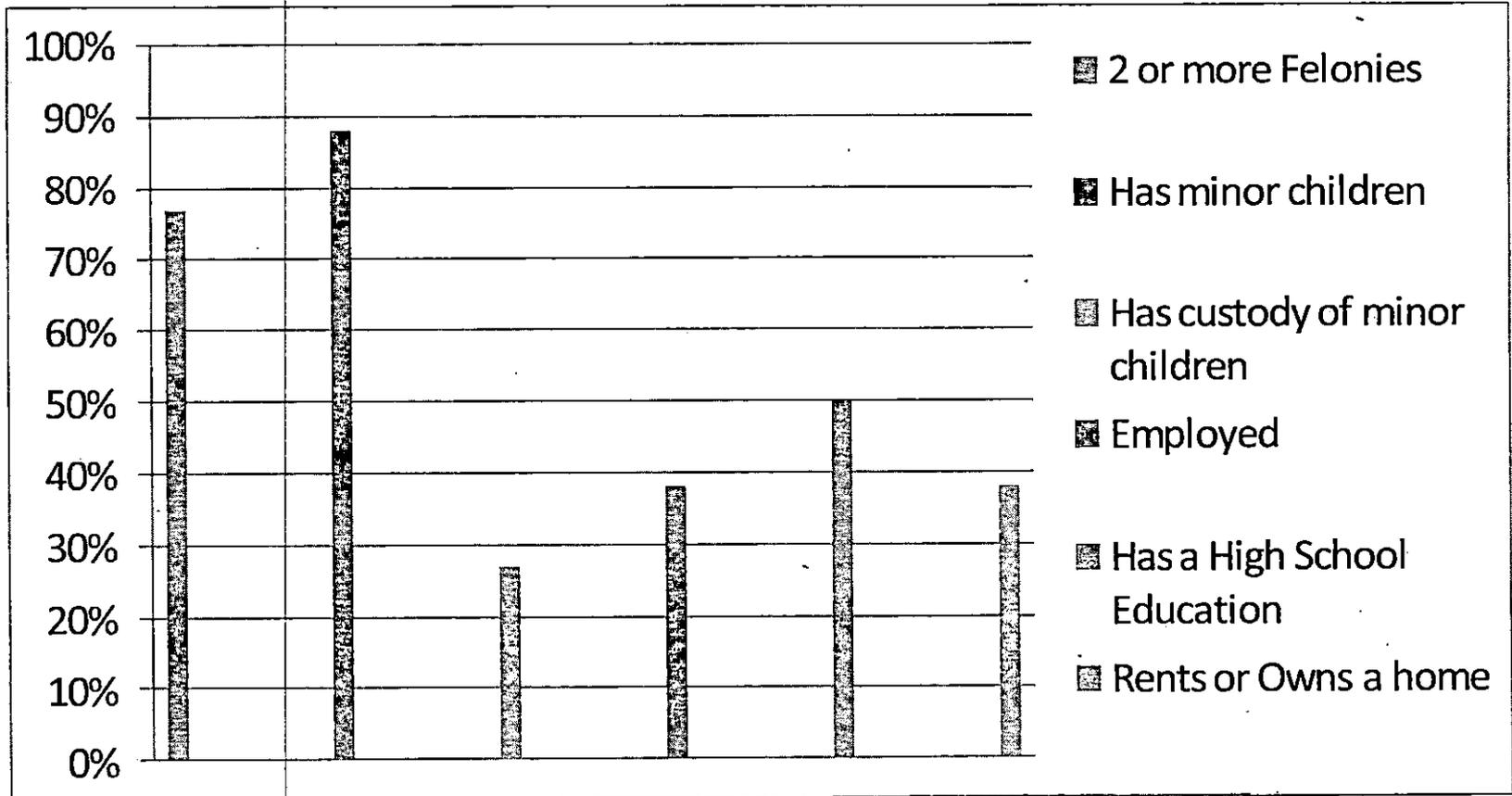




Mental Health (males)

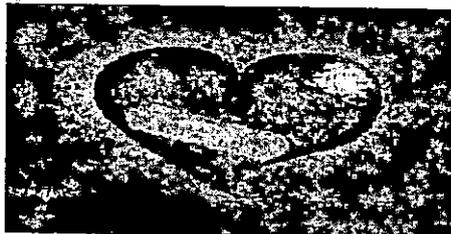
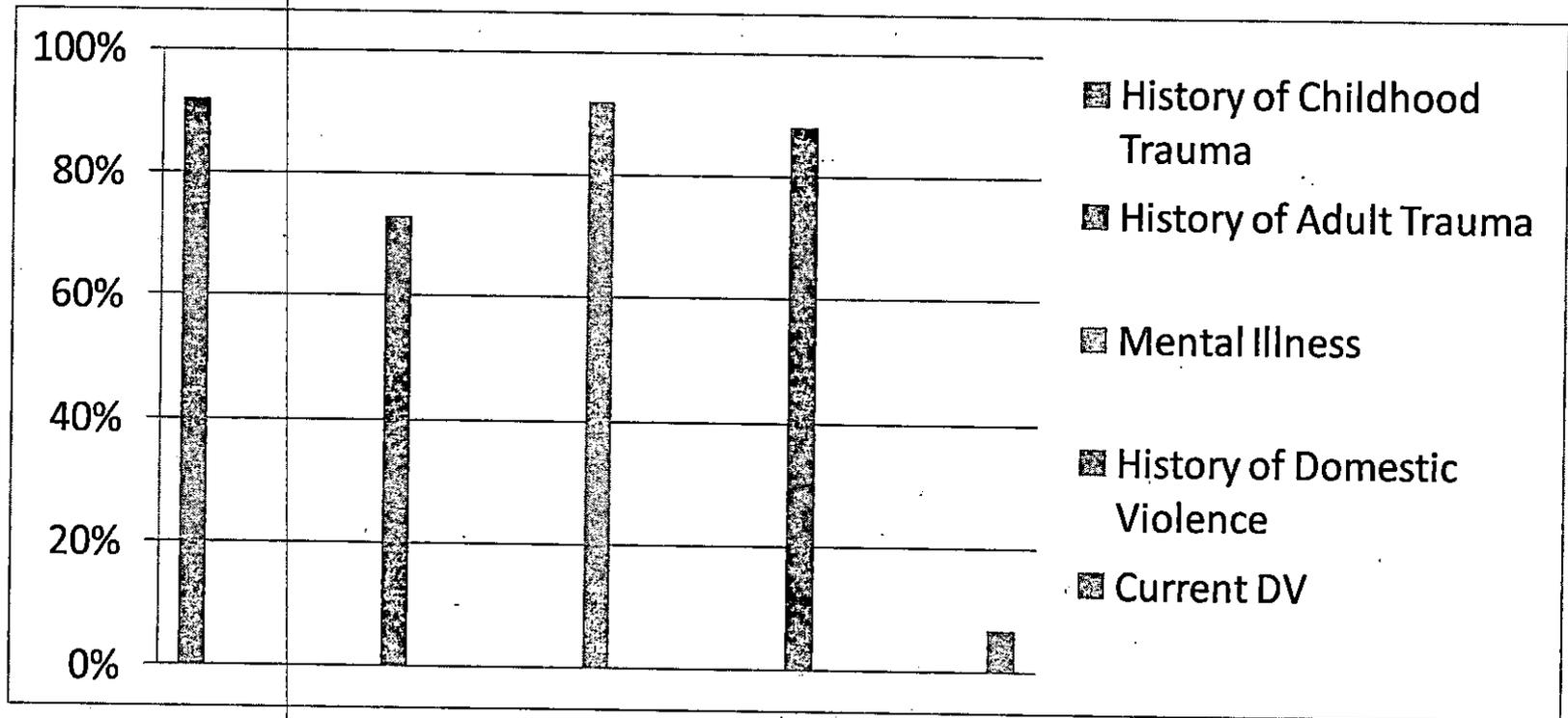


Case Management Needs (females)



Mental Health and Trauma

Statistics (females)



“What Works and What Doesn’t” *Dr. Edward Latessa*

#1 The RISK Principle (*WHO*)

Most intensive structured treatment & intervention programs are for offenders who:

- 1). Pose a higher risk of continued criminal conduct.
- 2). Have a higher probability of recidivating.

Placing lower-risk offenders in high risk offender programs:

- 1). Often increases failure rates
- 2). Tends to disrupt prosocial networks

#2 The NEED Principle (*WHAT*)

THE BIG FOUR:



1. Antisocial attitudes
2. Procriminal associates
3. Temperamental & antisocial personality patterns
4. History of antisocial behavior

THE REST:



5. Familial factors
6. Personal, educational, vocational or financial achievement
7. Prosocial leisure activities
8. Substance abuse

#3 The Treatment Principle (HOW)



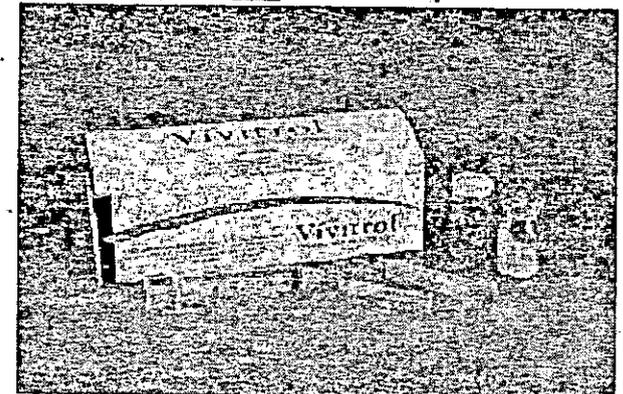
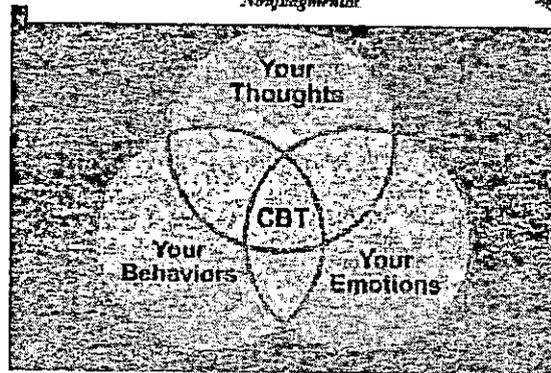
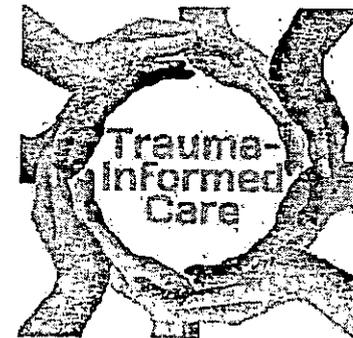
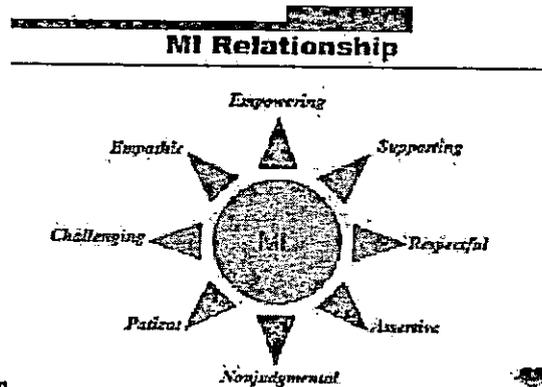
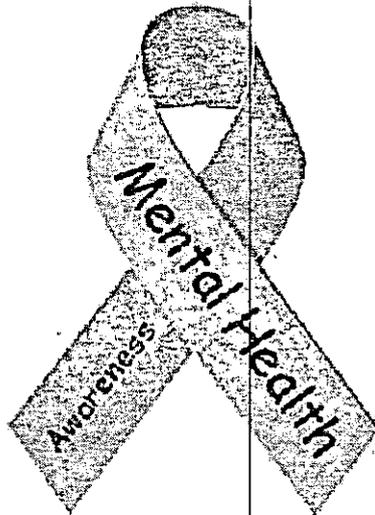
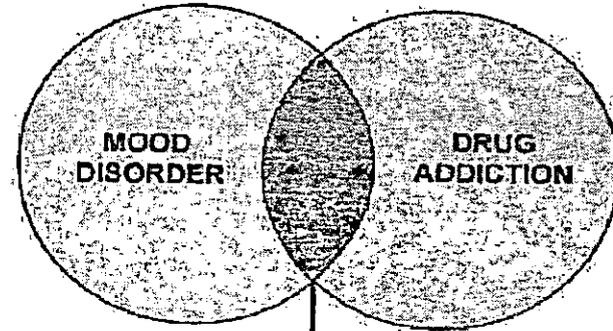
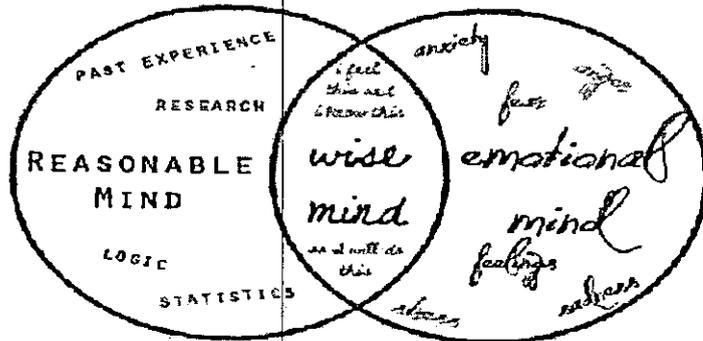
Most Effective:

- Behavioral
- Present circumstances
- Risk factors
- Action vs. talk oriented
- Structured
- Modeling/behavioral rehearsal
- Engender self-efficacy
- Challenge of cognitive distortions
- Problem-solving & self-control skills

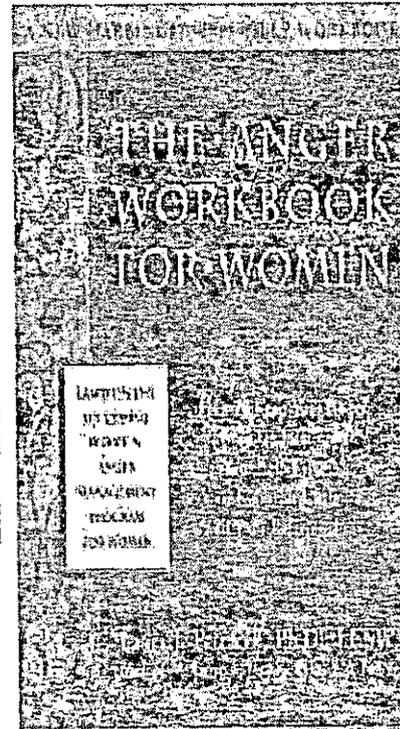
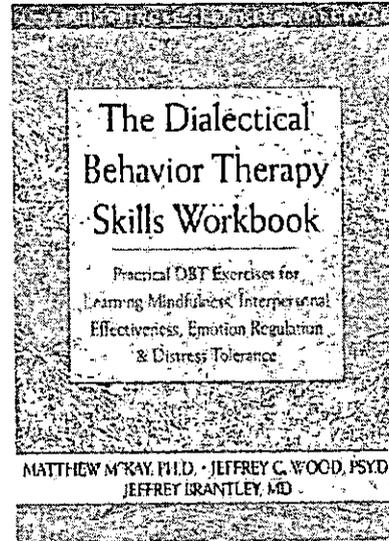
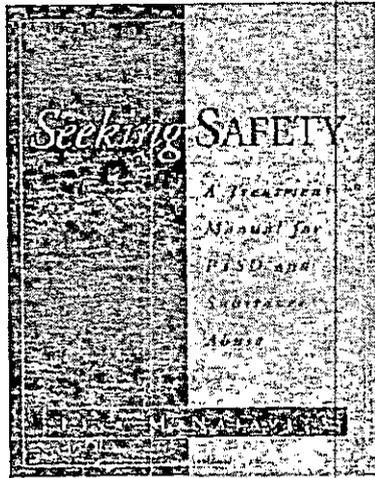
Done through:

- Structured social learning programs
- Cognitive behavioral programs
- Family-based interventions

Therapeutic Tools



Additional Curriculum



Parenting

STIRRT Curriculum



The Group Process

- **Support, Encouragement, Challenge, Skills Practice**



- **Scheduled flexibility**

6:00-6:10

TAP Charts & Master Assessment Plans

6:10-6:30

Client Check in

6:30-6:45

Review last group & today's SSC curriculum

6:45-7:10

Small Group Skills Practice

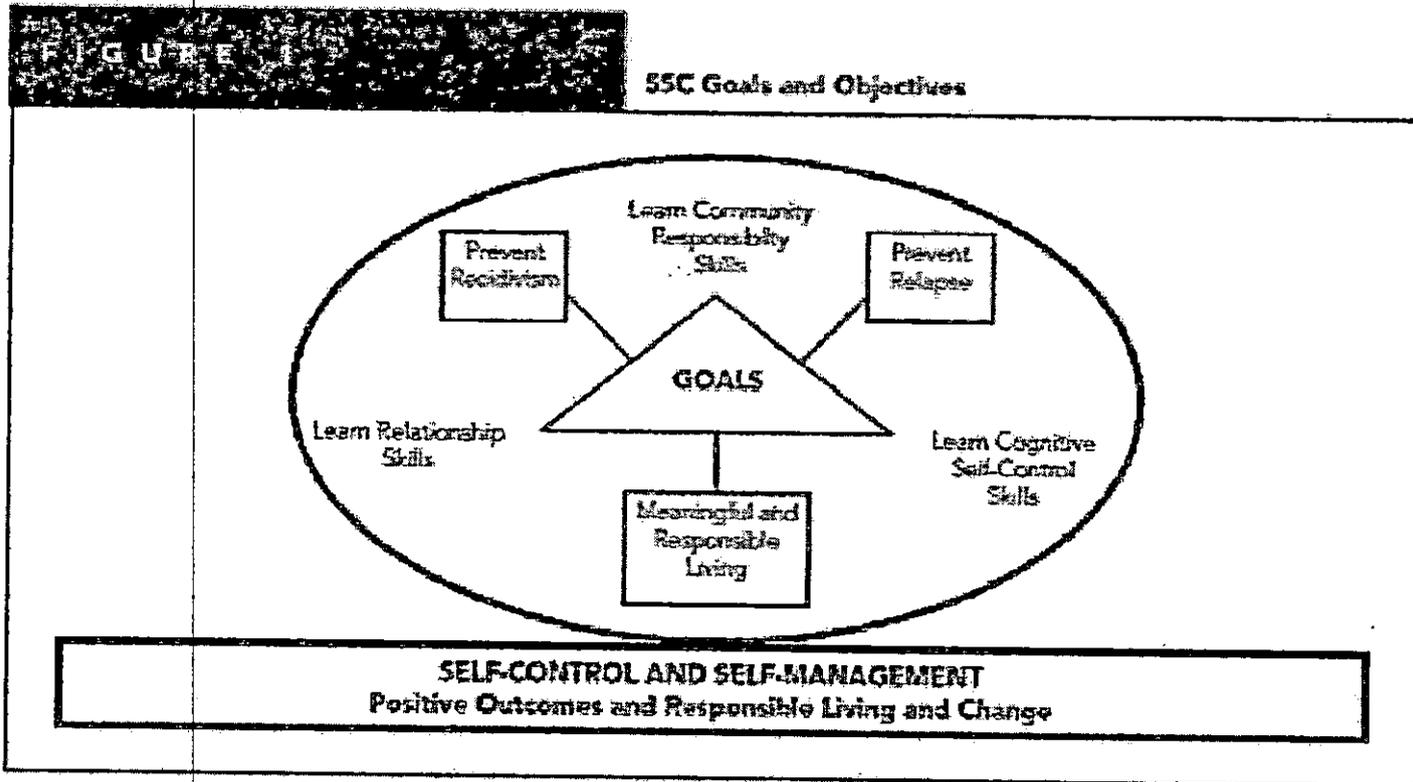
7:10-7:30

Large Group Discussions

7:30-8:00

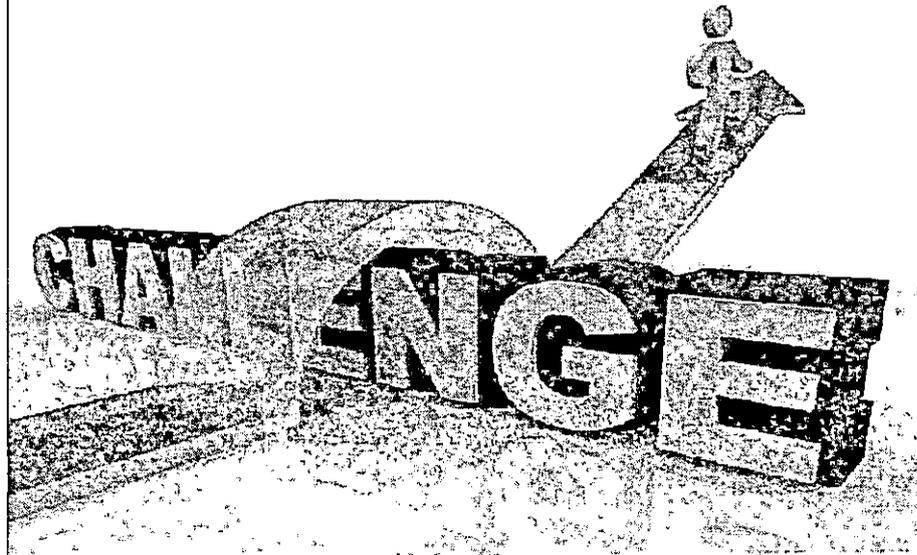
Client Check Outs & Take Away's

Self-Control & Self-Management



SSC : 3 Treatment Phases

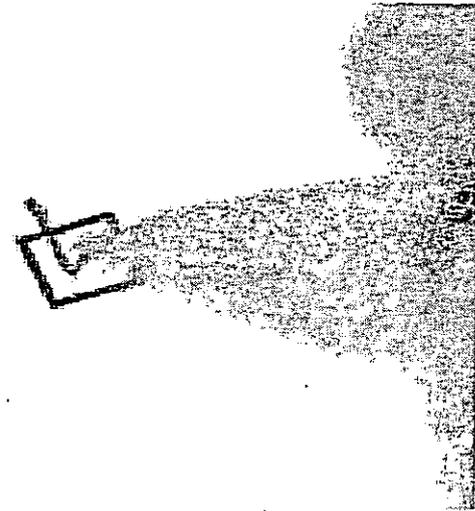
- Phase I - Challenge to Change



SSC : 3 Treatment Phases

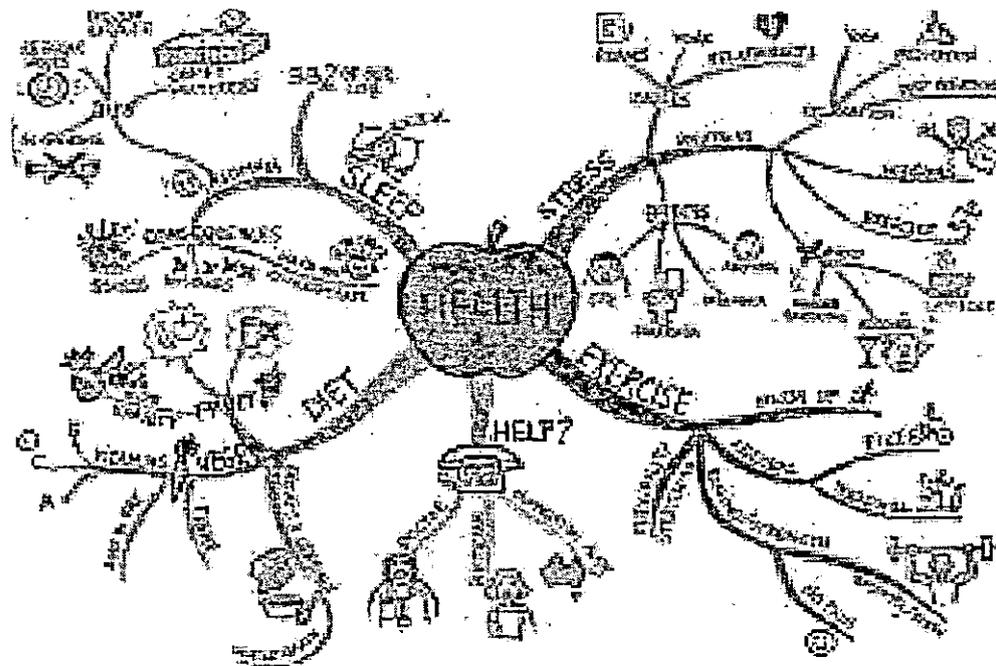
- Phase II - Commitment to Change

Yes



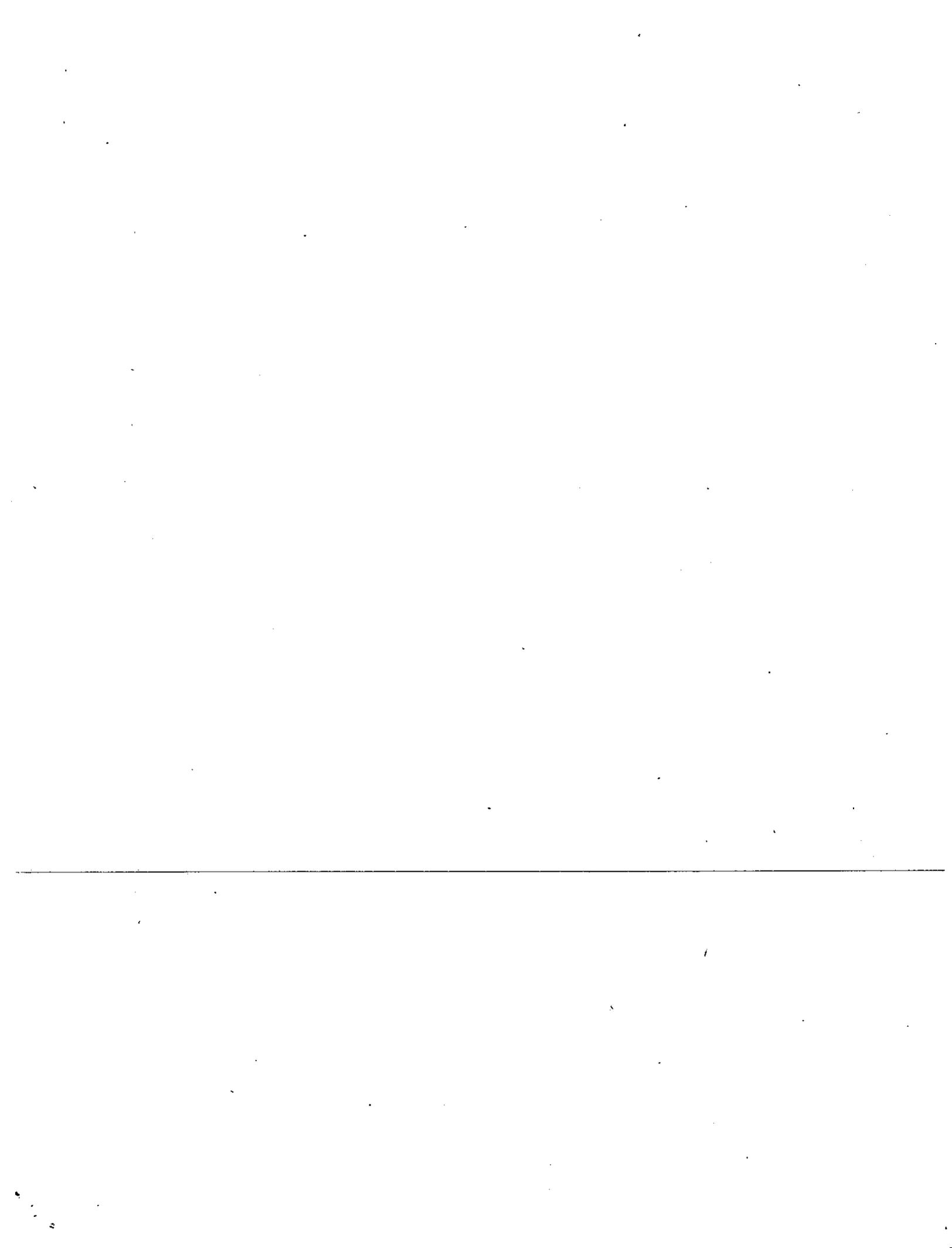
SSC : 3 Treatment Phases

- Phase III - Taking Ownership of Change



Summary

- Questions
- Observations
- Input
- Suggestions



**Treatment of Persons with Mental Illness in the Criminal and Juvenile Justice Systems (MICJS)
Legislative Oversight Committee Meeting Responses from Tuesday, August 18.**

Request 1: Oversight Committee requested like an outline of next steps for the medication consistency work and if there is an opportunity for potential legislation or any pilot considerations.

Medication Consistency Work group has provided the formulary for review. (See Attached Formulary).

Next Steps:

The last MICJS update regarding the work of the medication consistency workgroup reports that the group has completed the work on the formulary. The group will now be looking at the implementation phase. This will include looking at how to purchase medications on a broad scale to be available to jails and prisons. The group had a call with the Washington State to learn about a similar project there. MICJS members discussed the need for offering involuntary medications in jails and the complications clients face with not getting the needed treatment until their hearing and medications potentially impacting the outcome of the hearing.

The members met this morning and have identified areas of consideration and next steps for purchasing. On Oct 19th a larger meeting will convene to discuss options, benefits and costs. A plan to include Colorado Purchasing Office and CCI to the meeting is anticipated.

Request 2: Oversight Committee requested for recidivism rate for Department of Corrections (DOC), Division of Youth Corrections, and jails.

Colorado Department of Corrections Recidivism Rate:

Offenders returning to a Colorado prison within 3 years of release for either a technical violation or a new crime is reported as Forty Eight percent (48%) in 2010.

In 2008 a common definition for parole, probation, and non-departmental community placement was adopted across these settings.

Colorado Department of Corrections 2013 Statistical Report:

https://drive.google.com/file/d/0B8WLSXAb0Mg8cUNydkdCVnAzbXM/view?usp=drive_web

Colorado Department of Human Services: Division of Youth Corrections:

Pre-Discharge Recidivism: A filing for a new felony or misdemeanor offense that occurred prior to discharge (while the youth is under DYC supervision) from the Division of Youth Corrections.

Post-Discharge Recidivism: A filing for a new felony or misdemeanor offense that occurred within one year following discharge from the Division of Youth Corrections.

Thirty-four percent (33.9%) of youth discharged in FY 2009-10 received a new felony or misdemeanor filing within one year following discharge from the Division post-discharge recidivism.

Division of Youth Corrections Recidivism Evaluation of Committed Youth Discharged in Fiscal Year 2009-10

<http://www.colorado.gov/cdhsdyc/Resources-Publications/Recid2012.pdf>

Jails:

The Mental Illness Criminal Justice Task Force formed a data and health information workgroup that has developed and vetted the attached questionnaire and will be conducting region focus groups in collaboration with Colorado Regional Health Information Organization (COHRIO).

The purpose of these focus groups are to answer key questions regarding recidivism rates, jail based screening and treatment services as county systems have various processes and services in each region. See Attached MICJS Draft Focus Group Questions.

Question 4: Strategies for improving access to Rural Mental Health and addiction treatment services.

Key Recommendations from the Office of Behavioral Health Needs Analysis completed in 2015 by the Western Interstate Commission for Higher Education include the following strategies for improving rural mental health treatment services:

Telehealth:

- Used to connect patients and providers and to reduce costs.
- Telehealth has been found to be a cost-effective delivery method for prevention, early diagnosis, treatment, and care coordination.
- Telehealth can assist in solving access to care issues in rural and frontier areas, in underserved communities, for individuals with mobility issues, and to provide specialty care that is not widely available.

Primary care integration:

- Primary care providers in rural/frontier areas have to be trained to function independently.
- Integrating behavioral health services into primary care can help reduce stigma associated with seeking behavioral health services in small communities.
- Training for existing providers to deliver behavioral health services to leverage existing services would be beneficial. Colorado has a grant to expand Mental Health First Aid training. Such training heightens awareness of mental illness and can help rural/frontier communities and families identify when individuals are struggling.

Prevention and early intervention:

Funding for prevention and early intervention has the potential to help today and into the future.

Peer support services can be used to assist with community-based recovery and re-integration supports for both mental health and substance abuse and could be a valuable resource for tribal communities. Such supports were cited as a gap across all regions.

Question 5: Outcome measures and tracking youth entering the juvenile justice system and the connection to early childhood services.

The **Colorado Opportunity Project** supports low-income Coloradans with economic opportunities for upward mobility, and a pathway to the middle class that ends their reliance on safety net programs. State agencies are aligning their efforts to deliver evidenced-based programs to Coloradans to help move them up the economic ladder and towards self-sufficiency. The alignment of government programs eliminates fragmentation among state agencies, reducing duplication of services and making more efficient use of taxpayer dollars all while providing new economic opportunities to low-income Coloradans.

In 2013, 13% of all Coloradans lived in poverty¹. The impacts of poverty are significant. Those in poverty are more likely to have complex health conditions, and treating these conditions is expensive. Providing child care and food assistance is expensive. Housing Coloradans in the criminal justice system is expensive.

The Project uses high-quality, cost-effective, evidence-based programs already available in Colorado and improves them with better coordination and well-defined goals and measures, saving taxpayer resources and moving citizens out of poverty and towards independence.

The Colorado Opportunity Project is a collaboration of the Colorado Departments of Health Care Policy and Financing (HCPF), Public Health and Environment (CDPHE), and Human Services (DHS). Key agency initiatives, including 10 Winnable Battles, Two-Generation, and the Accountable Care Collaborative, as well as the Cross-Agency Collaborative on Quality Measurement, are tied together to deliver the Colorado Opportunity Project framework. Representatives from the Departments serve on the **Colorado Opportunity Project**. The Colorado Opportunity Project Framework is a model for creating a pathway to the middle class at every critical point in the life cycle. The model includes **indicators** that tell us whether people are getting closer to economic independence, or losing ground. "Interventions," or **programs**, are applied at each life stage in a cost effective manner to provide opportunities for people to reach these important milestones and climb the economic ladder.

Attached are the indicators and interventions the Colorado Opportunity Project is using to track Colorado's progress in addressing success at every life stage and provide opportunity to improve economic status. The framework paints a picture of the factors that lead to poverty, the impact of poverty on health and well-being, and the interventions that create opportunities for prosperity and a clear pathway to personal responsibility and transitioning up and out of safety net programs.

<https://www.colorado.gov/pacific/sites/default/files/Colorado%20Opportunity%20Project%20Fact%20Sheet.pdf>

<https://www.colorado.gov/pacific/hcpf/colorado-cross-agency-collaborative-reports>

Question 6: Provide recommendations on data needs and gaps in data collection.

MICJS's subcommittee efforts:

- A BJA grant proposal was submitted on March 10, 2015. We anticipate hearing the results of the application in September 2015. The proposal seeks funds to develop a statewide interagency strategic plan for a justice and health information exchange infrastructure. The structure will facilitate community and criminal justice health provider access to prior assessment and treatment data for continuity of care when offenders transition to different systems. This infrastructure can reduce gaps in service, facilitate evidenced-based treatment, and ultimately reduce recidivism of offenders with serious mental illness. Agencies that receive grant awards may be eligible for

implementation funds of up to one million dollars per year for three years after successfully completing the strategic planning phase.

- If the grant proposal is not funded, MICJS will submit a BJA technical assistance request to seek funds for the strategic planning phase.
- MICJS has collaborated with IJIS Institute to submit the BJA grant proposal. IJIS institute is a nonprofit corporation that provides government agencies technical assistance, training, and support services for information exchange and technology initiatives. They are currently developing a framework for criminal justice and health practitioner technology system exchanges. Once the project is complete, IJIS Institute will provide technical assistance to two pilot sites. This might provide another possibility for strategic planning resources.
- MICJS will continue to seek additional funding opportunities for this initiative.
- The subcommittee is also conducting regional focus groups to answer several key questions. As indicated in Question 2 regarding jails, the data and health information workgroup that has developed and vetted the attached questionnaire and will be conducting region focus groups in collaboration with Colorado Regional Health Information Organization (COHRIO). The purpose of these focus groups are to answer key questions regarding recidivism rates, jail based screening and treatment services as county systems have various processes and services in each region. (See Attached MICJS Draft Focus Group Questions.)

Question 7: Data on Screenings for individuals booked into jails/which jails have this process in place and which do not. Information on Mental health services in the jails.

The Office of Behavioral Health administers the Jail Based Behavioral Services (JBBS) and collaborates with local Sheriff Departments, and local community provider(s) who are currently licensed by the Office of Behavioral Health (OBH) to provide services within the jail, and have the capacity to provide free or low cost services in the community to inmates upon release. Most programs have at least a clinician position to offer screenings, assessment and treatment in the jail and a case manager position dedicated to transitional care and a seamless re-entry in treatment services in the community. Treatment providers screen all inmates for presence of substance use disorders, mental health disorders, trauma and traumatic brain injury and identify inmates with active duty or veteran military status.

Currently the following counties have JBBS programs: Adams, Alamosa, Arapahoe, Baca, Bent, Boulder, Cheyenne, Clear Creek, Conejos, Crowley, Delta, Denver, Douglas, Eagle, Elbert, El Paso, Hinsdale, Garfield, Grand, Gunnison, Jefferson, Kiowa, Kit Carson, La Plata, Larimer, Logan, Morgan, Montrose, Montezuma, Mesa, Otero, Ouray, Phillips, Pueblo, Routt, San Miguel, Washington, Weld and Yuma.

The MICJS subcommittee anticipates that further data will be collected regarding this issue as part of the focus groups regarding jail recidivism and jail services.

Question 8: Funding for competency evaluations and information on the necessity to file a D&N filed to fund competency evaluations for juveniles.

On Friday, August 28 the task force met to discuss potential juvenile competency legislation and the issues surrounding competency evaluations for juveniles. The task force members agreed that there are several issues surrounding access to evaluation services as well as restoration services. Funding for these competency and restoration services was also discussed and the task force has decided to study

restoration services in the upcoming year and determine if bill that addresses both competency and restoration services could be proposed.

Question 9: Oversight Committee is interested in the percent of individuals that qualify for disability (SSI/SSDI) and the percent of individuals that are veterans.

This request has been submitted to Health Care Policy and Financing's Data Analysis Section. We have received confirmation from our CBMS vendor that we do collect veteran's status. Our data analysis section will complete the analysis by eligibility category for submission to the task force.

Question 10: Recommendation to study PTSD and barriers to workers compensation for Police Departments related to safety of staff. Explore services for behavioral health treatment for law enforcement.

The Task force is meeting to outline our areas of study and project timelines on Friday, September 25th. The meeting will have a facilitator to assist us in identifying specific areas of study and a process for submitting potential legislation to the Oversight Committee.

updated 8/24/15 after input			
Preferred Formulary Psychotropic Medications: 2015			
Generic Name	Brand Name	Relative Cost per Unit*	Availability of Medication (MH); (P)
Anticholinergics and Antihistamines			
Benztropine tablets	Cogentin	\$	MH
Benztropine injection	Cogentin	\$\$	P
Diphenhydramine capsules	Benadryl	\$	MH
Diphenhydramine injection	Benadryl	\$	MH
Hydroxyzine tablets	Atarax	\$	P
Trihexyphenidyl 2, 5 mg tablets NTH	Artane	\$	
Fexofenadine	Allegra		
Desloratadine	Clarinet		
Loratadine	Claritin		
Levocetirizine	Xyzal		
Cetirizine	Zyrtec		
Antidepressants (SSRI)			
Citalopram tablets	Celexa	\$	MH
Escitalopram tablets	Lexapro	\$	P
Fluoxetine capsules	Prozac	\$	MH
Fluvoxamine	LUVOX		P
Sertraline tablets	Zoloft	\$	MH
Paroxetine	Paxil	\$	MH
Antidepressants (SNRI)			
Venlafaxine XR capsules	Effexor XR	\$	MH
Venlafaxine tablets	Effexor	\$	P
Duloxetine capsules	Cymbalta	\$\$	MH
Antidepressants (TCA) Tricyclic			

Generic Name	Brand Name	Relative Cost per Unit*	Availability of Medication (MH); (P)
Amitriptyline tablets	Elavil	\$	MH
Desipramine tablets	Norpramin	\$	P / C
Doxepin capsules	Sinequan	\$	MH
Imipramine tablets	Tofranil	\$	P / C
Nortriptyline capsules	Pamelor	\$	P / C
Antidepressants (Miscellaneous)			
Bupropion tablets	Wellbutrin	\$	P
Bupropion tablets	Wellbutrin XL	\$	P
Bupropion SR	Wellbutrin		P
Bupropion XL	Wellbutrin		MH
Mirtazapine tablets	Remeron	\$	MH
Trazodone tablets	Desyrel	\$	MH
Benzodiazepines (New start vs continue)			
Clonazepam tablets	Klonopin	\$	MH
Lorazepam injection	Ativan	\$	MH
First Generation Antipsychotics			
Chlorpromazine tablets	Thorazine	\$\$	P
Chlorpromazine injection	Thorazine	\$\$	MH
Fluphenazine tablets	Prolixin	\$	P
Fluphenazine Depot injection	Prolixin	\$\$	P
Haloperidol tablets	Haldol	\$	MH
Haloperidol Decanoate injection	Haldol	\$\$	MH
Haloperidol Lactate injection	Haldol	\$\$	MH
Loxapine capsules	Loxitane	\$	P
Perphenazine tablets	Trilafon	\$	P
Thioridazine 25 mg tablets	Mellaril	\$	
Thiothixene capsules	Navane	\$	P
Trifluoperazine tablets	Stelazine	\$	P

Generic Name	Brand Name	Relative Cost per Unit*	Availability of Medication (MH); (P)
Second Generation Antipsychotics - Atypical (oral)			
Clozapine tablets	Clozaril	\$	MH
Risperidone tablets	Risperdal	\$	MH
Risperidone M tab tablets	Risperdal M	\$	MH
Risperidone microspheres Depot Inj	Consta	\$\$\$\$	P
Ziprasidone capsules	Geodon	\$	MH
Ziprasidone injection	Geodon	\$	P
Olanzapine tablets	Zyprexa	\$	MH
Olanzapine ODT tablets	Zyprexa Zydys	\$	MH
Olanzapine SDV injection	Zyprexa	\$\$	P
Quetapine tablets	Seroquel	\$	MH
Aripiprazole tablets	Abilify	\$\$	P
Paliperidone tablets	Invega	\$\$	P
Iloperidone tablets	Fanapt	\$\$	P
Lurasidone tablets	Latuda	\$\$	P
Asenapine maleate tablets	Saphris	\$\$	P
Paliperidone palmitate injection	Invega Sustena	\$\$\$\$\$	P
Mood Stabilizers/Anticonvulsants			
Carbamazepine chew,tablets	Tegretol	\$	MH
Divalproex tablets	Depakote	\$	MH
Divalproex ER	Depakote	\$\$	MH
Gabapentin capsules	Neurontin	\$	MH
Lamotrigine tablets	Lamictal	\$	MH
Lithium Carbonate capsules /tablets	Eskalith/Lithobid	\$	MH
Oxcarbazepine tablets	Trileptal	\$	P
Topiramate tablets	Topamax	\$	P

Generic Name	Brand Name	Relative Cost per Unit*	Availability of Medication (MH); (P)
Antianxiety			
Buspirone tablet	Buspar	\$	P
Prazosin	Minipress		P
ADHD medications - Stimulants			
Atomoxetine	Strattera	\$\$	P
Methylphenidate (Ritalin)	Concerta		P
Mixed Amphetamine Salts	Adderall		P
Guanfacine generic- short acting	generic	\$	P
Clonidine generic- short acting	generic	\$	MH
Medications for Addiction Treatment			
Acamprosate (3 x day)			P
Buprenorphine (licensed)	Suboxone		P
Naltrexone ER injection	Vivatrol	\$\$	MH
Naltrexone Oral	ReVia		P
Methadone (licensed)	Dolophine		P
Naloxone			MH
MH = Must Have; P = Preferred; C = Have at least one available in the category			
\$ 0.01-1.00 per dose			
\$\$ 1.00-50.00 per dose			
\$\$\$ 50.00-100.00 per dose			
\$\$\$\$ 100.00-500.00 per dose			
\$\$\$\$\$ over 500.00 per dose			

**MICJS Jail Recidivism and Behavioral Health Services Focus Group
Questionnaire.**

Do you screen for mental illness and/or substance abuse among the population of people you serve?

- a. If so, do you use standardized assessment tools? Which one(s)?
 - b. At what threshold do you decide that someone needs a mental health intervention?
 - i. What kinds of interventions (if any) do you use if you find that an individual has a mental illness and/or substance abuse issue?
 - ii. What kinds of gaps do you experience when attempting to deliver these interventions?
2. Do you distinguish people with "Serious Mental Illness (SMI)" from others?
- a. How do you define SMI?
 - b. Do you keep data on SMI?
3. Do you keep general recidivism data?

- a. If so, how do you define and measure recidivism?

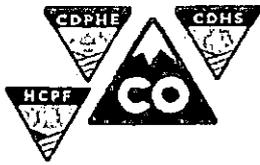
- b. If you answered "yes" to question #2, do you keep recidivism data specifically for individuals with SMI?

4. Do you currently exchange health information with other law enforcement and/or community mental/behavioral health entities? If so:

	Physical Health	Mental Health	Substance Abuse
Which entities do you currently share information with?			
What kinds of information do you share?			
What methods do you use to exchange this information?			

What kinds of gaps do you experience in your current setup?			

5. What is your attitude about the possible creation of a statewide mental health information exchange?
 - a. In what ways might this help you?
 - b. What are the biggest obstacles in the way of making that happen?
 - c. What specific things would need to happen in order for you to be willing and able to participate in such a health information exchange?
 - d. What other feedback do you have?



The Colorado Opportunity Project

Project Goal: To deliver evidence-based initiatives that provide the opportunity for all Coloradans to reach middle class¹ by middle age.

Below are the Colorado Opportunity Project "indicators"², or milestones, that help Coloradans stay on the path towards self-sufficiency and economic success.

LIFE STAGE



ADOLESCENCE
(ages 12 – 17)

Graduates from high school on time, develops healthy social emotional skills, not convicted of a crime, nor become a teen parent



TRANSITION TO ADULthood
(ages 18 – 29)

Currently sustainably employed having attended post-secondary education & has good physical/mental health



ADULTHOOD
(ages 30 – 40)

Employment status, has good physical /mental health & middle class household (300% FPL¹)

OPPORTUNITY INDICATORS

- ✓ high school graduation status
- ✓ violent arrest & property arrest rates
- ✓ teen parent status
- ✓ % of students (6th - 12th grade) who report ever feeling sad/hopeless or have considered suicide
- ✓ % of young adults (ages 18 - 25) who are currently depressed

- ✓ employed status of population (ages 16 - 19, by race and gender)
- ✓ % FPL/family income
- ✓ attending post-secondary training/education
- ✓ avg. # of days poor physical/mental health prevented usual activities, like self-care, work, or recreation

- ✓ avg. # of days poor physical/mental health prevented usual activities, like self-care, work, or recreation
- ✓ % of FPL/family income at age 29
- ✓ employment status of population (by education level, ages 25+)

¹ Middle class = having a family income of 300% Federal Poverty Level (FPL) or higher at age 40

² Selected indicators based on available statewide data and quality measures; older adult measures to be added



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LIFE STAGE



FAMILY FORMATION
(positive birth circumstances)

Planned pregnancy, born at healthy birth weight, to dual parent household without maternal depression



EARLY CHILDHOOD
(ages 0 – 5)

School readiness, healthy social emotional skills & family access to affordable, nutritious food



MIDDLE CHILDHOOD
(ages 6 – 11)

Math/Reading skills & healthy social emotional skills

OPPORTUNITY INDICATORS

✓ rate of low birth weight

✓ family income

✓ maternal depression

✓ single- or dual-parent household

✓ unintended pregnancy

✓ % of parents concerned about child's emotions, concentration, behavior, or ability to get along with others (ages 0 - 8)

✓ % of families relying on low cost food

✓ children whose family members read to them less than 3 days/week

✓ standardized test: math scores

✓ standardized test: reading scores

✓ % of parents concerned about child's emotions, concentration, behavior, or ability to get along with others (ages 9 - 14)

¹ Middle class = having a family income of 300% Federal Poverty Level (FPL) or higher at age 40

² Indicators in the Colorado Opportunity project framework have been vetted and finalized by the Department of Public Health and Environment, Human Services and Health Care Policy and Financing with the support of the Brookings institution and are based on available statewide data and quality measures

**First Regular Session
Seventieth General Assembly
STATE OF COLORADO**

INTRODUCED

LLS NO. 15-0058.01 Jane Ritter

HOUSE BILL 15-1025

HOUSE SPONSORSHIP

Rosenthal,

SENATE SPONSORSHIP

Newell,

House Committees
Judiciary

Senate Committees

A BILL FOR AN ACT

101 **CONCERNING COMPETENCY TO PROCEED FOR JUVENILES INVOLVED IN**
102 **THE JUVENILE JUSTICE SYSTEM.**

Bill Summary

(Note: This summary applies to this bill as introduced and does not reflect any amendments that may be subsequently adopted. If this bill passes third reading in the house of introduction, a bill summary that applies to the reengrossed version of this bill will be available at <http://www.leg.state.co.us/billsummaries>.)

Legislative Oversight Committee Concerning the Treatment of Persons with Mental Illness in the Criminal and Juvenile Justice Systems. The bill establishes a juvenile-specific definition of "incompetent to proceed" for juveniles involved in the juvenile justice system, as well as specific definitions for "developmental disability", "intellectual disability", "mental capacity", and "mental disability" when

Shading denotes HOUSE amendment. Double underlining denotes SENATE amendment.
*Capital letters indicate new material to be added to existing statute.
Dashes through the words indicate deletions from existing statute.*

used in this context. The bill clarifies the procedures for establishing incompetency, as well as for establishing the restoration of competency.

1 *Be it enacted by the General Assembly of the State of Colorado:*

2 **SECTION 1.** In Colorado Revised Statutes, 19-2-103, **add** (5.5),
3 (9.5), (9.6), (12.3), (12.4), and (14.3) as follows:

4 **19-2-103. Definitions.** For purposes of this article:

5 (5.5) "DEVELOPMENTAL DISABILITY" MEANS A DISABILITY THAT
6 IS MANIFESTED BEFORE THE PERSON REACHES HIS OR HER TWENTY-FIRST
7 BIRTHDAY, THAT CONSTITUTES A SUBSTANTIAL DISABILITY TO THE
8 AFFECTED INDIVIDUAL, AND THAT IS ATTRIBUTABLE TO AN INTELLECTUAL
9 DISABILITY OR OTHER NEUROLOGICAL CONDITIONS WHEN THOSE
10 CONDITIONS RESULT IN IMPAIRMENT OF GENERAL INTELLECTUAL
11 FUNCTIONING OR ADAPTIVE BEHAVIOR SIMILAR TO THAT OF A PERSON
12 WITH AN INTELLECTUAL DISABILITY. UNLESS OTHERWISE SPECIFICALLY
13 STATED, THE FEDERAL DEFINITION OF "DEVELOPMENTAL DISABILITY", 42
14 U.S.C. SEC. 15001 ET SEQ., SHALL NOT APPLY.

15 (9.5) "INCOMPETENT TO PROCEED" MEANS THAT A JUVENILE DOES
16 NOT HAVE SUFFICIENT PRESENT ABILITY TO CONSULT WITH HIS OR HER
17 ATTORNEY WITH A REASONABLE DEGREE OF RATIONAL UNDERSTANDING
18 IN ORDER TO ASSIST IN THE DEFENSE OR THAT HE OR SHE DOES NOT HAVE
19 A RATIONAL AS WELL AS A FACTUAL UNDERSTANDING OF THE
20 PROCEEDINGS AGAINST HIM OR HER.

21 (9.6) "INTELLECTUAL DISABILITY" MEANS A DISORDER WITH ONSET
22 DURING THE DEVELOPMENTAL PERIOD THAT INCLUDES BOTH
23 INTELLECTUAL AND ADAPTIVE FUNCTIONING DEFICITS IN CONCEPTUAL,
24 SOCIAL, AND PRACTICAL DOMAINS AND INCLUDES THE FOLLOWING
25 CRITERIA:

1 (a) DEFICITS IN INTELLECTUAL FUNCTIONS, SUCH AS REASONING,
2 PROBLEM SOLVING, PLANNING, ABSTRACT THINKING JUDGMENT,
3 ACADEMIC LEARNING, AND LEARNING FROM EXPERIENCE, CONFIRMED BY
4 BOTH CLINICAL ASSESSMENT AND INDIVIDUALIZED, STANDARDIZED
5 INTELLIGENCE TESTING;

6 (b) DEFICITS IN ADAPTIVE FUNCTIONING THAT RESULT IN A
7 FAILURE TO MEET DEVELOPMENTAL AND SOCIO-CULTURAL STANDARDS
8 FOR PERSONAL INDEPENDENCE AND SOCIAL RESPONSIBILITY. WITHOUT
9 ONGOING SUPPORT, THE ADAPTIVE DEFICITS LIMIT FUNCTIONING IN ONE OR
10 MORE ACTIVITIES OF DAILY LIFE, SUCH AS COMMUNICATION, SOCIAL
11 PARTICIPATION, AND INDEPENDENT LIVING, ACROSS MULTIPLE
12 ENVIRONMENTS, SUCH AS HOME, SCHOOL, WORK, AND COMMUNITY; AND

13 (c) THE ONSET OF INTELLECTUAL AND ADAPTIVE DEFICITS DURING
14 THE DEVELOPMENTAL PERIOD.

15 (12.3) "MENTAL CAPACITY" MEANS A JUVENILE'S CAPACITY TO
16 MEET ALL OF THE FOLLOWING CRITERIA:

17 (a) COMPREHEND AND APPRECIATE THE CHARGES OR ALLEGATIONS
18 AGAINST HIM OR HER;

19 (b) UNDERSTAND THE ADVERSARIAL NATURE OF THE
20 PROCEEDINGS, INCLUDING THE ROLE OF THE JUDGE, THE DEFENDANT'S
21 ATTORNEY, THE PROSECUTING ATTORNEY, THE DEFENDANT'S GUARDIAN
22 AD LITEM, IF APPLICABLE, OR WITNESSES, AND BE ABLE TO ASSIST IN HIS OR
23 HER DEFENSE;

24 (c) COMPREHEND AND APPRECIATE THE CONSEQUENCES THAT MAY
25 BE IMPOSED BY THE COURT OR RESULT FROM THE PROCEEDINGS;

26 (d) DISCLOSE TO COUNSEL FACTS PERTINENT TO THE PROCEEDINGS
27 AT ISSUE;

1 (e) DISPLAY APPROPRIATE COURTROOM BEHAVIOR; AND

2 (f) TESTIFY RELEVANTLY.

3 (12.4) "MENTAL DISABILITY" MEANS A SUBSTANTIAL DISORDER OF
4 THOUGHT, MOOD, PERCEPTION, OR COGNITIVE ABILITY THAT RESULTS IN
5 MARKED FUNCTIONAL DISABILITY AND SIGNIFICANTLY INTERFERES WITH
6 ADAPTIVE BEHAVIOR. "MENTAL DISABILITY" DOES NOT INCLUDE ACUTE
7 INTOXICATION FROM ALCOHOL OR OTHER SUBSTANCES, ANY CONDITION
8 MANIFESTED ONLY BY ANTISOCIAL BEHAVIOR, OR ANY SUBSTANCE ABUSE
9 IMPAIRMENT RESULTING FROM RECENT USE OR WITHDRAWAL. HOWEVER,
10 SUBSTANCE ABUSE THAT RESULTS IN A LONG-TERM, SUBSTANTIAL
11 DISORDER OF THOUGHT, MOOD, OR COGNITIVE ABILITY MAY CONSTITUTE
12 A MENTAL DISABILITY.

13 (14.3) "RESTORATION TO COMPETENCY HEARING" MEANS A
14 HEARING TO DETERMINE WHETHER A DEFENDANT WHO HAS PREVIOUSLY
15 BEEN DETERMINED TO BE INCOMPETENT TO PROCEED HAS ACHIEVED OR IS
16 RESTORED TO COMPETENCY.

17 **SECTION 2.** In Colorado Revised Statutes, **add** 19-2-1300.2 as
18 follows:

19 **19-2-1300.2. Legislative declaration.** (1) THE GENERAL
20 ASSEMBLY FINDS AND DECLARES THAT:

21 (a) THE JUVENILE JUSTICE SYSTEM IS CIVIL IN NATURE AND
22 FOCUSED ON TREATMENT RATHER THAN PUNISHMENT;

23 (b) IT IS CRUCIAL TO AVOID THE NEGATIVE CONSEQUENCES OF
24 PROSECUTION WHENEVER NECESSARY AND POSSIBLE, AND TO PROMOTE
25 MENTAL HEALTH TREATMENT PATHWAYS FOR JUVENILES IN THE JUVENILE
26 JUSTICE SYSTEM;

27 (c) JUVENILES DIFFER IN SIGNIFICANT AND SUBSTANTIVE WAYS

1 FROM ADULTS; THEREFORE, DIFFERENT STANDARDS FOR COMPETENCY ARE
2 NECESSARY FOR JUVENILES AND ADULTS;

3 (d) JUVENILES, LIKE ADULTS, ARE PRESUMED COMPETENT TO
4 PROCEED UNTIL SUCH TIME AS THEY ARE FOUND INCOMPETENT TO
5 PROCEED THROUGH A FORMAL COMPETENCY EVALUATION; AND

6 (e) AGE ALONE IS NOT DETERMINATIVE OF INCOMPETENCE
7 WITHOUT A FINDING THAT THE YOUTH ACTUALLY LACKS THE RELEVANT
8 CAPACITIES FOR COMPETENCE.

9 **SECTION 3.** In Colorado Revised Statutes, 19-2-1301, **amend**
10 (2) as follows:

11 **19-2-1301. Incompetency to proceed - effect - how and when**
12 **raised.** (2) A juvenile shall not be tried or sentenced if the juvenile is
13 incompetent to proceed, as defined in section ~~16-8.5-101(11)~~, C.R.S.
14 19-2-103 (9.5), at that stage of the proceedings against him or her. A
15 DETERMINATION OF COMPETENCY MUST INCLUDE AN EVALUATION OF
16 DEVELOPMENTAL DISABILITIES, MENTAL DISABILITIES, AND MENTAL
17 CAPACITY.

18 **SECTION 4.** In Colorado Revised Statutes, 19-2-1302, **amend**
19 (3), (4) (a), and (4) (c) as follows:

20 **19-2-1302. Determination of incompetency to proceed.** (3) If
21 the question of a juvenile's incompetency to proceed is raised after a jury
22 is impaneled to try the issues raised by a plea of not guilty or after the
23 court as the finder of fact begins to hear evidence and the court
24 determines that the juvenile is incompetent to proceed or orders the
25 juvenile referred for a competency examination, the court may declare a
26 mistrial. If the court declares a mistrial under these circumstances, the
27 juvenile ~~shall~~ MUST not be deemed to have been placed in jeopardy with

1 regard to the charges at issue. The juvenile may be tried on, and sentenced
2 if adjudicated for, the same charges after he or she has ACHIEVED OR been
3 found to be restored to competency.

4 (4) (a) If the court orders a competency evaluation, the court shall
5 order that the competency evaluation be conducted in the least-restrictive
6 environment, INCLUDING HOME OR COMMUNITY PLACEMENT IF
7 APPROPRIATE, taking into account the public safety and the best interests
8 of the juvenile.

9 (c) The competency evaluation shall MUST, at a minimum, include
10 an opinion regarding whether the juvenile is competent INCOMPETENT to
11 proceed as defined in section ~~16-8.5-101(4)~~, C.R.S. 19-2-103 (9.5). If the
12 evaluation concludes the juvenile is incompetent to proceed, the
13 evaluation shall MUST include a recommendation as to whether THERE IS
14 A LIKELIHOOD THAT the juvenile may ACHIEVE OR be restored to
15 competency and identify appropriate services to restore the juvenile to
16 competency.

17 **SECTION 5.** In Colorado Revised Statutes, 19-2-1304, **amend**
18 (1) and (3) as follows:

19 **19-2-1304. Restoration to competency hearing.** (1) The court
20 may order a restoration TO COMPETENCY hearing, as defined in section
21 ~~16-8.5-101(13)~~, C.R.S. 19-2-103 (14.3), at any time on its own motion,
22 on motion of the prosecuting attorney, or on motion of the juvenile. The
23 court shall order a RESTORATION OF COMPETENCY hearing if a mental
24 health professional who has been treating the juvenile files a report
25 certifying that the juvenile is ~~mentally~~ competent to proceed.

26 (3) At the RESTORATION TO COMPETENCY hearing, the court shall
27 determine whether the juvenile HAS ACHIEVED OR is restored to

1 competency.

2 **SECTION 6.** In Colorado Revised Statutes, 19-2-1305, **amend**
3 (1) and (2) as follows:

4 **19-2-1305. Procedure after restoration to competency hearing.**

5 (1) If a juvenile is found to ~~be~~ HAVE ACHIEVED OR BEEN restored to
6 competency after a RESTORATION TO COMPETENCY hearing, as provided
7 in section 19-2-1304, or by the court during a review, as provided in
8 section 19-2-1303 (2), the court shall resume or recommence the trial or
9 sentencing proceeding or order the sentence carried out. The court may
10 credit any time the juvenile spent in confinement or detention while
11 incompetent TO PROCEED against any term of commitment imposed after
12 ACHIEVEMENT OF OR restoration to competency.

13 (2) If the court determines that the juvenile remains ~~mentally~~
14 incompetent to proceed and the delinquency petition is not dismissed, the
15 court may continue or modify any orders entered at the time of the
16 original determination of incompetency or enter any new order necessary
17 to facilitate the juvenile's ACHIEVEMENT OF OR restoration to ~~mental~~
18 competency.

19 **SECTION 7. Safety clause.** The general assembly hereby finds,
20 determines, and declares that this act is necessary for the immediate
21 preservation of the public peace, health, and safety.