GOVERNOR'S BEHAVIORAL HEALTH SERVICES PLANNING COUNCIL

JUSTICE INVOLVED YOUTH AND ADULTS – SUBCOMMITTEE REPORT

2015

Report presented to:
Governor's Behavioral Health Services Planning Council

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INTRODUCTION

The interface between the mental health and criminal justice systems is substantial. The increased involvement of people with mental illness in the criminal justice system has been a serious problem for state and local governments for some time.

The Governor's Behavioral Health Services Planning Council (GBHSPC), formerly the Governor's Mental Health Services Planning Council (GMHSPC), issued a Charter with the recommendation to merge the GBHSPC Forensic Subcommittee and Kansas Reentry Policy Council (KRPC) Mental Health Task Force. The merger was in response to numerous concerns over the years regarding the overlap of these two groups in the form of target population, tasks and membership that address issues and problems facing Kansans with mental illness in or at risk of entering the criminal justice system.

In January 2013, leadership of both groups convened to develop a Charter to consolidate the work of the two groups to streamline information sharing and recommendations to inform public policy. This work generated the newly formed Justice Involved Youth and Adult (JIYA) Subcommittee of the GBHSPC.

The JIYA Subcommittee will convene constituents at a policy level to carry out the vision and mission with the intent to promote actions for state level change through policy recommendations and planning.

JUSTICE INVOLVED YOUTH AND ADULTS SUBCOMMITTEE CHARTER

1. Develop a strategic plan to identify goals and objectives for state level change through policy and planning.
2. Formulate and prioritize strategies to achieve objectives of the strategic plan.
3. Implement strategies through workgroups, including timeline for completion.
4. Develop project management process for monitoring of the strategic plan.
5. Issue annual policy recommendations and planning to the Secretary from the Departments on Aging and Disability Services (KDADS), Children and Families (DCF), and Corrections (KDOC).

VISION AND MISSION

The vision and mission of the JIYA is as follows:

Vision

Justice involved Youth and Adults with behavioral health needs will achieve recovery.

Mission

To promote a recovery oriented system of care for individuals with behavioral health needs in or at risk for involvement in the justice system through policy recommendations and planning focused on prevention, diversion, treatment and reentry.

MEMBERSHIP

Randall Allen, *Kansas Association of Counties*

Lori Ammons, *UKP, KDOC Mental Health Program Administrator*

Charles Bartlett, *KDADS*

Randy Bowman, *Director of Community Based Services, KDOC – Juvenile Services*

Mike Brouwer, *Douglas County Sheriff's Office*

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Lesia Dipman, *Program Director, Larned State Security Program*

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Mark Gleeson, *Office of Judicial Administration*

Kathleen Graves, *KDOC, Deputy Secretary of Parole and Community Corrections*

Courtney Henderson, *Criminal Defense Attorney*

Jason Hess, *Executive Director, Heartland RADAC*

Sandy Horton, *Kansas Sheriff's Association*

Ed Klumpp, *Local law enforcement*

Patricia Long, *Department for Children and Families*

Marie McNeal, *KDOC Director Community Corrections*

Benet Magnuson, *Kansas Appleseed*

Chris Mechler, *OJA*

Viola Riggin, *UKP, KDOC Director of Health Care*

Susan Rome, *Johnson County Mental Health*

Nancy Ross, *Consumer/Family Member*

Sheli Sweeney, *Association of CMHC's*

Dennis Tenpenny, *Community Support Services Director, Valeo Behavioral Healthcare*

Susan Wallace, *Family Member*

SUBCOMMITTEE AND WORKGROUP SUMMARIES

When the Justice Involved Youth and Adults Subcommittee (JIYA) was established in 2013, the subcommittee worked to identify and prioritize key issues by surveying the subcommittee members on issues of utmost importance to the justice-involved population. Through this work, the subcommittee was able to define four priority issues and established four associated workgroups and tasks for each workgroup. The following workgroups emerged as a result: Collaboration, Access to Care, Diversion and Prevention, and Medicaid. Over the past year, the workgroups of the JIYA took the opportunity to clearly refine the broad goals which were established when the workgroups were first formed. As a result of this progression, overlapping discussions emerged from the Collaboration and Access to Care Subcommittees. As a result, these two committees have since merged. Throughout this year, the workgroups have defined their previous goals, established new goals, and identified barriers that may prevent recommendations from being implemented. The full JIYA subcommittee has also incorporated recommendations which emerged during quarterly meetings.

DIVERSION AND PREVENTION

Workgroup Charter:

Expand pre and post arrest diversion programs, such as crisis intervention team programs and specialty courts, such as mental health courts, drug courts, and juvenile courts.

Workgroup Goals:

Recommend programming, training, and collaboration for diverting mentally ill offenders of minor crimes to treatment from time of arrest to prior to conviction where appropriate. Consider the special needs of the justice-involved individual, possibly including poor motivation for treatment, addressing high risk/need areas for recidivism, and cognitive behavioral interventions or other support needs to address high risk areas. Provide recommendations to address one or more of these issues (ie: plant correctional support specialists in CMHC's).

Previous Recommendations:

- Annual state funding/sponsorship of 3 full CIT Classes. This recommendation is partially implemented. The number of CIT classes was expanded with diversion dollars as recommended from the Governor's Mental Health Task force. Funds are expected to be approved.
- Support the current plan for 6 one-day CIT Classes in various regions. The group recommends an outcome evaluation 6 months post class to determine the effectiveness of this class which could lead to subsequent recommendations for additional classes.
- ***Hire a Behavioral Health Coordinator for the state of Kansas.*** *(Presented to the GBHSPC and approved as a CIT Coordinator, however the subcommittee would like to expand the function of the position. See recommendations below under Full Subcommittee**).***

Recommendations currently being considered:

- Diversion option for individuals with a mental health issue (when statutorily possible and other criteria met). There is consensus about the need, but more in depth look needs to take place. The Diversion survey yielded some helpful results that need more analyzing and follow up. *Review of RFPs and those program initial outcomes need to be reviewed before a full recommendation is made in this area*.
    - Data from Johnson County's diversion program will be reviewed for outcome information.

Barriers to Implementing Recommendations:

- Funding for the Behavioral Health Coordinator (formerly CIT Coordinator) position.
- Funding for mental health programs/services/court costs is an identified barrier for diversion programs. While grants funds are helpful in the start-up of new programs, a funding source for uninsured clients to receive the ongoing services needed in mental health is a barrier. Medicaid expansion could be one means of reducing this barrier.

Future goals:

- Consideration of Co-responder expansion.
- Specialty Courts – review outcomes and consider recommendations.

COLLABORATION AND ACCESS TO CARE

Workgroup Charter:

Increased community collaboration to improve systems coordination between behavioral health providers (community mental health centers, substance use disorder treatment providers, and state hospitals) and criminal justice (law enforcement, courts, county jails, state correctional facilities) possibly using the Promoting the Engagement for Risk Reduction in Kansas (PERKS) model.
Address access to Community-Based Resources at Reentry / Discharge from incarceration (including adults, juveniles and probation/parole) with a focus on a recovery oriented system of care and reducing recidivism.

Workgroup Goals:

Determine specific community entities that would benefit from increased collaboration and care coordination. Write a statement of the problem that is supported by measurable facts. Develop a plan of focus, with one or two goals/outcomes of the collaboration. Consider necessary training required to support the focus. Address policy issues needed to facilitate the change. Establish an implementation plan to accomplish the collaboration and outcomes.

Previous and Current Recommendations:

1. Recommend specific communities conduct a community readiness assessment (chosen from a list of recommended models: Sequential Intercept model, Strategic Prevention Framework (SPF), Council for State Government community assessment, etc.) This would drive training and technical assistance targets/needs for communities.

a. Identify and recruit experts and communities that would function as technical advisors. Shawnee, Johnson, and Sedgwick counties are examples of communities that have done this. Also, Valeo, Topeka Police Department, and Shawnee County Sheriff collaboration, and Valeo and St. Francis collaboration are good examples. These communities could provide TA to other communities.

b. Create Webinar Series that multiple communities could access - ideas:
    i. Crisis Intervention Team (CIT)/Mental Health (MH) Co-responders/MH Crisis
    ii. Courts/MH Diversion
    iii. Cross Agency Liaisons
    iv. Juvenile Community Intervention Programs/Juvenile Detention Alternatives Initiative (JDAI)
    v. PERKS Model (Promoting Engagement for Risk Reduction in Kansas)
    vi. Cross Training - Criminal thinking for social workers and MH First Aid and substance use disorders to Correctional types
    vii. Substance Use Disorder (SUD) and MH Peer support
    viii. Offender Workforce Development Services (OWDS) training

c. This assessment could lead to development of a Regional Model of supports.

2. Expand Crisis Stabilization Services available statewide:

    a. Sustain models like Rainbow Services, Inc. (RSI) and like models (Valeo Crisis Center and Community Crisis Center in Wichita) in every major metro area and able to serve more surrounding counties.
    b. Research why juveniles are not included in these services - they need to be addressed
    c. Take age and gender specific issues into account.
    d. Rural communities use of crisis stabilization teams that include SUD and MH peer mentors.
    e. Use certified SUD and MH peer mentors to engage folks in jails or juvenile detention centers - or other settings as possible.
    f. Use of Recovery Centers - places for people to engage and sustain their recovery
    g. All MHC should have crisis mobile response teams.
    h. MHC should be engaged with jails and juvenile detention centers for screening and discharge planning.

3. Enhance Electronic Information Sharing

    a. Recommend there be investigation of how information can be exchanged between all types of crisis/emergency responders.
    b. Can KHIN (Kansas Health Information Network) help here?
    c. What statutes need to be explored?
    d. Clarify how Behavioral Health information can be shared.
    e. Would ONE unique identifier among all systems help facilitate?

4. Funding Methods/Priorities:

    a. Move from fee for service (paying for sickness) to cost avoidance/ (paying for wellness); from acute to chronic condition management, paying for outcomes rather than services. The benefits of this type of payment model incentivizes prevention and wellness rather than illness by paying providers of service for health outcomes achieved by clients/offenders rather than just paying for a service.
    b. Make mobile and otherwise crisis response teams a funding priority.
    c. Educate counties and hospitals (who partially fund CMHC's) on the benefits of reinvesting resources toward crisis services to reduce greater costs in the service continuum.
    d. Use existing resources of communities that have been successful - i.e. county administrators to talk to county administrators, hospital staff talking to their counterparts.
    e. Fund Community Mental Health Centers (CMHC) responsibility to provide state hospital discharge type services to other populations like those discharges from jails, juvenile detention centers, prison, Psychiatric Residential Treatment Facilities and other incarcerated and institutional settings (since many of these folks used to release from state hospitals).

SUSPENSION OF MEDICAID

Workgroup Charter:
Initiate the suspension rather than termination of Medicaid/ disability benefits for eligible incarcerated individuals.

Workgroup Goals:
Track the implementation of the Kansas Eligibility and Enforcement System (KEES), as we understand there is a direct link between KDHE's ability to electronically "turn off" and "turn on" benefits for individuals becoming incarcerated as well as releasing from incarceration. When implemented, KEES will be a streamlined enrollment system, with faster approvals for requested programs. Benefits could be processed within a day of an applicant going online and providing correct and verifiable information. Explore replication of the plan with the county jails and city lock-ups. Develop a plan for implementation. Explore replication of the plan with Larned State Hospital for the sexual predator and psychiatric units when medical hospitalization occurs.

Additionally, a workgroup group is involved in establishing a RFP through the Department of Labor to gain access to VINE (Victim Information and Notification Everyday), the National Victim Notification Network. This service tracks the custody status of offenders 24 hours a day. If designated agencies have access to this network, notification can be provided to KDHE regarding when to "turn off" eligibility for incarcerated individuals who no longer are eligible for benefits and "turn on" eligibility upon their release into the community.

Previous recommendations:

1. Monitor when the KEES system becomes live. Work with KDHE for notification to "turn on" eligibility upon an incarcerated individual's discharge into the community.
2. Monitor when the VINE system becomes available for access in Kansas.
3. Medicaid eligibility during incarceration following sentencing for offenders hospitalized over 24 hours for jails.

Current recommendations:

1. Begin working with KDHE, KDOC, and jail representatives to establish the process of "turning on" eligibility for incarcerated individuals who have previously qualified for Medicaid benefits prior to their release.
2. Consider the use of VINE for automated notification to KDHE.

FULL SUBCOMMITTEE

Current Recommendations:

1. Include Hospital Association and Sheriff's Association representatives as members of the GBHSPC. The local hospitals are key players missing at the table in most communities yet they have a vested fiscal interest in these issues.

2. Funding Alternative: Both primary workgroups of this Subcommittee discussed funding programs as the major barrier to accomplishing recommendations. The Subcommittee as a whole made the following recommendation:

    a. **Use braided funding or a cross- system method** for funding programs. There is a need to move from the piece meal funding approach to more of a global funding model where efficiencies and collaborative partnerships participate in a shared funding approach.

3. Hire a **Behavioral Health Coordinator** for the state of Kansas to conduct community assessments and identify the needs of individual communities (*See recommendation #1 from the Collaboration and Access to Care workgroup).* Once the community's needs are identified, the coordinator would then identify and recruit experts within the state of Kansas to function as technical advisors for the community. As a part of the assessment process, the coordination of CIT initiatives in each community would be considered. The position would also allow for more extensive data collection and tracking for CIT's and other community collaborative efforts. A braided funding approach for the position would solidify the collaborative effort and could include: KDADS, KDOC, DCF, county jails, law enforcement agencies, and courts. Through this type of funding effort, a sustainable collaboration plan for the community would be established for the justice-involved population.

SUMMARY

The JIYA, through its diverse members of the subcommittee and workgroups, provides a unique avenue for members to come together to collaborate, analyze, and create recommendations for the GBHSPC. The primary outcome of the JIYA for this fiscal year was to develop the broad workgroup goals into a series of recommendations to be considered by the council. The recommendation from the Diversion and Prevention workgroup to hire a CIT Coordinator was expanded by the Subcommittee to a Behavioral Health Coordinator for the state of Kansas. The position would be funded through several state entities across the justice system and facilitate a collaborative approach across agencies. There was also the recommendation to include Hospital Association and Sheriff's Association representatives as members of the GBHSPC. The JIYA subcommittee will work to further develop and implement targeted areas of focus from the GBHSPC for FY 2016.