No Returns Rates of Offenders Released from KDOC Facilities During CYs 2008-2011
Mental Health Levels 4 to 6 Recidivism: Measurement is Based on 12 Month Calendar Year

	CY 2008		CY 2009		CY 2010		CY 2011	
	Ave Raw	Ave Ratio	Ave Raw	Ave Ratio	Ave Raw	Ave Ratio	Ave Raw	Ave Ratio
No Returns								
Mental Hlth Lvl 4	192	44.24%	190	46.00%	190	45.45%	251	55.04%
Mental Hlth Lvl 5	25	5.76%	17	4.12%	31	7.42%	32	7.02%
Mental Hlth Lvl 6	37	8.53%	40	9.69%	41	9.81%	44	9.65%
Total No Returns	**254**	**58.53%**	**247**	**59.81%**	**262**	**62.68%**	**327**	**71.71%**
Returns/Recidivism	180	41.47%	166	40.19%	156	37.32%	129	28.29%
Total (All Releases)	434	100.00%	413	100.00%	418	100.00%	456	100.00%

Note. No Returns is based on Total Releases minus (the sum of Re-Admissions in CY08 to (CY13 Jan to June))

Ave Raw Data shown are data of total offenders who did not return to a KDOC prison facility after the released calendar year

Data Source: Data is from OMS system and is based on Released Years: 2008, 2009, 2010, &2011

How KDOC addresses the release planning needs of offenders with mental illness

At least 20-25% of returning offenders need mental health care. Probably 10% are Severely and Persistently Mentally Ill (SPMI).

Gap: Inside the rate of mental illness is higher; sometimes the structure of prison camouflages the need for services at release, and sometimes the mental health issues are first discovered as they near release, and/or after release.

During incarceration, offenders receive mental health counseling, medication management, and other traditional mental health services. They also receive skills-building classes through the mental health contractor.

New: Through a Second Chance Act grant we have established Mental Health Case Managers at three prisons (Lansing, El Dorado and Larned), who manage specialized caseloads of SPMI offenders, and provide them with cognitive skills-building *Thinking 4 a Change* classes. *Recent research indicates that two-thirds of SPMI offenders are high risk on the cognitive domain/anti-social thinking.*

New: Through new program dollars at two prisons (Topeka [women] and Larned [men]) we have established Peer Support Coordinators. They are working with mentors to establish recovery plans for offenders, helping them to prepare for release, improve their ability to self-regulate, and partake in their own recovery.

Gap: KDOC needs to have staff and volunteers trained in recovery-oriented Certified Peer Specialist training (through KDADS). In March and April KDOC applied for two SAMHSA grants to fund this training, and establish care coordination and recovery services for probationers (SG and WY counties) and parolees (SN and JO counties).

As MIOs near release KDOC provides discharge planning services. This includes processing benefits applications, with the support of a central office position liaising with the state and federal agencies that process/decide applications. This also includes contacting community mental health centers to set appointments; making sure the offender has medication at release; addressing housing when needed.

Gap: We do not have discharge planning services at Ellsworth or Norton, except in a very small measure. In upcoming negotiations for future contract services, we are trying to address this, if we can afford it.

In the community after release KDOC helps meet their needs by,

- ***Liaisons in the community mental health centers*** in four counties (WY, SN, SG, Saline).
- ***Specialized parole officers*** (Wichita, Topeka, Kansas City) (offenders who got discharge planning and a specialized parole officer recidivated at 12% compared to 39% [down from 74%] per a Council of State Governments study of 03/04 releases vs. 06/07 releases of offenders with mental illness).

- ***Supportive housing programs*** in WY and SN counties (with care coordination, linkages to treatment and housing support, leading to permanent housing; this program to date has served 24 very high-risk/needs offenders, with a 25% recidivism rate).

Gaps:

- *Some community mental health centers are not as responsive* to partnering to work with offenders under supervision. We'll continue to partner with KDADS on building this strategy as part of the regional recovery centers.
- *Many MIOs are dually-diagnosed*; building more care coordination and recovery services between mental health and substance abuse providers will benefit this population. KDOC grant applications will continue to seek these services; and KDOC will continue to partner with KDADS to support the regional recovery centers that will contribute to this effort. *Both substance misuse and mental illness benefit from cognitive interventions. Working with CMHCs to deliver cognitive-based skills-building services will improve outcomes.*
- *Specialized POs only exist in three counties*; we need them in Johnson, Reno, Saline, Douglas, Lyon, and SE Kansas. These POs maintain smaller caseloads and work closely with mental health service systems to address mental health needs as a significant part of supervision.
- *Housing options are too limited for this population*; stable housing is a significant factor in stability and staying connected to treatment
    - KDOC has small contracts with landlords for two units in WY, SN and SG counties, where we lease two units and they serve as transitional units for homeless offenders, which often are these offenders with special needs. Generally these contracts cost us about $15,000 per year, and when we house MIOs in these units we provide close case management. More of these contracts would be very beneficial for this population.
    - A facility at the old state hospital grounds in Topeka may provide an opportunity to establish a residential center, where we could house 25 offenders, either those leaving prison, or in lieu of returning/entering prison from parole/probation, where we could establish a recovery oriented system of care. Having one staff post with 24 hour cover (5 staff), a care coordinator, and partnerships with local providers who have a presence at the facility (as well as a parole officer), would provide a team that could work with this population toward recovery, stability and success.
- *Employment is an issue for this population.* Not all are eligible for benefits (in spite of strengthened partnerships and strategies to access benefits). We hope to develop a model based on research and some models around the nation to provide specialized employment services for this population. It requires more tailored employment opportunities, with more flexibility on the part of employers, and more supported employment. It is a significant factor in recovery, and is worth the investment. We will need to find a way to fund a few specialized job specialists for this work.

Mental Health Center	Accept Uninsured?	Intake	Medication	Case Management	Therapy	Ability to pay difference?
Bert Nash MHC	yes	walk-in	2 months	after intake	immediately	yes
COMCARE - Wichita	yes	2-10 days	1 wk-SPMI/2 mo-others	approx. 2 months	2-3 wks after intake	yes
Dodge City Area Mental Health	yes	1-10 days	1-2 months	week after intake	week after intake	yes
Elizabeth Layton Cntr for Hope & Guidance (Franklin Co)	yes	1-2 weeks	4-6 weeks	8 weeks	rarely	yes
Four County Mental Health	yes	1 month	1-2 months	1 month	1 month	no
Garden City Area Mental Health	yes	1 month	4-6 weeks	4-6 weeks	4-6 weeks	no
High Plains Mental Health	yes	2 weeks	2-3 months	1 week SPMI/30 days-others	30 days	no
Horizons	yes	few days	about 1 month	2 weeks	2 weeks	no
Johnson County Mental Health Center	yes - only SPMI	3 weeks	4-5 weeks	4-5 weeks	4-6 weeks	no
Kanza Mental Health Center	yes	1 week	2 weeks	1 month	2 weeks	yes
Mental Health Center of East Central Kansas	yes	2 weeks	1-2 months	1-2 weeks after intake	2-4 weeks	no
Prairieview	yes	3 weeks	1-2 months	1-2 months	1-2 months	no
Saline County MHC	yes	up to 2 wks	1 week	2 weeks	2 weeks	no
South Central Kansas Mental Health	yes	1 week	1 week	2 weeks	2 weeks	no
SEK Mental Health Center	no	2 weeks	2 weeks	2 weeks	1-2 weeks	no
Southwest Guidance Center (Liberal)	yes	2-3 weeks	2-3 weeks	2-3 weeks	2-3 weeks	no
Valeo Behavioral Health	yes	1 day	1 day access by calling	1-3 days	1-2 weeks	yes
Wyandotte Mental Health	yes	1 week	30 days			yes

If there is a difference in the timeframes based on the parolees ability to pay what are those differences:

Those answering "yes" indicated the following explanation regarding the differences:

- based on the eligibility for services i.e. diagnosis, medical coverage
- The offender must have the $80 for the required intake psych evaluation. In some cases, the offender who may be in crisis will be able to utilize the crisis center and can be referred at that time to Psychiatric services. If the offender is in crisis the $80 fee can be waived at that time
- Those who have insurance or Medicaid are seen much quicker. No one is seen if they cannot pay the copay up front. They will not do an intake without the first $30 being paid.
- If they have a past bill or are not able to pay the co-pay they may not be able to obtain services
- If offender cannot pay, KANZA refuses service after balance gets to be around $150-$200.
- If they cannot pay their part, they cannot get another appt in some cases. This is not because they are parolee's, it's everyone.
- The time could be extended by a couple of weeks but typically for basic services there is no difference. The difference that I see the most is the medication that is given. If there is no medical coverage, Comcare will voucher or sample out the medications which limits the different medications available. I also see a difference in the housing as if there is no medical coverage, there is no housing (group homes) and case management is very limited

What successes have you had with working with your area mental health center?

- Many offenders have done well after receiving their services when they had not done well before.
- They have also been able to help clients with substance abuse issues.
- In the past, not the best. However, we have a liason through a grant and things are a little more seamless.
- Had one offender who was thinking homicidal thoughts and they got him right in and he is currently on medication and going to anger management classes.
- They have done well with individuals who have a dual diagnosis.
- YES – THERAPIST ALWAYS CALL BACK IF YOU CALL THEM.
- Knowing the right people to assist with problem cases when possible, working closely with case managers to help the clients/offenders to meet with them and help enforce the importance of participating in mental health treatment. We also have the KSHOP program that helps to steam line and provide and pay for addition supports for some offenders that need more assistance.
- We have monthly luncheons provided by South Central Mental Health to discuss clients and their progress. We are also able to inform the treatment provider of any issues we may be having with the offenders.
- We have had a lot of success working with SPMI offender's and HPMHC. We start the process prior to the offender's release from DOC and they are generally able to get in for intake within a day or two of their release from DOC and begin therapy the following week. They are also set up with a Case Manager within the first week they are out. They are seen as much as the therapist feels is appropriate regardless of insurance.
- I have really good success with Parolees receiving their medications. Some offenders have had to wait a month to be seen when they needed help immediately.
- Offenders who receive Area Mental Health services seem to do better than they did before the treatment.
- Mutual housing support, coordination with some case managers, their expertise with the SOAR process and keeping us updated whether or not a mutual client will get benefits.
- Many of the offenders have completed their services successfully and we have seen that they do better than they had before.
- Good response when an emergency situation arises, such as suicidal issues
- I have had several clients benefit from case management.
- Case management is pretty good, mental health not so good
- I have really good success with Parolees receiving their medications. Some offenders have had to wait a month to be seen when they needed help immediately
- Easy to communicate with
- Area Mental Health has always been easy to access or speak with. They always know that when I call and say that someone needs to see a therapist, they are very quick about getting an appt. They have even asked if I can bring them up there now, which has happened.
- We have worked very well together and have built a relationship that continues to help the clients. The clinicians trust the information that I provide to them. I work with all entities of Comcare (CSS,

OPS, Crisis, SCOAP, ATS, Admin) and feel that the relationships built have significantly helped the clients be more successful in the community

- Having a referral source and in between person with Thomas Runge, Forensic Evaluation Services in Hays, KS that works for us, NWKCC/Parole
- For the most part communication is good. They call when they have concerns or vs. verse and they sent reports/letters to the PO
- Labette Mental Health is good about getting offenders in and trying to help them with any problems. The biggest issue is getting Offenders to take residence verification and pay stubs in to their appointment, which prolongs them from being seen.
- Emergency Medication Assistance

What challenges have you had with working with your area mental health center?

- They are often short-staffed.
- Sometimes hard to make contact with to get feedback.
- They will not make appointments with offender's while they are in the facility. They want the offender to actually come in and make the appointment.
- None so far.
- They now only work with individuals who have been assessed as SPMI. Other individuals who don't have insurance must go to the Johnson County Health Partnership, which has received a Federal grant and offers services on a sliding fee scale.
- FACILITY NOT HAVING SERVICES SET UP PRIOR TO RELEASE FOR MENTAL HEALTH CENTER THERAPY. IF THEY CAN SET UP FOR A MEDICATION APPOINTMENT AT THE MENTAL HEALTH CENTER, WHY WOULDN'T THEY SET IT UP FOR THERAPY? THEN THEY WOULD BE HOOKED UP TO SERVICES IMMEDIATELY WHEN RELEASED AND HAVE AN INTAKE SCHEDULED.
- They only do limited work with sex offenders
- None
- Our biggest challenge has been getting clients in quickly for medication evaluations/appointments. It is not unusual for someone to have to wait 2 months for an initial medication evaluation. Our clients have started going to the First Care Clinic for medications because they are usually able to get in to see a doctor and set up on medication much quicker.
- My biggest concern with them is Substance abuse counseling it is not the best I prefer to send them to Preferred Mental health instead. I have had better luck with them and they are held more accountable for their actions. Preferred Family is good with talking with Parole and getting releases signed.
- They tend to be short staffed.
- They are short staffed which means the offender sometimes have to wait longer to receive services.
- Limited funding to obtain services, lack of communication in regards to status of offenders, lack of collaboration to provide services to mutual clients. Lack of immediate services including medication and psychiatric services for offender.
- The time frame to get initial appointments set if it isn't an emergency
- They are located in the country, with no bus transportation. The long wait time for appointments, they do not have an emergency system set up, unless the person is suicidal. The substance abuse program in Anderson county is below par
- They don't have any money. They have gone to doing a lot of group counseling because of budget cuts. They have good people but they are spread thin. If as I have heard recently that one third of our people have mental health concerns and if this effects recidivism, then perhaps we should be budgeting money directly for their care on the street. Maybe the local mental health centers could directly bill us for their co-pay etc. That would seem cheaper than paying for jail days or putting them in prison
- My biggest concern with them is Substance abuse counseling it is not the best I prefer to send them to Preferred Mental health instead. I have had better luck with them and they are held more

accountable for their actions. Preferred Family is good with talking with Parole and getting releases signed

- Turn over with staff. Fees are a challenge to pay by some offenders. Location of facility is in Hiawatha 30-60 minutes from all areas it services
- Medication issues have been the biggest challenge. Sometimes the facility is called to get a script sent to a local pharmacy because the med check appt is well after the 30-day supply is gone. Many of the scripts are very expensive and the offenders can only get them if they are samples
- That they are overwhelmed and sometimes clients fall through their cracks
- They are stretched thin and they don't follow up with calls or any reports so can check on client's progress or digression
- Client's ability to pay for services, co pays and even with sliding scale services is too costly. Some will get a prescription for medication and then cannot afford medication. They don't always have samples to hand out.
- I have not had any issues or challenges with Mental Health except getting them to get me the release of information.
- They sometimes do not understand why or what mental health evaluation the offender needs when it is listed as a special condition and there is no other information.
- Communication

Kansas Department of Corrections

December 2012

KDOC Mental Health Care

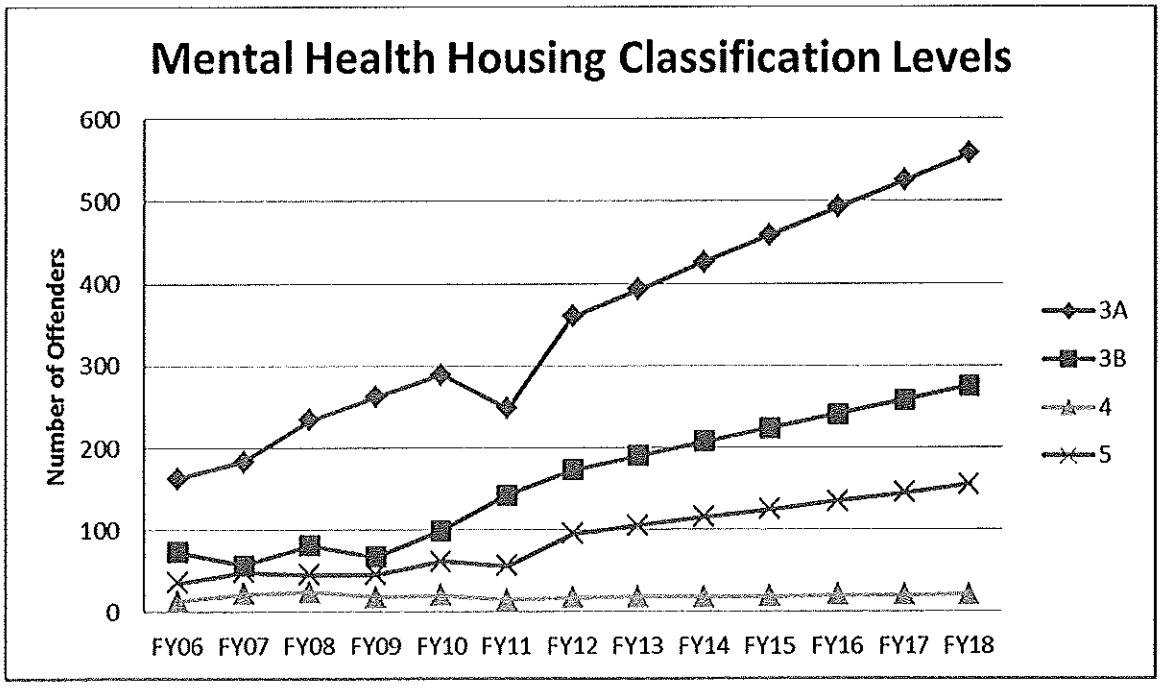
Key Issues

It is anticipated that the Kansas Department of Corrections will show increasing numbers of admissions of offenders requiring mental health treatment during incarceration, as this is the current trend. The following key issues need to be addressed:

- Increased required number of specialized mental health beds.
- Projected increase in offenders with special mental health needs requires additional mental health staffing levels to provide care to these offenders.
- Conducting evidence-based correctional mental health treatment is extremely important to reduce recidivism.
- Finding appropriate placements upon parole for the most difficult offenders with significant history of self-injurious, impulsive behaviors is very challenging.

Specialized Beds – Historical/Projected

The table below defines the mental health housing classification levels for the KDOC population. The Housing Classification Levels below are defined as: 3A – Offenders with mental illness who have shown symptoms within the past 6 months. 3B – Offenders with symptoms of a major mood disorder or who are marginally stable. 4 – Requires a single-cell due to mental disorder. 5 – Requires placement in a specialized mental health unit. The information provided begins at FY06 through FY12 and projections to FY18:



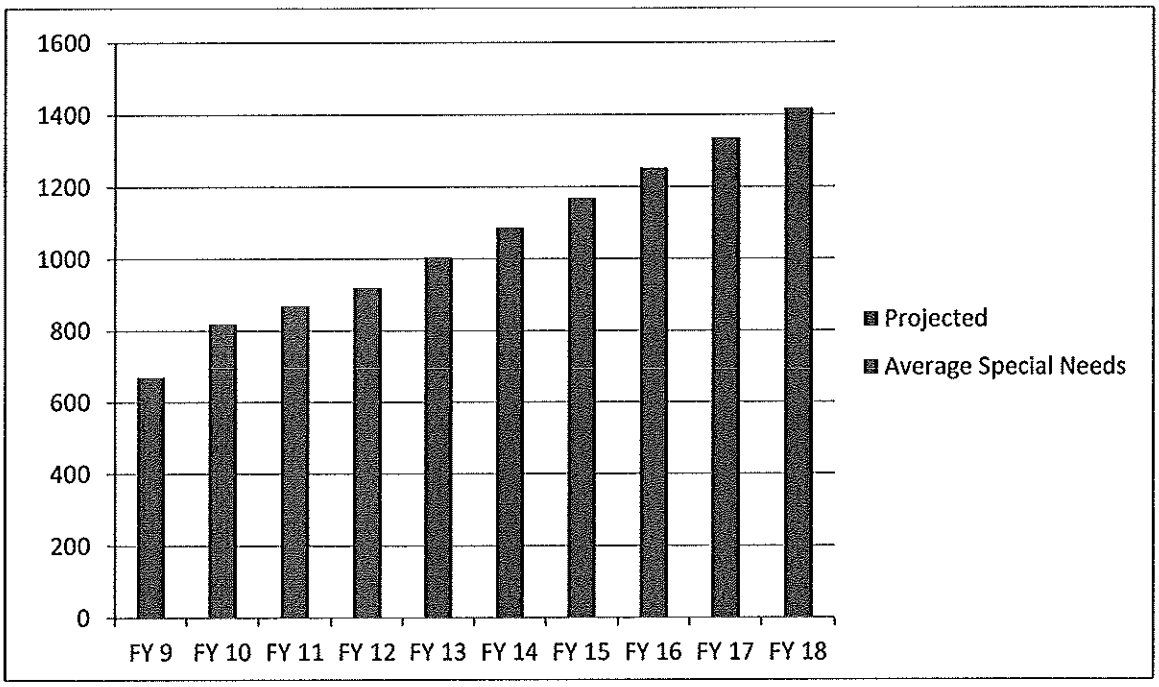
- Level 3A: Requires housing at a facility with mental health treatment available.

- In the past 6 out of 7 years, these placements have steadily increased.
- Anticipate annual increases averaging 16%.

- Level 3B: Limits placement at facilities with comprehensive mental health/psychiatric services.
  - Averaging a 20% annual increase over the past 7 years.
- Level 4: Requires a single cell in the general population setting.
  - These housing placements have remained relatively stable over the past several years most likely due to facility constraints with single cells in general population areas as well as attempts to safely and appropriately place the mentally ill in specialized housing.
- Level 5: Requires housing in a specialized mental health unit.
  - Average annual increase of 21% over the past 7 years.

Special Needs Offenders – Historical/Projected

The following table shows the numbers of offenders requiring consistent mental health follow up due to their serious mental illness. The graph indicates historical numbers beginning with FY09 through FY12 and projections to FY18.



- There was an average 11% increase in the special mental health needs population between FY09 and FY12.
- Projected increase from 691 offenders in FY 2009 to 1,400 offenders with serious mental illness in FY 18. Not all offenders within this category will require a specialized mental health bed; however the mental health staffing levels will need to increase to serve the needs of these offenders who reside in the general population.

Offenders Prescribed Psychotropic Medications - Historical

Average Inmates on Psych Meds	
FY 09	1,558
FY 10	1,666
FY 11	1,704
FY 12	1,824

Current Specialized MH Beds

Current specialized mental health beds - facilities:
108 beds = LSSH Moderate to Non-aggressive Mentally ill inmates
120 beds = LCF TRU (Cognitively impaired, residential, transitional)
150 beds = LCMHF Segregated mentally ill inmates
14 beds = TCF (females) Mental Health Pod
382 beds = Total

Additional placements for mentally ill offenders within KDOC:
20 beds = EDCF single-celled inmates due to a mental disorder (incl. RDU)
40 beds = LCF/*HCF single-celled inmates due to a mental disorder
15 beds = TCF (females) GP inmates
75 beds = Total

Key:
LSSH: Larned State Security Hospital
LCF TRU: Lansing Correctional Facility Treatment & Reintegration Unit
LCMHF: Larned Correctional Mental Health Facility
TCF: Topeka Correctional Facility
EDCF: El Dorado Correctional Facility
RDU: Reception and Diagnostic Unit
HCF: Hutchinson Correctional Facility
GP: General Population

Anticipated Needs – MH Beds

- Over the next three years, there will be an additional 118 specialized mental health beds needed by FY15. Between FY 15 and FY 18 there will be an additional 45 mental health beds needed (Total 163 specialized mental health beds).
- Currently, 5% (457 offenders) of the total population is placed in a specialized mental health bed or specialized placement within the general population.

KDOC Mental Health Classification – Detailed Description

1) **Stable Population Inmates** – MH Class I inmates do not have a mental health diagnosis. However, mental health services are not just for inmates diagnosed with mental illness. Inmates within a correctional facility are often faced with grief/loss issues, situational anxiety, and or sadness due to their current condition of incarceration. Service needs for these individuals include:
   a) Short term clinical intervention targeting towards conflict resolution and is situational when the inmate is dealing with family crisis and/or outside influences.
   b) Grief counseling when family members are lost during incarceration and is usually a shared responsibility with chaplain services
   c) Anger management/adjustment counseling to promote stabilization with the inmate when dealing with recent disciplinary and/or security related situations.
   d) They have no special housing needs due to mental illness.

2) **MH Class II (Non-Specific)** – MH Class II (Non-Specific) are inmates with non-severe Axis I and II diagnoses. Examples of these types of diagnoses include adjustment disorders with anxiety or depression, sleep disorders, and mild character disorders. These inmates function at a relatively high level of self-sufficiency within the system. They do not require chronic medication or special housing, and only occasionally require intensive clinical services such as crisis level placements. These inmates do require specific planning by licensed mental health staff specifically trained to identify the social and emotional needs of the patient. These inmates are identified in the KDOC system as a MH class II. These inmates usually require assistance in the following areas:
   a) Possible placement in a two person cell to prevent inmates diagnosed with situational depression from being alone or isolated.
   b) Possible short term placement in a single cell to prevent those inmates diagnosed with situational anxiety disorders/social anxieties from becoming over stimulated.
   c) Support with adjustment difficulties to maintain their current level II and not deteriorate. This may require monthly contacts by mental health staff, group therapy, medication, or activity therapy during exacerbated episodes.
   d) If necessary treatment planning specific to their individual diagnosis that is evaluated and maintained by the psychiatrist at least annually.
   e) These inmates may have a tendency to have trouble with other inmates due to their mental illness and therefore, may need conflict resolution services more than the stable population inmates.
   f) These inmates are not usually identified as needing specific mental health re-entry services and/or social services within the community upon release. However, these inmates are at a higher risk for return to prison if they are not well adjusted with their current condition upon release.

g) These inmates can be managed in any current correctional facility environment within Kansas.

3) **MH Class III (Medication Specific)** – This category represents inmates that are diagnosed with moderate to significant Axis I and II diagnoses. Examples of these types of diagnoses include Major Depression, PTSD, Generalized Anxiety Disorder, and Obsessive Compulsive Disorder. These inmates function at a moderate level of self-sufficiency within the system. They require chronic medication, housing considerations, and more frequent intensive clinical services such as crisis level placements. These inmates require specific treatment planning by a multi-disciplinary treatment team that is more extensive than the MH Class II Non-specific inmate. Currently these inmates are identified in the KDOC system as a mental health class III. These MH Class III inmates usually require assistance in the following areas:
   a) Possible placement in a two person cell to prevent inmates from being alone or isolated.
   b) Possible placement in a single cell to prevent those inmates from becoming over stimulated.
   c) Support with adjustment difficulties to maintain level III status and not deteriorate. This may require monthly contacts by mental health staff, group therapy, and activity therapy during exacerbated episodes.
   d) Required treatment planning by a multidisciplinary team to include medical staff to ensure proper medication administration and maintenance.
   e) Psychiatry visits at least every 90 days.
   f) Individual or group therapy sporadically
   g) These inmates may have a tendency to have trouble with other inmates due to their mental illness and therefore, may need conflict resolution services more than the stable population inmates.
   h) These inmates may be identified as needing re-entry services and/or social services within the community upon release. These inmates will have a higher risk for return to prison if they are not well adjusted with their current condition upon release to include outpatient psychiatry visits, and medication maintenance.
   i) Movement and placement of these inmates is limited only by available psychiatric services on site. LCMHF, LCF, HCF, TCF, and EDCF can handle this type of inmate without restriction. WCF, ECF, NCF, are limited in the number of inmates they can take in this classification.

4) **MH Class IV (Special Needs)** - Inmates with significant to severe Axis I and II diagnoses. Examples of these types of diagnoses include Major Depression with psychotic features, Bipolar Disorder, Borderline Personality Disorder, and Undifferentiated Schizophrenia. These inmates function at a moderate to minimal level of self-sufficiency within the system. They require chronic medication, housing considerations, and frequent intensive clinical services such as crisis level placements, individual therapy, and chronic care clinics. These inmates require specific treatment planning by a multi-disciplinary treatment team that is extensive and may require multiple treatment and medication adjustments. Currently these inmates are identified in the KDOC system as a mental health class IV. These MH Class IV inmates usually require assistance in the following areas:

a) Possible placement in a two person cell to prevent inmates from being alone or isolated.
b) Possible placement in a single cell to prevent those inmates from becoming over stimulated.
c) Possible placement on crisis level in the infirmary.
d) Significant support to maintain their current level IV. This may require monthly or more frequent contacts by mental health staff, ongoing group therapy, and ongoing activity therapy.
e) Required treatment planning by multidisciplinary team to include medical staff to ensure proper medication administration and maintenance.
f) Psychiatry visits at least every 90 days.
g) These inmates usually have trouble with other inmates due to their mental illness and therefore, may need conflict resolution services routinely.
h) These inmates are likely to end up in segregation due to repeat disciplinary reports especially those inmates that have significant Axis II diagnoses.
i) These inmates may display acting out behavior such as feces throwing, head banging, assaultive behaviors, and passive aggressive communication with security.
j) These inmates may demonstrate moderate to severe self-harming gestures.
k) These inmates are identified as needing re-entry services and/or social services within the community upon release. These inmates will have a higher risk for return to prison even with coordination of services in the community. However the chances of success have proven to be much higher with re-entry intervention prior to release.
l) These inmates need community social services to include outpatient psychiatry visits, medication maintenance, and active therapy while in the community.
m) These inmates usually are housed in a facility with 24 hour nursing care in case of crisis level placement or deterioration of symptoms. WCF, ECF, and should be limited to the number of Class IV MH inmates they take and each inmate should be carefully screened to ensure they are stable prior to transfer. Destabilization of the inmate's condition while at these 2 facilities should result in immediate transfer to LCF, EDCF, or HCF. NCF should be able to handle a small population of significantly mentally ill (5-7) in A-Cell house, however if destabilization occurs they will need to be transferred to LCF, EDCF, or HCF as well.
n) Of the 890 inmates in this Class IV category, approximately 113 inmates are inmates that transition to MH Class level VI (Severe) needing inpatient placement, and are usually on the revolving facility circuit. They tend to get passed from facility to facility. These inmates with severe behavior disorders currently do not have an adequate housing placement identified for males or females. LSSH is unable to take these inmates due to minimal security staffing. LCMHF, TCF and EDCF are the primary facilities currently housing this type of inmate.

5) **MH Class V and VI (Mental Retardation and Severe and Persistent Mentally Ill)** – These inmates are diagnosed with severe and persistent mental illness or retardation. Examples of these types of diagnoses include Major Depression with psychotic features, Schizophrenia, Schizoaffective Disorder, and other psychotic disorders. These inmates do not function without assistance with Activities of Daily Living

(ADL's) within the system. They require chronic medication, special mental health programming/ housing, and frequent intensive clinical services such as crisis level placements, individual therapy, and chronic care clinics. These inmates require specific treatment planning by a multi-disciplinary treatment team and full time psychiatry services available to them daily to adjust the medication and treatment. Currently these inmates are identified in the KDOC system as a mental health class VI. These MH Class VI inmates usually require assistance in the following areas:

a) Single Cell Mental Health Bed Placement.
b) Periodic Inpatient Hospitalization.
c) Periodic placement on crisis level in the infirmary.
d) Weekly or daily contacts by mental health staff, individual and group therapy, and ongoing activity therapy.
e) Required treatment planning by a multidisciplinary team to include medical staff to ensure proper medication administration and maintenance.
f) Psychiatry visits at least monthly.
g) These inmates usually have trouble with any form of social interaction with general population and should not be housed within the general population for long periods of time.
h) These inmates may display acting out and assaultive behaviors.
i) These inmates may demonstrate severe/serious self-harming gestures.
j) These inmates are identified as needing re-entry services and/or social services within the community upon release. These inmates will have a higher risk for return to prison even with coordination of services in the community. However the chances of success have proven to be much higher with re-entry intervention prerelease.
k) These inmates need community social services to include outpatient psychiatry visits, medication maintenance, and active therapy while in the community.
l) These inmates may require Civil Commitment hearings upon release from the correctional system.

PROGRAM OVERVIEW

Kansas Department of Corrections currently contracts with Correct Care Solutions to provide comprehensive mental health services to inmates in the custody of KDOC. These services are provided by mental health employees of CCS, who are typically located on-site. This contract is monitored for contract compliance, community standard of care, and compliance with NCCHC and ACA standards by employees of Kansas University Physicians, Inc.

CCS's comprehensive contract requires at a minimum the following mental health on-site services:

1. Psychological evaluation (RDU and other forensic assessment)
2. Individual psychotherapy
3. Group psychotherapy
4. Activity therapy

5. Case consultation and review
6. Psychotropic medication
7. Segregation monitoring and review
8. Transfer screening and hearings
9. Administration of restraints (and monitoring)
10. Crisis intervention
11. Discharge Planning
12. Clinical Service Report Services

When transfer to a more psychiatrically-oriented placement is indicated, CCS has the following options:

1. TRU at LCF
2. LCMHF
3. TCF Mental Health Pod (female population)
4. LSSH

The following sections provide an overview of the sites providing more intensive psychiatric/mental health services throughout the KDOC.

I. Treatment and Reintegration Unit (LCF)

Overview of Services

This unit opened in 1999 and has 120 residential beds and two crisis level beds. It is generally full with a small waiting list. There is currently a Program Manager, two Activity Therapists and two Mental Health professionals working in the unit. All inmates in this program are required to participate in either individual and/or group therapy. The general criteria for admission to this program include mental health class VI designation, difficulty functioning in general population due to mental illness (including post-traumatic brain injury and dementia) and/or mental retardation. Admissions to TRU can come from any KDOC facility. The TRU unit is not well-designed for severe behavioral acting out. Treatment on the unit is focused on skill development towards the goal of reintegration back into a general population setting. Releases are typically back to general population, release into the community, or in some cases, to LCMHF or LSH. While turnover in the unit is variable, it averages 5-6 inmates per month. A small number of inmates are maintained on the unit long-term. The TRU had 11 different inmates placed on crisis level status over the past year. LCF (maximum and medium units) had 37 different inmates placed on crisis level status over the past year.

There are four tracks in TRU:

1. Release Planning: Treatment in this track is typically done in groups and is designed for inmates approaching their release dates.
2. Adjustment to Incarceration: This track is used for inmates who have been on a crisis level and is normally limited to 30-90 days.
3. Testing: These inmates normally come directly from RDU for the purpose of more extensive evaluation, but may be referred from other sources.
4. Special Needs/High Maintenance: Some, but not all of these inmates have been diagnosed with mental retardation.

II. Larned Correctional Mental Health Facility (LCMHF)

Overview of Services

The definition for targeted inmates designated for treatment at LCMHF (and TCF) as defined by the Consent Decree for the KDOC from the 1980's is as follows:

1. Definition of inmates with Serious Mental Illness:
"A substantial disorder of thought, perception, mood, orientation, memory, or intellectual deficit which grossly impairs judgment, behavior, the capacity to recognize reality or function effectively in the same environment with peers."
Diagnostic Categories:
i. Organic Mental Disorders (dementia, organic brain syndrome)
ii. Thought Disorders (Schizophrenia, Delusional disorder, others)
iii. Anxiety and Dissociative Disorders, including PTSD
iv. Mood Disorders (Bipolar Disorders, Major Depression, Dysthymia)
v. Adjustment Disorders
vi. Personality Disorders with a tendency for decompensation (emotional lability, suicide attempts, brief psychotic episodes, paranoid personality, borderline personality, narcissistic personality, schizotypal personality)
vii. Severe Eating Disorders and sleep disorders

2. Definition of inmates with "Behavior Disorders:"
"An inmate with a repetitive behavioral problem that causes a significant problem in conforming to societal norms of acceptable behavior in establishing meaningful, satisfying interpersonal relationships or interferes with a personal sense of satisfaction of well being."
Diagnostic Categories:
i. Sexual Disorders
ii. Impulse Control Disorders
iii. Substance Use Disorders
iv. Personality Disorders including:
(i) Antisocial Personality Disorder
(ii) Other personality disorders including schizoid, histrionic, dependent, passive aggressive, obsessive compulsive personality disorder.

There has been an increase in the number of inmates entering into the KDOC with Serious Mental Illness. Due to this increase, the needs for mental health programming have intensified, primarily for inmates in need of Acute Care. Acute Care within the KDOC is, "Traditional psychiatric hospitalization for the case of those mentally ill inmates who are de-compensated and unable to function effectively (dangerous to self or others, unable to care for basic self-care, in need of intensive treatment)."

LCMHF currently has 150 program beds. LCMHF receives inmates from all KDOC institutions except TCF. Inmates typically are transferred from maximum-security units. If a KDOC site indicates an inmate is in need of more acute care and cannot be best managed at their site, the site initiates a due process hearing regarding potential transfer. If at the due process hearing, it is decided the inmate's needs are best met at LCMHF, the inmate is then transferred. The monthly turnover is typically 5-10 inmates. Once an inmate is stabilized, the inmate may be transferred to another KDOC site.
Inmates may be housed at LCMHF long-term if clinically indicated.

LCMHF acts as the gatekeeper for transfer/treatment at LSSH. The correctional staff ratio at this facility is 1 staff to 2 inmates compared to the 1 to 3.5 ratio in most correctional facilities. This higher staff to inmate ratio allows for closer monitoring of inmates. For this reason, almost all inmates who are on involuntary medication status are housed at LCMHF. LCMHF had 49 different inmates placed on crisis level status last year. It should be noted that while LCMHF's staff ratio is higher than other KDOC facilities, it is not in line with an inpatient hospital setting such as LSSH which has a 1.4 to 1 staff to patient ratio. This limits LCMHF in its ability to provide intensive inpatient services when LSSH is unable to take inmates LCMHF recommends for inpatient services due to security limitations.

In 1992 LCMHF's mission was to provide transitional care. Any inmate needing long term mental health care would be transferred to LSSH. Now, LCMHF has also become a long term care facility.

LCMHF consists of five 31 bed units:

1. E Unit: Administrative and Disciplinary segregation and inmates on crisis level
2. F1 Unit: Special Programming Unit – Each inmate on this unit has specialized programming depending on mental health need. Some examples of inmates treated include:
    - Inmates previously in long-term segregation and are attempting to transition back to general population
    - Potential LSSH transfers
    - Inmates struggling in the 'general population' units at LCMHF
3. F2 Unit: Special Care Unit
    - Stable, chronically mentally ill; usually requiring long-term support
    - Inmates requiring careful monitoring for hygiene problems and medication compliance
    - Inmates transitioning into the F3 and F4 units
    - Segregation overflow
    - Inmates transferring to medium custody at other sites
4. F3 and F4 Units: Generally houses the mentally ill who are more stable. These are the 'general population' units at LCMHF.

There are 3 different incentive levels on these units. 1X1; 2X2; and Full Privileges. Incentives include Activity Therapy hours, day hall hours, eating meals in the chow hall, evening yard time, and the ability to obtain a job.

III. Topeka Correctional Facility (TCF) – Mental Health Pod

Overview of Services

Mental health services are distributed throughout the facility. TCF has a designated mental health pod (Pod 4) with 15 beds being used to house patients with significant mental health issues. This pod is not segregated from general population. There is one designated crisis level room within the infirmary and 4 crisis level rooms within pod 4. When the needs exceed the space within the mental health pod, the Reception and Diagnostic Unit (Pod 2) is used as an overflow for housing. There is an average of between 3-5 inmates on a crisis level at any given time. TCF had 40 different inmates placed on crisis level status over the past year.

IV. Larned State Hospital (LSH)

Overview of Services

Although the KDOC has established a comprehensive mental health treatment model carried out by the medical contractor, some inmates fall outside of the realm of this treatment model. Therefore, the department established a "safety net" to provide mental health treatment to offenders who fall outside of the realm of appropriateness of treatment within a correctional facility. The department established a Memorandum of Agreement with Larned State Security Hospital (LSSH) to treat those inmates who would be better served within a hospital setting, rather than a correctional institution.

It should be noted that KDOC has no accredited mental health hospital facility, and LSH is its only resource for mental health hospital (inpatient) services. Larned Correctional Mental Health Facility is not an accredited hospital, but was intended for placement of acute and chronically mentally ill inmates. It is a male-only facility. The only resource for both inpatient and acute/chronically mentally ill female inmates is the State Security Hospital at Larned. The MOA between KDOC and SRS specifies:

1. The KDOC has between 103 -115 beds available for use (90 beds in addition to the original 25 beds).
2. At least 60 beds will be "secure residential" beds.
3. At least 30 beds will be "acute care" beds for males.
4. Up to fifteen additional female beds that either be "secure residential" or "acute care."
5. "these 90 beds are in addition to 25 beds that have been available to KDOC"

Kansas Department of Corrections & Juvenile Justice Authority – Incarcerated

KDOC: Offender Average Daily Population – 9,390

Fiscal Year	Average Special Needs	Average Offenders Prescribed Psych Meds	Suicide Precautions Continuous Monitoring visits	Total # inmates on CL
FY 09	671	1,558	596	610
FY 10	818	1,666	806	729
FY 11	869	1,704	1,013	679
FY 12	1,029	1,741	1,110	914

JJA: Offender Population – 320

Fiscal Year	Average Special Needs	Average Youth Prescribed Psych Meds	Step 4 Classification
FY 11	97	77	7
FY 12	106	95	8

GOVERNOR'S MENTAL HEALTH SERVICES PLANNING COUNCIL

FORENSIC SUBCOMMITTEE REPORT

2011

Report presented to:
Wes Cole, Chair and Scott Jackson, Co-Chair
Governor's Mental Health Services Planning Council and
SRS Secretary Robert Siedlecki

Prepared by:

Randy Bowman, Chair
Members of the Forensic Subcommittee
Leslie Huss, SRS/Forensic Subcommittee Liaison

Vision Statement	***Create an environment in Kansas that provides state of the art mental health services as well as promotes recovery, self-sufficiency,*** a ***crime free lifestyle, and personal strengths for the forensic population**.***
Mission Statement	***Address issues and problems facing Kansans with mental illness in or at risk of entering the criminal justice system, through advocating for appropriate mental health services for the forensic population.***

*For purposes of this report the term forensic population identifies a group of individuals living with a mental illness who are at risk of entering or have already entered the criminal or juvenile justice system.

SUBCOMMITTEE MEMBERS

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**Diversion in the field of forensics refers to programs that divert individuals with serious mental illness (and often co-occurring substance use disorders) away from jail and provides connections to needed community-based treatment and support services.*

Introduction and Overview

The Forensic Subcommittee of the Governor's Mental Health Services Planning Council (GMHSPC) is a group of stakeholders and forensic professionals charged with examining issues in Kansas as they pertain to the forensic population and making needed recommendations for improvement to the Governor's Mental Health Planning Council. Over the past ten years, the Forensic Subcommittee advocated for many improvements within the forensic system. Some examples have been: Successfully advocating for SRS to create a Forensic Coordinator position in Central office to focus on expanding forensic services and programming around the state; completing a thorough study on admissions to Larned State Security Program in order to collect data and develop a recommendation for a mobile evaluator program; served on planning committee throughout the years for the annual Crisis Intervention Team Training statewide summit; completion of a jail survey in 2003 that identified concerns and needs of jails around the state regarding detainees with mental illnesses. From that study emerged a recommendation that SRS implement statewide mental health and law enforcement cross trainings, which were done.

Over the past ten years, SRS has collaborated with JJA and KDOC on numerous initiatives. Some of these initiatives have involved blending of state and federal funds to provide services, program development, and/or funding of positions. Other initiatives have included the sharing of staff resources and other non-monetary contributions. The most recent effort has been the development of *PERKS (Promoting Engagement for Risk Reduction in Kansas)* A multi-agency collaboration to provide cross training to criminal justice agencies and community mental health centers. In May 2010, SRS and KDOC jointly applied for a Bureau of Justice Assistance grant to fund *PERKS.* Although the grant was not awarded, both agencies have been able to implement *PERKS* in two pilot communities (Johnson and Shawnee Counties).

In July 2003, a report from the President's New Freedom Commission on Mental Health was published that identified many barriers and unmet needs that made it difficult for people with mental illnesses to recover, including a fragmented mental health system across the levels of government and other agencies. The Commission made a series of recommendations that would help transform the mental health system in America. Within this Commission were fifteen subcommittees whose charge was to review the mental health service delivery system in a specific area, Criminal Justice being one of them. Although this report was published almost seven years ago, to this day, it continues to be very much a large part of transforming the mental health system across the nation.

The New Freedom Commission's Criminal Justice Subcommittee report focused on three primary areas where intervention is crucial for individuals with mental illness who come into contact with the criminal justice system:

1. Pre-arrest/Contact with law enforcement- Individuals with serious mental illness are coming into contact with law enforcement and instead of being referred to mental health services, are being arrested for minor offenses. Interventions and programs to address this area of concern would include the pre-booking diversion Memphis model of the Crisis Intervention Team (CIT), post-arrest diversion programs (intervention occurs after arrest,

but jail stays are very short- less than 24 hours-48 hours), and mental health courts. During the past four years, the effort to expand CIT in Kansas has been remarkable in the development of new programs in Sedgwick and Shawnee counties. In 2009, the City of Wichita began the state's first mental health court. The SCOAP (Sedgwick County Offender Assessment Program) which provides a post-booking diversion program for individuals in need of mental health treatment who have been arrested for non-violent crimes. The combination of the Mental Health Court and SCOAP has reduced the number of persons with a mental illness in the Sedgwick County jail from 62% in 2005 to 47% in 2009.

2. Service for those incarcerated in jails and prisons- For individuals with severe mental illnesses who are arrested and incarcerated, appropriate mental health services must be made available to them. Such services would include: Screening, referrals, crisis intervention, suicide prevention, and medications. Through cross training of correctional officers and improving communication and collaboration between CMHCs and corrections, Kansas continues to focus efforts on early and appropriate identification of those with serious mental illness who are incarcerated both in county jails and state prisons.

3. Discharge planning prior to release from jail and prison- Reentry transition programs to link inmates with serious mental illnesses to community based services such as mental health treatment, housing, and Social Security are just a few vital resources needed to reduce the risk of recidivism. In 2010, Johnson County was awarded a grant from Bureau of Justice Assistance to implement the state's first FACT program (Forensic Assertive Community Treatment Team) out of the Johnson County Detention Center. The Reentry Planning Program out of the Douglas County Detention Center received a grant from the Bureau of Justice Assistance to continue with the work they are doing.

Throughout this past year, Kansas has achieved some success towards these goals and recommendations. These three points for intervention have served as guidelines for the Forensic Subcommittee in planning and prioritizing its goals for the past five years.

List the goals and action steps completed by the subcommittee during the past year.

The Forensic Subcommittee has provided its endorsement and technical assistance as needed for the following accomplishments during the past year:

1) Increased the number of community-based, clinicians trained in competency evaluations by conducting a training at Larned State Hospital in October 2010 and another in Lawrence in September 2010. A total of 109 people attended the trainings. Althought the wait time for admission to LSSP has remained overall steady for the past three years, the number of community competency evaluations SRS paid for has increased by 29%. In FY 09, SRS reimbursed CMHCs for 281 competency evaluations and in FY10, there were 375. The number of admissions

to LSSP for competency evaluations has decreased by 22%. In FY09, there were 69 admissions and in FY10, there were 53.

2) On November 15, 2010, the subcommittee met with representatives of a group who refer to themselves as the "Board of Foresnic Examiners" to hear their proposal to change the forensic competency statutes (K.S.A. 33-3301; 3302; 3303; 3305; and 3306). The proposal addressed : wait time for admission to LSSP, the credentialing of forensic evaluators, clarifying/improving definition of persons who are not competent to proceed; and options for the courts for persons not restorable to competency. After careful review, the Forensic Subcommittee determined there were still many questions that needed answered before they endorsed this proposal.

3) SRS contracted in Fall 2009 with Four County Mental Health Center to conduct court and mental health cross trainings around the state. In 2010, over 238 court personnel (judges, attorneys, other court staff) were trained on mental illnesses, mental health laws in Kansas, and resources.

4) Began process of reviewing and revising the Forensic Subcommittee's By-laws. The by-laws have not been reviewed for over five years.

1. **Please list your recommendations in priority order in the following table. Identify which New Freedom Commission goal(s) will be influenced by implementing the recommendation and what resources would be required to implement including fiscal resources.**

Priority	Recommendation	NFC Goal	Resources
1	*The state of Kansas make a priority the funding of pre and post arrest diversion programming for individuals with mental illness and cross- training of people working in the criminal justice system*	***2c Mental Health Care is Consumer and Family Driven-Policies,*** *procedures and agency activities protect & enhance the rights of people with mental illness*	• Funding for programming such as CIT, cross-trainings, reentry programs • Knowledge and time of Subcommittee members participating in meetings, trainings, and committees related to pre and post arrest program development and implementation
2	*Develop a system that provides quality and timely services to persons detained in a county jail or forensic hospital in need of:* • *Mental health treatment* • *Competency Evaluations*	***2c Mental Health Care is Consumer and Family Driven-Policies,*** *procedures and agency activities protect & enhance the rights of people with mental illness*	• Community-based evaluators trainings • Court Cross-training for attorneys and judges funded by Mental Health Block

	• *Competency Treatment* • *Not Guilty by lack of Mental State Evaluations* • *Pre-sentence Evaluations* • *Treatment in lieu of Confinement* • *Sex Predator Evaluations*		Grant funds for FY2011 • Funding for psychotropic medications • Mental health staff within the jails and forensic hospitals

2. What does the committee plan to do in support of the recommendations?

In order to support the recommendations set forth by the Forensic Subcommittee, the following goals, strategies, and activities for 2011-2012 have been developed:

Goal/Recommendation #1: Promote the development, implementation, and sustainability of both adult and juvenile pre- and post- jail diversion programming.		
Strategy	**Activity**	**Target Date for Completion**
Increase law enforcement/mental health cross-trainings, especially statewide implementation of Crisis Intervention Team (CIT) model and other programs that focus on diverting individuals with mental illnesses from arrests and into appropriate mental health services	• Subcommittee members will actively participate on various planning, training, and other local and state committees developing CIT and other jail diversion programs • Disseminate information to communities around the state on what pre-arrest programs have been developed	This is an ongoing activity as several communities around Kansas are in various stages of planning the development of a CIT program.
Increase key stakeholders' knowledge of the CIT model and its efforts within Kansas to expand CIT	• Subcommittee members will attend the Annual CIT Summits, serve on the planning committees, or assist with implementing the CIT trainings.	• 5th annual CIT summit was held on Feb, 2011. Close to 125 people from law enforcement, corrections, mental health, consumer run organizations attended • Ongoing
Increase knowledge of key stakeholders (Law Enforcement, Judges, County Attorneys, Court Services, CMHCs) on alternatives to jail programs in Kansas and nationwide	• Provide 5-6 cross- training opportunities at conferences, various CLE's around the state. This will be done through a contract with Four County Mental Health Center.	• New RFP to be issued 4/11 • New contract to be awarded 7/11 • Trainings with current contract (Four County MHC) are scheduled for March 16, 22, 23; April 20; and May 17 and 18, 2011
Explore funding opportunities to expand pre -and post-arrest diversion programming in	• Collaborate with SRS/DOC grant writer for diversion	• Ongoing

Kansas	related grant opportunities	
Provide sustainability of the Kansas CIT Training initiative upon the expiration of the current funding by the Tower Foundation	• Explore other grant opportunities • Include in request for FY2013's SRS Budget Enhancements	• Ongoing

Goal/Recommendation #2: Increase access to quality and timely mental health care for people who are detained in jails and forensic hospitals		
Strategy	**Activity**	**Target Date for Completion**
Increase the number of community-based competency evaluators	• Complete 2 competency evaluator trainings within the state • Educate communities about the CMHC network of back-up competency evaluators	• Competency evaluator trainings scheduled at LSH for April and October 2011
Increase the knowledge of key court personnel such as Judges and attorneys of the competency statutes, available community resources to conduct evaluations	• Included in the curriculum for the Court Cross-Trainings that are to be completed by Four County Mental Health Center	• Trainings are scheduled for March 16, 22, 23; April 20; and May 17 and 18, 2011
Increase collaboration between key mental health and criminal justice system stakeholders.	• Support the implementation of PERKS o Identify two members of the Forensic Subcommittee to serve on the PERKS workgroup o Provide updates on PERKS at all Forensic Subcommittee meetings o Have Forensic Subcommittee members from Johnson, Shawnee, Ford, and Finney counties encourage their agency personnel to attend the PERKS community cross trainings as	• Ongoing o July 2011 o Ongoing o Summer & Fall 2011

	appropriate	
Explore mental health programming for persons incarcerated or released to the community who have a history of violence and other high risk behaviors.	• Partner with the Mental Health Task Force's Mental Health Programs Workgroup to identify Best Practices and make recommendations to improve programming o Identify three members of the Forensic Subcommittee to serve on this workgroup o Provide updates on the progress of this workgroup at all Forensic Subcommittee meetings.	• Ongoing o July 2011 o Ongoing

3. **Please include supporting documentation for each recommendation and appropriate references in the subcommittee narrative report.**

Conclusion

As with last year, this coming year will continue to challenge members of the Governor's Mental Health Services Planning Council and its Subcommittees to be creative, collaborative, and committed with fewer resources than ever. The Forensic Subcommittee sees this as an opportunity to work even harder to advocate for the most effective and efficient practices in the field of forensics- especially those that occur early on and allow access to treatment that is appropriate and benefit the consumer and society. The Forensic Subcommittee encourages the continued collaboration between SRS, KDOC, and JJA that has proven successful in recent years. For this coming year, the Forensic Subcommittee has chosen to continue to make pre and post arrest diversion its first priority. To appropriately divert individuals from jails, prisons, forensic hospitals, and into community-based services can greatly impact the system as a whole and provide for an improved quality of life for consumers. In addition to the pre and post arrest diversion, the Forensic Subcommittee also recognizes that for those persons with mental illnesses who are not diverted and end up incarcerated, quality and timely access to needed mental health treatment and evaluations are extremely important and should be a high priority for the local and state entities to address.

Justice Involved Youth and Adult (JIYA) Subcommittee
(formerly known as the Forensic Subcommittee)

Leadership: Rick Cagan (NAMI - Kansas) and Lori Ammons (Kansas Department of Corrections) - Co-Chairs

Introduction & Overview: The interface between the mental health and criminal justice systems is significant. 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.

To address issues and problems facing Kansans with mental illness in or at risk of entering the criminal justice system, the Governor's Mental Health Services Planning Council (GMHSPC) and Kansas Reentry Policy Council (KRPC) independently convened a group of stakeholders such as law enforcement, courts, jails and prisons to join with consumers and family members in addressing this troublesome situation.

For several years, both groups have met to prioritize goals and activities around transforming policies, programs, and funding. Areas of focus have included:

- Community-based strategies such as the Crisis Intervention Team (CIT) model, specialty courts (drug courts, Mental Health Courts), and post-arrest diversion programs.
- Capacity building to include cross training for law enforcement agencies and mental health centers
- Access to timely and appropriate services for individuals detained in a forensic hospital, jail and prison, and reentry to reduce recidivism
- Continuity of care with prescription medications
- Increasing capacity of community-based competency evaluators
- Resource allocation at State Mental Health Authority to create a Forensics Coordinator to expand forensic services and programming across the state
- Data collection on pressing concerns and needs of jails regarding detainees with mental illness

Accomplishments: Kansas has experienced significant accomplishments in mental health legislation, programs and services - some of which have been influenced by both groups:

- Adoption of HCR 5032 by the Kansas House and Senate in 2012 recognizing CIT as a best practice for law enforcement intervention with persons who have a mental illness
- Significant growth in the number of officers trained in CIT, with more than 900 law enforcement officers trained statewide.
- CIT programs are established in seven Kansas communities, with a statewide CIT Leadership Group convening to support expansion of CIT efforts across the state.
- State resource allocation supports a Forensic Coordinator position at KDADS Behavioral Health Services, as well as cross-training of law enforcement and behavioral health providers; and, reimbursement of competency evaluations performed by Community Mental Health Centers (CMHCs)
- Johnson, Shawnee, Ford & Finney Counties have implemented PERKS (Promoting Engagement for Risk Reduction in Kansas), a multi-agency collaboration to provide cross training to criminal justice agencies and community mental health centers.
- A 2012 Mental Health and Criminal Justice Issues Policy Forum was held on September 10, 2012 in Topeka, followed by the 6th Annual Kansas CIT Summit. Over 200 constituents representing law enforcement, criminal justice staff, consumer and family members, and behavioral health professionals attended both events.
- In 2013, the Kansas Senate and House approved $25,000 for an annual contract with the Kansas Law Enforcement Training Center for Crisis Intervention Training for FY 2014.

In October 2012, 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 gave birth to 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.

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 will consist of constituents representing behavioral health services, juvenile and adult corrections, law enforcement, courts, education, consumers and families, regional prevention centers, and treatment providers.

Co-chairs will convene and facilitate quarterly meetings of the Membership to execute and monitor tasks to be carried out through formal workgroups. Formal workgroups will be established with specific focus as identified and report back to Membership on an ongoing basis. The first meeting is scheduled for July.

Explanation of This Year's Goals: The Charter of the JIAY Subcommittee sets forth the following goals:

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 and Corrections.

Membership will show their commitment to continuous improvement by reviewing the Charter on an annual basis.

Keys Issues/Gaps

(identified by attendees at 7/16/13 Meeting)

- Correctional Facilities:
    1. Access to Resources at Reentry/Discharge
    2. Medicaid Suspension & Termination Issues
    3. SMI / SPMI Gap – Those with serious mental illness may not be eligible for services, but may de-stabilize without services.
- Law Enforcement Personnel
    1. Being solution focused on a call stretches resources for officers.
    2. Availability of mental health personnel for law enforcement to rely on.
    3. What were intervention opportunities that would have circumvented event that landed them in jail?
- Jails
    1. Training for jail personnel
    2. Medicaid Suspension & Termination Issues
- State Security Program (LSH)
    1. Lack of resources in jail with tools, training in mental health to deal with aggressive detainees
- Substance Use Disorder Treatment Providers
    1. Lack of substance use disorder treatment & detox beds in community
    2. Lack of resources & care coordination between agencies in community.
    3. Lack of housing - need transitional pockets of beds.
    4. Lack of bed capacity for KCPC Care Coordination (KDOC) - For example a bed for substance use treatment upon release, however upon time for release no bed is available.
    5. Assistive outpatient treatment management (court-ordered treatment)
- Consumers / Family Members
    1. Long-term court orders for medication compliance is needed
    2. Need specialty behavioral health beds in KDOC - backlog at RDU at EDCF
- Children/Youth
    1. 3% of youth in foster care system cross over to CINC to JO. Judges think they can get more services if they are in one or the other system.
    2. Lack of resources & care coordination for youth.
    3. Access to services for transitional aged youth (aging out of foster care system). Many youth are transitioning into homelessness.
- Policy Issues
    1. Increase hospital beds (inpatient, KDOC, & specialty beds)
    2. Increase diversion programs to reduce recidivism

3. Increase supply of 30 day medication for MH at reentry/discharge
4. Develop maintenance type program for long-term care.