Approved: 11-23-05
Date

MINUTES OF THE HOUSE CORRECTIONS & JUVENILE JUSTICE COMMITTEE

The meeting was called to order by Chairman Ward Loyd at 1:30 P.M. on March 7, 2005 in Room 241-N of the Capitol.

All members were present except:
Kathe Decker- excused
Mike Peterson- excused
Stephanie Sharp- excused
Dale Swenson- absent
Kevin Yoder- excused

Committee staff present:
Jill Wolters, Revisor of Statutes Office
Diana Lee, Revisor of Statutes Office
Jerry Ann Donaldson, Kansas Legislative Research
Becky Krahl, Kansas Legislative Research
Connie Burns, Committee Secretary

Conferees appearing before the committee:
Marilyn Cook, Comcare Community Mental Health Center
Roger Haden, KDOC

Others attending:
See attached list.

Marilyn Cook, Executive Director, Comcare Community Mental Health Center, provided the committee a power point presentation on the Kansas Mental Health System. (Attachment 1) The Community Mental Health Centers (CMHC) are state funded but county administered. There are 29 licensed CMHC with a combined staff of 4,500 that provide services in over 120 locations in every county.

Funding is:
- 70% from public sources, (local, state, federal),
- private insurance
- self pay
- 105 counties contribute more than $21 million annually
- By regulation, CMHCs provide services to all regardless of ability to pay

The CMHCs are licensed by SRS and target the population who have Severe and Persistent Mental Illness (SPMI) and Serious Emotional Disturbance (SED). SPMI determination is based on mental conditions on Axis I.
The Number of SPMI Adults Served:
- 7,775 in 1992
- 18,800 in 2003

The number of children/adolescents with SED:
- 6,034 in 1992
- 18,900 in 2003

The mental health system crosses boundaries and shares clients with:
- Corrections
- Aging
- Schools
- Primary Care
- Child Welfare

CMHC's provide care to over 110,000 individuals and more than 97% of all citizens seeking public mental health care are seen at CMHC's.

Mental Health Reform:

- 1990 – MH reform legislated
- Implemented in phases
  - Osawatomie State Hospital
  - Topeka State Hospital
  - Larned State Hospital

Goals of Reform

- Decrease the number of individuals living in State Mental Health Hospitals (SMHHs) and maintain them in communities with services wrapped around them (community-based services)
- Simply put, a shift from institutional to community-based care
- CMHCs as gatekeepers

The cost prior to Mental Health reform:

(1) for an adult was $70,000 a year
(2) for a child/adolescent $149,000 a year

The core services following Mental Health reform for adults:

- Case Management
- Attendant Care
- Supported employment/education activities
- Medication Management
- Crisis Services

Kansas currently has 3 State Hospitals:

- Osawatomie State Hospital
- Larned State Hospital
- Rainbows Mental Health Facility (Kansas City)

Number of Admissions has increased 67%:

- In 1999 – 1859 admissions
- In 2003 - 3115 admissions

The average length of stay has decreased. Two state hospitals were closed in 1996 the Topeka State Hospital and Winfield DD Facility. The impact of Mental Health Reform on State Mental Health Hospitals has seen the number of accessing increased 67%, with over 50% new to the Mental Health system. From 1990 to 2003 the average daily census decreased from 1283 to 293 a reduction of 77%.

Major Findings:

- State Hospitals are necessary
- Role of SMHH is changing – any further decrease in beds should be done in a planned way with all stakeholders
- Community-based services and local community impatient services have to be adequately funded

Recommendations: 3 Pronged Focus:

- Front end services
- TX in SMHH/Inpatient facility
- Transition to communities

In the 2002/2003 Legislative Session, SRS proposed to close Rainbow Mental Health Facility with the claim it would result in a $400,000 savings in State General Fund ($3.3 million all funds) and expand bed capacity at OSH.

Forensic Subcommittee Government Report of Mental Health Services Planning Council, August 2004. Primary recommendations:

- Single state entity to take responsibility for the growing clinical, fiscal, social, and legislative issues involved with the forensic population

- Found offenders with MI return to state correctional facilities on condition violations at a rate of 75 - 80% (compared to 40 – 45%)
- Nearly 50% of MI offenders are homeless at the time release

Forensic Subcommittee Recommendations:

- Train/educate local law enforcement officers
- Identify diversion strategies
- Collaboration needed with CMHCs and jails to ensure adequate follow up
- Monitor medical availability following release
- Insufficient collaboration among primary agencies serving this population

Challenges:

- Service integration
- Need to decrease incidents of incarceration for SPMI population
- Financing the care of the uninsured
- Access

Roger Haden, KDOC, provided a briefing on KDOC Mental Health Programs. (Attachment 2) The KDOC provides a comprehensive range of mental health services for inmates that include initial screening and evaluation, crisis intervention, medication management, intensive therapeutic activities for serious mental illness, and discharge planning for mentally ill offenders preparing for release. KDOC 's health services contractor, Correct Care Solution (CCS), provides mental health services for inmates as a component of the health services contract.

Upon initial admission to the Department of Corrections, each inmate is screened for significant current or previous mental health problems. Following the screen, a psychologist then completes an evaluation of each inmate to determine appropriate placement in a DOC facility. In addition to mental health diagnoses consistent with DSM-IV classification, the Department uses an internal mental health classification system which identifies mental disorder, treatment need, housing considerations, employability, and functionality.

Increased emphasis on Release and Transition services, especially in building collaborative partnerships with community resources, the major areas which need attention for the mentally offenders are:

- Disability assistance
- Housing
- Continuity of care especially in medication management
- Employment

The meeting was adjourned at 3:20 pm. The next meeting is March 8, 2005.

HOUSE CORRECTIONS AND JUVENILE JUSTICE COMMITTEE
GUEST LIST

DATE 3-7-05

NAME	REPRESENTING
Richard A. Samaniego	Kearney & Assoc.
Mary Beth Kidd	JJA
Nancy Rapp	SRS-HCP-MH

UNDERSTANDING THE KANSAS CMHC SYSTEM AND ITS INTERFACE WITH THE CRIMINAL JUSTICE SYSTEM

Presentation Goals:

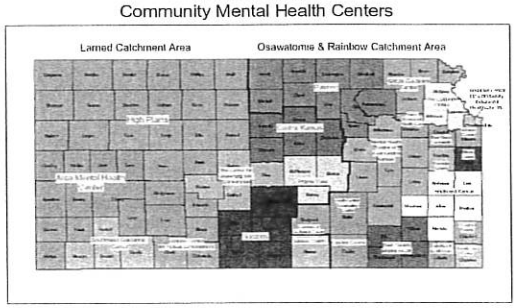
1. Help you better understand the public CMHC system
2. Outline MH reform (1990) that caused the deinstitualization of many mentally ill individuals
3. Tie both to the current status of the state hospital system and the criminal justice system

The Kansas Community Mental Health System

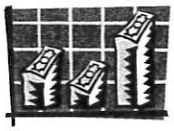
- 29 licensed CMHCs
- Combined staff of over 4,500
- A system of care provided in over 120 locations (services in every county)
- State funded, county administered

Who Are We?

State of Kansas
Community Mental Health Centers



Funding:



- 70% from public sources (local, state, federal)
- Also private insurance, self pay
- 105 counties contribute more than $21 million annually
- By regulation, CMHCs provide services to all regardless of ability to pay

- CMHC's provide care to over 110,000 individuals
- 36,000 target population
- More than 97% of all citizens seeking public mental health care are seen at CMHC's
- CMHC's in Kansas are licensed and regulated by SRS

House C&JJ
3-7-05
Attachment 1

The Target Population

- Adults with a severe and persistent mental illness
- Children with serious emotional disturbances

Determining Eligibility for SPMI

1) Diagnosis
2) Functioning
3) Risk Factors

Components of the Diagnostic Manual (DSMIV-TR)

Axis I:	Disorders that may be the focus of clinical attention
Axis II:	Personality Disorders
	MR Conditions
Axis III:	Medical Conditions
Axis IV:	Current life stressors
Axis V:	Global Assessment of Functioning Score (GAF)
	Current/Highest functioning past year

Axis I Disorders

Substance-related D/O's	Dissociative D/O's
Schizophrenia/other Psychotic D/O's	Factitious D/O's
Mood D/O's	Somataform D/O's
Anxiety D/O's	Sexual & Gender Identity D/O's
Adjustment D/O's	Eating/Sleep D/O's

Axis II Disorders Personality Disorders

Paranoid	Narcissistic
Schizoid	Avoidant
Schizotypal	Dependent
Antisocial	Obsessive-Compulsive
Borderline	Mental Retardation
Histrionic	

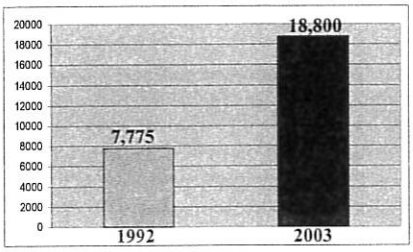
Determining Eligibility for SPMI:

(Refer to handout)

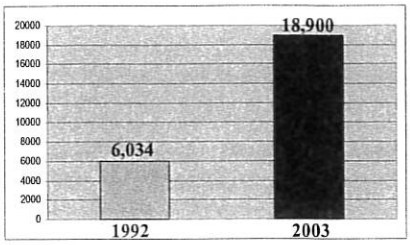
3 Step Process:

1) Diagnosis
2) Functioning over past 2 years
3) Risk Factors – need score of 10 or greater to be eligible for SPMI determination

The # of SPMI Adults Served:



The # of Children/Adolescents with SED:



Why is it Important?

- Only those with SPMI (target population) are eligible for community-based services (especially case management)
- State provides little other funding for the non-target population

Connection to the Criminal Justice System

- Often family members call law enforcement to intervene
- When incarcerated, people with untreated MI are especially vulnerable to assault/intimidation by predatory inmates
- Collaboration is needed, as criminal justice system nor the mental health system can make the changes needed on its own

MH Reform:

- 1990 – MH reform legislated
- Implemented in phases

- Osawatomie State Hospital
- Topeka State Hospital
- Larned State Hospital

Goals of Reform:

- Decrease the number of individuals living in State Mental Health Hospitals (SMHHs) and maintain them in communities with services wrapped around them (community-based services)
- More simply put, a shift from institutional to community-based care
- CMHCs as gatekeepers

Cost:

Prior to MH reform:

– $70,000/adult/yr.

– $149,000/child-adolescent/yr.

Core Services Following MH Reform: (Adults)

(incentivised by increasing rates)

- Case management
- Attendant care
- Supported employment /education activities
- Medication management
- Crisis services

Kansas Currently Has 3 State Hospitals:

- Osawatomie State Hospital
- Larned State Hospital
- Rainbow Mental Health Facility

State Hospital Closures:

Two facilities closed in 1996:

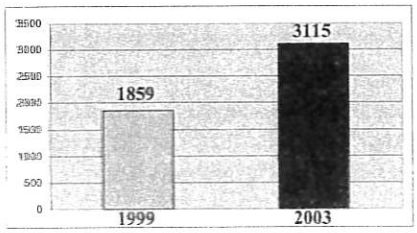
- Topeka State Hospital
- Winfield DD Facility

Primary Basis for Admission to SMHH:

- Danger to self or others
- Inability to care for self
- Some do use state hospitals for short term, acute stays when a local psychiatric inpatient facility does not exist in an area

Admissions:

The # of admissions increased 67%



- Average length of stay decreased:

30% @ RMHF
37% @ OSH
45% @ LSH

Impact of Mental Health Reform on SMHH:

- The number accessing SMHH increased 67% in the past 5 years
- Kansas recidivism rate is 12%, national average is 8% (believed to be tied to short length of stay)
- Over 50% new to the MH system

Project Steering Committee Report Concerns

(27 member group – report meant to be a guide)

Findings:

- State hospitals running near or at capacity
- Summer 2004 concerns about suspending admissions
- Increased numbers of those with complex forensic needs

Major Findings:

- State hospitals are necessary
- Role of SMHH is changing - Any further decrease in beds should be done in a planned way with all stakeholders
- Community-based services and local community inpatient services have to be adequately funded

Recommendations:

3 Pronged Focus:

- Front end services
- TX in SMHH/Inpatient facility
- Transition to communities

Forensic Subcommittee Government Report

Mental Health Services Planning Council, August 2004

Primary recommendations:

- Single state entity to take responsibility for the growing clinical, fiscal, social, and legislative issues involved with the forensic population
- Found offenders with MI return to state correctional facilities on condition violations at a rate of 75-80% (compared to 40-45%)
- Nearly 50% of MI offenders are homeless at the time of release

Forensic Subcommittee Recommendations:

- Train/educate local law enforcement officers
- Identify diversion strategies
- Collaboration needed with CMHCs and jails to ensure adequate follow up
- Monitor medical availability following release
- Insufficient collaboration among primary agencies serving this population

Criminal Justice/Mental Health Consensus Report

- 600 page comprehensive report
- A blueprint that local, state and federal policy makers can use to improve response to people with MI who are involved with, or at risk of involvement with the criminal justice system
- Full report: www.consensusproject.org

Overarching Themes and 46 Policy Statements Developed

Involvement with the mental health system	Improving collaboration
Contact with law enforcement	Training, practitioners, policymakers and community
Pretrial issues, adjudication, and sentencing	Elements of an effective mental health system
Incarceration and re-entry	Measuring and evaluating outcomes

(2)

KANSAS

KANSAS DEPARTMENT OF CORRECTIONS
ROGER WERHOLTZ, SECRETARY

KATHLEEN SEBELIUS, GOVERNOR

House Committee on Corrections and Juvenile Justice
Presentation: KDOC Mental Health Programs
March 7, 2005

The Department of Corrections provides a comprehensive range of mental health services for inmates that include initial screening and evaluation, crisis intervention, medication management, intensive therapeutic activities for serious mental illness, and discharge planning for mentally ill offenders preparing for release. The Department's health services contractor, Correct Care Solutions (CCS), provides mental health services for inmates as a component of the health services contract.

PREVALENCE OF MENTAL ILLNESS

Mental Health: Internal Classification System

Upon initial admission to the Department of Corrections, each inmate is screened for significant current or previous mental health problems. Following the screen, a psychologist then completes an evaluation of each inmate to determine appropriate placement in a DOC facility. In addition to mental health diagnoses consistent with DSM-IV classification, the Department uses an internal mental health classification system which identifies mental disorder, treatment need, housing considerations, employability, and functionality. A continuum of services is available which generally relates to this classification with ascending order indicating increased need for or intensity of services.

Mental Health Classification – Mental Disorder (OMIS data, 2-8-05, N=8,959)

1 – None, exclusive of a primary diagnosis of substance abuse/dependence: 3,183
2 – Primary diagnosis of a paraphilia or personality disorder, not the focus of treatment: 2,040
3 – Transient mental disorder, primary focus of treatment, less than 6 months duration: 562
4 – Serious Mental Disorder on Axis I or Axis II, primary focus of treatment: 1,819
5 – Primary diagnosis of mental retardation: 24
6 – Severe and Persistent Mental Illness: 254
Not coded: 1,077

(Note: the SPMI designation is made according to specific criteria set forth by the state mental health authority (SRS). It is very likely that a portion of the inmates coded in level 4 also should be in the SPMI category. However, it often occurs that the mental health practitioner is unable to verify the inmate's self-report with community provider records at the time of classification. When data is unavailable, the prudent step is to classify at the lower level. See note on SPMI below.)

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3-7-05
Attachment 2

Mental Health Classification – Treatment Needs (OMIS data, 2-8-05, N=8,959)

1 – Not currently requiring mental health treatment: 5,169
2 – May require time-limited mental health services: 1,730
3 – Requires on-going mental health services that may include medication management: 1,042
4 – Requires special needs treatment monitoring: 723
5 – Requires mental health structured reintegration program at LCF-TRU: 86
6 – Requires intensive mental health placement at LCMHF or TCF-MHU: 144
7 – Requires hospitalization at LSSH: 1
Not Coded: 64

(Note: some discrepancies occur between the OMIS data and the EMR data resulting from the current inability of the two systems to communicate and share information fully.)

The following information, based on data compiled from the contractor's EMR (Electronic Medical Records) system on February 8, 2005, indicates some markers of the current prevalence of mental illness in the inmate population. This data represents current population and is based on 8,736 records (some records were missed in the initial data sharing between the systems).

Mental Health Diagnoses: Of the 8,736 records:

- A total of 1,892 inmates (21.7%) had no mental health diagnosis
- A total of 1,930 inmates (22.1%) had been diagnosed with an Axis I disorder solely.
- A total of 1,183 inmates (13.5%) had been diagnosed with an Axis II personality disorder solely.
- A total of 3,731 inmates (42.7%) had been diagnosed with both an Axis I and Axis II disorder.
- These inmates represented a total of 15,315 diagnoses (similar to medical conditions, a person may have multiple diagnoses).

Of those inmates with at least one Axis I diagnosis: 1,930
Number of total Axis I diagnoses: 3,646
Diagnostic Categories represented: (these have been arranged to generally represent the disorders that generally require the greatest amount of professional service, from most to least; generally the first three categories are considered more serious mental disorders.)

Psychotic Disorders: 104
Mood Disorders: 602
Anxiety Disorders: 275
Adjustment Disorders: 158
Substance Induced Disorders: 41
Cognitive Disorders: 13
Sexual Disorders: 130
Impulse Control/ADHD/Bereavement/Learning Disorders: 92
Substance Abuse/Dependence Disorders: 2,191
Miscellaneous (sleep, eating, etc.): 40

Of those inmates with at least one Axis II diagnosis: 1,183
Number of total Axis I diagnoses: 1,222
Diagnostic Categories represented: (Axis II diagnoses represent personality disorders and mental retardation categories which can be the focus of clinical attention. Personality disorders are considered to be ingrained patterns of approaching the world; typically these patterns are more distressing to others around the person than they are to the person. Such patterns are very difficult to change, and are made even more so when there is little investment in the part of the person to make any changes. Some forms of personality disorders can be very destructive, and must be the focus of clinical attention in order to ensure the safety of the individual and those around him. In terms of diagnoses related to intellectual functioning, these inmates may or may not take significant professional time, depending on the level of adaptive functioning deficits exhibited. Please note again that an individual may have more than one Axis II diagnosis at any given time.

- Antisocial Personality Disorder: 316
- Avoidant Personality Disorder: 15
- Borderline Personality Disorder: 25
- Dependent Personality Disorder: 13
- Histrionic Personality Disorder: 19
- Obsessive Compulsive Personality Disorder: 12
- Narcissistic Personality Disorder: 72
- Paranoid Personality Disorder: 10
- Schizoid Personality Disorder: 11
- Schizotypal Personality Disorder: 5
- Personality Disorder, Not Otherwise Specified: 610
- Categories of Mental Retardation: 114

The final group of this data represents the largest number of inmates – those inmates who currently carry both an Axis I and an Axis II diagnosis. Typically the focus of clinical attention remains on the Axis I diagnosis, and treatment can be complicated by the presence of an Axis II diagnosis.

Number of current inmates with both Axis I and Axis II diagnosis: 3, 731
Number of Axis I and Axis II diagnoses: 10,447
Number of Axis I diagnoses: 6,788
Diagnostic Categories Represented in Axis I:

- Psychotic Disorders: 287
- Mood Disorders: 1,146
- Anxiety Disorders: 427
- Adjustment Disorders: 276
- Substance Induced Disorders: 69
- Cognitive Disorders: 20
- Sexual Disorders: 435
- Impulse Control/ADHD/Bereavement/Learning Disorders: 167
- Substance Abuse/Dependence Disorders: 3,895
- Miscellaneous: 66

Number of Axis II diagnoses: 3,659
Diagnostic Categories Represented in Axis II:

- Antisocial Personality Disorder: 812
- Avoidant Personality Disorder: 107
- Borderline Personality Disorder: 117
- Dependent Personality Disorder: 70
- Histrionic Personality Disorder: 25
- Obsessive Compulsive Personality Disorder: 8
- Narcissistic Personality Disorder: 150
- Paranoid Personality Disorder: 29
- Schizoid Personality Disorder: 16
- Schizotypal Personality Disorder: 20
- Personality Disorder, Not Otherwise Specified: 1,939
- Categories of Mental Retardation: 366

SPMI: In addition to those inmates classified as SPMI in the internal Mental Health Classification system, a significant number of other inmates are designated by the provider within the Special Needs category. These inmates require more intensive follow-up and service. Of those with Serious Axis I diagnoses, the number of inmates classified as Special Needs averaged 718 per month for FY 2004 and 894 for the first half of FY 2005. This group, approximately 10% of the population, generally contains inmates with criteria that the mental health provider considers most likely to meet community SPMI criteria.

Inmates on Psychotropic medication:

- In December, 2004, 1,988 inmates (22.1% of the population) were prescribed psychotropic medication.
- The average for the past year (FY 2004) was 1,596 inmates (17.7% of the population)
- For FY 2003 the average was 1,508 (16.8% of the population)
- As a comparison, the information below was reported by the mental health provider in a January, 2000 report which gave the population percentages on psychotropic medications for the 5-year period as follows 1995-1999:

  1995 - 7.6% 1996 - 9.1% 1997 - 10.8% 1998 - 12.0% 1999 - 12.5%

Mental Health Services Utilization

	FY 2004	FY 2005 (July-Dec.)
Monthly Average of intakes	212	247
Monthly Average of follow-up encounters	2,326	2,287
Monthly average of crisis level cases	208	277
Monthly average of crisis placements	57	64

Monthly average of newly diagnosed Axis I disorders (excluding sole diagnosis of substance use disorder)	102	150

Suicide Gestures and Attempts

- For the period July through December, 2004, health service records indicate 99 suicide threats or gestures, 3 suicide attempts, and 2 suicides.
- For the previous fiscal year (FY 2004), records indicate a total of 316 threats or gestures, 37 attempts, and 2 suicides.

RDU admissions:

- Based on mental health classification related to housing level, the Department has experienced dramatically increased levels of mental health needs for offenders entering the system.
- Level 3 classification allows multi-person housing in a facility with comprehensive MH services,
- Level 4 indicates a need for single person housing, and
- Level 5 indicates a need for housing in a specialized MH unit including LCF-TRU, TCF-MHU, LCMHF, or LSSH. The table below shows the number of inmates classified at each of these housing levels for since 2001:

	2001	2002	2003	2004	2005 (6 months)	
Level 3 -	41	150	280	316	187	(374)
Level 4 -	6	26	48	23	8	(16)
Level 5 -	27	52	69	47	30	(60)

MENTAL HEALTH SERVICES (FY 2006 contract)

- Mental Health Staffing:
  - Total FTE: 107.65
  - Mental Health Professionals, Masters Level or above: 66.60
  - Psychiatrists: 5.75
  - Psychiatric RN: 4.5
  - Activity Therapists and Discharge Planners: 20.5

- Mental Health Services include:
  - Psychological and Psychiatric assessment and diagnosis
  - Medication management
  - Individual and group counseling services
  - Case management
  - Crisis intervention and Segregation Review
  - Activity therapy

- Release and Discharge planning for mentally ill offenders
- Forensic evaluation services.
- In addition beginning with the transfer of the male Reception and Diagnostic Unit from Topeka to El Dorado in the March, 2001, the contract also provides for intake psychological assessment and evaluation services.

- Mental Health Costs Estimate: $7.4 million (18% of healthcare contract)
  - Staffing: Approximately $5.6 million
  - Psychotropic Medications: Approximately $1.1 million
  - Other (indirect and shared costs, nursing, administrative, etc.): App. $.7 million

- Special Mental Health Housing Units

	capacity	current
Lansing Correctional Facility, Treatment and Reintegration Unit:	78	78
Topeka Correctional Facility, Mental Health Unit:	15	12
Larned Correctional Mental Health Facility (LCMHF):	150	148
Larned State Security Hospital (LSSH):	25	8

CHALLENGES AND FUTURE FOCUS

I. Managing treatment resources in terms of appropriate treatment modality (roles of psychiatric (medication) and non-psychiatric treatment).

- The health care provider issued psychiatry practice guidelines for its staff at the beginning of 2003. These guidelines provided direction to the psychiatrists regarding those diagnostic categories that should receive the majority of their focus, specifically those categories most often associated with severe and persistent mental illness (schizophrenia, bipolar disorder, major depressive disorder).
- The impact of this approach has involved the development of referral recommendations for the mental health professionals, to provide them guidance as to those disorders or symptom constellations that warrant referral to the psychiatrist, versus those disorders or symptoms that should first be addressed via another treatment modality (such as group psychotherapy).
- Additionally, a statewide group psychotherapy program was developed to target those inmates who will be directed into non-psychiatric treatment initially. It is anticipated that consistent application of both the psychiatry guidelines, the referral recommendations to psychiatry, and the new group therapy program will lead to a decline in the use of psychotropic medication overall.

II. Additional specialized mental health housing units.

- As noted above, the number of inmates requiring specialized housing due to mental health reasons has been increasing. If the trend for special housing

placements continues we could experience a 200% increase in these placements since 2001.

III. Development of specialized programming for MH housing units including enhanced staff training in managing mentally ill offenders.

IV. Increased emphasis on Release and Transition services, especially in building collaborative partnerships with community resources. The major areas which need attention for the mentally offender are:

- Disability assistance
- Housing
- Continuity of care especially in medication management
- Employment