Cognitive Disabilities

Colorado 2020

URGING:

- Prohibition of Administrative Segregation & Support for Alternatives
- Proposed Medicaid Waivers
    - Continuity of Care for Justice-Involved Populations
    - Re-vamp of Colorado Mental Health Supports Waiver
    - Medicaid Supported Employment Waiver Services
- Fair Housing Compliance among Medicaid Providers
- Peer Services and Peer-Run Respite
- On-going Olmstead Planning & Medicaid Re-Design

ADVOCACY

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1. Executive Summary

The challenge of various forms of cognitive disability, often co-occurring, are found throughout the world and in Colorado and hit especially hard with homelessness and incarceration. The harmful impacts are felt not only by the person but by the community as well.

For State Agencies, diverse and co-occurring cognitive disability among clients brings huge administrative challenges.

We've got some great federal laws from an advocate's prospective, but substantial state compliance is rare and enforcement is expensive. That's why we saw Colorado advocates pushing last session for the repassing of Federal Parity Law under Colorado state law.

What are 3 Big Federal Laws Colorado is not complying with:

- Title II of the Americans with Disabilities Act, the Olmstead Decision (this includes the great need for Housing)
- Medicaid Network Adequacy for people with Cognitive Disabilities, especially those who are Homeless and/or Justice-Involved.
- Title II of the Americans with Disabilities Act & the Fair Housing Act -- the requirement to make "reasonable accommodations" in policies, practices, procedures and services.

On the one hand, who isn't sympathetic to the daunting prospect of substantially complying with SIMPLE LAWS that must be applied in EXTREMELY COMPLICATED CIRCUMSTANCES.

On the other hand, individuals are made homeless and/or incarcerated by the failure of Colorado State Government to comply with these laws.

We need to make it easier to comply with these laws that are necessary but take real time, energy and resources to understand and implement on a statewide basis.

Our separate Appendices with citation to several medical research articles are meant to make the point that many of these cognitive disabilities are co-occurring and often seen in homelessness and incarceration.

We suggest legislation to:

- **Prohibit Administrative Segregation** in Colorado Jails & Prisons among vulnerable populations
- Empower the State to engage in inclusive, on-going **Olmstead Planning** that produces Measurable Goals, Reasonable Time Frames, and Proposes Funding to Support the Plan. Such plan must include not only services, but also housing and placements as required by law.

- Authorize the State to engage in **Medicaid Re-Design to ensure Medicaid Network Adequacy for people with Cognitive Disabilities**, with special attention to those who are Homeless and/or Justice-Involved.
- Authorize the creation of a **Peer Run Respite Program** in Colorado.
- Authorize an inclusive **ADA/Fair Housing workgroup** to identify "reasonable accommodations" of policies, practices, procedures and services to enable service provision and placement of people with cognitive disabilities with Medicaid certified providers.
    - **This also implicates Colorado Medicaid's Too Dangerous/Too Difficult To Treat** problem.

2. Prohibition of Administrative Segregation in County Jails & Support for Alternatives

Colorado has been a leader in restricting the use of Administrative Segregation in Prisons – this after the horrific death of Christopher Lopez at San Carlos Prison. This became a national cause due to the deliberate indifference of prison officials to Lopez' safety.

In fairness, most prison and jail officials are not competent to deal with the complex health concerns, both physical and/or mental, of incarcerated populations.

Currently, New Jersey has one of the model laws prohibiting Administrative Segregation among VULNERABLE POPULATIONS within prisons and jails.

Colorado needs to:

- build on what has already been done,
- take inspiration from the New Jersey Law banning AdSeg/Solitary for vulnerable populations, and
- seek technical assistance from the Vera Institute of Justice or others if necessary.

See Selected Appendices at the end of this document –Appendix 1. References also included in separate MAIN APPENDIX:

- **Colorado Law**
- **New Jersey Law**
- **Rule 45 of the United Nations Mandela Rules (Solitary Confinement)**
- **Vera Institute of Justice Alternatives to Segregation Resource Center**

3. Proposed Medicaid Waivers

a. Continuity of Care for Justice-Involved Populations

Discharge Planning from jails and prisons for people with cognitive disabilities is very complicated and it is largely a question of accessing Medicaid Services and often placements.

NY Continuity of Care for Justice-Involved Populations

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b. Re-vamp Colorado Mental Health Community Supports

The problems with Colorado's Community Mental Health Supports waiver go to the heart of large-scale need for mental health and substance abuse long term services based on a need for supervision.

Shockingly, the CMHS waiver is not meant for those people – it's meant for people with mental illness who need assistance with activities of daily -- & substance use problems without "mental illness" renders the person ineligible as well.

Further, this raises parity concerns.

Some states have begun the process of establishing a true continuum of care for people with substance use issues and most states that have an MI waiver don't have a requirement for assistance with activities of daily living to our knowledge.

This very much needs to be the subject of Medicaid Re-Design and Comprehensive Continuums of Care for people with cognitive disabilities.

This is not okay.

See examples of other relevant Medicaid waivers in Appendix 2 of this document. References are also included in Main Collection of Appendices in Separate Document:

- **Colorado's Community Mental Health Supports Waiver (discriminatory & concerning Targeting Criteria)**
- **CT Mental Health Waiver (0653.R02.00)**
- **Illinois Behavioral Health Transformation section 1115 demonstration**
- **Michigan's 1115 demonstration request entitled Pathway to Integration.**

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c. Medicaid Supported Employment Waiver Services

We are championing the inclusion of Supported Employment in most adult waiver services.

See link below:

Medicaid.gov – List of State Waivers including Supported Employment

4. Fair Housing & Medicaid Placement Providers

The issue for many people with cognitive disabilities under FAIR HOUSING is REASONABLE ACCOMMODATION, often not reasonable modification of the premises.

As the Joint Statement of the US Department of Housing and Urban Development and US Department of Justice note (see below), REASONABLE ACCOMMODATIONS include:

- Rules,
- Policies,
- Practices, and/or
- Services.

These are the kinds of REASONABLE ACCOMMODATIONS that many people with cognitive disabilities need to secure a placement.

Further, many of these individuals are Medicaid recipients. It becomes obvious very quickly that without the Medicaid Agency actively participating to secure the reasonable accommodations, many individuals with cognitive disabilities remain homeless.

This is another huge task we are asking the Colorado Department of Health Care Policy and Financing (HCPF) to assume. While the legal obligation may already be there, the financial resources may not be.

We are proposing that HCPF receive the resources to provide necessary guidance and leadership in this area. Fair Housing has the potential to maximize the use of existing resources where appropriate.

JOINT STATEMENT OF THE DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT AND THE DEPARTMENT OF JUSTICE

REASONABLE MODIFICATIONS UNDER THE FAIR HOUSING ACT (2008)

"The Act also makes it unlawful for any person to refuse "to make reasonable accommodations in rules, policies, practices, or services, when such accommodations may be necessary to afford ... person(s) [with disabilities] equal opportunity to use and enjoy a dwelling." The Act also prohibits housing providers from refusing residency to persons with disabilities, or, with some narrow exceptions.'

. . .

"Courts have applied the Act to individuals, corporations, associations and others involved in the provision of housing and residential lending, including property owners, housing managers, homeowners and condominium associations, lenders, real estate agents, and brokerage services. Courts have also applied the Act to state and local governments, most often in the context of exclusionary zoning or other land-use decisions."

Notre Dame Journal of Law, Ethics & Public Policy	Bazelon Center for Mental Health Law
"Disability Discrimination in Long-Term Care: Using the Fair Housing Act to Prevent Illegal Screening in Admissions to Nursing Homes and Assisted Living Facilities" (2012) By Eric Carlson	**The Illegality of "Independent Living" Requirements in Rental Housing, Assisted Living Centers and Continuing Care Retirement Communities (2004)**

5. Peer Services and Peer-Run Respite

Peer Services are CRITICAL for many reasons, one of the most important is that some individuals with cognitive disabilities need a significant level of daily emotional support.

Professionals may find they were not successful because they did not have the time to provide such intensive support. Further, some individuals may TRUST the peer service provider more than the traditional medical professionals.

Colorado has Peer Services, but they need to be greatly expanded to address the needs of the homeless and incarcerated populations that are woefully underserved.

Long time mental health advocate Amy Smith has been researching and making proposals for a Peer Run Respite for several years.

In 2018, Mathematica Policy Research published their findings that a New York Peer Run Respite saved the state money and reduced hospitalizations.

It is time for Colorado to have Peer-Run Respite.

SAMHSA.org (peer workers)	Vocalvirginia.org (peer run programs)
Power2u.org – evidence for peer run crisis alternatives	Wisconsin Department of Health Services – Peer Run Respites
Power2u.org – directory of peer respites	**Mathematic Policy Research, published in** "Psychiatric Services"**---** The Effectiveness of a Peer-Staffed Crisis Respite Program as an Alternative to Hospitalization (2018)

6. The Need for Medicaid Funding of On-Going Olmstead Planning & Medicaid Re-Design

To Comply with Olmstead and Medicaid Network Adequacy and to make the Progress necessary, Colorado State Government MUST have yearly:

- Measurable Goals
- Reasonable Time Frames and
- Funding to Support the Plan

Coloradans with Cognitive Disabilities are Homeless and Incarcerated due to the State's failure to have a Comprehensive and Effectively Working Olmstead Plan.

The US Supreme Court balanced the interests of people with disabilities and the interests of State Governments in predictability and rational planning in the landmark case L.C. v. Olmstead (1999), holding that Title II of the Americans with Disabilities Act prohibits the unnecessary institutionalization of people with disabilities.

In that case, the Court observed that a State Plan to prevent the unnecessary institutionalization of people with disabilities might shield the State from liability if the Plan were COMPREHENSIVE and EFFECTIVELY WORKING.

In 2011, based on subsequent caselaw and interpretation, the US Department of Justice provided guidance that an Olmstead Plan must have:

- Measurable Goals
- Reasonable Time Frames, and
- Funding to Support the Plan

That has subsequently been followed by other Courts, including the Minnesota Federal Court.

Colorado needs Comprehensive Olmstead Planning through a standing entity that works year-round and updates at least on a yearly basis. Further, this Olmstead Planning Group should make an annual report to the Legislature.

ADA.gov (olmstead)	**Minnesota**'s Olmstead Plan
2011 US Department of Justice Olmstead Guidance	**2014 Colorado Olmstead Initiative**

7. Conclusion

Long term care for people with cognitive disabilities is at the heart of Criminal Justice Reform and Ending Homelessness.

Unfortunately, it won't work without COMPREHENSIVE CONTINUUMS OF CARE, including housing and placements.

Further, it won't work with TRAUMATIZING SEGREGATION in Colorado Jails.

It is in embracing the highest levels of human rights, care and safety that individuals, family members and Colorado Communities have the realistic possibility of winning and winning big.

Selected Appendices

(Main Collection of Appendices in Separate Document)

Appendix 1: Solitary Confinement (Administrative Segregation)

Selected Colorado Law on Limitations to Solitary Confinement (Administrative Segregation)

- C.R.S. 19-2-203 (Youth)
- C.R.S. 17-1-113.8. Persons with serious behavioral or mental health disorders – longterm isolated confinement - work group - medication-assisted treatment
- C.R.S. 17-1-113.9. Use of administrative segregation for state inmates - reporting

- **NJ A314**

Restricts use of isolated confinement in correctional facilities.

- **Bill Summary:** This bill restricts the use of isolated confinement in correctional facilities in New Jersey.

The bill prohibits inmates incarcerated or detained in correctional facilities from being placed in isolated confinement unless there is reasonable cause to believe that the inmate or others would be at substantial risk of immediate, serious harm as evidenced by recent threats or conduct, and any less restrictive intervention would be insufficient to reduce that risk.

The bill defines isolated confinement as "confinement of an inmate in a correctional facility, pursuant to disciplinary, administrative, protective, investigative, medical, or other classification, in a cell or similarly confined holding or living space, alone or with other inmates, for approximately 20 hours or more per day with severely restricted activity, movement, and social interaction."

The bill provides that the correctional facility is responsible for establishing the justification for isolated confinement by clear and convincing evidence, and that inmates may not be placed in isolated confinement for non-disciplinary reasons. Certain exceptions to the restrictions on isolated confinement for facility-wide lock downs, emergency confinement, medical isolation, and protective custody are provided by the bill.

The bill requires that inmates receive a personal and comprehensive medical and mental health examination, conducted by a clinician, before being placed in isolated confinement. However, in a county correctional facility, a preliminary examination is to be conducted by a member of the medical staff within 12 hours of confinement and the clinical examination is to be conducted within 48 hours of confinement.

The bill requires that initial procedures and reviews providing timely, fair, and meaningful opportunities for an inmate to contest the confinement are to be made available. The procedures are to include the right to an initial hearing within 72 hours of placement and reviews every 15 days thereafter, in the absence of exceptional circumstances, unavoidable delays, or reasonable postponements; the right to appear at the hearing; the right to be represented at the hearing; an independent hearing officer; and a written statement of reasons for the decision made at the hearing.

The bill provides that the final decision to place an inmate in isolated confinement is to be made by the facility administrator, except in cases involving medical isolation, and that an inmate is to be removed from isolated confinement if the administrator determines that the inmate no longer meets the standard for isolated confinement.

The bill requires that a clinician evaluate each inmate placed in isolated confinement on a daily basis, in a confidential setting outside of the cell whenever possible, to determine whether the inmate is a member of a vulnerable population. However, in a county correctional facility, an inmate in isolated confinement is to be evaluated by a member of the medical staff as frequently as clinically indicated, but at least once a week.

The bill provides that an inmate determined to be a member of a vulnerable population is to be immediately removed from isolated confinement to an appropriate placement.

An inmate is a member of a vulnerable population, as defined in the bill, if he or she is:

- **21 years of age or younger; is 65 years of age or older;**
- **has a disability based on a mental illness,**
- **a history of psychiatric hospitalization,**
- **or has recently exhibited conduct, including but not limited to serious selfmutilation, indicating the need for further observation or evaluation to determine the presence of mental illness;**
- **has a developmental disability;**
- **has a serious medical condition which cannot effectively be treated in isolated confinement;**
- **is pregnant; is in the postpartum period, or has recently suffered a miscarriage or terminated a pregnancy;**
- **has a significant auditory or visual impairment;**
- **or is perceived to be lesbian, gay, bisexual, transgender, or intersex.**

The bill further provides that no inmate is to be placed in isolated confinement for more than 15 consecutive days, or for more than 20 days during any 60-day period, and that cells or other holding or living spaces used for isolated confinement are to be properly ventilated, lit, temperature-controlled, clean, and equipped with properly functioning sanitary fixtures.

The bill provides that staffing patterns for correctional and program staff are to be set at levels necessary to ensure the safety of staff and inmates under the provisions of the bill.

- **Selected Definitions** ○ **"Correctional facility"** means any State correctional facility or county correctional facility, and any State, county, or private facility detaining persons pursuant to any intergovernmental service agreement or other contract with any State, county, or federal agency, including, but not limited to, United States Immigration and Customs Enforcement.

○ **"County correctional facility"** means a county jail, penitentiary, prison, or workhouse.

• Vox.com article on the New Jersey Solitary Confinement Law
Rule 45 of the United Nations Mandela Rules (Solitary Confinement) 1. Solitary confinement shall be used only in exceptional cases as a last resort, for as short a time as possible and subject to independent review, and only pursuant to the authorization by a competent authority. It shall not be imposed by virtue of a prisoner's sentence. 2. The imposition of solitary confinement should be prohibited in the case of prisoners with mental or physical disabilities when their conditions would be exacerbated by such measures. The prohibition of the use of solitary confinement and similar measures in cases involving women and children, as referred to in other United Nations standards and norms in crime prevention and criminal justice,28 continues to apply.
Vera Institute of Justice: Safe Alternatives to Segregation Resource Center

Appendix 2: Selected Medicaid Waivers

Colorado's Mental Health Supports Waiver
Eligibility Group A person experiencing a severe and persistent mental health need that **requires assistance with one or more Activities of Daily Living (ADL);** Is 18 years of age or older with a severe and persistent mental health need; Currently has or at any time during the past year leading up to assessment has a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the Diagnostic and Statistical Manual of Mental Disorders (DSM-5); and Has a disorder that is episodic, recurrent, or has persistent features, but may vary in terms of severity and disabling effects; and Has resulted in functional impairment which substantially interferes with or limits one or more major activities. A severe and persistent mental health need does not include: Intellectual or developmental disorders; or **Substance use disorder without a co-occurring diagnosis of a severe and persistent mental health need.**
CT Mental Health Waiver (0653.R02.00) Provides adult day health, community support, supported employment, assisted living, assistive technology, brief episode stabilization, chore services, home accessibility adaptations, home delivered meals, non-medical transportation, overnight recovery assistant, peer supports, personal emergency response systems, recovery assistant,

specialized medical equipment, transitional case management for individuals w/mental illness ages 22 and older

The Illinois Behavioral Health Transformation section 1115 demonstration authorizes the state to implement 10 pilots. The 10 approved pilots include:

1. Residential and Inpatient Treatment for Individuals with Substance Use Disorder (SUD) Pilot (will be statewide and will have no annual enrollment limits);
2. Clinically Managed Withdrawal Management Services Pilot;
3. SUD Case Management Pilot;
4. Peer Recovery Support Services Pilot;
5. Crisis Intervention Services Pilot;
6. Evidence-based Home Visiting Services Pilot;
7. Assistance in Community Integration Services Pilot;
8. Supported Employment Services Pilot;
9. Intensive In-Home Services Pilot; and
10. Respite Services Pilot.

On June 21, 2016, Michigan submitted an 1115 demonstration request entitled Pathway to Integration.

The purpose of this demonstration was to allow Michigan to broaden the crucial component of residential substance disorder services in the state's existing network of substance use disorder (SUD) providers and SUD benefits to provide a broader continuum of care for beneficiaries seeking help with a SUD, including withdrawal management services in residential treatment facilities that meet the definition of an Institution for Mental Disease (IMD). Benefits under this demonstration were to be provided through a managed care delivery system.

The state believes that offering a full continuum of SUD treatment and recovery supports based on American Society of Addiction Medicine (ASAM) criteria or other nationally recognized, SUD-specific program standards, would result in improved health outcomes and sustained recovery for this population. The demonstration was approved on April 5, 2019, to be effective until September 30, 2024.