Mental Health/Jails Task Force
Colorado Commission on Criminal and Juvenile Justice
Minutes

May 11, 2017 1:30PM-4:30PM
700 Kipling, 4th Floor Conference room

ATTENDEES:

TASK FORCE MEMBERS

Joe Pelle, Boulder County Sheriff
Jamison Brown, Colorado Jail Association
Frank Cornelia, Colorado Behavioral Healthcare Council
Patrick Fox, Officer of Behavioral Health
Norm Mueller, Defense Bar
Lenya Robinson, Healthcare Policy and Financing
Abigail Tucker, Community Reach Centers
Doug Wilson, State Public Defender
Dave Weaver, County Commissioner
Joe Morales, Parole Board
Matthew Meyer, Mental Health Partners
Tina Gonzales, Colorado Health Partnerships

ABSENT

Evelyn Leslie, Private Mental Health Providers
John Cooke, State Senator, District 13
Charles Garcia, CCJJ Member At-Large
Michael Vallejos, 2nd Judicial District
Charles Smith, Substance Abuse and Mental Health Services Administration

STAFF

Richard Stroker, CCJJ consultant
Kim English, Division of Criminal Justice
Germaine Miera, Division of Criminal Justice

GUESTS:

Moses Gur, CBHC
Todd Spanier, Arapahoe County
Nicole Glover, CMHIP
Sonia Reardon, CMHIP
Ali Moaddeli, Arapahoe County
James Pinkney, Colorado School for Family Therapy
Vincent Atchity, Equitas Foundation

Issue/Topic:	Discussion:
Welcome and Introductions	Mental Health/Jails Task Force Chair Joe Pelle welcomed the group and reviewed the agenda. He then asked Task Force members and attendees to introduce themselves. The Sheriff also informed the group that Senate Bill 17-207 was approved by the legislature and thanked everyone who worked on the CCJJ recommendation.

Issue/Topic:	Discussion:
Report Back / Data update **Action:**	Sheriff Pelle introduced Todd Spanier, a criminal justice planner from Arapahoe County. Todd directed Task Force members to a handout in their packets and explained that he and his colleague, Kally Enright had compiled data to present to the Group. The handout is titled the 'Top 20 Crime Types by Number of Bookings for Offenders Diagnosed by Jail Medical Staff with a Behavioral Health Disorder Between 2011 and 2015'. *DISCUSSION* • Todd explained that the crime types are broken out by percent of bookings, percent of jail days, total jail days and total bookings. • Most of the crimes on the list are not considered serious crimes, and the serious crimes constitute a small percentage of bookings. • The category of 'Fugitive of justice' has the highest number of bookings at 38%. This includes arrests on warrants from another jurisdiction. • Doug explained that the category of Burglary in the 2nd degree describes breaking into a house. • Todd clarified that the people on the list have been screened and diagnosed while in the jail, however if they are not bonded out at all they won't be on the list. • The handout includes a 'frequent flier' summary on the last page. • Todd explained that the analysts matched 40 of the names of the frequent fliers against health association data and those people alone in one year cost Colorado $1M in emergency room visits. Tina Gonzalez from Colorado Health Partnerships also provided booking data: • The data included information on overall bookings and those with behavioral health claims. • The data included information both pre and post Affordable Care Act. • The Colorado Health Partnership data includes information from eight mental health centers and 48 counties. • The data represents all of western slope, all of southern Colorado, and all the counties to the east of Denver – everything but the northeast corner of the state. • In 2014 there were approximately 30,000 bookings (29,977) and 20%

	(6,120) had behavioral health claims or encounters. • In 2015 there were approximately 31,000 bookings and 31% of those people (9,670) had behavioral health claims or encounters. • Many of these people are repeat offenders year after year.

Issue/Topic:	**Discussion:**
Presentation / New Haven Diversion Project **Action:** Dr. Fox to ask Dr. Baranoski for any written materials that outline the concept of the program and/or gives guidelines to the court liaison	Dr. Patrick Fox introduced Dr. Madelon Baranoski, the Director of the New Haven Diversion Project and explained that she is joining the meeting via conference call to outline details of the program. Patrick noted that Task Force members have questions about the role of different players in the diversion program, possible issue areas around implementation of such a program, and details about how people are identified to participate in the program. *DISCUSSION* • Dr. Baranoski started her presentation by stating that the purpose of the program is to save the state money. Connecticut was putting people not competent for minor crimes in the state hospital at an extraordinary expense. These people would cycle through repeatedly. • A subset of the population was never connected to services. • People would get released, become disengaged and then be rearrested. • The New Haven project provides wrap-around services to people with mental illness, and services are HIPAA protected. • The evaluation helps determine if 1) the person should be admitted to an emergency room or 2) if they are not at that level of illness, would they agree to mental health services and would they agree to a care plan to be provided to a judge. • The mental health clinician provides referrals, sets up appointments and monitors progress. • The clinician will make an appointment for a particular type of service, the client signs a release of information, the clinician talks to the public defender, and then the client signs another release (HIPAA) for the clinician to talk to the judge. • The clinician presents the mental health plan to the judge along with a monitoring plan and the judge makes the decision. At that point the charges are still in place and the client is given a continuance and another court date. If the client doesn't show for that court date the clinician investigates why and if whether there's a failure with treatment. • A noncompliance order is then sent to the court and a person may end up in jail, but not very often. • Question - If there is a prescription around types of crimes that can be diverted and those that cannot. The statute says misdemeanors and crimes where nobody was seriously hurt. However, if someone is a repeat offender it limits the ceiling of level of crime. The judge has discretion. • Question - What if someone has a higher crime? Felonies are moved to a higher court.

	• Sometimes people with high charges have mental health needs so the clinician will still perform an evaluation and give the report to the treating unit in the jail. The clinician will still see them but they won't be eligible for diversion due to the higher charge. • Question - In Connecticut are there pretrial services that perform pretrial supervision? Pretrial supervision is for felonies, for misdemeanors there is no official pretrial. • Question – Is the HIPAA release just for the public defender and the judge? Yes, the public defender negotiates with the prosecutor. • Question - If there's noncompliance is everything that happened before that available to prosecution? The prosecutor is in court when the diversion plan is presented and can argue against it. However the DAs don't currently argue very much. • Sometimes the public defender will argue that they don't want the person diverted and that they should 'walk' that day. They will argue that they don't want someone tied into mental health services and don't want to keep the case open. The clinician can tell the defender to talk to their client and that services can be offered without going through the court. • It's up to the attorney to argue for someone's civil rights. Yale came out strongly against mental health courts because in mental health court someone can't plead not guilty. • Question - When a client fails and returns to court for prosecution are the assessments available to prosecution? No, that's the MH record and that is where HIPAA comes in • A mental health record of the client is not available unless they put mental illness forward as a defense. • Colorado VRA gives victims a voice in major decisions involving their case and gives them right to be notified. Question – Is there something similar in Conn.? Yes, someone goes under supervision for a year or two and then their case can be purged. In that case the victim has to be notified. The victim also has to be notified if there's bodily harm and if it is a domestic violence case. • Question - With DV in particular, are those clients diverted and is the victim involved? With DV if there is bodily harm then diversion works a little bit differently and more as case planning for probation. • If risk is perceived to be higher than can be managed, then clinicians will provide reentry services. • Question – in defining failure, people might not show up for an appointment but doesn't mean someone isn't making progress. When it comes to determining failure, that's essentially a clinician's assessment. • New Haven Diversion also had to learn to monitor their own treatment agencies. • A forensic unit was developed which takes care of higher risk clients connected with the CJ system or likely to be. In that unit there's more monitoring and more engagement and a needs assessment based on the LSI. • Also urines are not reported to the court unless there's no movement and no interest in moving forward.

	• Clinicians have learned how to be more creative, as the court trusts the program more they tolerate the slips. • The court needs to understand what's confidential. For example in Connecticut, a man stabbed people in a coffee house and he talked to the clinician - the prosecutor pressed the clinician for information and the clinician refused. The court needs to understand the clinician does not work for the court. • Question – At any point from meeting with liaison, assessment and consultation – will there be jail time involved, or does everything take place in one day? Most happen in one day. • There is a 'gap group' that isn't let back out to the community. They might be high or intoxicated or refusing all treatment. When they are incarcerated the clinician visits them in jail. If someone does go to jail, the clinician uses that time to talk to them in lock-up. • Question - How is the liaison resourced at the court house, do they have their own office? Are they free to move throughout the courthouse? The clinician moves freely, in the beginning they take a lot of donuts and bagels to grease the skids. • In Conn. one senior judge was against the program in the beginning and thought it diluted the court, but he became one of the strongest advocates. • Clinicians had to learn not to advocate for an outcome, but rather to simply inform the court of the options. It took a lot of nursing this through in the very beginning. • Question - What is the level of licensure for clinicians? Most are licensed social workers but one is an Advanced Practice Registered Nurse. • APRN and LCSW's can right an emergency evaluation paper to have police transport someone to an emergency room, for example either suicide or severe psychosis usually needs to go to the hospital. • The transfer needs to be run by the judge to get his buy in, but the judge will often send them to the hospital. • The clinician is state employee but it's a state mental health system. In Colorado it would be a CMHC employee, but it would be based in court, similar to the JBBS programs. • In Conn. The mental health center is a state run center and is full access with in-patient and out-patient care. A referral is made for someone with a named time and appointment, which is usually the same day they're in court. The person is either given a bus ticket or a case worker will drive them over. But the geographical distance between courthouse and the mental health center is only about a mile and New Haven has been successful because of that. • Without the Conn. Mental Health Center it wouldn't work. • Question - How did this become a statewide system? Is there a battle to keep it statewide? It started in 3 large cities including New Haven, data was collected on effectiveness and that data demonstrated a reduction in competencies to stand trial by half in first year (this is explained in the vignette provided by Dr. Baranoski). That's what made the Department of Health want to fund it. • Initially the plan was to legislate that the court would order this and

	oversee placement, but there was concern within the Department of Mental Health that any judge would order inpatient. So instead the pilot demonstrated that this could be done on an outpatient model. • The Connecticut statute gives the high level overview, but the granularity isn't there. It would be great to acquire the handbook Connecticut gives to their LSCWs. Dr. Fox offered to reach out to Dr. Baranoski and ask for any written materials that take the concept of the program and gives guidelines to the court liaison.

Issue/Topic:	**Discussion:**
Review of Discussion to Date / Plan to move forward **Action:** Determine whether there should be DA representation at the meetings. Invite a VRA expert to present at the next meeting. The June meeting will include a presentation about the level of crimes and a presentation from a VRA representative	Commission consultant Richard Stroker walked Task Force members through an overview of future work plan components. *DISCUSSION* • Richard offered a synopsis of essential work plan components and goals going forward as follows: 1- Identification of eligible participants (who) 2- System elements (how) 3- Identification and collaboration with key partners 4- Provision of services by Behavioral Health (what) • The first step is to identify which lower level crimes would be eligible for diversion and the identification of individuals with specific mental health needs and frequent criminal justice entry (frequent utilizers of jails). • Ideally the eligible crimes will be lower level crimes that are non-felony and non VRA. • These would include theft, fraud, trespassing and nuisance crimes due to mental illness. • The group will need to have more discussion about the delineation between misdemeanor and felony crimes. • Sheriff Pelle suggested starting with the statute used in Connecticut and changing the names of the agencies to reflect Colorado's agencies. • The group discussed VRA crimes and whether or not they should be off the table for the discussion. There was some consensus that there's a greater likelihood for buy-in and success if the focus is on misdemeanors and not VRA crimes. • A question was asked about whether there should be DA representation at the meetings. • Richard noted that the first big chunk to tackle is 'who', and the next area to focus on will be 'how' in terms of system elements and process. The group will need to decide if they want to focus on the area of post arrest/pre adjudication. • The New Haven program is based on deferred prosecution, and periodic returns to court. The arrest will remain on the record but without a conviction. • The Task Force will need to determine if the person is moving out of the criminal justice system or receiving services while the case is still

	pending. • Doug said he thinks the focus area should be post-arrest to pre-filing, which will have different VRA considerations. He said it would be beneficial to have someone present at the next meeting who is an expert in VRA issues. • Doug also suggested not including the word 'misdemeanor' in the statute because the difference between misdemeanors and felonies is often just about money. • Sheriff Pelle reiterated that he doesn't want to battle with advocacy groups to get the program off the ground. Domestic violence and other victim advocacy groups will not support a program that includes any crimes of violence. • Other members of the Task Force said they also believe it will be a losing battle with advocacy groups to include any crimes of violence. • Domestic violence cases come with a lot of supervision. • Ideally, this would work great as a pilot program – then with solid data there could be an effort to push it statewide. • The criteria for inclusion at the front end of the program is essential to ensure the right balance, so clinicians aren't doing a ton of fruitless assessments. • Question - How does this translate in Colorado? There isn't one umbrella organization that provides mental health services. • Richard asked if the Task Force wants to break into working groups to tackle the work, or if they want to work on each element as a group. • Dr. Tucker replied that she believes the group does better work when they tackle the issues together as a full group, rather than breaking into smaller working groups. • At the next meeting there should be a presentation about the level of crimes preferably from Doug, and a presentation from a VRA representative. • Richard reminded Task Force members that the goal is to conclude this portion of the work in three months, which means the group will need to complete one topic each meeting for next three months.

Issue/Topic:	**Discussion:**
NEXT STEPS AND ADJOURN **Action:**	Richard summarized that the group will tackle one issue area each month over the next three months as follows: 1- Identification of eligible participants (who) - JUNE 2- System elements (how) - JULY 3- Identification and collaboration with key partners and provision of services by Behavioral Health (what) – AUGUST

Next Meeting – ROOM CHANGE

June 8, 2017 1:30pm – 4:30pm 710 Kipling, 3rd floor conference room