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

July 13, 2017 1:30PM-4:30PM
700 Kipling, 4th Floor Conference room

ATTENDEES:

TASK FORCE MEMBERS

Joe Pelle, Boulder County Sheriff, chair
Frank Cornelia, Colorado Behavioral Healthcare Council
Patrick Fox, Officer of Behavioral Health
Norm Mueller, Defense Bar
Abigail Tucker, Community Reach Centers
Joe Morales, Parole Board
Jamison Brown, Colorado Jail Association
Tina Gonzales, Colorado Health Partnerships
Evelyn Leslie, Private Mental Health Providers
Patrick Costigan, 17th JD District Attorney's Office*
Maureen Cain, Criminal Defense for Doug Wilson

ABSENT

Dave Weaver, County Commissioner
Charles Smith, Substance Abuse and Mental Health Services Administration
Matthew Meyer, Mental Health Partners
Doug Wilson, State Public Defender
Lenya Robinson, Healthcare Policy and Financing
John Cooke, State Senator, District 13
Charles Garcia, CCJJ Member At-Large
Michael Vallejos, district court judge, 2nd Judicial District

STAFF

Richard Stroker, CCJJ consultant
Kim English, Division of Criminal Justice
Laurence Lucero, Division of Criminal Justice

GUESTS

Dr. Reo Leslie, Co. School for Family Therapy	Adam Zarrin, Governor's Office
Vincent Atchity, Equitas Foundation	Moses Gur, CBHC
Gina Shimeall, Defense Attorney	
Peggy Heil, Division of Criminal Justice	

Issue/Topic:	Discussion:
Welcome and Introductions	Mental Health/Jails Task Force Chair Joe Pelle welcomed the group and asked Task Force members and attendees to introduce themselves. He welcomed Patrick Costigan, a prosecutor from the 17th Judicial District, and explained that he is now an official member of the Task Force. Sheriff Pelle reviewed the agenda and asked CCJJ Consultant Richard Stroker to provide a recap of the June meeting.

Issue/Topic:	Discussion:
Recap of June meeting results **Action:**	Richard Stroker reviewed the outcomes and decisions that were agreed upon by the group at the June meeting as follows: **Decisions previously agreed upon by the group:** I. <u>Develop a model/pilot program</u> That can be used to divert individuals with behavioral health needs/issues from jail – so that their needs can be addressed by appropriate service providers in the community. II. <u>Timing of this Diversion</u> After arrest but pre-filing III. <u>Eligible individuals for diversion under this pilot</u> a) Individuals with Behavioral Health needs/issues (see SB17-242) b) Charged with committing "lower level" crimes: a. Petty offenses b. Misdemeanors c. Lower felonies (Felony 4, 5, 6) d. Drug Felonies (D3 and D4) e. Non-VRA crimes c) Who may be frequent jail utilizers DISCUSSION: Richard noted that at the June meeting Patrick recommended looking at SB17-242 for a comprehensive definition of behavioral, mental health and substance use disorders. He explained that copies of the legislation and definitions are in everyone's packets. Richard described that the next steps for today are to focus practical considerations including how this would work in the jail and how to fold in treatment, etc.

Issue/Topic:	Discussion:
How/What/Sequencing – System elements and key partners **Action:** 1. Identify a brief screen that could be standardized 2. Locate the 2005 legislation establishing the DOC screen	Richard facilitated a group discussion on the sequencing of a model behavioral health diversion program including system elements and key partners. The first topic area debated was that of <u>WHO would identify eligible participants, how it would occur and through what method.</u> Discussion: • People need to be able to be identified NOT by a specialist, but by whoever the intake person is. Not necessarily a trained clinician or member of the behavioral health staff. • Oftentimes the assessments and information already exist in the system and people are already known by name. The info is often available but is also often siloed. For example information available in Boulder doesn't connect with information from Jefferson County or Adams, etc. • Many jails have a booking nurse, including jails with the Jail Based Behavioral Health Services Program (JBBS). However rural jails or busy metro jails can run into significant delays when it comes to accessing assessments. • Oftentimes the client will explain their own issue, their diagnosis and their meds. • The bigger challenge is with the handoff – not necessarily identifying the folks. • A standard screen would be helpful – but every jail has a different kind of software. • This first step for this group should be to identify a brief screen that could be standardized. • There is an important difference between a screen and an assessment. A screen can be done by a lay person but an assessment usually has to be done by someone that has been trained. It's a credentialing difference. Colorado is a state that doesn't have mandatory jail accreditation standards, they're voluntary in Colorado. • Charlie explained that state law lays out a standard behavioral screening process for the Department of Corrections (DOC) which is also an option for jails. It was originally written in 2005 to include counties but got marked up in the legislative process to focus on DOC. It could be valuable to pull up that law. It might be a platform by which this approach could be applied. • Joe explained that 70 percent or more of the people booked into our jail are able to post bond or make PR and are only there a few hours, therefore they are not screened. • A standardized screen would provide consistent information and would be a great data source. • Any of the following people could administer a screen: pretrial services staff, an arresting officer, jail staff, nursing staff and even the judge. • It would be critical to clarify WHOSE job it is to administer the screen while also creating a network to make sure that it gets done.

- WHAT the screen looks like is a different questions – this group will need to identify models or promising screens.

The second topic area discussed was that of <u>HOW the assessment would work and whether or not everyone who is potentially eligible would need an assessment.</u>

Discussion:

- Much of this information already exists locally; a local provider might very likely already have this information. If the group chooses to use existing resources many front-range jails already have JBBS and can access that info.
- If someone were being trained it would need to be made clear that this is a clinical assessment, not a forensic assessment.
- The person performing the assessment would need to be an individual who at a minimum has a master's degree, is a licensed MH professional or is supervised by a licensed MH professional.
- The group may want to be generous in our definition in order to be able to access enough providers, while also establishing a minimal standard.

The third topic area discussed was that of <u>HOW the information is shared and when. What is the method for information sharing?</u>

Discussion:

- Abigail expressed caution around implementing a process which requires report writing and extensive documentation as it can significantly slow down a system. Additionally, the person who receives the information should <u>not</u> be another person between who makes the decision. The assessment is need-to-know information. Make it a consistent person and make it a conversation. What is good with Connecticut is the level of trust and trust will need to be built over time. Information should be shared by phone and in person - and decrease the number of people you have to go through to get the info to the decision maker.
- Joe explained that for the PACE program in Boulder the process is that the funnel is wide at the top but funnels into the decision maker.
- Question - what happens to the document with the recommendation? Any behavioral health professional will have to document the info. And it will need to be maintained.
- Info sharing adds complexity but sharing info from a jail to a therapeutic provider will be valuable. The other piece is about sharing WHAT information because there are protections. There is a nuance when it comes to sharing the info and legal records sharing of information is complex too.
- Sharing info criteria is important dependent on whether something is pre-plea or not.
- If this is created as a pilot, an individual county or maybe three counties could go in together for a proof of concept model.
- There has to be a voluntary match. There has to be a way to make a recommendation and then a way for the treatment provider to agree to

treatment. Post arrest, plea conviction.

- There could be a problem with when the screening happens especially if someone comes in late at night and meets the magistrate the next day, there could be very limited turnaround time. It's doable; it's just about how it's done. It could also be harder the more rural the community – but it could be possible.
- The assessment would still happen before someone gets to the judge. The person will need the screen, then they will meet with the MH professional for the assessment. Part of what will make this work is the relationship between the stakeholders and communication.
- Connecticut took a long time to establish the process. They started with a pilot and then went statewide, but it took a long time.
- The DA, PD, Judges and jail administrators would ALL have to buy in. And the receiving healthcare system has to buy in too. Community substance abuse treatment programs or mental health program needs to buy in too.
- A dedicated team meets every morning and there is mutual understanding about the case.
- In a mental health court someone has to plead guilty/post adjudication. This system would be pre-plea. Mental Health courts aren't available in every jurisdiction but the ideal would be that this program would be available in every jurisdiction.
- The volume is at intercept 1 and 2, one outcome of this could be a huge reduction in competency evaluations.
- A recommendation will need to be made and supported with information. If a recommendation isn't made than it is assumed that there isn't a recommendation.
- In the Connecticut Model it seems in many cases there was just an agreement between the judge and others and that many recommendations were uncontested.
- Connecticut is a tiny state with strong centralized state government. The MH experts are state employees who work in the courts. Employees in the county jail work for county mental health providers, who worked in the courts every day. Over time the process went a lot faster.
- The criteria for acceptance into the diversion program need to be agreed upon by all parties from the start. When an individual meets such criteria, and because they meet the criteria, the recommendation is automatic. The criterion has already been agreed upon by all the parties – so the 'recommendation' is about the criteria being met.
- Also in Connecticut, the person comes before the judge with the recommendation for an appointment with a treatment provider and that appointment has already been scheduled.
- In Connecticut if the criteria have been met there is agreement from the mental health center, the appointment has been made, there is buy-off from the DA and PD and transportation has been established.

	The fourth topic area discussed was that of <u>WHO makes the diversion decision.</u> Discussion: • The judge makes the decision and accepts the individual into the program. • The judge would advise that they read the report and would indicate that the person has been identified with a disorder. • A bond provision would allow them to have a PR bond without posting any of their own funds. • In exchange they would agree to go to a community reach center within 24 hours. Failure to do that would result in a warrant for their arrest. • This is not just a pre-bond issue. It's a diversion program that would be instead of being released on a PR bond. This is true diversion. If it fails then the charge is reinstated. The person is diverted; it doesn't have to be a plea. The upfront decision is made by the DA, PD and judge that this is appropriate. • Requiring the DA to do anything makes this a non-starter. • In Jefferson County the diversion program requires a guilty plea. • If offenses that involved victims are removed from eligibility, it could be treated differently than a guilty plea. It could be unsupervised deferred judgement. • In Connecticut the receiving agency reports to the court about whether someone is doing fine or not doing fine. It shifts management of the case from the justice system to the behavioral healthcare system. • Patrick said that when it comes to Diversion, the court doesn't have any power over the person. If someone doesn't do well a complaint is filed. • Essentially under this program a person would start in the jail, and then they're in the BH system, then the BH system punts back to the CJ system if the person doesn't comply. Most of this takes place in the BH health world; if it doesn't work the person will be returned to CJ system. • In creating a MH diversion pilot program it's easy to conduct a system where there is a review by the court, if the person doesn't cooperate than the diversion goes away and the case can go forward. • Diversion means no charges, deferred means charges go away

Issue/Topic:	**Discussion:**
NEXT STEPS AND ADJOURN **Action:** 1. Abigail, Charlie, Jamison and Joe to bring sample screening instruments	Richard summarized the day's discussion as follows • The group agreed to a general approach with much to be resolved. • For today's purposes - At this initial appearance before a judge, with the information provided, a person will be recommended into a program. There is a diversion agreement created at that time with expectations for the individual. There is coordination with a community provider and a plan will be put in place. The court will review the case at a later date to determine compliance, maybe at the three or four month mark. If a

person receives a favorable report from the provider the case is moved to the behavioral health realm. If there are problems the charges can be filed and will go through the rest of the system.

Richard summarized the work yet to be done:

- At next meeting write something up that captures the framework.
- Identify or solicit volunteers who may be amenable to participation.
- Identify the things we need to drill down on a little further.
- Richard asked who could bring some screens for the group to evaluate. Abigail and Charlie volunteered to bring some examples including the old DOC screen. Joe Pelle also offered to bring some screening instruments. Jamison will bring one from Denver.
- The Task Force will complete its framework at the August meeting, then begin the work of engaging with a community provider so this pilot could actually be realized.
- The group also needs to identify jurisdictions willing to work on the pilot and bring those people in to get their buy in.

<u>August meeting</u>
Framework
Screens and Assessments
Working with community partners

Miscellaneous:

- The issue was raised about competency and if someone violates the conditions of a PR bond and it's a felony, it will be a felony violation charge.
- Question – what about people who are incompetent? If someone is incompetent they shouldn't be prosecuted or in this program.
- The screening and assessment are for impairment, not incompetence. Someone can be severely impaired, but if the diagnosis is so grave there is concern about someone being in the community they won't be eligible.
- You can't place criteria on incompetent people.
- Still need to discuss exclusionary criteria – need to address this. Incompetency

The meeting adjourned at 3:45pm

<u>Next Meeting</u>

August 10, 2017 1:30pm – 4:30pm 700 Kipling, 4th floor Training room