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

August 9, 2018 1:30PM-4:00PM
710 Kipling, 3rd Floor Conference room

ATTENDEES:

TASK FORCE MEMBERS

Joe Pelle, Boulder County Sheriff, chair (on the phone)
Patrick Costigan, 17th JD District Attorney's Office
Abigail Tucker, Community Reach Centers
Tina Gonzales, Beacon Health Options (on the phone)
Jamison Brown, Colorado Jail Association
Jagruti Shah, Office of Behavioral Health
Megan Ring, Public Defender's Office
Frank Cornelia, Colorado Behavioral Healthcare Council
Cynthia Grant, AllHealth Network
Norm Mueller, Defense Bar

ABSENT

Charles Smith, Substance Abuse and Mental Health Services Administration
Joe Morales, Adult Parole Board
Benjamin Harris, Department of Healthcare Policy and Financing
John Cooke, State Senator, District 13

STAFF

Richard Stroker, CCJJ consultant
Laurence Lucero, Division of Criminal Justice
Kevin Ford, Division of Criminal Justice

GUESTS

Vincent Atchity, Equitas Foundation
Peggy Heil, Division of Criminal Justice
Danielle Weittenhiller, Office of Behavior Health
Dr. Shasha Rai, Denver Jail Researcher
Lucy Ohanian, Colorado State Public Defender

Issue/Topic:	Discussion:
Welcome	Richard Stroker, Consultant to CCJJ, welcomed and informed the group that Mental Health/Jails Task Force Chair Joe Pelle was unable to attend in person but will be attending the meeting via phone. Richard welcomed new Task Force members, Megan Ring from the Colorado Public Defender's Office to replace Doug Wilson, and Dr. Cynthia Grant from AllHeath Network to replace Matt Meyer. Task Force members and guests introduced themselves.

Issue/Topic:	Discussion:
Recap of July meeting **Action:**	Richard Stroker provided a recap of last month's meeting. The group has worked effectively for the past months on a number of issues which relate to individuals who come to the jails and have significant mental health issues. 1. The first area tackled by the group was about the issue of individuals who are placed in the jails because of specific behavioral health issues but do not have criminal charges. The Task Force produced recommendations where behavior health interventions occur during the contact with law enforcement officers to prevent jail detention. 2. The second area of work focused on improving opportunities to divert people who have committed low level offenses from the criminal justice system into the behavior health system. 3. The Task Force is now focused on the third area which is providing mental health services for individuals who are struggling with significant behavior health needs that are beyond the jails' ability to provide. Those individuals are not eligible for diversion or release due to the seriousness of their charge. The group is working on the possibility to move individuals from jails to other locations to receive necessary mental health services while maintaining their inmate status. A working group including Abigail Tucker, Jagruti Shah, Jamison Brown, Frank Cornelia and Moses Gur have developed the outline of a recommendation regarding how this population could be managed in other locations with services.

Issue/Topic:	**Discussion:**
Implementation/Designation of regional, secure mental health facilities	The written model that was presented at the last meeting has been fleshed out to include July's discussions. The written model (in blue below) was included in the meeting materials: Colorado State Forensic Jail Stabilization Unit Goal: To reduce jail length of stay for individuals struggling with significant behavioral health issues that exceed jail resources to safely manage and adversely impact individuals' ability to rapidly access services and process through the justice system. Intended Population: Individuals booked into Colorado jails on misdemeanor or felony charges who are ineligible for redirection programs and whose behavioral health needs exceed jail resources and as such require an appropriate setting for stabilization and treatment; often such a facility would need to be 27-65 designated. The Task Force estimates that the size of the intended population would be between 100-120 individuals per year. Facility: Private hospital or private acute care facility that is 27-65 designated and credentialed with all Regional Accountable Entities (RAEs) for the Department of Healthcare Policy and Financing (HCPF) reimbursement. Ideally at least four facilities scattered throughout the State to ensure regional access with locations based on a balance of geography and volume. Services: Services are two-fold and can be iterative depending on individual case. o Behavioral health stabilization for acute needs o Competency Evaluation & Restoration o Services that prepare the individual for return to the jail setting Chain of Custody & Security: To address Sheriff Department's needs for chain of custody, facilities will work with the Sheriff's Office in the design and implementation to ensure access controls meet demands of detention for individuals in custody. It will be necessary to draft a contract to document the chain of custody from the detention facility to the private facility. This does not impede facilities from hiring their own security staff. Process: • Determine Eligibility • Custody Transfer • Treatment (stabilization, restoration, or both)

- Transition back to Jail & Court System (ensuring rapid process to mitigate decompensation risks upon return to jail)
- Re-entry post court hearings

Determining eligibility for transfer:

- Within the targeted population highlighted above, facilities may consider whether the individual would meet 27-65 criteria but for being in the jail setting.
- Jail officials would need to decide if the individual's need exceeds the resources available in the facility. These considerations should focus on maintain the safety of all individuals involved.
- Ultimately, it is the jail's decision on whether a transfer should happen. Following the decision, courts should be notified but it is important to not require its approval.
- It will be the jail's responsibility to transfer the individual to the appropriate facility.

Parties involved in the process:

- The jail and its identified mental health professional (whether internal, vendor, or ad hoc) would determine if the individual meets 27-65 criteria and exceeds jail's capacity to provide services.
    - Some jail facilities will require new resources to access mental health professional supports to make this determination.
- Facility staff will need to be prepared to navigate and accept referrals. Jail personnel will need an accessible methodology to make a referral directly to the facility staff.
    - It is critical to ensure that referrals can be processed within hours to make a determination and proceed on appropriate next steps.
    - Within the referral process, jail officials will need to inform the facility of any specific restrictions placed on the individuals (e.g., visitation limits).
- Jail personnel will notify courts of transfer as necessary and appropriate.

Process at the Facility:

- Facility will need to have access to stabilization techniques, specifically

medications, 24/7 to ensure that those needs can be addressed immediately upon acceptance.

- The facility will need to be secure enough to manage the population and earn the comfort of jail officials (e.g.; Locked doors with staff access only, ability to provide electronic health record privacy for high profile case)
- It will be necessary to staff the facility at the highest level of care that may be needed to ensure that all acuity can be appropriately accepted.
    - Some potential considerations: 24/7 nursing staff and access to a doctor who can provider orders.
    - High acuity populations that require 1:1 clinical staffing.
    - Potential medical oversight for any potential withdrawal management needs.
    - Security staffing agreements that meet sheriffs' needs.
    - Recruitment and retainment considerations for a very specific workforce.

Remaining Questions:

1. Population estimate calculations to be confirmed
2. Payment for facilities both for treatment and other costs
3. Workforce consideration to effectively staff such a facility
4. Chain of custody agreement & other specific security considerations

Dr. Tucker reviewed the document with the group and made the following comments:

One of the barriers of this concept is that jails are not designated by the Office of Behavior Health as "27-65" facilities and therefore jails cannot initiate procedures for involuntary administration of medication. The only exception is when an individual is placed on hold in the State Hospital for competency and returns to jail, the hold can be maintained in the jail until the next court date. Unfortunately, while many jails are familiar with this process, many still do not have the staffing to institute that permission.

The receiving facilities would be 27-65 designated private hospitals or private acute care facilities and eligible for reimbursement for Medicaid. The primary goal is to stabilize the acute needs regardless whether competency is raised or not.

The process envisioned would be similar to a medical emergency and initiated by the Sheriff's Office. No court order would be needed.

Important protocols should be in place to ensure access controls which meet

demands for detention for individuals in custody.

The receiving facilities should have the ability to review referrals 24/7.

DISCUSSION:

The group discussed at length the estimated number of beds that are needed across the state and reached consensus that a number between 100 to 150 beds seems appropriate based on the data from Denver and that it represents a realistic number of 25 beds in the four quadrant of the state. It was also mentioned that in 2009, about 150 beds were reduced at Fort Logan.

Sheriff Pelle cautioned to distinguish between the number of beds needed for the population with severe acute needs and for people on the waiting list for competency evaluations and restorations. He explained that, in the Boulder jail, there are numbers of individuals on the waiting list for competency restoration but very few cases are actually acute.

Richard Stroker commented on the challenge to estimate a precise number of beds needed but believed that, if the local jails establish contracts with the receiving facilities that includes a number of beds in the event that those services are needed, an exact number may not be relevant.

Dr. Tucker added that this concept is not envisioning the construction of new facilities but the use of beds in existing facilities. Local jurisdictions would have the ability to skim down or increase according to the needs and contract in place with the facility in the region.

A potential concern was expressed that, given the backlog of cases for competency beds, beds might get filled first with competency evaluations and restorations instead of being filled with those who really need it and with acute condition. *The intent of this recommendation is to attend someone's immediate need for stabilization regardless of the need of competency.*

A concern for security and safety in the receiving facilities was expressed. In most cases, the untreated mental health condition makes a person dangerous and, once treated with appropriate medication, the acuity and the associated safety risk decrease tremendously. Additionally, the process described in this recommendation includes security protocols agreed upon between the jails and the receiving facilities. It was also highlighted that the receiving facility should have right to accept or decline a jail detainees based on the number of beds available, the level of staffing and ability to keep the person safe.

The group discussed at length the workforce consideration and how to ensure consistency of the level of services. It was suggested that criteria could be defined to ensure consistency across the state but acknowledged that these

efforts will primarily depend on the resources of the jails and the relationship established between the jails and the regional receiving facility. These cases may not look the same between jurisdictions but the jails will determine when they do not have the capacity and/or the credentials to provide the kind of services that are needed.

Richard Stroker directed the group to a document with suggested language for the remaining questions (in Blue below).

Payment for facilities both for treatment and other costs:

- The transferring jail will be responsible for paying for the costs of services provided by the receiving facility during the first 24 hours after the transferred detainee is placed at the receiving facility consistent with the terms of any agreements developed between the transferring jail and receiving facility concerning costs and expenses for the care of transferred detainees.

- It is expected that the receiving facility will seek reimbursement from Medicaid and other appropriate sources to address costs and expenses associated with the provision of care and services to transferred detainees beyond the first 24 hours of care after placement of the transferred detainee at the receiving facility.

Chain of custody agreement & other specific security considerations

- The transferring jail will be responsible for transporting or arranging for the transportation of the detainee to the receiving facility.

- The transferring jail will be responsible for providing or arranging for necessary and appropriate security for the detainee while the detainee is at the receiving facility.

- The transferring jail may utilize its own staff to provide necessary and appropriate security for the transferred detainee, or may develop agreements with other counties, law enforcement agencies or other entities to provide necessary and appropriate security at the receiving facility.

DISCUSSION:

What happens if a jail detainee is not covered by Medicaid?
Most jails try to enroll every inmate as they come in. If an individual is not covered, the jail will pay for the services as the individual is still in the jail custody. Other suggestions for Medicaid coverage should be explored and included in the recommendation.

The receiving facility has to be designated as an acute general care facility in order to receive Medicaid payments. There is no parity between medical and behavior health with regards to emergency transportation as "acute care" is defined in the federal guidelines as medical emergency and not behavioral.

One of the next steps for this group is to identify the facilities across the state that would qualify for Medicaid reimbursement.

If an individual has an emergency medical condition, is the hospital reimbursed only for what is covered by Medicaid or is there extra funding for this service?
The receiving facility is only reimbursed for what is covered by Medicaid.

What would be the incentives for the receiving facilities to accept this population considering that services might cost more than typical care? Should additional funding be identified?
It was suggested that, if the security cost and Medicaid coverage are ensured and the services are cost neutral for the facilities, this may be good incentive, as '*a filled bed is better than an empty bed*'. It was believed that the services might not cost more than typical care considering that if the services are not covered by Medicaid, the jails would pay for services.

The chain of custody agreement and other specific security considerations generally depend on the relationship and agreement established between the jails and the receiving facilities.

Should the group identify cost and funding mechanism for such process?
It was suggested that funding for services is already handled one way or another.

Sheriff Pelle believed that the primary issue is not the payment but the need for services that are beyond the jails' ability to provide. The issue remains that there are individuals in the jails with acute mental conditions who actively try to harm themselves and facilities won't accept them. These individuals continue to pose a real danger unless they are medicated. He believed that jails are willing to ensure payment within their existing budget and will work with the hospitals for the payment/reimbursement of services.

Dr. Tucker commented that there are costs that Medicaid will not cover and suggested that the group discuss further the issue of cost and funding.

Frank Cornelia suggested that, adding to existing resources, local jurisdictions may want to contribute jointly to a percentage incentive to support this project.

Dr. Grant also suggested that a call for service could be placed to identify facilities that may be willing to partner. She agreed that incentives might be necessary for other costs the facilities will have to consider such as specifications associated with building design to accommodate this population, staff training, security equipment etc.

Sheriff Pelle expressed the idea of placing a Request for Service (RFS) which would allow interested facilities to respond with a proposal that includes all the

	required subsidies they need to provide this service. It was suggested that the role of the state could be to post a RFS to help the counties identify potential entities interested to partner. Once interested parties have been identified, contracts may be established at the local level. Jamison Brown asked the group for clarification or confirmation on the M1 hold legislation. He understood that if an individual is placed on a M1 hold and has criminal charges on his/her record, facilities will not admit the person. None of the task force members have heard of this particular issue and do not believe criminal charges are exclusion criteria but may be hospital policy. The group agreed to clarify this issue at future meetings.

Issue/Topic:	**Discussion:**
Next steps and Adjourn	The working group will incorporate all comments and discussions into the drafted document. At the next meeting, the group will discuss the roles of the state versus counties, incentives for the local facilities, will define the type of institutions, and how to incorporate the idea of a Request for Service into the recommendation. Sheriff Pelle and Richard Stroker thanked the group for the continued participation and efforts. Meeting was adjourned at 3:10 pm

Next Meeting

September 13, 2018 1:30pm – 4:00pm 710 Kipling, 3rd Floor Conference room