Community Corrections Task Force
Colorado Commission on Criminal and Juvenile Justice

Minutes

August 8, 2013, 12:30PM-4:30PM
710 Kipling, 3rd floor conference room

ATTENDEES:

CHAIR

Peter Weir, 1st Judicial District
Theresa Cisneros, 4th Judicial District, District Court Judge

TASK FORCE MEMBERS

Glenn Tapia, Division of Criminal Justice
Gregg Kildow, Intervention Community Corrections Services
Shannon Carst, Colorado Community Corrections Coalition
Greg Mauro, City and County of Denver
Dennis Berry, Mesa County Criminal Justice System
Christie Donner, Criminal Justice Reform Coalition
Kathryn Otten, Colorado Department of Labor and Employment
Steve Reynolds, 9th Judicial District
Harriet Hall, Jefferson Center for Mental Health (phone)
David Lipka, Public Defender (phone)
Joe Cannata, Voices of Victims
Eric Philp, Division of Probation Service
Claire Levy, State Representative
Steve Hager/DOC Division of Adult Parole and Community Corrections

STAFF

Paul Herman, CCJJ consultant
Kim English, Division of Criminal Justice
Germaine Miera, Division of Criminal Justice

ABSENT

Anthony Young, Parole Board
Steve King, State Senator
Stan Hilkey, Sheriff, Mesa County
Bill Gurule, 12th Judicial District, Probation

Issue/Topic:	Discussion:
Welcome and Introductions	Peter Weir and Theresa Cisneros welcome the group and preview the agenda.

Issue/Topic:	Discussion:
Process Working Group – Report Back **Action**	During the July meeting Glenn Tapia presented a thorough process map of the various progressions for all client populations coming into and moving out of community corrections. The group made it through most, but not all of the populations. In order to ensure the task force has a complete understanding of all the processes, Glenn returned to his original presentation to wrap up the final few slides. The goal of the presentation was to identify issues of concern and add them to the list from the last meeting. *DISCUSSION POINTS* • **Diversion IRT – Referral Process** -There are many ways for an offender to land in an IRT bed. -Often, they're already in Community Corrections but could have just been caught with new drug use or they could've had a new assessment. -The originating case manager will make a referral to the provider. -An out of district referral needs board review and is then placed on a waitlist and given a bed date. -IRT is a closed model (90 days) so there is a waitlist. --A Diversion IRT client can go to any of the 5 IRT programs. -This is the same issue with transition clients transferring – they can go to any of the five programs. -77-80% of those with needs are matched to a corresponding program, with this level of treatment there is better success. -In an ideal world there would be IRT programs and placements at every location. -The Diversion waitlist for IRT is about 90 days. • **Transition IRT – Referral Process** -The DOC offender is assessed when they first arrive at DOC. -Those offenders then may or may not go to a prison TC. -DOC clients that end up in an IRT bed may or may not have previously spent time in a DOC TC. -The DOC case manager will generate and initiate the referral. -DOC will refer a potential IRT offender to all 5 providers at once (this is called a shotgun referral). -This, however, does not include a referral to JERP. -DOC inmates will say the screening process at DOC lends itself to deceiving DOC officials in order to lower their score, so they would be eligible for

Issue/Topic: (continued) Process Working Group – Report Back **Action**	treatment. This was actually probably a prior practice. However, there have been changes in DOC practices regarding the needs of seriously mentally ill inmates. -It was stated that yes, offenders have been known to pretend to not need treatment. This can often happen when an offender doesn't want to be stigmatized. -DOC is currently implementing a brand new classification instrument because of the past concern over inmates feeling they had to minimize their condition. -JERP is not IRT or RDDT. -As for DOC classification changes – the Department is revamping P-codes and they're becoming much more targeted. There are, however, some difficulties regarding transition offenders and Jackie McCall from DOC will be joining us at the next meeting to clarify these issues. -In theory IRT is primarily for high risk/high needs offenders with substance abuse issues. -RDDT is more for high risk/high needs offenders with substance abuse AND seriously high mental health issues. -With a shotgun referral there is a blast out to all five providers, then the offender is accepted by one, and put on the waitlist and eventually placed. -Some DOC offenders may be on the waitlist for IRT but have already completed the TC at DOC. As a result they could bypass IRT placement and be placed in regular community corrections with outpatient treatment as continuing care. -Ideally, an offender should go to an IRT program in the region they're going to be placed in for their regular community corrections stint. -IRT referrals don't go to a primary preferred facility – it's always the straight shotgun approach. -A northern Colorado based offender will go to San Luis for treatment, and then back to community corrections in Greeley. -This is a problem with post release continuity of care for DOC folks. -The 5 IRT's are in Larimer, Mesa, Denver, Weld, Alamosa. -130 beds altogether - A person destined for IRT and community corrections is usually on two waitlists. -The 2 waitlists are the DOC waitlist for IRT (meaning a community corrections inmate could be held because they're waiting for IRT but have already been in a TC at DOC) then there's a waitlist at the provider level as well. -What can happen is that the person is approved for IRT but still waiting for community corrections approval. -IRT beds are used by the DOC, Division of Parole and state district courts, and residential community corrections programs -80% of IRT beds are DOC beds. -There is definitely a need for more IRT beds. -Diversion referrals to IRT can sit and wait in community corrections and get intensive out-patient treatment as the next best thing. -Are there empty beds in any region? No – they're maximized. -If someone is assessed as needing IRT but goes into TC could that be hurtful? -Should there be an IRT program in DOC so that people could be placed there

Issue/Topic: (continued) Process Working Group – Report Back **Action**	as they transition out to community corrections? -Could that be a solution and eliminate a couple of steps? -There are regulations from the Office of Behavioral Health for IRTs - for every 12 clients there is one case manager and a therapist. It's the rule of 12. -The cost and actual funding for IRT is currently more in sync. The last time an RFP request was put out the financial model was not workable for some programs. -Another issue is that IRT providers also have to be licensed by OBH. -Another ongoing problem is that the level of state regulation with specialized beds has doubled or tripled the regulation requirements for a regular 'vanilla' bed. -Not every program should have IRT beds, it's complicated and clinical. -There should, however, be a fix around the shotgun process. -IRT has a central scope of work. It's a 90 day program with 40 hours of treatment per week, treatment 6 days/week. Groups need to be run by at least a CACII with minimum dosage, length of time, etc. -Therefore the dosage is the same program-to-program but there's variation in the schedule of classes. -DCJ just completed a study by program and looked at 45 day IRT programs compared to 90 day IRT programs. 90 day IRT folks are a little more serious. Most people succeed in IRT, but after community corrections AND IRT the success rate is 3 out of 4. That's a much higher success rate with a walkaway rate of less than 2%. There is a lot of positive engagement with these IRT clients. -IRT programs produce a client that is really easy for the community corrections facility to manage. -Is there standardization in the KIND of therapy, Cognitive Behavioral Therapy, etc.? Yes. -all IRTS are CBT driven with a list of curricula. Therefore about 20 hours/week of programming would be the same from program to program. The other 20 hours may vary by program. - **Diversion RDDT – Referral Process** -This referral can happen presentence, in probation, or when the offender gets into the community corrections program. -This can be an in or out of district referral. -Often, a Diversion referral is originally placed in a regular bed. Then there could be a clinical problem diagnosis or behavioral problem, the case then gets staffed by the treatment team, a referral is made, and then they're placed -This is how the bulk of the referrals are made. -There are 120 RDDT beds in the system. -There are 6 providers of RDDT. -Jeffco has RDDT beds but not IRT beds.

Issue/Topic: (continued) Process Working Group – Report Back **Action**	• **Transition RDDT – Referral Process** -Transition IRT's are formally flagged or identified, but RDDT's are not. -These offenders are usually placed in a regular transition bed, and then community corrections looks to see if they meet the criteria. -P-codes don't work here because P-codes are specifically about mental health - not substance abuse. -The screening for dual diagnosis is not done at DOC. -The process at Fillmore is different due to the evolution of that particular program. It was originally a modified TC and took folks with mental health issues out of San Carlos, long before RDDT. -Fillmore has kept their relationship with the prison and in-reaches to DOC and pre-selects inmates. -With Fillmore, the DOC case manager and facility are coordinating together. -There is a lack of a formal transition process to RDDT beds from DOC and there needs to be a better process. -At next month's meeting Paul will ask Jackie to present all of the duties of a DOC case manager to see where the referral fits into their priorities. - Outcomes from the DOC LEAN initiative have prompted some changes regarding many of the CM duties at DOC. - When CTAP (Colorado Transition Accountability Plan) is in place at DOC it may fix a lot of these issues. -If DOC had placement coordinators, the case manager and coordinators would likely have vastly different duties. -From the institutional side there are case managers, re-entry/pre-release specialists, and clinical staff. For some offenders there's a marriage of clinical and case management, especially with those who are dually diagnosed. -Clinical and case management workers at DOC are working mostly with mental health cases, not with the dually diagnosed cases. -What a case manager knows and what a clinical person knows may be different. -There are currently 'whole package' problems regarding appropriately identifying an inmate's issues, then preparing the inmate and referring them. -This is about responsivity and matching the right people, to the right services, at the right place at the right time. -Another problem is that a lot of these decisions on transferring someone are date driven. -The triggers in the system are based almost entirely on times and dates and not readiness. There is no real integration, which drives inefficiency for case managers. -There are also HIPPA issues regarding waivers and confidentiality. -Also, the quality of info that the board and providers get is problematic. And without quality information, the default decision for boards is to usually just say 'no.'

Issue/Topic:	Discussion:
List of Statutory Prohibitions **Action**	At the July meeting someone raised the issue of crimes statutorily ineligible for a direct sentence to community corrections because of a mandatory DOC sentence. Pete Weir pulled together a list of those crimes and has provided that to the group to review.
Issue/Topic: (continued) List of Statutory Prohibitions **Action**	*DISCUSSION POINTS* • This list was of excluding crimes revised a couple years ago. • This is current policy set up by the General Assembly for direct sentence ineligibility. • When someone pleads guilty to a crime of violence (COV) there's a stipulated range that can't be changed. • If someone is convicted of a COPD (code of penal discipline) violation it's unlikely they would be reconsidered to community corrections – this is the takeaway. • Drug offenses are now slightly different after the passage of SB 250. • Under the new scheme, only DF1 drug offenses will be ineligible for community corrections (when SB 250 goes into effect). • DF1s will now have a minimum of 8 years. • This list will need to be revised in light of the new drug laws

Issue/Topic:	Discussion:
Broader System Needs **Action**	Paul Herman led a discussion with the group regarding broader system needs for community corrections. During the last couple months, this task force has been engrossed in discussing details of the inner workings of community corrections facilities especially as it pertains to offenders moving in and out of the different halfway houses. Next month we'll invite representatives from DOC to help shed some light on both the clinical and case management duties inside the institutions. Paul explained that in reviewing the original charge for this group one of the issues the CCJJ hoped this task force would study is the broader system needs of Colorado's community corrections system that may not currently be met. The conversation at CCJJ last January centered around the fact that the community corrections system started 30+ years ago and has been evolving ever since. A lot of that evolution has been internal due to driving factors on behalf of stakeholder needs. This group needs to look at the evolution of community corrections to see if there are current system needs <u>now</u> that aren't being met? Are there business

Issue/Topic: (continued) Broader System Needs **Action**	practices not being met regarding boards and providers? Are there statutory revisions or broader systemic kinds of suggestions to improve the system? Are there policy recommendations that could help? *DISCUSSION POINTS* • One major issue now, at least in Jefferson County, is a NIMBY ("not in my backyard") problem. Jeffco County Commissioners had a terrible time recently trying to relocate a halfway house. • Is this a statewide, broader policy level issue or just something that has to be dealt with jurisdiction to jurisdiction? • Should this group start by looking at business practices for DOC, boards and providers? Ways that business can be done differently? • We'll wait for a presentation from Kellie Wasko and Jackie McCall at DOC before moving to the business practices discussion. • As for policy issues and broader system needs – do we need greater standardization? Meaning, the manner in which an offender is accepted or denied by boards (for both Diversion and Transition). • This was one of the reasons to convene this group originally. How important is the community piece of community corrections and is there a need to standardize the community corrections board process? • The differences board to board are vast. • Is it in the purview of this task force to work on pulling together education for board members? • Some board members won't ever accept certain 'types' of offenders regardless of the individual circumstances. • Yes, education is critical. Board members will often say no to offender acceptance, citing that the inmate 'Needs to do more time in DOC.' What board members don't understand is that if they deny an offender that doesn't mean they'll get more time. The main issue that needs to be clarified with board members is "What does a 'no' vote mean" – board members need to understand this piece. • Would an educational piece for community corrections boards be policy or business practice? • Could this group work on an on-line course for board members? • We should pull info from the EBDM (Evidence Based Decision Making) project in Mesa County along with what Greg is doing with the Denver board. • Boards don't just screen offenders, they also try to find locations for community corrections facilities, and they educate the community through Kiwanis and rotary clubs. • Community Corrections in general could use a public outreach and education component about what a halfway house is and isn't. Maybe in conjunction with community partners. • There are public image challenges around how community corrections is classified as corrections vs. residential facility, benefits, regulations, inmate status, etc. • The definition of 'inmate status' continues to be a huge problem with federal regulations.

Issue/Topic: (continued) Broader System Needs **Action**	• What are we currently doing that enhances and what further retards a person's chance of success. • We've advanced specialized programs in community corrections but haven't necessarily re-examined the core base structure. Meaning "vanilla beds" – should short-term, 'regular' community corrections start addressing more 'vanilla' needs. • We need to do better with RNR (risk, needs, responsivity) - rather than just dealing with the big 4 criminogenic needs, let's deal with the lower 4, too. We need to see Community corrections as staged along criminogenic needs areas structurally and programmatically AND with funding tied in as well. • There's a pilot program in Boulder to see what would happen with waiving subsistence payments. • The average length of stay in RDDT is 6 months, and then it's onto regular community corrections. • Too many people with mental health issues have been pushed into corrections due to current day lack of mental health facilities. • Both the JERP and Arches programs have a relationship with local mental health centers. • Maybe there should be a step-down program for halfway house folks with mental health issues reentering the community. • How we define community corrections in this state limits us, can we redefine, in a logical thoughtful method, a system that allows us to collaborate and take advantage of transition periods, etc.? • If we're going to redefine Community corrections, it's going to go in the direction of higher risk, higher need offenders – but this goes back to good, fast and cheap. You can't have all three, only two of those. • Maybe the system needs even longer term facilities that would be residential, but would coordinate broader community service needs with navigators, etc. • What we're talking about is a continuity of care step down program. • We don't have a good way to identify needs and connect folks with services. • Just because someone has discharged their sentence doesn't mean they're ready for next steps to reintegrate. • For those who need it and are receptive to it, is there a way to support a relatively seamless transition back to a regular life? • There is definitely a system disconnect when it comes to finding continuity of care • Is community corrections even the right <u>name</u> for us, does it relay to the public what we want to relay? Does it tell the public what we are? People think we're DOC? Are we a re-integration center, especially with including more human services, and more family, etc.? If we're moving to a different model should we have a new identifier? Or would this just be rebranding? • There's no *community* in community corrections, no ownership and engagement. • Is there a benefit to augmenting the current system to maintaining the mental health folks in their own facility, not necessarily correctional?

Issue/Topic: (continued) Broader System Needs **Action**	• Straight mental health is rare. It's almost always combined with substance abuse as dual diagnosis. • Is it time to go to the Dept. of Behavioral Health and push back? It's not okay for corrections to be the new mental health. Can we push back against being the fall-guy? • Also – keep in mind that with the flow charts we didn't get to sex offenders or parolees. The sex offender population always gets pushed to the lowest priority.

Issue/Topic:	**Discussion:**
Next Steps **Action**	Paul discussed the outcomes from this meeting with the task force members. *DISCUSSION POINTS* • Staff will pull together info and outcomes from today. • We'll have Jackie McCall and Kellie Wasko here next time with DOC perspective. • We'll drill down next meeting into a variety of issues including broader policy side.

Future Meeting Dates:

Meeting Schedule 2013

September 5th 12:30pm – 4:30pm TBD