Mental Health/Point of Contact Through Jail Release Task Force
Colorado Commission on Criminal and Juvenile Justice

Minutes

July 7, 2016 1:30PM-4:30PM
700 Kipling, 4th floor Training Room

ATTENDEES:

CHAIR

Joe Pelle, Boulder County Sheriff

TASK FORCE MEMBERS

Frank Cornelia, Colorado Behavioral Healthcare Council
Patrick Fox, Officer of Behavioral Health
Jeff Goetz, Colorado Jail Association
Tina Gonzales, Colorado Health Partnerships
Beth McCann, State Representative, District 8
Norm Mueller, Defense Bar
Abigail Tucker, Community Reach Centers
Dave Weaver, County Commissioner
Doug Wilson, State Public Defender

ABSENT

John Cooke, State Senator, District 13
Charlie Garcia, CCJJ Member At-Large
Evelyn Leslie, Private Mental Health Provider
Matthew Meyer, Mental Health Partners
Joe Morales, Parole Board
Charles Smith, Substance Abuse and Mental Health Services Administration

STAFF

Richard Stroker, CCJJ consultant
Christine Adams, Division of Criminal Justice
Kim English, Division of Criminal Justice

Issue/Topic: Welcome/Introductions **Action:**	Discussion: Sheriff Pelle opened the meeting by asking members to introduce themselves and who they represent. Richard Stroker then introduced himself as the new CCJJ Consultant who will be working with the group to help them move forward with their work. Mr. Stroker stated that he has worked in this field for 38 years and in South Carolina at the Department of Corrections for 25 years in a variety of criminal justice areas. He has been a consultant for the Center for Effective Public Policy for the last 13 years where has been able to work in all 50 states. Mr. Stroker stated that he is here to help and that later in the discussion he hopes to help the group develop their area of focus, structure and process. Sheriff Pelle stated that the group has spent the first meeting discussing the problems and that by the end of this meeting may decide the area of focus.

Issue/Topic:	**Discussion:**
Colorado Behavioral Health 101 **Action:**	Dr. Fox and Mr. Cornelia presented information on the Colorado Behavioral Health Care system and Community Mental Health. The slides used during this discussion are provided online (at colorado.gov/ ccjj/ under - Mental Health/Jails Task Force, "Materials"). Colorado Behavioral Health Care System Dr. Fox stated that the system is very complex, including how it is organized and how it is paid for. Information on the organization and interaction of the Department of Human Services with the Department of Health Care Policy and Financing (HCPF) Behavioral Health and Managed Care Section, Department of Public Health and Environment (DPHE) and the Department of Regulatory Agencies (DORA) are provided online (at colorado.gov/ccjj/ under - Mental Health/Jails Task Force, "Materials"). These agencies regulate and manage the three primary ways that health care is paid for including Medicaid (HCPF), insurance (DORA) and indigent funds (DHS). Dr. Fox explained that the Office of Behavioral Health (OBH) has two parts: the mental health institutes and the community mental health providers. The institutes include the 449 licensed beds at Pueblo (300 of which are forensic) and the 94 beds at Fort Logan (which is predominantly civil). Community behavioral health services has approximately $145 million budget, most of which comes from general funds (state dollars) along

	with some cash funds, reappropriated funds and federal funds. The federal funds are Block Grants, the majority the majority of which is for substance abuse. Many other states have their Block Grant funds allocated in a similar way. The Crisis Response System was established to create crisis support lines, walk-in centers, stabilization units, mobile care and respite care ($20 million allocated for these services) and a 24/7 hot line/warm line system ($4.4 million) and a media campaign ($600,000). The hot line/warm line program went live in December 2013 while the stabilization, mobile and respite units went live in December 2014. The OBH is the single state authority within DHS for administering the Federal Block Grant. OBH also licenses substance abuse facilities and manages the civil commitment under Colorado Revised Statute, Title 27, Articles 80, 81 and 82. The issue of mental health holds, psychiatric hospitals, and related licensing are also included in the behavioral health statutes (Title 27, articles 65-69). Dr. Fox feels that we have a fractured system because the DPHE license's various facility types and for reasons he is not sure about historically, the OBH funds substance abuse facilities. This may not be the most efficient way to govern. He feels that as we discuss these issues we should consider if it make sense for the OBH to issue these licenses. Regarding unmet need trends, Dr. Fox stated that housing is an issue and that vouchers cannot compete with the rising cost in many areas even if they are areas where the population itself is not rising. This is particularly true in the recreational, or ski resort, areas where individuals cannot earn a living wage. Individuals with co-occurring service needs are also a challenge. Some facilities are able to provide mental health and substance abuse services concurrently while other individuals must go to one service or another independently. It is often difficult to receive holistic treatment. However, this is less of an issue in the metro area. A needs assessment study was conducted to identify service gaps and Dr. Fox noted that that the OBH is working with HCPF to better align funding sources to remove these gaps. He stated that funds may become available as people migrate out of the indigent population and into Medicaid but the use of those funds still must be decided. Dr. Fox feels it would be useful for those funds to be used to create a more comprehensive delivery of services and for those services to be available across the state. OBH is also working to align regulatory efforts with other state agencies

	like HCPF to see if it would be possible to audit entities simultaneously instead of multiple times a year. Dr. Fox stated that this was begun about 1.5 years ago and seems to be working well. Dr. Fox stated that approximately 20 years ago there were discussions about the specific allocations of beds. Bed allocations were generally distributed by region. The Denver-metro area had beds at the Mental Health Institute at Fort Logan while the rest of the state had beds at the Mental Health Institute in Pueblo. But Fort Logan has been reduced from about 225 beds in CY 2000 to 94 beds today. Some of those allocated beds went to Pueblo. This resulted in situations where someone at the Arapahoe County Detention Facility, which is 15 miles from Fort Logan, is sent to Pueblo (approximately 110 miles away) because of where the beds are located. The DHS is currently looking at ways to reallocate those beds more appropriately. Sheriff Pelle asked what the status of the facilities is that were closed (e.g., were they repurposed, empty). Dr. Fox stated that at the Mental Health Institute at Fort Logan the units no longer meet safety codes and there is no grandfathering allowed. They did renovate one unit and it was very expensive. The other units would require even more massive renovations or they must build new. Funding has been received to conduct site master plans for both campuses and those are ongoing now. It is hoped that a report will be received by the end of September to help determine what would need to be done to bring those locations up to code and to be able to house more patients. A challenge is that this will be a huge financial cost, both capital and operational. A 24/7 facility is expensive because you must cover all three shifts. Dr. Fox stated that the patient to staff ratios in Colorado Mental Health Institutes is lower than many state psychiatric hospitals across the country. In comparison to jails where physical barriers are used, these are open units where more staff is necessary. Jails are predominantly custody staff with a complement of treatment staff whereas the Mental Health Institutes have a significant contingent of healthcare staff. In order to meet the Medicaid standards the Mental Health Institutes must have a full complement of treatment team (i.e., rehab and physical therapists, social workers, psychologists, psychiatrists, medical clinic services, pharmacists, and dietary staff). Dr. Tucker asked if Dr. Fox was aware of the cost per square foot. She noted that she was curious because jails are essentially building mental health units and she is curious about the cost difference. Dr. Fox stated that he does not know the cost per square foot but he does know that the per diem for one of the hospital beds varies between $676 to over $900 at Pueblo and approximately $800/day at Fort Logan. Sheriff Pelle stated that is roughly 10 times the cost of incarceration. Dr. Fox then stated that

the per diem for inmates in the RISE program at the Arapahoe County Detention Facility is $308. That is approximately 2.5 times less expensive than the mental health hospitals.

Dr. Tucker stated that what she finds disappointing is that mental health hospitals are likely much more successful in recovery than jail based systems but that data is not usually presented in this ways. Dr. Fox agreed and said that the cheapest way to handle people with brain disorders is to keep them in jail rather than building more mental health institutes. There are other alternatives between jails with no site services and intensive inpatient hospitals. Jails can have programs built into them that offer some services like the RISE program in Arapahoe County. The per diem is high for a jail restoration program but that is because many jails across the country have programs where mental health providers stop by the jail but are not on permanent staff and actually built into the system.

Dr. Fox stated that we have to decide what the important factors are. If cost is all that matters the answer is simple and unfortunate. Or we must determine how much capacity we want to build in the jails or how to avoid bringing them into the jails at all.

Dr. Fox stated that the WICHE study is available on the DHS/OBH website (https://sites.google.com/a/state.co.us/cdhs-behavioral-health/home-old/news-resources-reports--publications).

Community Mental Health Centers

Mr. Cornelia stated that he would discuss community based providers and community managed care organizations but wants to first reiterate that the Colorado Behavioral Healthcare Council (CBHC) is a membership organization and does not provide clinical services; they are occasionally a fiscal agent for a grant program (e.g., currently the Mental Health First Aid program) and they will be celebrating their 50th anniversary in 2017. They have a long history of advocacy for mental health care.

The OBH provides the majority of licenses around the state but there are approximately 700 licenses for substance use as well as other provider types that are not CBHC members. In addition, there are other organizations that represent substance abuse providers. CBHC's largest membership category is the Community Mental Health Centers (CMHC). The handouts provide a map of the areas that each CMHC is responsible for are provided online (at colorado.gov/ccjj/ under - Mental Health/Jails Task Force, "Materials"). These areas are not codified in statute but are based on a grant program that was initiated in 1963 with some modifications since then. The newest CMHC is the Aurora Mental Health Center.
CMHCs cover the entire state and all are not for profit. They use a variety

	of funding sources including Medicaid and other grants, gifts and donations. The OBH provides a very small portion of their total funding. The impact of the lack of treatment impacts the criminal justice system by affecting emergency room access, homelessness, and suicide rates (CO is 7th in the country). In addition, as we have discussed, there was the issue of deinstitutionalization. There was originally a plan to create 1500 CMHCs nationwide with the purpose of providing counselling, education/prevention, inpatient/outpatient services, emergency response, and partial hospitalization. Colorado statute still reflects this definition of community mental health. It may be useful to think about whether this is the definition the group want CMHC's to maintain. Mr. Cornelia stated that many CMHCs provide school based services as these programs are designed to meet local needs. Thus, there is a lot of regional variability. Some specialty mental health clinics include the Asian Pacific Development Center and Servicios de La Raza. These clinics and other specialty clinics serve specific populations. There are four Managed Service Organizations (MSOs) that contract with the state to fund substance abuse programs. We have seven sub-state regions. The handouts provide a map of the areas within each sub-state planning area (SSPA; colorado.gov/ccjj/ under - Mental Health/Jails Task Force, "Materials"). Some MSOs manage multiple SSPAs. Funding is distributed to the SSPAs proportionally. These providers (approximately 40 across the state) deliver everything from detox to residential and every service in between. There are five behavioral health organizations (BHO; colorado.gov/ccjj/ under - Mental Health Jails/Task Force, "Materials"). The BHO system was founded in 1995 and is responsible for 1.3 million Medicaid plan members. This in not necessarily the number of people receiving services but the number they are responsible for. If someone is Medicaid eligible they may be privately insured or not have insurance. BHOs are responsible for providing access to services for everyone that is eligible for Medicaid. Nor does it mean that they are responsible for the entire population of Colorado (approximately 4 million). A few years ago CBHC contracted with an external company to conduct a cost/benefit study and found that the BHO system saved Colorado approximately $100 million since its inception in 1995. The payment method is a provider driven / managed care / risk model vs. a traditional managed care risk models. What this really means is that providers are incentivized to keep people out of higher cost services. This drives a full continuum of prevention services. Mr. Wilson stated that he was confused about the funding and how this

	was related to a possible new source of funding discussed last month. Mr. Cornelia and Dr. Fox explained that BHOs receive a certain amount per month regardless of the number of people they serve. But the incentive to treat these people in the community and avoid the catastrophic costs of hospitalization if they did not treat them. In addition, Dr. Fox stated that Colorado is already an Institutions for Mental Disease (IMD) state. The Medicaid Institutions for Mental Diseases exclusion prohibits the use of federal Medicaid financing for care provided to most patients in mental health and substance use disorder residential treatment facilities larger than 16 beds. But there is still an opportunity to reach out to jails. We could possibly relax the rules that had previously prevented the use of these funds to treat individuals on probation and parole. It may not increase or incentivize hospitals to build beds. It is not a new tool because our state is already one of the 15 IMD states. Dr. Fox stated that Medicaid, at the state level, does not pay for IMDs, but you can seek a waiver. We have a 1915-B3 waiver that states that we will provide certain services which allows us to use state level Medicaid money to pay for IMDs. However, this money can only be used for private providers that are not normally payable with Medicaid money. Dr. Tucker stated that another limitation is the number of days people are in an institution. While the average length of stay is only 7 days, the limitation of only 15 days may not be enough for some patients. Mr. Cornelia went on to say that crisis service providers are not members of CBHC but provide mobile and respite care, crisis walk-in centers and crisis support lines services. There are seven community mental health centers in the Denver-Metro area, including Boulder. These centers provide walk-in and crisis stabilization units. There are also multiple units around the rest of the state. Mental Health First Aid Colorado (MHFA) is a community coalition that provides leadership from CBHC. CBHC's hope is that one day MHFA will be as common as CPR first aid is. They want lay people to recognize a need for mental first aid. Sheriff Pelle stated that the Boulder County EDGE program uses MHFA, and the Sheriff's Office uses MHFA as a CIT (Crisis Intervention Team) refresher since officers were first trained in CIT 15 years ago. Also, MHFA is a good way to start people quickly learning about these issues. Ms. English asked how the Arapahoe County RISE program was funded? Dr. Fox stated that it was funded through state general funds and that it was part of Governor Hickenlooper's "Restoring Individuals Safely and Effectively" Initiative. OBH wanted to preserve hospital bed space because there's been a 500% increase in competency evaluation requests over the last 10 years and the number of restorations has doubled. As a result of this and as part of the settlement agreement to see people within

	28 days, OBH would like to expand Ft Logan to 244 (from the current 94) beds and expand Pueblo by 16 beds. The design would be for civil with enhanced security (but not maximum security) beds. With the DOC and San Carlos on the same campus their biggest limitation is recruiting and retaining staff in those geographic areas. It is much easier to maintain staff in the Denver-metro area. Representative McCann asked about a pediatric facility to which Dr. Fox replied that Ft Logan does not currently involve a child facility but the units would not be built for specific populations so as needs change the composition could change as well. Ms. Gonzales stated that the RISE program was originally only accepting referrals from 10 counties, none of which were the counties she works with. She asked if this had changed. Dr. Fox stated that now referrals from all counties are accepted. He believes a notification was sent to Judicial this week regarding the ability for all defendants, regardless of county, to apply for the RISE program. Ms. English also asked about the $25 million that was applied to the Crisis Services. Was this also from Governor Hickenlooper's plan? Yes. Dr. Fox stated that it was originally a lower amount of money (approximately $10 million), but with stakeholder input, and the fact that this was something that Jeanne Ritter was very involved with, the funding was increased to $25 million.

	Discussion:
Issue/Topic: Sequential Intercept Model **Action:**	Dr. Atchity will discuss the Sequential Intercept Model from a health perspective (see colorado.gov/ccjj/ under - Mental Health/Jails Task Force, "Materials"). He began by stating that the Equitas Foundation began about 20 months ago as private foundation by philanthropists who, who due to family issues, found the intersection of the criminal justice and mental health systems. The foundation does not provide funds but supports a continuing focus on this topic by reaching out to large and small groups as well as helping with the dissemination of information and with events about this topic in Colorado and nationally. Dr. Atchity stated that when you look at the Latin word "health" it is similar to the word "whole." But he feels that really, we come at it from a fragmented approach, which is not successful. Society cannot look criminal justice and mental health separately but must look at what the person needs as a whole. He asked how many times we should do the same thing where a quarter of the population fails before we revise our practice. Other fields, farmers for instance, would not allow 25% of their crop to fail over and over again without changing their procedures.

	The Sequential Intercept Model was developed by the Gains Center within SAMHSA. There are 5 intercepts: 1. Law enforcement • When 911 is called; the first people on the scene. • CIT training is all about recognizing a mental health crisis. 2. Initial detention/initial court hearings • Public defender and district attorney cooperation to identify someone who will benefit from treatment rather than immediate criminalization. 3. Jails/Courts • Opportunities to manage those who are in custody as well as using specialty courts to handle those who have been arrested and/or charged. 4. Reentry • Provide access to care for a smooth hand off when transitioning back into the community. 5. Community corrections • This addresses the way probation and parole can provide health care that is not focused on criminal management. Dr. Atchity stated that we can begin a sequential intercept model conversation at any point and discuss where the gaps exist and where communication or promising steps exist. But Dr. Atchity feels that from a broader community health perspective it may be “too little, too late.” He feels that from a civilized perspective we should not want to manage our mental health through the criminal justice system. He went on to say that it is unfortunate that our society defaults to primary care for healthcare when it is really a community health issue. Access to these kinds of systems has been low but things like the Affordable Care Act provide new financing structures that are tipping the scale to help us think more about population health. Dr. Atchity stated that one benefit of these recent changes has been our access to data. We’ve found that 20% of the people are responsible for 80% of the cost and of those 20% we’ll find that 20% have serious diagnoses and are responsible for a large amount of the costs. It’s appropriate that these people cost so much. But another large percent will have problems such as mental health or substance abuse, obesity or cardiopulmonary issues (issues that Dr. Atchity said are a result of not taking care of ourselves early on). We need data integration to best help these people and while we have a ton of anecdotal understanding of the problems, our data systems are not connecting.

	When referring to his handout from the Marshal Project (see https://www.themarshallproject.org/2016/05/15/13-important-questions-about-criminal-justice-we-can-t-answer#.JucrTEJpd [1]) there are many things we do not know about the criminal justice system. This is a national problem. We do not want to wait for criminal justice to become involved with someone with mental health vulnerabilities and we do not need the criminal justice system to be one's first connection with mental health resources. Project Launch is an example of an education based system meant to help individuals avoid the criminal justice system. We know that the odds of someone who has been suspended or expelled from pre-school going on to the criminal justice are extremely high. So efforts for discipline related to restorative justice have been made. Dr. Atchity went on to say that when you go to jail in this country it seems you are damned for life given the subsequent collateral consequences of arrest and confinement. There are whole industries that acknowledge that people should be employable and educated. But this is just the tip of the iceberg if we believe in corrections. Housing is an important issue as it is difficult to receive the needed treatment if one is homeless. Housing is often the bottom line. Another important issue includes "coverage to care." There are approximately 20 million more people in this country with access to care since the Affordable Care Act passed. This is a promising moment but there are still bed and provider shortages. It is still cheaper to lock people up than to treat them. Sheriff Pelle stated that from the time of our initial contact we have discussed the need for continuity of care. But the challenge for this group will be determining what the statewide barriers are. What services need to be provided to provide this sequential intercept model? Dr. Atchity stated that what Equitas has is support for this goal and the ability to disseminate information and help with communication to help promote the shifting of funds. Mr. Wilson stated that we put a lot of money into this but we do a lot of this post-charge or post-conviction. The only alternative for the defense is to raise competency issues. He stated that if this group could increase attention to intercepts 1 and 2 pre-plea, the defense bar would be able to support this. To Mr. Wilson, diversion is something that happens before charges are filed. He feels that court should not be used as coercion. Sheriff Pelle noted that if you have someone who is mentally ill but unwilling to be treated the only way to get them treatment is to arrest and

[1] Note that this was passed out as a handout but did not print correctly so it is suggested that the link be used instead.

	charge them. He stated that there has to be some acknowledgement that we will always have some people in jail with mental health problems but programs like EDGE allow for a warm hand off. However, Sheriff Pelle agreed that there may be room for pre-plea steps, particularly if we have stabilization. He noted that 1600 people were handed off to EDGE and not arrested last year.

Issue/Topic:	**Discussion:**

Follow-Up From June Meeting
 	
Action:
 	
Mr. Goetz will send the revised survey out to the county jails.
 	
Ms. English will look into what information may be available about jail "frequent flyers".
	One of the things we wanted know about was the size and characteristics of the mentally ill who are currently in jails. Jeff Goetz is developing a survey to send to the jails. One thing Sheriff Pelle wants to know is how many people in each jail have an Axis I diagnosis on any given day? It might not be possible for every jail to answer this question but most do some sort of assessment. Also, how many inmates are acutely mentally ill and should be in some other facility?
	
	Mr. Goetz stated that through the Colorado Jail Association (CJA) he has developed a few survey questions that will be asked. Jails are aware that a data request is coming but this group should note that it will only be from 40 counties. Sheriff Pelle asked the group if there are questions they want to Mr. Goetz to include on the survey.
	
	Main Areas of Focus:
	• What does the jail population look like regionally and statewide?
	• What is the average number of inmates in custody that have an Axis I thru V diagnosis?
	• What is the average number of inmates that need treatment?
	    o This includes those who utilize the jail frequently and are known to have issues but who have not been seen yet.
	    o Mr. Goetz stated that we know that 20% of our population takes up approximately 90% of our time.
	• Who is providing the mental health services in the jail?
	    o Sheriff Pelle stated that in just Boulder there are four different providers.
	    o We need to make sure we look at the way systems are paying for services r to ensure that line items are not missed.
	• It may be useful to ask about how much service providers are charging.
	    o Medication formularies are different between different sized jails. One of the purposes of the state Medication Consistency Work Group is to make sure the medications are consistent and constant. Previously patients would receive high dollar samples but then they would have

	expensive prescriptions. So one thing is to ensure that generic brands are used. • For individuals who are not covered by Medicaid, is there any kind of enrollment program? Mr. Wilson asked if when this group is discussing people in the jail that they are talking about those that have been booked, not those that were the issue in Senate Bill 16-169 (M1s -- those who are in jail for a 72 hour mental health hold because they are an imminent danger to themselves or others). Sheriff Pelle stated that these individuals are not really an issue for front range jails, only in rural areas (e.g., Delta) where options for placement are severely limited. Sheriff Pelle assumes that most, if not all of the individuals who would fall in this category, are brought to the Denver area for a secure bed. But he agreed that this is something to add to the survey. • A question to add, to address this issue, would be if a jail accepts M1s and if so, how many annually? Mr. Wilson also asked if we know what the charges are for the people sitting in jail are? We could have high risk/high charge or low risk/low charge individuals, both with axis I diagnoses but who should not be sitting in the jail. Sheriff Pelle stated that we can add this to the survey but noted that reporting will be disparate because the research needed for this information will be big. Ms. English stated that this information may be available from the County Planners who have access to jail data. She also stated that DCJ does not have access to this data but they do work with the county planners so she will check with them to see what data is available. Sheriff Pelle stated that we may have created a research project. Dr. Tucker noted that instead of creating a new research project we could take the Adams County project which will be on an open source data sharing system and expand it to other counties to create their own systems.

Issue/Topic: Next Meeting/Work Plan **Action:**	**Discussion:** Mr. Stroker summarized this afternoon's meeting by stating that it may be useful if we categorize the problem areas into two major categories and then list the themes discussed today: Diverting people out of the criminal justice system • Need for data and information • Explore and expand promising initiatives regarding diversion programs (e.g., Seattle, Charlotte, NC) • Divert people from the system pre-plea • CIT training – Consider arrest decision making options • Understand local and state system providers • Better understand cost and funding options • Frequent jail utilizers (low level offenses) Incarceration • Need for data → survey will answer population questions • Need to define extent of present mental health / behavioral health issues and options • Recognize there will be some individuals with acute mental health / behavioral health needs – need effective response options • Need to share information /data • Need to understand service options and opportunities • Better understand costs/funding • User of jails for M1s (72 hour holds) These are the themes Mr. Stroker heard today, not solutions. At the next meeting he would like to spend time discussing breaking into groups that may work on these topics, what should be focused on, and who else we might need to bring to the table. Mr. Stroker stated, and Sheriff Pelle and the others agreed, that these lists are long and the group's time is short so it may be most useful to decide which issues to tackle. It will be more productive to work on a few things rather than working so broadly that we cannot achieve anything in such a short time.

Adjourned at 4:30 pm

Next meeting: August 11th, 700 Kipling, 4th Floor training Room, 1:30 – 4:30pm